Agenda Item No.8d

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Emma Hardwick	Decision		High	Med	Low
	Discussion	√		√	
	Information				
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
Alison Webb	Strategic				
	Operational	√			
	Governance		**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
CQC Domain: (safe, caring, effective, responsive, well-led)	Safe, effective, responsive.				

Meeting Date: 29th January 2019

Report Title: QEH response to LeDeR Annual Report

PURPOSE:

The purpose of this report is to provide the Board with information for discussion and strategic development following the completion in December 2017 of the Learning Disabilities Mortality Review (LeDeR) Programme Annual Report and its subsequent publication in May 2018.

The recommended action in this report will help deliver improved outcomes for stakeholders and ensure the Trust is meeting its statutory reporting requirements.

SUMMARY:

The Learning from Deaths Mortality Review Programme identified 9 recommendations to improve the quality of health and social care provision for people with learning disabilities; using these recommendations, 9 action points have been developed to ensure that the Trust is acting on the recommendations made and that it is meeting its statutory requirements.

RISK ASSESSMENT (CROSS-REFERENCE WITH RISK REGISTER WHERE APPROPRIATE):

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience
√	√		√	√	√

RECOMMENDATIONS / ACTION POINTS

- To develop a robust system for reporting and investigating every death of a person with Learning Disabilities.
- All internal investigations to be reported back to the mortality review committee and

learning to be shared.

- To review and update the Trusts learning from Deaths policy.
- All patients with Learning Disabilities accessing the Trust should be asked for a copy of their Health Action Plans.
- The named health care co-ordinator of those with two or more long term health conditions should be identified and recorded in the patient's record.
- Improve identification and recording of reasonable adjustments; including a regular audit schedule for reasonable adjustments.
- Regular review of the provision of mandatory learning disability awareness training.
- Develop easy read literature for patients and carers around pneumonia and sepsis.
- Review training provided around MCA and audit of compliance.

Background

The Learning Disability Mortality Review Programme (also known as LeDeR) was established to drive improvement in the quality of health and social care service delivery for people with learning disabilities (LD) by looking at why people with learning disabilities typically die much earlier than average. The programme has been commissioned by HQIP on behalf of NHS England and is being led by the University of Bristol's Norah Fry Research Centre. The requirements of LeDeR are also supported by the National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care, National Quality Board 2017.

Through local and national retrospective reviews of deaths, health and social care professionals, and policymakers will be supported to understand causes of death and amenable factors contributing to the overall burden of excess premature mortality for people with learning disabilities. The programme will identify variation and best practice and assess the impact of service change leading to the identification of key recommendations for improvement.

The National Learning Disability Mortality Review Programme is working with other agencies such as the Learning Disability Public Health Observatory and the Transforming Care (Winterbourne View) Improvement Programme to reduce such health inequalities faced by people with learning disabilities.

The programme has developed a review process for the deaths of people with learning disabilities. All deaths receive an initial review; those where there are any areas of concern in relation to the care of the person who has died, or if it is felt that further learning could be gained, receive a full multi-agency review of the death. Deaths subject to the current priority review themes (aged 18-24years or from a Black or minority ethnic background) receive multi-agency review and expert panel scrutiny. At the completion of the review, an action planning process identifies any service improvements that may be indicated.

National Reporting

The LeDeR annual report 2016-2017 identified that from 1st July 2016 to 30th November 2017, 1,311 deaths were notified to the LeDeR programme. The most frequent role of those notifying a death was Learning Disability Nurse (25%), most commonly working in a Community Learning Disabilities Team.

Key information about the people with learning disabilities whose deaths were notified to the LeDeR programme includes:

- Just over half (57%) of the deaths were of males
- Most people (96%) were single

- Most people (93%) were of White ethnic background
- Just over a quarter (27%) had mild learning disabilities; 33% had moderate learning disabilities; 29% severe learning disabilities; and 11% profound or multiple learning disabilities.
- Approximately one in ten (9%) usually lived alone
- Approximately one in ten (9%) had been in an out-of-area placement.

By 30 November 2017, 103 reviews had been completed and approved by the LeDeR quality assurance process. Reviewers indicated that in13 (13%) the person's health had been adversely affected by one or more of the following: delays in care or treatment; gaps in service provision; organisational dysfunction; or neglect or abuse. From the 103 completed reviews, there were 189 learning points or recommendations identified. The most commonly reported learning and recommendations were made in relation to the need for:

- Inter-agency collaboration and communication
- Awareness of the needs of people with learning disabilities
- The understanding and application of the Mental Capacity Act (MCA).

LeDeR was able to use the commonly reported themes to develop 9 National recommendations based on completed local reviews of deaths in 2016-2017 they are as follows:

- Strengthen collaboration and information sharing, and effective communication, between different care providers or agencies.
- Push forward the electronic integration (with appropriate security controls) of health and social care records to ensure that agencies can communicate effectively, and share relevant information in a timely way.
- Health Action Plans, developed as part of the Learning Disabilities Annual Health Check should be shared with relevant health and social care agencies involved in supporting the person (either with consent or following the appropriate Mental Capacity Act decision-making process).
- All people with learning disabilities with two or more long-term conditions (related to either physical or mental health) should have a local, named health care coordinator.
- Providers should clearly identify people requiring the provision of reasonable adjustments, record the adjustments that are required, and regularly audit their provision.
- Mandatory learning disability awareness training should be provided to all staff, and be delivered in conjunction with people with learning disabilities and their families.
- There should be a national focus on pneumonia and sepsis in people with learning disabilities, to raise awareness about their prevention, identification and early treatment.
- Local services must strengthen their governance in relation to adherence to the Mental Capacity Act, and provide training and audit of compliance 'on the ground' so that professionals fully appreciate the requirements of the Act in relation to their own role.
- A strategic approach is required nationally for the training of those conducting mortality reviews or investigations, with a core module about the principles of undertaking reviews or investigations, and additional tailored modules for the different mortality review or investigation methodologies.

Trust progress with LeDeR Programme actions

Within the Trust we have 3 staff who have completed the LeDeR review training and have so far completed 4 reviews on behalf of LeDeR. From undertaking their reviews, these staff have identified and raised some ongoing issues with the LeDeR review system and the difficulties obtaining necessary notes and amount of time taken to complete reviews. As an organisation, we have proactively supported external LeDeR reviewers in gaining access to Trust documentation and are currently working towards development of a standard operating procedure to support this.

The Learning Disability Liaison service currently holds responsibility to ensure all deaths are reported to LeDeR in a timely manner and the Mortality Review Committee is responsible for allocating an appropriate individual to complete the internal investigation of every death of a person with learning disabilities. This individual is also responsible for ensuring any learning from the investigation is shared widely to support the ongoing development of the service and to ensure that we adhere to the requirements set out in the National Guidance on learning from Deaths.

To support implementation of the recommendations within the Trust, 9 action points have been identified and will be completed by the learning disability liaison service and the Mortality review committee, these action points will be developed over the next 12 months and progress will be reported back to the board in December 2019 along with an update on the LeDeR annual report for 2018.