Appendix 3

Subject:	Learning from Learning Disability Deaths	**Date: 7/04/2022**	
Prepared By:	Lisa Richmond – Learning Disability Specialist Nurse		
Approved By:	David Selwyn		
Presented By:	David Selwyn		
Purpose			
To provide Trust Board with an update on specific Leaning Disability aspects from the Learning from Deaths programme		**Approval**	
		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

Nil

Executive Summary

Since the start of 2022, there have been 7 deaths in patients with learning disabilities in the trust.
• 4 of these were respiratory related deaths.
• None of these deaths were from a BAME background. Patients were primarily White British.

The LD nurse now receives data shared from the LeDeR reviews on a bimonthly basis relating to patients who have died whilst at Sherwood Forest Hospitals.
This aims to identify themes and trends which can support leaning across the organisation.
During the period from November 2021 to Feb 2022, there were 9 reviews completed with 7 ongoing.

Of the 9 reviews 5 were focused reviews, which means they took more time to gather information.
3 reviews met the deadline of 6 months from the notification date.
6 reviews were completed outside of the deadline due to delays in accessing SJCR and GP records, delays were also experienced due to continued pressures on systems due to covid 19 and awaiting coroner's inquest reports.
There were also technical problems with the LeDeR platform as it was new last year. These issues were not related to SFH.

There were issues identified relating to the quality of the SJCRs. Some information received has been too sparse to add to the review. This has been found at both SFH and other acute hospital providers and is part of our on-going SJCR quality improvement process.

When looking for patterns around cause of death respiratory health has been identified as an issue. 6 out of 9 deaths from the reviews taken had a respiratory issue included.

Learning identified that was related to hospital care were shared from the reviews and fedback to clinicians and/ or community services, as appropriate.
The review for one patient death found there were delays in discharge due to the availability of social care placements, which lead to a prolonged hospital stay. Actions have already been implemented from this and the learning shared.

Another review found issues in how hospitals communicate with each other, particularly electronically shared data. IT systems should ensure clear transfer of information between hospitals to allow continuous care and improve quality of care.

A positive finding has also been shared from a review; hospital staff allowing the patient's staff to remain with him while in hospital to support the patient and his family.

Trust Board is also asked to note the following additional updates;

There has been a change in practice which now sees deaths of people with a diagnosis of autism being review in the same way as LD deaths.
Autism reviews can now be uploaded onto the LeDeR platform. However clear pathways need to be established to be able to identify autism deaths as there are for learning disabilities. Work will also be required to review Autism SCJR pathways and how these can be embedded similarly to the LD pathway.

Nottinghamshire CCG has been given funding for a band 6 Learning disability speech and language therapist to work with acute providers. Work is currently underway to review how this role is able to best support Learning Disability patient/service user pathways for SFH.

Issues relating to ReSPECT forms for LD patients has been identified as an internal challenge.
The LD nurse plans to meet with the Senior Resuscitation team to look at the auditing of ReSPECT forms for LD patients and will sit as part of the ReSPECT development group to support with the ongoing work within the organisation.