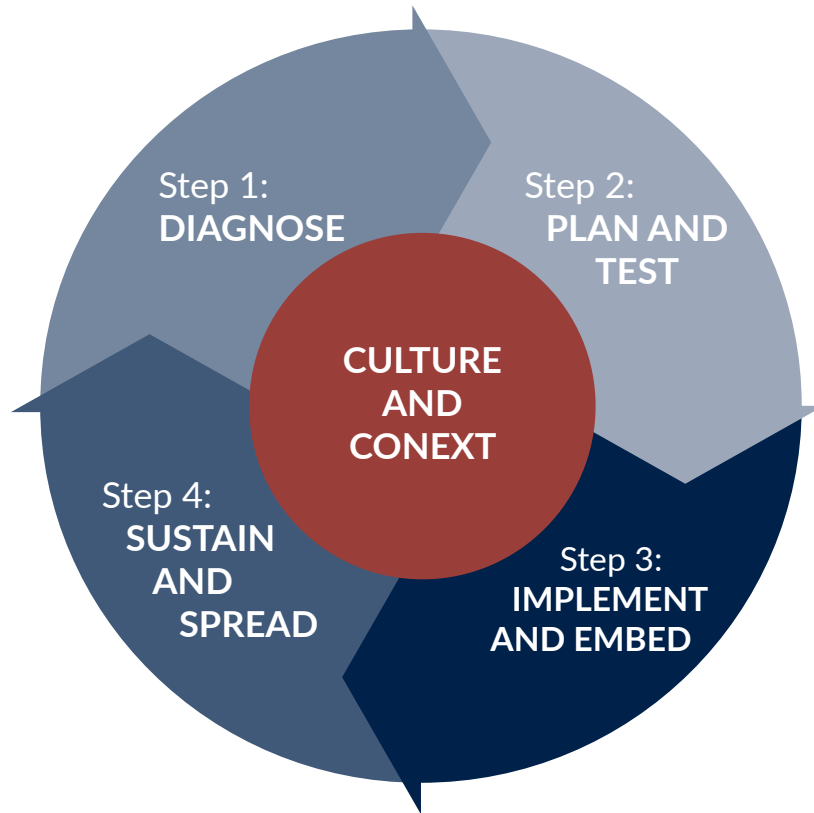




QOF QI Case study: Learning disability death review

Practice details: Urban practice 12,000 patients, 50 patients on Learning Disability QOF register = 0.4% prevalence



The team elected to focus on the implementation high quality in-house death reviews for learning disabled patients.

They used the RCGP QI wheel for general practice (available in RCGP's How to get started in QI guide for advice).



Culture and context:

The learning disability QI Domain document had raised awareness in the practice of the health inequalities experienced by people with a learning disability - including significant premature mortality. Reference was made to the learning disability mortality review programme - [LeDeR](#). The local LeDeR steering group had also shared its recent annual report with the CCG which had made it available to practices.

As is true nationally the commonest causes of death locally were:

Pneumonia	Aspiration pneumonia
Sepsis	Ischaemic Heart Disease
Dementia	Epilepsy



Diagnose:

The practice manager had made records available to the LeDeR team of a patient on the practice's learning disability register who had died during the previous year. The patient was only 44 years old. The practice had not conducted a review in-house following this death. It was decided that this would be helpful learning for the whole practice team.



Plan and test:

Consideration was given about how to conduct the review. Government guidance on learning from deaths was reviewed. It was decided to develop a clear plan for the review, and a practice meeting was held to discuss this. The following decisions were taken:

- The person performing the review would be someone who had not consulted with the patient in the past and would be given a half day protected time for the process.
- A policy of openness and trust should be adopted and that this was a no-blame learning experience.
- A structure for the review was created
- The review would be presented to the clinicians in the practice and discussed.
- Actions from the review would be recorded and their completion monitored by the practice manager.
- The learning points from the review would be shared with the network

Diagnose:

The QI lead met with the person nominated to perform the record review to develop a plan.

It was agreed that important components for the practice presentation would be as follows:

- Some personal details of the individual to help visualise and empathise with them as a person – known as a ‘pen portrait’. This would include whether the practice was aware of any reasonable adjustments that would have helped the individual access services. This might involve a discussion with the person who knew them best in the practice.
- Recorded cause of death and whether the coroner was involved.
- Significant co-morbidities and how these were recorded and visible in the patient notes.
- Prescribing history and its rationale including evidence of structured medication review.
- Evidence of whether the death could have been expected and whether there was any evidence of advance care planning.
- Evidence of continuity of care and recording of reasonable adjustments in the practice.
- Evidence of completion of detailed annual health checks using an appropriate template including creation of and saving of a health check action plan.
- Evidence of health promotion and screening activity e.g. cervical screening, blood tests, sexual health advice, dietary advice, regular annual flu vaccinations etc.
- Evidence of any recording of implementation of the Mental Capacity Act to assess the person’s capacity and record their best interests if lacking decision-making capacity.

Plan and test:

The GP, nominated to perform the review, discussed the process with the local learning disability team. The team made it clear that the local LeDeR (learning disability mortality review programme) had a steering group that was attended by a representative (safeguarding nurse) from the CCG. It was suggested that the individual could learn about LeDeR from the CCG rep and possibly ask to attend the meeting with the CCG representative, as an observer.

These discussions helped the GP understand more about the LeDeR process, how death reviews are conducted, how learning from the review is defined, and how the learning is put into action locally. The GP read the [national LeDeR annual report](#), the summary of the [CIPOLD enquiry](#) and latest information from NHS digital about [morbidity and life expectancy for people with learning disabilities](#). The GP developed a template for recording the information to be evaluated from the record. A half day of protected time was allocated for the process.

The QI lead presented the outline of the plan to the network peer review meeting. Suggestions were made about how to develop actions to improve care from the learning.

Area for improvement

The patient had Down’s syndrome, multiple co-morbidities including dementia and had died from aspiration pneumonia.

The GP completing the review gave a presentation to the whole practice with background information, suggestions of learning points from the case and possible actions the practice could take from the learning.

- Health checks had been completed each year but there was no evidence of completion of a health check action plan.
- Flu vaccinations had been administered most years but not every year.
- The patient had had 3 admissions during the previous 18mths with aspiration pneumonia.
- There was no evidence of any discussion or recording of advance care planning in the notes.
- The patient had been seen by 6 different healthcare professionals in the practice in the last 12 months.

★ Actions from learning:

- The practice to audit quarterly whether health check action plans are created at the health check.
- The individual performing the health check to set a digital review date for actions on the plan.
- The practice to create a system starting on 1st September every year to ensure that all on the learning disability register are offered a flu vaccinations and that those with no capacity to consent have a best interest decision made and recorded about whether to administer the jab. Uptake of flu vaccinations in the LD population to be monitored monthly from end September to end December.
- The practice to nominate a healthcare professional to review the 50 patients on the LD register to determine which if any were at highest risk of premature mortality or of death within the next 12 months. Advance care planning then to be considered for this cohort and discussion at palliative care meetings if appropriate.
- The practice to review methods of improving continuity of care for those at highest risk on the LD QOF register.

📦 Implement & embed:

Audit of notes, performed by the practice audit clerk at each quarter end, showed the number of those who had had a health check and had an action plan created rose from only 30% in the first 2 quarters to 80% by the third quarter.

By the end of December, 70% of all those on the LD QOF register had received a flu jab – an increase from 50% the previous year.

The review of patients on the register revealed 5 people with serious complex co-morbidities who also had evidence in the record of poor continuity of care. Each

patient was allocated to a GP in the practice to take overall responsibility for ongoing care management including advance care planning if appropriate.

The learning about life expectancy, morbidity, and premature mortality for people with a learning disability was shared with the team at the Palliative care meeting.

🔄 Sustain and spread:

The practice shared its enhanced understanding of the LeDeR programme with the network. It also shared the death review process that it had used. The network decided to organise network wide learning from the LD team about premature mortality in people with a learning disability.

➡ What the practice did next:

The practice maintained the monitoring processes established after the review in order to ensure better continuity of care for complex patients, better care planning and improved outcomes.

🔍 What evidence did the practice provide for QOF payment:

The contractor completed the annual QOF QI domain self-declaration. They kept a copy of the action from learning plan and the clinical audits performed following the review for future payment verification if needed, as well as evidence for future CQC inspections and to support individual clinicians in their annual appraisal.

