Learning from Deaths
Trust Board in public

Date: 30th August 2018
Agenda item: 2.4

| Executive sponsor          | Professor Des Holden – Medical Director  |
|                          | Dr Richard Brown – Director of Outcomes |
| Report author(s)          | Jonathan Parr – Clinical Governance Manger |
|                          | Richard Brown – Director of Outcomes |
| Report discussed previously: | Mortality Group |
| (name of sub-committee/group and date) | Executive Committee for Quality and Risk (Aug 2018) |

Action required:

| Approval ( ) | Discussion ( ) | Assurance (✓) |

Purpose of report:

This report is presented to the Trust Board (in public) as a quarterly updated in the Learning from deaths learning disability reviews

Summary of key issues

- 5 deaths of learning disability patients have been reported in in Quarter 1
- All 5 patients are waiting for SJR review by Chiefs
- A previous case which was discussed at Chiefs has been forwarded for a more detailed RCA
- During Quarter 1 there were 304 deaths in the Trust
- Based on the Trust categorisation of deaths there was 1 which was a category 3 where there may have been suboptimal care however different care might reasonably be expected to have affected the outcome

Recommendation:
- The Trust Board note the contents of the report.

**Relationship to Trust strategic objectives and assurance framework:**

SO1: Safe – Deliver safe, high quality care and *improving* services which pursue perfection and be in the top 25% of our peers

SO2: Effective – As a teaching hospital, deliver effective and improving sustainable clinical services within the local health economy

SO3: Caring – Work with *compassion* in partnership with patients, staff, families, carers and community partners

SO4: Responsive – To *continue to be* the secondary care provider of choice for the *people of our community*

SO5: Well led – To be a *high quality* employer of choice and deliver financial and clinical sustainability around a patient centred, clinically led leadership model

**Corporate impact assessment**

<table>
<thead>
<tr>
<th></th>
<th>Compliance with LeDeR regulations. CQC Effectiveness Domain.</th>
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<tbody>
<tr>
<td><strong>Legal and regulatory</strong></td>
<td><strong>impact</strong></td>
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<td></td>
<td><strong>Financial impact</strong></td>
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<tr>
<td></td>
<td>None directly in relation to this paper</td>
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<tr>
<td><strong>Patient experience/engagement</strong></td>
<td>Medical Examiners contact relatives/carers as part of the M.E Programme</td>
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<tr>
<td><strong>Risk and performance management</strong></td>
<td>Issues identified with categorisation of deaths being in line with national SJR categories.</td>
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<tr>
<td><strong>NHS Constitution/equality and diversity/communication</strong></td>
<td>Supports the NHS Constitution</td>
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**Attachments**

- Learning from deaths dashboard
Learning disability deaths and mortality review
Trust Board in public

Date: 30th August 2018

1. Introduction

The Learning Disabilities Mortality Review (LeDeR) Programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015 for an initial three-year period.

A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The Programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR Programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

At the completion of the initial review the local reviewer will decide if a full multi agency review is required or not. If not, the local reviewer will complete an action plan detailing any learning points or recommendations that should be considered which will be fed back to the Trust. If there are any areas of concern in relation to the care of the person who has died, or if any further learning could be gained from a multiagency review of the death that would contribute to improving practice, the death will be subject to multiagency review with once again any actions fed back to the Trust where required.

2. Process at SaSH

The process for notification at SaSH lies with the Clinical Governance Compliance Manager. LD Deaths are presently picked up using a number of sources as there is presently no one reliable way to identify LD patients in the organisation. However using one or more of the following has ensured we identify any patient with a learning disability dying at the Trust:

- CERNER Flag
- Notification from Medical Examiner/Bereavement Office
• Coding
• Safeguarding
• Direct report from member of staff caring for patient.

Once identified, the Clinical Governance Compliance Manager notifies the LeDeR team via the online form. They also act as liaison with the external reviewers.

3. LeDer Quarter 1 2018/19 Update

The Trust has reported 5 deaths of people with Learning Disabilities to the LeDeR team, 1 from Sussex patients the remainder for Surrey based patients.

![Bar Chart: LeDeR Notifications 17/18]

Following notification, the CCGs are then responsible for the review and there has been no further feedback from the CCGs on any investigations of our patients. The main reason for this has been delays in completing reviews primarily due to the moderation stage from the central LeDeR team in Bristol. It was agreed at the last regional LeDeR steering group meeting that there is no need to wait for the case to be approved by the LeDeR team to take the learning from it and can be done as soon as the review is complete. This would be looked at further when there is a workshop being run for reviewers from across the region in October. It was also noted that additional monies are now being made available to CCGs to take on further reviewers to address with the backlog, an issue not unique to our region.

The process for identification of deaths of patients within the Trust now seems to be more embedded with less delays in timescales between the notification of death and the notification to LeDeR.
In addition to the external reviews, the Trust continues to review any LD death using the RCP Structured Judgement Review template. These are being completed by the Divisional Clinical Chiefs and then scrutinised at the Chiefs meetings. However, there is now a small backlog but this was raised with Chiefs and there is plan to get on track by end of Qtr2.

Monthly reports also come to the Mortality Group.

4. All Trust Deaths - Quarter 1

At the Trust we review deaths in a number of ways. Every person who dies is subject to a review. The level of review will differ dependent on the individual circumstances relating to the death. The Trust has been piloting a Medical Examiner programme whereby all deaths are reviewed by one of a group of senior consultants.

The overall number of deaths in Qtr 1 was 304. Of those 228 were assigned a category of death which is 75%. Of this group 208 were assigned category 1 which denotes no concerns with the care and or that the death was expected or unavoidable, this accounts for 91% of patients who had been categorised. There were 19 deaths categorised as 2 which is still expected and/or unavoidable however there may be some areas of improvements. Category 3 there was 1 death, suboptimal care however different care might reasonably be expected to have affected the outcome. For these deaths many are Sis and are subject to detailed RCAs.

Where we do not have a category of death this is often due to the death being referred to the coroner.

There is a need to review the categories of death used as there is some inconsistencies. This has been discussed at the Trust Mortality group and a new proposed category system will be discussed in September Mortality Group for roll out.

7. Recommendation
That the Trust Board note the contents of the report.

Jonathan Parr
Clinical Governance Compliance Manager
Dr. Richard Brown
Director of Outcomes
August 2018