Quality Committee - Cover Sheet

Subject:	Learning from Learning Disability Deaths	**Date: 21/09/2022**	
Prepared By:	Lisa Richmond – Learning Disability Specialist Nurse		
Approved By:	Dr D Selwyn		
Presented By:			
Purpose			
To provide Quality Committee with an update on specific Leaning Disability aspects from the Learning from Deaths programme		**Approval**	**x**
		Assurance	**x**
		Update	
		Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
x			**x**	

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		x		

Risks/Issues	
Financial	
Patient Impact	
Staff Impact	
Services	
Reputational	

Committees/groups where this item has been presented before

Executive Summary

A new National LeDeR policy was published in March 2021, with an expectation for Integrated Care Systems (ICS) to implement key changes in the policy by the 1st April 2022.

The acronym LeDeR is still being used but this now stands for 'Learning from lives and deaths – people with a learning disability and autistic people'.

Key focus and vison are for an ICS that systematically acts upon findings in LeDeR reviews and improves the quality of care provided to people with learning disabilities and autism in order to improve outcomes, stop people from dying prematurely and embed system-wide learning and improvement.

Since March 2022, there have been 14 deaths in patients with learning disabilities in the trust.
- 4 of the deaths were respiratory related.
- 7 of the deaths currently have no death certificate available or are still with the coroner.
- 1 of the deaths was a bowel perforation, 1 was metastatic oesophageal cancer, and 1 was an intracerebral brain hemorrhage.
- There were more male deaths than females. 9 of these were male, and 5 were female.
- Patients were primarily from a White British background.

The LD nurse receives data shared from the LeDeR reviews on a bimonthly basis relating to patients who have died whilst at Sherwood Forest Hospitals. The aim of this is to look for themes and trends which can support learning across the organisation. During the period from March 2022, there were 5 reviews completed, and the remaining reviews are still ongoing.

Of the 5 reviews that have been fed back to the LD nurse, 1 was a focused review. The reason for this means they took more time to gather information due to the cause of death being one of the 4 core areas of focus for Nottingham and Notts ICS: Non-LD Autism, Deaths within BME groups, Respiratory Health, Sepsis.

Some of the themes identified from SFH data included:

-Recognition of frailty and comorbidities should have led to an earlier discussion of the implementation of a ReSPECT form.

-MCA documentation and ensuring that the medical team is adhering to MCA principles. From the focused review, it was highlighted that the ReSPECT documentation stated both had capacity and lacked capacity.

- To ensure that documentation is clear and concise based on thorough assessments.

There were however positive areas of practice feedback:

- Families were kept involved in making decisions.

-External carers were able to visit one of the patients and spend time with him (during the Covid restrictions period).

There were issues identified relating to the quality of the SCJRs . Some information received has been too sparse to add to the review. This has been found at both SFH and other acute hospital providers.

There was poor response to a request by supported living placement for resources around staffing when patient became increasingly frail and increase in physical health needs. This issue is not isolated to SFH.

Issues relating to ReSPECT forms for LD patients has been identified as an internal challenge. The LD nurse continues to meet with the Senior Resuscitation team to look at the quality of ReSPECT forms for LD patients and the LD nurses sits as part of the ReSPECT development group to support the ongoing work within the organisation to try and support the clinical team with the issues identified from the LeDeR reviews.