Learning Disabilities Mortality Review (LeDeR) Programme

# Briefing Paper 14: Comparison of potentially avoidable deaths

This Briefing Paper considers the concept of 'potentially avoidable' deaths and explains why we should not compare potentially avoidable deaths of people with learning disabilities to those of people without learning disabilities.

**National guidance on Learning from Deaths**

The national guidance on Learning from Deaths, published in March 2017, provides a framework for NHS Trusts and NHS Foundation Trusts to identify, report, investigate and learn from deaths that occur in their care. Briefing Paper 13 summarises the main points of the guidance, and how it relates to the LeDeR programme.

As part of the guidance, Trusts are required to collect and publish specified information about deaths. This includes the total number of the Trust's in-patient deaths and the deaths that the Trust has subjected to case record review. Of the deaths subjected to review, Trusts are required to provide estimates of how many deaths were judged to be potentially avoidable.

The dashboard on which deaths are recorded by Trusts requires separate data for people with learning disabilities (See: https://improvement.nhs.uk/resources/learning-deaths-nhs/#resources)

**Potentially avoidable deaths**

Potentially avoidable deaths are those that have been clinically assessed using a recognised methodology of case record/note review and determined more likely than not (having a more than 50% chance) to have resulted from problems in healthcare and therefore to have been potentially avoidable.

**Comparison potentially avoidable deaths identified in SJR and LeDeR reviews**

There are several reasons why it would not be appropriate to compare potentially avoidable deaths using SJR case note review, and LeDeR methodology:

- Case note review methodology generally considers the last episode of a person's care. The LeDeR reviews look beyond this to the whole pathway of care the person received, not just the most recent episode.
- Case note review generally considers the actions (or inactions) within a single agency. The LeDeR review looks at actions (and inactions) across a range of different agencies involved in the person's care.

- Case note review generally considers only what is documented in the case notes being reviewed. The LeDeR review gains the perspectives of those who knew the individual best, including families wherever possible, to obtain a broader range of perspectives about the sequence of events leading to death.
- Case note review generally considers one or a few pieces of a 'jigsaw' about the care experiences of the individual who has died. The LeDeR review considers the bigger picture, bringing in pieces of the jigsaw from multiple sources, and looking at the way in which they fit together.

It is clear, therefore, that what may appear to be potentially avoidable using the LeDeR methodology, may not be identified as such by case record/case note review. We are not comparing like with like. As an example:

*Terry, a person with learning disabilities is admitted to hospital in a moribund condition, and despite all treatment dies the following day from sepsis which developed from aspiration pneumonia. Case note review of his death identifies that all appropriate treatment and care, in line with best practice, had been delivered, his death was not likely to have resulted from a problem in healthcare and was not avoidable.*

*However, when we take a broader lens we find that Terry's care providers were not following the most up-to-date feeding plan for the person, that they had raised concerns about his persistent cough with a GP but did not feel listened to, and that they did not recognise Terry's continuing deterioration until his sudden collapse. Taking all of these potentially modifiable factors into consideration, we could conclude that Terry's death was potentially avoidable: there were problems with the delivery of healthcare (no investigation of persistent cough), social care (feeding plan not adhered to), and the interface between health and social care (carers feeling as though their concerns were not listened to by GP).*

Thus, because of the different methodologies adopted, it would not be appropriate to compare the proportion of 'avoidable deaths'. Thus, it is essential for Trusts to be aware that their investigations of deaths will almost certainly identify a significantly smaller proportion that are deemed to be potentially avoidable than will be the case for the much broader investigations under the LeDeR methodology.

Our experience to-date is that there is significant learning and resulting service improvement opportunities that can come from a range of deaths, not just those considered to be potentially avoidable. It is this learning, and the impact of resulting service improvement actions, that is at the heart of the LeDeR programme.

**Further information**

NHS Improvement (2017) Learning from deaths in the NHS. Helping providers to learn from deaths that occur in their care. Available from: https://improvement.nhs.uk/resources/learning-deaths-nhs/