NHS
Halton
Clinical Commissioning Group

NHS
Warrington
Clinical Commissioning Group

LeDeR Annual Report

2019-2020

The Learning Disabilities Mortality Review
(LeDeR) Programme

Document Version Control

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Contents

1. Introduction

The Learning Disability Mortality Review (LeDeR) programme is part of a national focus upon improving the lives and care of people with Learning Disabilities. It has derived as an outcome from a series of national reports that describe that whilst care in many instances has improved over the last decade, many aspects have not. There are still marked health inequalities for people with learning disabilities, compared to that of the general population. To put this into context the life expectancy for people with learning disabilities in 2020 can be equated to what the rest of the general public could have expected in 1940. Today, people with learning disabilities die, on average, 15-20 years sooner than other people in the general population. These health inequalities are not inevitable, and progress can be achieved by preventative and/ or timely access healthcare. Reviewing the circumstances surrounding the deaths of people with a learning disability provides a real opportunity to learn from the past to help prevent avoidable deaths and improve future care for others.

Since 2019 NHS Halton Clinical Commissioning Group (HCCG) and NHS Warrington Clinical Commissioning Group (WCCG) agreed to take a combined approach to delivery of the LeDeR programme through the establishment of a LeDeR panel, shared Local Area Contact, and agreed governance frameworks to capture local learning.

This annual report focuses on Halton and Warrington in respect of activity and findings relating to Learning Disability Mortality Review (LeDeR) for 2019-20. The report has been produced by HCCG and WCCG as required by the 'The NHS Long Term Plan January 2019'. The report provides;

- An overview of the progression against the LeDeR recommendations made nationally,
- An overview of the LeDeR review activity undertaken for Halton and Warrington
- An overview of the work that has been undertaken locally to engage with the national programme and implement positive actions for any learning identified.

2. National LeDeR Programme

The Learning Disabilities Mortality Review (LeDeR) programme is a national initiative to review the deaths of people with Learning Disabilities. The programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

The LeDeR Programme supports reviews of deaths of people with learning disabilities aged 4 years and over; and the Programme supports reviews of all deaths, irrespective of the cause of death or place of death.

The programme is led by the University of Bristol, on behalf of NHS England/Improvement (NHSE/I). The programme is a joint health and social care project, involving healthcare providers across the health economy, Local Authorities and Clinical Commissioning Groups'.

The NHS long-term plan, confirmed that the NHS will continue to fund the Learning Disability Mortality Review Programme (LeDeR). It stated:

"Across the NHS, we will do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives."

The plan went further in saying:

"Action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people" and

"the whole NHS will improve its understanding of the needs of people with learning disabilities and autism, and work together to improve their health and wellbeing".

The aim of the programme is to drive improvement in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities in this population, through mortality case review.

This work forms part of the wider Transforming Care agenda and NHSE/I's commitment to address health inequalities experienced by people with learning disabilities.

3. National Progress

The LeDeR national Annual Report was published in 2019 (see link below) providing analysis on the work of the programme. The report detailed 10 recommendations for action: -

Recommendation 1.

A continued focus on the deaths of all adults and children from BAME groups is required.

Recommendation 2.

For the Department of Health and Social Care (DHSC) to work with the Chief Coroner to identify the proportion of deaths of people with learning disabilities (and possibly other protected characteristics) referred to a coroner in England and Wales.

Recommendation 3. *(Repeated from the House of Lords Select Committee on the Mental Capacity Act 2005).*

The standards against which the Care Quality Commission inspects should explicitly incorporate compliance with the Mental Capacity Act as a core requirement that must be met by all health and social care providers.

Recommendation 4.

Consider the recommendations from the 'Best practice in care coordination for people with a learning disability and long-term conditions'4 (March 2019) report and:

• Establish and agree a programme of work to implement the recommendations.

• Liaise with NIHR regarding the importance of commissioning a programme of work that develops, pilots and evaluates different models of care coordination for adults and children with learning disabilities.

Recommendation 5.

Adapt (and then adopt) the National Early Warning Score 2 regionally, such as the Restore2 in Wessex5, to ensure it captures baseline and soft signs of acute deterioration in physical health for people with learning disabilities by:

• Involving people with learning disabilities, their families and professional organisations.

• Disseminating for use across acute, primary and community settings.

Recommendation 6.

Consider developing, piloting and introducing:

• Specialist physicians for people with learning disabilities who would work within the specialist multi-disciplinary teams.

• A Diploma in Learning Disabilities Medicine

• Making 'learning disabilities' a physician speciality of the Royal College of Physicians.

Recommendation 7.

Consider the need for timely, NICE evidence-based guidance that is inclusive of prevention, diagnosis and management of aspiration pneumonia. The outcome of such considerations should be shared with DHSC and NHSE.

Recommendation 8.

Right Care to provide a toolkit to support systems to improve outcomes for adults and children at risk of aspiration pneumonia.

Recommendation 9.

Safety of people with epilepsy to be prioritised. The forthcoming revision of the NICE Guideline 'Epilepsies in children, young people and adults' to include guidance on the safety of people with epilepsy, and safety measures to be verified in Care Quality Commission inspections.

Recommendation 10.

For a national clinical audit of adults and children admitted to hospital for a condition related to chronic constipation. The National Clinical Audit and Patient Outcomes Programme is one way this could happen.

Detail of the local work and activity linked to the national LeDeR recommendations as relevant to Halton and Warrington CCG's can be found below in section **5.0**

3.1 Key learning and findings from the 2019 national LeDeR annual report included:

- In 2019, the number of deaths notified was 3,060 (England and Wales)
- For deaths notified in 2019, the median (average) age at death was 61 for males and 59 for females, an increase of 1 year for males since 2018.
- The proportion of people with learning disabilities dying in hospital was 60% in 2019;
- Of the deaths reviewed in 2019, 72% had a DNACPR decision. Reviewers felt that the majority of these (78%) were appropriate, correctly completed and followed.
- The most frequently reported underlying cause of death was in the ICD-10 chapter of disorders of the respiratory system: 20% of males and 19% of females died from these causes. The proportion varied by age – with the highest proportion (26%) being in people aged 65 and over.

Full detail of the national LeDeR 2019 annual report can be found below:
http://www.bristol.ac.uk/media-library/sites/sps/leder/LeDeR_2019_annual_report_FINAL2.pdf

4. Local Progress

In 2019 in response to capacity demands, competing priorities upon reviewers and to enable sustainability of approach HCCG and WCCG agreed to jointly pilot a panel multi-agency approach to completion of the LeDeR reviews. This moved away from the previous method of allocating one review to one reviewer. Systems were developed and implemented to support the panel and dedicated administration support identified.

All cases are triaged and HCCG and WCCG support identification and collection of the information needed ahead of the panel.

The panel consists of an independent chair, and multi-agency representatives with a broad range of knowledge and skills in relation to learning disability who meet regularly to review the circumstances surrounding a notified death to identify local learning. The panel provides capacity to discuss multiple cases in one panel sitting which has enabled HCCG and WCCG to be able to achieve compliance at time of reporting, with completing LeDeR reviews within the NHSE/I expected timeframes.

Due to the impact of Covid 19 a formal evaluation of the pilot is still required, and this is identified as a priority for 2020- 2021. The learning will be shared with partners and the Cheshire/Merseyside LeDeR steering group and options to deliver on a larger scale evaluated.

Appendix 1 to this report provides a flowchart of the process from initial notification to completion of the review, including pathways to learning and the supporting governance arrangements.

5. Local Activity

Locally across Halton and Warrington in the reporting period there have been 21 deaths notified to LeDeR. In total within the reporting period 24 deaths have been reviewed including 3 backlog reviews. The table below shows the status of the reviews for the 2019-2020 reporting period.

Table 1

CCG	Reviews notified 2019-20	Allocated	Completed	Removed from LeDeR- no LD
Halton	9	9	6	3
Warrington	15	15	14 (1 awaiting closure due with coroner)	0

5.2 Backlog reviews

An additional £5 million was invested by NHSE/I in 2019/2020 to address the backlog of un-reviewed cases and increase the pace with which reviews are allocated and completed. The money was invested in developing a dedicated workforce through a Commissioning Support Unit (CSU) to undertake reviews and develop systems and processes to embed mortality reviews and quality improvement activity across the health and social care system.

HCCG and WCCG had a backlog of reviews from pre-December 2018 that met the specification for completion by CSU. These have all been transferred and are expected to be completed by end of December 2020. HCCG and WCCG Local Area Contact (LAC) is in regular contact with the CSU to ensure this process runs smoothly.

In addition to the CSU work, 1 backlog review has also been allocated to an individual reviewer funded by NHSE/I.

All reviews completed as part of the backlog work once complete are discussed at the Halton/Warrington LeDeR panel for quality assurance, sign off and to ensure the capture of local learning.

Backlog reviews allocated:

Table 2

CCG Area	Total allocated	Completed to date
HCCG	15	3 (awaiting QA)
WCCG	13	1

5.3 Learning into Action

Undertaking a review of a death of a person with a learning disability, is a vital first component but it is the lessons learned from a review that are most important. These have allowed practitioners in Halton and Warrington to share best practice, identify local lessons and identify recommendations for service improvements to avoid the re-occurrence of similar events and potentially any avoidable contributory factors to the early deaths.

For 2019-20 learning from reviews was substantiated through two main routes

- Dissemination of key messages back to partner organisations via the active role of panel members, and the formation of regular reports and updates to the Transforming Care Partnership, HCCG, WCCG, and the local safeguarding adult's boards
- The delivery of two LeDeR – learning into action conferences one for Halton and one for Warrington. The conferences used anonymised reviews that focused on key learning areas and the common themes and trends noted from national learning. A drama group was commissioned to bring the scenarios to life and stimulate active engagement from the conference participants.
  The events had very positive evaluation and helped engage local services with the agenda and this will be utilised and built upon for 2020-2021 with a multi-agency learning into action group.
  A legacy video from the conferences was also commissioned and this has been used locally to further cascade learning. Link to the video can be found below:
  https://vimeo.com/430665513/9c96dc68c8

The Cheshire and Merseyside Steering Group is well established and meets regularly. The group is well attended from partners in the region including CCG's, Health Education England, NHSE/I Lead for the LeDeR Programme, and self-advocates, who are critical to supporting the work of the group in challenging the group to remain focussed on the purpose of the programme.
Alongside providing a coordinated forum for areas to share learning from cases and approaches being taken to address learning, NHSE/I as facilitators of the group also utilise the group to receive assurance that the learning and

recommendations arising from the reviews are reflected in and are being progressed via agreed actions and a group shared action plan.

A Learning into Action collaborative was set up by the NHSE/I to better co-ordinate national responses to premature mortality review learning. The collaborative brings together experts by qualification, professional experience and lived experience. The Learning into Action collaborative have provided information slide decks in relation to cancer, constipation, respiratory disease, sepsis, pharmacy, annual health checks, improvement standards and do not attempt cardiopulmonary resuscitation orders (DNACPRs). These have all been shared via the steering group for wider distribution onto partners.

5.4 Support to National Recommendations

Local areas of development related to the national LeDeR report recommendations (section 4) are detailed below:

Table 3

Recommendation	Supporting actions
1) Focus on the deaths of all adults and children from BAME groups	HCCG, WCCG have identified awareness raising re LeDeR with BAME group as a priority for 2020-2021
2) DHSC to work with the Chief Coroner to identify the proportion of deaths of people with learning disabilities	Where local deaths have been reported to the coroner liaison has been effective and supportive of LeDeR.
3) CQC inspections should incorporate compliance with the Mental Capacity Act	HCCG, WCCG seek assurance from commissioned services in respect of compliance with the MCA. Quarterly reporting supports assurance re levels of staff training re MCA.
4) Consider the recommendations from the 'Best practice in care coordination for people with a learning disability and long-term conditions'4 (March 2019) report	HCCG, WCCG will support any workstreams relating to LeDeR as advised via the Transforming Care Partnership. Community Matron HALTON (BWCHT) carries caseload of people with a learning disability who have complex long term conditions
5) Adapt (and then adopt) the National Early Warning Score 2	St Helens and Knowsley NHS Trust (STHK) have utilised NWES2 since March 2019.

	Warrington and Halton Hospital foundation Trust engaged in the pilot of NEWS2 and implemented from early 2019.
6) Consider developing, piloting and introducing: • Specialist physicians for people with learning disabilities who would work within the specialist multi-disciplinary teams. • A Diploma in Learning Disabilities Medicine • Making 'learning disabilities' a physician speciality of the Royal College of Physicians.	HCCG, WCCG would support this development. STHK have recruited a Learning Disability Specialist Practitioner WHHFT consultant is a member of the WCCG HCCG LeDeR panel. Community Matron Halton (BWCHT) is V300 prescriber for patients on case load.
7) Consider the need for NICE guidance re prevention, diagnosis and management of aspiration pneumonia	HCCG, WCCG would support the guidance if becomes available. NWBFT Halton have created Signs of Aspiration posters and SALT assessments to ensure signs of aspiration is included in assessment with SALT and Community Matron Halton .
8) Right Care to provide a toolkit to support systems to improve outcomes for adults and children at risk of aspiration pneumonia.	HCCG, WCCG will support the roll out and implementation of the toolkit once available. Aspiration pneumonia is identified as a local priority area for focus for 2020- 2021.
9) Safety of people with epilepsy to be prioritised. Updated NICE guidance to include this. CQC inspections to have a focus on this.	Guidance to be reviewed with commissioned services.
10) National clinical audit of adults and children admitted to hospital for a condition related to chronic constipation to be undertaken.	HCCG, WCCG would ensure support to any national audit in respect of this. Chronic constipation was used as a learning scenario in the 2 LeDeR conferences facilitated by HCCG, WCCG in the last year. The legacy video from the events continues to be used to raise awareness of this topic.

6. What we have learnt in 2019-2020

The findings of LeDeR reviews completed locally are showing some alignment with both national and Cheshire/Merseyside wide findings.

Exceptions to this relate to:

- Gender- for Warrington there were more deaths notified for females than males, this will continue to be reviewed in 2020-21 (see table 4)
- Average age at death- for both Halton and Warrington this is above the nationally reported average from LeDeR data. In the general population of England from 2016- 2018, the median age at death was 83 years for males and 86 years for females (see table 4)

6.1 Demographic Data Comparisons

Table 4

Demographic	Halton	Warrington	LeDeR national picture
Gender Male	**3 50%**	**5 33%**	**58%**
Female	**3 50%**	**10 66 %**	**42%**
Age Under 55	**2**	**4**	
55-64	**1**	**4**	
65 and over	**3**	**7**	
Average age at death	**65**	**62**	**60**

- The LeDeR panel have noted there has been only 1 notification of a death for people with learning disabilities from the black, Asian or minority ethnicities (BAME) in 2019-2020. This is picked up for targeted awareness raising in 2020-2021 and aligns to the national LeDeR recommendation and findings.

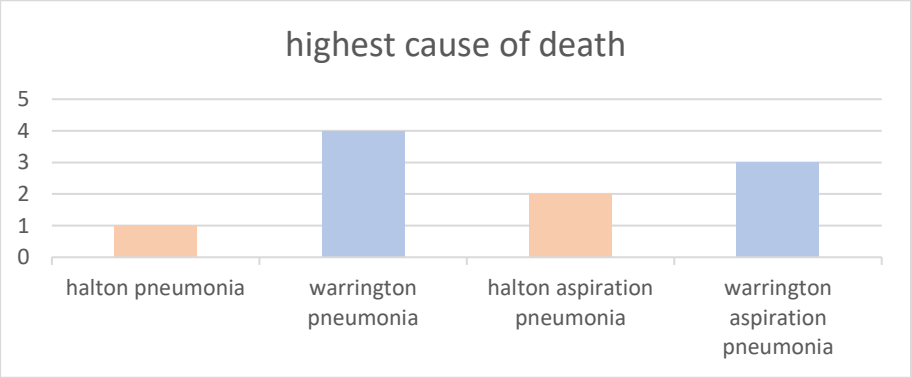
6.2 Cause of Deaths

Of the 21 reviews conducted in 2019/20 the two most common causes of death were:

1. Pneumonia – a breathing condition in which there is inflammation (swelling) or an infection of the lungs or large airways

2. Aspiration pneumonia- occurs when food, saliva, liquids, or vomit is breathed into the lungs or airways leading to the lungs, instead of being swallowed into the oesophagus and stomach

Table 5

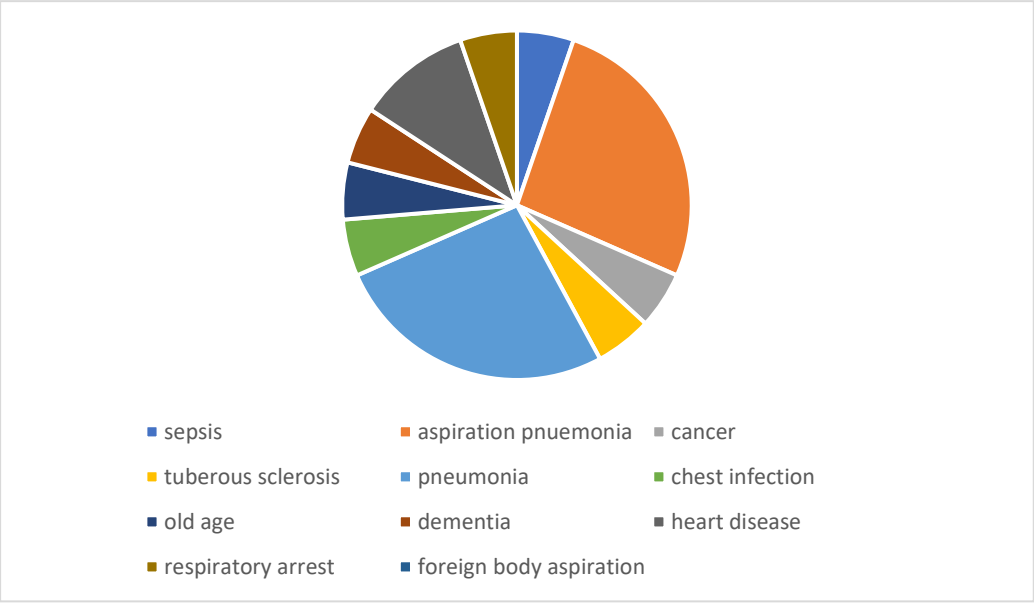


LeDeR reporting from national data:

- the most frequently reported underlying cause of death was in the ICD-10 chapter of disorders of the respiratory system: 20% of males and 19% of females died from these causes.
- The second most frequently reported underlying cause of death in people with learning disabilities was in the ICD-10 chapter of disorders of the circulatory system: 15% of males and 14% of females died from these causes.

The full range of primary cause of death from the 21 reviews undertaken is detailed below amalgamated for WCCG and HCCG:

Table 6



6.3 Place of death

Table 7

Place of death	Halton	Warrington	England
Hospital	50%	53%	46%
Own home (inc. nursing home)	50%	47%	

Deaths in hospital for the general population are reported at approx. 60%

6.4 Do not attempt cardio- pulmonary resuscitation decisions (DNACPR)

From the 21 reviews completed in the reporting period a DNACPR was in place for 100% of the Halton reviews and 86% of the Warrington reviews. The national LeDeR data indicated that a DNACPR was in place for 72% of the cases reviewed. This places both Halton and Warrington above the national picture and warrants further exploration in 2020-21.

It is noted for both boroughs that there is active engagement from learning disability services into end of life care planning for people with a learning disability. The panel evaluation of the reviews did not highlight any concerns in relation to the decision making surrounding the DNACPR's in place.

Halton utilise NWAS care plans and ERISS system to ensure plans are in place for people with DNACPR and Preferred Place of Care plans.

6.5 Learning into Action themes:

The most reported themes for targeted learning into action were reasonably consistent across both Halton and Warrington and relate to:

- Annual health checks (AHC), including screening
  Halton- 4 completed out of 6 reviews
  Warrington- 6 completed out of 15 reviews; in several reviews the information was not known. AHC were not in place for 2 reviews where the individuals lived in a nursing home.
- Mental Capacity Act compliance

  It was noted that recording of compliance with the Mental Capacity Act (MCA) in the information available for the reviews was harder to find. Capacity or best interest's decision making was referred to, but detailed evidence of procedures followed was harder to seek assurance on. Primary care recording of MCA is a noted area for improvement. This is picked up for further awareness raising for 2020-21

- Reasonable adjustments
  Formal recording of reasonable adjustments was good by acute care providers. Within community services and primary care, the recording of reasonable adjustments considered and implemented has scope for improvement. There was assurance from liaison with providers that such considerations were made however this was not reflected overall in the records shared.
- Family input to the LeDeR reviews
  This will be focused on in the formal evaluation of the LeDeR panel pilot. From the reviews completed to date this is acknowledged as a challenge and an area for further consideration within the panel processes. This is picked up as a priority for 2020-21

6.6 Grading of care

The chart below shows the grade and criteria for measuring care used in LeDeR reviews and the score achieved during 2019.

From the 21 reviews undertaken in this reporting period care was graded as:

Table 8

Grade of Care	Description	Number	
		Halton	Warrington
1	This was excellent care (it exceeded current good practice).	**2**	**0**
2	This was good care (it met current good practice in all areas).	**4**	**10**
3	This was satisfactory care (it fell short of current good practice in minor areas, and no significant learning would result from a fuller review of the death).	**0**	**3**
4	Care fell short of current best practice in one or more significant areas, but this is not considered to have had the potential for adverse impact on the person and no significant learning would result from a fuller review of the death	**0**	**2**
5	Care fell short of current best practice in one or more significant areas, although this is not considered to have had the potential for adverse impact on the person, some learning could result from a fuller review of the death	**0**	**0**
6	Care fell short of current best practice in one or more significant areas resulting in the potential for, or actual, adverse impact on the person	**0**	**0**
Total		**6**	**15**

HCCG and WCCG review all deaths as a multi-agency panel.
Each panel consists of:

- Independent Chair
- Learning disability nurse/matron representative
- Primary care representative
- Social care representative
- LAC
- Acute representative

The panel members may vary from the pool of available representatives from both Halton and Warrington. This allows for effective multi-agency review for all deaths and for impartial review from representatives not directly involved in the care of the individual.

The panel have noted for the reporting period that 66% reviews have been graded as good care and 9% as excellent. To ensure there is no local bias for 2020-21 a sample of reviews will be subject to external peer review and grading.

Whilst not reported in large numbers the LeDeR panel did note some variance in the access to specialist learning disability services for people with a learning disability whose main place of residence was a nursing home. Healthcare needs were met by the nursing home however recognition of the need for any learning disability service specialist input was missed which would have enabled improved holistic care and compliance with the Mental Capacity Act. It is noted the 2 reviews graded as falling short of expected practice were for individuals living in a nursing home.

To underpin any change to practice, the feedback relating to good practice and areas for improvement are explored and agreed by the LeDeR panel and captured to inform future learning into action for Halton and Warrington.

7. What we did well

Panel Pilot

The Halton and Warrington LeDeR panel has been built upon effective partnership working and engagement. The panel reviewers are from a variety of backgrounds and organisations and ensure a robust review process.
At time of reporting the total number of trained LeDeR reviewers and the respective employing organisation type is detailed in the table below:

Table 9

Organisation	Number of panel reviewers
WCCG/HCCG	X 4
Local Authorities (Halton and Warrington)	X4
Acute provider (WHHFT and STHK)	X4
Community Provider (BCHCT)	X1
LD service (HBC and NWB)	X5
Primary Care	X2

Whilst still requiring a formal evaluation the panel has proved successful in:

- enabling a timely response to the completion of reviews and preventing a return to a back log of reviews
- building a team of skilled reviewers who can apply robust case discussion and critical challenge to the care and services delivered
- raising the profile of LeDeR across Halton and Warrington- especially within primary care services
- a shared understanding of the local areas for action

7.1 LeDeR Conferences

As referenced in section **5.3** the LeDeR conferences were a success locally and continue to embed learning through use of the legacy video. The video has been shown to the Governing Body of HCCG and WCCG as part of the CCG's ongoing commitment to the LeDeR programme.

7.2 Local Actions

Key partner organisations across Halton and Warrington have shown commitment and support for the LeDeR programme in this reporting period. Highlights of the development work taken to improve accessibility, quality and the experience of services for people with a learning disability is detailed below:

Table 10

Organisation	Key Developments
St Helens and Knowsley Acute Trust	Recruitment of a Learning Disability & Autism Specialist Practitioner. This role supports all aspects of planning and delivering care for someone with a learning disability at STHK. Development of: • integrated pathway toolkit - to assist STHK staff delivering treatment / care, for a patient with a

	learning disability or complex additional need, from referral to discharge. • a reasonable adjustments care plan • hospital communication book • supported use of Disdat tool • bespoke training for consultants and medical students re learning disability and autism • learning disability and autism strategy
Warrington and Halton Hospital Foundation Trust	Learning disability strategy in place, and all staff receive training re learning disability which includes LeDeR, and specialist learning disability trainer post funded. Lessons learnt from learning disability deaths are shared via mortality review group to Clinical Business Units', and to safeguarding committee and included in staff training. A learning disability steering group has been formed that will monitor learning disability improvements in line with the national standards and learning from deaths Delivered programme of sepsis awareness raising with link to learning disability and diagnostic overshadowing Emergency care pathway in place to support the care of patients with a learning disability WHHFT Adult Safeguarding Team has worked with the Trust mammography team in improving the experience of our patients with a Learning Disability through provision of a suite of reasonable adjustments and accessible information.
Bridgewater Community Healthcare Trust	Learning Disability Community Matron in post supporting people with complex health conditions in Halton. All high- risk learning disability patients supported by the Community Matron are flagged and up to date information shared with acute services. Community Matron provides learning disability annual health checks to patients who struggle with mainstream access.

	Community Matrons chairs advanced planning meetings with NWB and learning disability nursing team re patients who are classed as needing advance planning care. All deaths of people with a learning disability are reviewed for lessons learned, and the Trust holds a quarterly Learning from Deaths meeting to review learning and identify and themes / trends. Where issues are identified from partner agencies these are shared via safeguarding or incident reporting process. Safeguarding Adults Team representatives attend all patient safety meetings to support decision making and practice re Mental Capacity Act compliance.
Halton Local Authority Halton Learning Disability Nursing Team.	Provision of support guidance re Mental Capacity Act and Dols to all Care Homes to aid understanding, and decision making. Learning disability nurses linked to named GP practices and offer support as needed with learning disability annual health checks. Attendance at Eol meetings to support decision making and practice re Mental Capacity Act compliance and DNACPR decisions. Team have established links with local hospitals to support reasonable adjustments and learning disability pathways Team delivered a joint presentation with NWBH to GP's/practice nurses in Halton, around what is a learning disability, annual health checks, mortality review and and support that is available from services. Established effective links and pathways with Clatterbridge (specialist cancer care) and the Halton Community Matron (BWCHT) for people with a learning disability needing to access cancer care at Clatterbridge.
Warrington Local Authority	Delivery of MCA training which is promoted to and accessible for all care providers. Additional targeted work is also undertaken with individual providers when the need for MCA training has been highlighted.

	Development of a specific role to support DoLS authorisations and the use of priority Management Conditions to deliver and monitor key requirements in care plans to ensure that care is personalised and, in the adults, best interests and to minimise the impact of any necessary restrictions. WBC working together with Speak Up, the local commissioned advocacy service supported two Grand Round training sessions with staff at WHHFT to promote application of the MCA and use of advocacy. Speak Up also produced flowcharts and information sheets for each ward and attended a safety briefing to promote advocacy awareness.
North West Boroughs	Health passports reviewed and uploaded to RiO to enable the information to be current and able to be shared as required electronically preventing any delays WCCG/Primary care/Speak up and NWBH developing a series of videos for people with a learning disability re: Health facilitation Promoting health screening for individuals on the dynamic support database All nurses/HCA trained in venepuncture this is utilised to support de-sensitisation work and has improved understanding of the process and pathways for access to the service Support out-patient appointments for people with a learning disability as required from local acute trusts Let's check reviews being completed by video-conference calls to prevent delay due to Covid restrictions Promoting health screening for known Dynamic Support Database individuals NWB Halton have created Signs of Aspiration posters and SALT assessments to ensure signs of aspiration is included in assessment with SALT and Community Matron Halton .

7.3 Covid 19

Whilst extending beyond this reporting period the local partnership response during the key months of the Covid pandemic is to be commended. Learning disability services ensured all high-risk individuals were known and that hospital passports were shared very early on with local Acute hospitals. Rapid reviews were also completed for all learning disability deaths to enable timely learning and response. In depth learning from reviews during the Covid pandemic will be included for 2020-2021 annual report.

8. Next Steps in 2020-2021

Learning from the reviews in 2019-2020 has informed development of priority areas of focus for 2020-2021:

- Formal evaluation of the panel pilot needs to take place. The evaluation will then inform options to sustain future timely completion of the reviews
- Establish a Halton and Warrington learning into action group to allow focus from multi-agency partners on the areas identified from the reviews. Priority areas for focus are:
  1) Aspiration pneumonia
  2) Mental Capacity Act
  3) Uptake of screening programmes
- Targeted awareness raising of the LeDeR programme with BAME groups through liaison with partners, learning disability and autism support organisations, and cultural/religious communities.
- Inclusion of learning disability health checks in the Primary Care Network Direct Enhanced Service (Des) this will support local action to improve the uptake, quality and effectiveness of the health checks for people with a learning disability
- Review and evaluate how to improve family liaison and input to the local LeDeR review process
- Peer review for a sample of cases from HCCG, WCCG LeDeR panel

9. NHSE/I Assurances

There are four performance indicators NHSE/I requires each CCG to report against when assessing how well we are doing with local delivery of the LeDeR programme.

These are:

• CCG's are a member of Learning from Deaths Report (LeDeR) Steering Group and have a named person with lead responsibility.

HCCG and WCCG are fully compliant with this indicator √

• There is a robust CCG plan in place to ensure that LeDeR reviews are undertaken within 6 months of the notification of death to the local area.

HCCG and WCCG are fully compliant with this indicator √

• Each CCG has systems in place to analyse and address the themes and recommendations from completed LeDeR reviews.

HCCG and WCCG are fully compliant with this indicator √

• An annual report is submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews.

HCCG and WCCG are fully compliant with this indicator √

Appendices:

Appendix 1

LeDeR process and Governance

Flow chart.docx