

As Trusts were able to determine their own local approaches to undertaking mortality review and defining those deaths which should be in scope for review, mortality data is not comparable between Trusts. As such, the Trust is using the data locally to monitor the review of mortality and to assist in the ultimate aim of learning from deaths and improving the quality of services. Due to the nature of the services provided by the Trust, there will be a number of deaths that will be 'expected'. Nevertheless, we are always mindful that even if the person's death was 'expected', their family and friends will feel deeply bereaved by their loss and we are putting in place enhanced processes to support people who have been bereaved by a death of someone in our care. We will also be undertaking a review of a sample of these 'expected' deaths to identify any learning in terms of the quality of our care provision.

Explanatory notes

** Please note, all figures stated in the section below relate to deaths 'in scope' for mortality review. Deaths 'in scope' are defined in the Trust's Mortality Review Policy as:*

- all deaths that have occurred within Trust inpatient services (this includes mental health, community health, learning disability and prison inpatient facilities);
- all deaths in a community setting of patients with recorded learning disabilities;
- all deaths meeting the criteria for a serious incident, either inpatient or community based;
- In addition, from 1 October 2017, any other deaths of patients in receipt of EPUT services not covered by the above that meet the criteria for a Grade 2 case note review – these are identified on a case by case basis and will include:
 - any patient deaths in a community setting which has been the subject of a formal complaint and/or claim by bereaved families and carers;
 - any patient deaths in a community setting for which staff have raised a significant concern about the quality of care provision;
 - any deaths of patients deemed to have a severe mental illness in a community setting – for the purposes of this policy, this will be deemed to be any patient with a psychotic diagnosis (schizophrenia or delusional disorder) recorded on electronic clinical record systems that are recorded as having been under the care of the Trust for over two years.
- any deaths identified for thematic review by the Mortality Review Sub-Committee (including a random sample of 20 expected inpatient deaths per annum).

Figures are only stated for Q1 – Q3 of 2017/18. Q4 information will not be reported to the Board of Directors until June 2018. Information in relation to Q4 2017/18 (and updated information in relation to Q1 – Q3 2017/18) will, therefore, be reported in the Trust's Quality Account for 2018/19.

At the time of preparing this Quality Account, the thematic reviews and expected inpatient death review sample for 2017/18 are in the process of being defined and commissioned and figures are therefore not included within the data below. Information in relation to thematic reviews including the random sample of 20 expected inpatient deaths will therefore be reported in the Trust's Quality Account for 2018/19.

The figures contained in this section of the Quality Account are consistent with the agreed approach for reporting quarterly information to the Board of Directors and are reported as at 20 March 2018.