Surrey and Sussex Healthcare
NHS Trust

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| **TRUST BOARD IN PUBLIC** | **Date: 30TH November 2017**<br><br>**Agenda Item: 2.5a** | |
| **REPORT TITLE:** | Learning Disability and Mortality Governance | |
| **EXECUTIVE SPONSOR:** | Des Holden<br>Medical Director | |
| **REPORT AUTHOR (s):** | Richard Brown<br>Director of Outcomes | |
| **REPORT DISCUSSED PREVIOUSLY:** (name of sub-committee/group & date) | Mortality Group. ECQR & SQC. | |
| **Action Required:** | | |
| **Approval ()** | **Discussion ()** | **Assurance (√)** |

**Purpose of Report:**

To provide the Trust Board with an overview in relation to the requirements of the learning disability (LD) learning from deaths review programme and to provide a summary of actions underway in relation to an overall mortality governance/reporting.

**Summary of key issues**

There is a national requirement to review and report the deaths of people with learning disability.

There were 4 deaths of people with a known learning disability in the first 2 quarters of the financial year 2017/18 (1% of total deaths in reporting period). All 4 deaths were categorised as 1 – Expected or Unavoidable,

Plans are in place to deliver the Trust requirements with regards to the LD death review programme which is being monitored via Effectiveness Committee as well as reported to Executive Committee for Quality and Risk.

Further communications will be planned to raise awareness of the LD programme to enable further identification of LD patients.

A programme to support the use of the Royal College of Physicians Structured Judgement Review methodology is currently in development.

**Recommendation:**

Board members are asked to note:

The requirement for on-going quarterly mortality reports to the Trust Board.
Improvements to mortality reporting and governance will be monitored via Effectiveness Committee

| **Relationship to Trust Strategic Objectives & Assurance Framework:** | |
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| **SO1**: Safe – Deliver safe high quality and improving services which pursue perfection and be in the top 20% against our peers<br>**SO2:** Effective – As a teaching hospital deliver effective, improving and sustainable clinical services within the local health economy<br>**SO3:** Caring – Working in partnership with staff, families and carers<br>**SO4:** Responsive – Become the secondary care provider of choice our catchment population<br>**SO5:** Well led - Become an employer of choice and deliver financial and clinical sustainability around a patient focused clinical model | |
| **Corporate Impact Assessment:** | |
| **Legal and regulatory impact** | The Trust is required to publish mortality data through public Board |
| **Financial impact** | None in relation to this paper |
| **Patient Experience/Engagement** | None in relation to this paper – however discussions with families are taking place via Medical Examiner Project |
| **Risk & Performance Management** | Ability to identify and report LD patients who may not have been 'flagged' on the Trust system |
| **NHS Constitution/Equality & Diversity/Communication** | The approach to reviewing LD deaths is significant in relation to Equality and the NHS Constitution. |
| **Attachment:** | |
| Learning from deaths dashboard Q2 | |

**TRUST BOARD IN PUBLIC 30TH November 2017**
**Learning Disability Deaths and Mortality Review**

## 1. Introduction

The Learning Disabilities Mortality Review (LeDeR) Programme has been established in response to the recommendations of the Confidential Inquiry into the premature deaths of people with learning disabilities (CIPOLD). It was commissioned by NHS England and is managed by the Healthcare Quality Improvement Partnership (HQIP). There are a number of requirements for the Trust, specifically:

- Have a policy in place focusing on review of deaths
- From April 2017, Trusts must **collect** new quarterly information on deaths
- From Q3 2017 onwards Trusts must **publish information** on deaths, reviews and investigations quarterly via an agenda item and paper to public board meetings.
- From June 2018, Trusts must **publish an annual summary** of this data in their quality accounts.

Alongside the above requirements an overall review of the governance associated with mortality reporting in the Trust is underway.

This paper outlines the key actions which are currently underway.

## 2. Learning Disability Deaths – Reporting

Appendix A contains the current information for quarter 1 and 2 which details the total number of deaths in the Trust, those subject to a clinical review and the category of death assigned. Alongside the overall number of deaths the total numbers of LD deaths are included alongside the number reviewed and the category assigned.

In summary for:

- Quarter 1 of the 2017/18 year there were 2 known LD deaths both categorised as 1 – Expected or unavoidable
- Quarter 2 of the 2017/18 year there were 2 known LD deaths both categorised as 1 – Expected or unavoidable

All LD patient deaths must be reported externally to the national LeDeR team. Once reported the death may be subject to a detailed external review and feedback will be given to the Trust.

Further work is underway to utilise the RCP SJD which is a detailed and structured methodology for mortality review. This will provide a detailed insight into the care of the patient.

## 3. Mortality Reporting Improvement Plan

To support the overall LeDeR review a plan has been developed to look at the Trust systems and processes for reviewing and learning from all deaths.

A new policy is now in place.

The Mortality Group has updated its Terms of Reference and now includes thematic reviews as standing monthly agenda items.

Further work is needed to review an electronic reporting and review system – Datix has launched a new module however there are other products which may be more suitable.

Standard reporting templates for Divisions are currently being developed to ensure a consistent and focused reporting method.

In development is a system to apply the Structured Judgement Review (SJR) methodology to specific categories of deaths. Once the categories are agreed training will be implemented.

Further communication is needed to raise awareness of the LeDeR programme and this will be developed in the coming weeks.

## 4. Recommendation

The Board is asked to note:

- The requirement for on-going quarterly mortality reports to the Trust Board.
- The current position with regards LD deaths and overall mortality figures.
- The progress and further actions in the mortality reporting improvement plan

**Richard Brown**
**Director of Outcomes**
**November 2017**