NHS

Blackpool Clinical Commissioning Group
Fylde and Wyre Clinical Commissioning Group

Governing Bodies in Common

Report Details	
Meeting Date	1 September 2020
Report Title	Fylde Coast CCGs Joint Annual LeDeR Report - April 2019 - March 2020
Presenter	Jane Scattergood, Director of Nursing and Quality
Prepared By	Claire Lewis, Head of Quality
Report Requirements	Noting

Committee Discussion	
	Date
Senior Management Team	
Clinical Commissioning Committee	
Quality, Improvement and Engagement Committee	23 June 2020
Finance and Performance Committee	
Audit Committee	
Primary Care Commissioning Committee	
Recommend to CCG Governing Body – Part I or Part II	Part I – 1 September 2020

Internal Assurance Process (indicate if not applicable)	
Clinical Lead	Dr Michelle Martin (Quality) Dr Kath Greenwood (for Learning Disabilities)
Senior Lead Manager	Claire Lewis, Head of Quality
Finance Manager	N/A
Has a Quality Impact Assessment been completed?	Not for the production of the annual report. The LeDeR programme is nationally directed and is recognised as an initiative to identify learning from deaths which can drive improvement in the quality of services to people with learning disabilities.
Has an Equality Impact and Risk Assessment been completed? If not, please explain why.	Not for the production of the annual report. The national LeDeR programme is designed to identify care issues which may impact on the health inequalities, which are well documented for people with learning disabilities.
Patient and Public Engagement completed	Not for the production of the Annual Report. However, there is an improvement action identified in relation to increasing engagement with the learning disabilities community
Financial Implications	The Local Area Contact and reviewers require recurrent funding. Non-recurrent funding is currently in place in the Fylde Coast CCGs and a contribution is made to the ICS for reviewer posts at varying stages of recruitment, which are not fully meeting the demand as yet.
Are there any associated risks? If so, are the risks on the Risk Register? If yes, please include the risk descriptor and current risk score.	The risks have been on the risk register in relation to delivery of the LeDeR programme. This has been about not only funding but securing Local Area Contact capacity and reviewers. Reviewers are being recruited at an ICS level which will increase capacity, but for now, the Fylde Coast CCGs are also meeting demand with non-recurrent monies to pay local reviewers.
Report Authorised by Executive Lead	Jane Scattergood

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Fylde Coast CCGs
Joint Annual LeDeR Report April 2019- March 2020

Introduction

The national LeDeR Programme has been in place for a number of years and requires that all deaths of people with learning disabilities are notified on the LeDeR platform and reviewed, to identify areas of care and treatment from which learning and improvement can be identified.

Previously, the Quality Improvement and Governance Committee has been provided with updates and briefings, including the CCG risk of failure to deliver this programme. The Committee has also been made aware of the Annual Report published by Bristol University and the Department of Health and CQC responses.

This year, the North West Region and the Lancashire and South Cumbria ICS are collating a report from each CCG about the delivery and impact of the LeDeR programme. The Fylde and Wyre CCG and Blackpool CCG draft report is attached, which had to be submitted to the ICS lead by 12/6/20 in the prescribed template, to enable the Lancashire and South Cumbria collation process.

CCGs are required to place the Lancashire and South Cumbria report on the CCGs' website by 30 September 2020. CCGs' Chairs will be required to sign off the collated ICS report in order to meet this deadline.

The Governing Bodies are being given an opportunity to understand the local Fylde Coast position through the following report, prior to seeing the data, themes and actions which will be identified in the Lancashire and South Cumbria report.

Recommendation

Members of the Fylde Coast CCGs Governing Bodies are asked to note the report.

Report to (Committee):	NHSE
Report Title:	Blackpool CCG and Fylde and Wyre CCG contribution to the Lancashire and South Cumbria Learning Disability Mortality Reviews (LeDeR) April 2019-March 2020

Report Author:	
Name:	
Title:	
Date:	

Contributing Author:	
Name:	Claire Lewis
Title:	Head of Quality Fylde and Wyre CCG and Blackpool CCG
Date:	12/6/20

Contributing Report Intelligence:	
Name:	
Title:	
Date:	

Executive Lead Sign-Off:	
Name:	
Title:	
Date:	

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EXECUTIVE SUMMARY

OVERVIEW
THE PROBLEM
THE SOLUTION
KEYS TO SUCCESS
FINANCIAL HIGHLIGHTS
GOVERNANCE ARRANGEMENTS - REGIONAL

INTRODUCTION

WHAT LEDER MEANS FOR LANCASHIRE AND SOUTH CUMBRIA (REGIONAL)
To be completed by Regional
Introduction to the LeDeR programme and what it means to your local area - CCG
The LeDeR programme involves an initial review for all deaths of people with learning disabilities, which meet the inclusion criteria. The purpose of the initial review is to provide sufficient information to determine if there are any areas of concern in relation to the care of the person who has died, or if any further learning could be gained from a multi-agency review of the death, which woul contribute to improving practice. The LeDeR programme is one source of information about the quality of service and support our Fylde Coast residents with learning disabilities experience. It provides us with an independent view of care from the family and the reviewer's perspective. This, along with other information, enables the Fylde and Wyre and the Blackpool CCGs as commissioners to work with our commissioned providers to make improvements. The reviews also tell us whether previous areas of identified improvement have actually been made in a sustained and effective way. From April 2019 to March 2020, 33 deaths were notified in the LeDeR programme for the Fylde Coast, 15 for Blackpool and 18 for Fylde and Wyre residents. There was a similar split of male and female in Blackpool though in Fylde and Wyre there was a higher proportion (61%) of females. The roles of those making the most frequent notifications of a death were Social Workers/Support Officers (13); Community Learning Disability Team members (7); NHS Foundation Trust staff, including mortality governance staff (5); Primary Care (2); Care Providers (3). Key information about the people with learning disabilities whose deaths were notified to the LeDeR programme includes (see table below): • More people died at their home than in hospital. • All but 4 of the 33 notifications were recorded as of 'white British' ethnicity, with 1 'any other white background' and 1 'Irish'. • Only 1 person across the Fylde coast had been in an out-of-area placement. Early on in the roll out of the national LeDeR programme, Blackpool CCG was able to secure some LeDeR reviewer time from within the commissioned learning disabilities service. Whilst this has remained a competing pressure with other workload during 2019/20, the learning disability service has been able to complete reviews and integrate the learning with other hospital and community services, which they sit alongside within Blackpool Teaching Hospitals NHS Foundation Trust.

In addition, the Trust is directly contributing to the reviews, by supporting the involvement of a small bank staff offer for both Blackpool and Fylde and Wyre CCG cases.

During 2019, both CCGs contributed financially to a developing Lancashire and South Cumbria LeDeR provision. In addition, Fylde and Wyre CCG secured an independent not-for-profit social enterprise to host two enthusiastic and committed reviewers, as the Lancashire and South Cumbria time-limited resource was stretched. The reviewers are also establishing excellent relationships with Fylde Coast service providers, which enrich the quality of information collated for the review and the priority which providers attach to acting on review findings.

For several months the Local Area Contact (LAC) role was delegated, to give the time to engage with Lancashire and South Cumbria and Regional initiatives in order to catch up on a backlog of reviews. The LAC role has now reverted to the CCGs Head of Quality.

Overall, in 2019/20 this has put the Fylde Coast in a much stronger position to undertake reviews within the agreed timescales and to ensure these are of a good quality which will impact on service improvement.

During and following the completion of the reviews, leads in our local trusts (Lancashire and South Cumbria NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust) meet and there are regular meetings with reviewers.

In 2020/21 arrangements will be strengthened with a quarterly health inequalities meeting involving the CCG Head of Quality, LAC (if different from the Head of Quality), CCG GP clinical lead for learning disabilities, trust mortality governance leads, LeDeR reviewers and a self-advocate. The group will consider recently completed reviews, to ensure consistency in the quality of mortality reviews and alignment with other processes eg safeguarding investigations, Structured Judgement Reviews, Child Death Overview Panels, coroners' proceedings, service quality reviews, complaint investigations. This quality assurance and information sharing will enable the group to give constructive feedback to reviewers to enrich future reviews. It also gives the local team invaluable insight into training needs which can be incorporated into commissioned services' training improvements and audits required to evidence sustained service improvement.

Acknowledgement and statement of how the learning disability community has been involved in the LeDeR programme and the production of the annual report - CCG

We have not involved people with a learning disability in the production of our annual report. This is an area for improvement in 2020/21 and we propose to explore the best way to do this.

Where it is appropriate, reviewers may engage with a person with a learning disability, when carrying out a review.

The quarterly Transforming Care meeting across Lancashire and South Cumbria, also affords an opportunity for representatives of the learning disability community to inform the programme.

The CCGs fund the NW Training and Development Team/Pathways Associates which on a Lancashire and South Cumbria footprint supports us to engage effectively with self-advocates. The LeDeR programme aims, methods and outcomes was shared and views sought, at the NW conference that was held and hosted in Blackpool in 2019.

THE SOLUTION

To be completed by Regional

KEYS TO SUCCESS

To be completed by Regional

FINANCIAL HIGHLIGHTS

To be completed by Regional

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Glossary/Acronyms	
ASD	Autistic Spectrum Disorder
CCG	Clinical Commissioning Group
CHC	Continuing Healthcare
L&SC	Lancashire and South Cumbria
LD	Learning Disability
LeDeR	Learning Disabilities Mortality Review
MAR	Multi-Agency Review
NHSE	NHS England

STATEMENT OF PURPOSE

A clear statement of purpose around LeDeR locally – CCG

The Fylde and Wyre CCG and Blackpool CCG are committed to maintaining and developing the LeDeR programme by promoting its benefits and achievements; encouraging notifications; supporting high quality and timely reviews; sharing the learning and as commissioners, acting on review findings to ensure service practice improvements are implemented and sustained.

LeDeR is now integral to the CCGs systems and processes of quality governance, aligned with the serious incident review processes and reporting to the joint Quality Improvement and Engagement Committee. LeDeR provides some of the essential information to inform learning disability commissioning. The LeDeR review findings also feed into CCG Care and Treatment Reviews and Transforming Care meetings. These proactively provide multi-disciplinary plans to support people with a learning disability, where they are already or are at risk of, admission to a mental health or learning disability in-patient setting.

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COMMISSIONING INTENTION

In 2019/20 the profile of LeDeR notifications received was (as recorded at 22/5/20):

	BCCG	**FWCCG**
Number of notifications	15	18
Number of males	8	7
Number of females	7	11
Age range	22-91	20-85
Number 60-69	9	3
Number 70-79	2	5
Number 80-89	2	3
Number who died at home	9	10
Number who died in hospital	6	6
Place of death not identified	0	2
Number in out of area placements	0	1
Number from an ethnic minority group	0	0
Number requiring multi-agency review	2	0
Care fell short of expected good practice and this significantly impacted on the persons wellbeing and/or had the potential to contribute to the cause of death	2	0
Care fell short of expected good practice but did not contribute to cause of death	7	4
This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the persons wellbeing)	1	3
This was good care (it met expected good practice)	2	5
Review not complete, outcome not determined yet	3	6
The recorded primary causes of death have included: Sepsis, ischaemic bowel disease, pneumonia, aspiration pneumonia, respiratory failure, Alzheimers Disease, spontaneous intracranial haemorrhage, bronchopneumonia, congestive cardiac failure, pancreatic cancer and frailty of old age. Some of these issues are recognised as features of the general population eg frailty of old age and some within improvement programmes for the whole population eg identification and management of sepsis. Some areas are also recognised in national data, including previous LeDeR annual reports, as affecting people with learning disabilities in particular eg aspiration pneumonia.		

Considering the themes from the reviews, it is evident that some appear in the learning points for improvement and recognition of good practice in equal measure, ie:

- A need for more training in and application of the Mental Capacity Act Framework in community and hospitals, including in relation to decisions about treatment, no treatment, DNACPR and end of life care, whilst also recognising examples where this has been applied and documented well

- Fast referral for and assessment from Speech and Language Therapy regarding feeding and swallowing, with good care plans, contrasting with a need to recognise the importance of referral for this professional input and for regular and timely review and revision of the feeding and swallowing care plan

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- Excellent partnership working; onward referral to engage specialist services with other examples of needing to improve awareness of the breadth of services available and access for people with learning disabilities

- Good information sharing between teams and professionals with other examples of where this needs to be improved

- Need for better training in dementia and early recognition, contrasted with good anticipatory care plans

- Need for better treatment monitoring/review eg for antipsychotic medication, contrasted with regular epilepsy review

- Evidence of annual health checks and meaningful health action plans, including pre-visit checklists, whilst some need improvement

- Hospital staff not recognising, seeking and valuing the input of familiar carers and under use of the hospital passport to aid understanding and communication with the patient, contrasted with good in-reach support from normal carers who were made to feel welcome and valued

Other themes include:

- Lack of awareness of how to source equipment; timeliness of doing so and delay in sourcing and access to Occupational Therapy advice and support

- Staff training need in communicating with people with learning disabilities and engaging them through reasonable adjustments, in their care and treatment

- Inadequate co-ordination and communication in preparation for and at hospital discharge to enable onward safe care eg regarding DNACPR, referrals for specialist assessments, medicines

- Health screening not offered or best interests rationale not adequately documented

- Lack of carers assessments, which would potentially make provision to optimise carers skills and resilience

- Training required in the appropriate development and use of risk assessments

- Good relationships between care provider and primary care, with good support provided by primary care

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DEATHS IN OUR LOCAL AREA – NUMBERS OF PEOPLE WHO HAVE DIED AND HAVE HAD THEIR DEATHS REVIEWED - Region will complete this section				
CCG	Date notified	Cause of death	Age	Grading
Regional				

Total average age at time of death:	Region to complete
Predominant cause of death:	Region to complete

FEEDBACK FROM LEDER REVIEWERS **Recommendations made by reviewers for local actions - CCG**
Requires Improvement
• Reviewers initially had significant difficulty in obtaining records, especially from GP practices. Lancashire and South Cumbria has been providing a much-valued central function to support this, which has improved the situation, although there remains some challenge • The timing of Structured Judgement Reviews undertaken in the acute trust, has typically been well in advance of the LeDeR review and has sometimes been difficult to obtain and the quality can be variable, but has been improved with the commitment of the trust Mortality Governance Lead • The LAC needs to have the capacity to respond to reviewers in a timely way, whether that is for support and guidance or for signing off their completed reviews
Positive Feedback
• The interim LAC appointment established good relationships with local reviewers and a foundation on which to continue

PERFORMANCE AGAINST NATIONAL TARGETS - Regional
To be completed by Regional

OUTCOMES AND ACHIEVEMENTS - Regional

Outcomes and achievements – CCG
• The CCGs now has reviewer capacity matched to the level of demand, such that new notifications are assigned promptly • Primary Care services commissioned by the CCGs are required contractually to clearly identify people requiring reasonable adjustments and the quality contract has been used as a mechanism to increase primary care engagement with health needs assessments and health action plans. Learning Disability awareness training is also required for all practice staff.

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LEDER SUBJECT ACCESS PATHWAY

Strategic action plan and progress against it – CCG

The CCGs main strategic aim for 2019/20 has been to establish a reliable LAC and reviewer resource so that these functions are fulfilled in a timely way. Some of this support has been achieved through a financial contribution to a Lancashire and South Cumbria ICS arrangement and partially through direct contracting for the functions.

The CCGs now have enough completed reviews from which to report to the Quality and Engagement Committee.

The importance of addressing the learning from individual deaths cannot be over-estimated. This is a crucial aspect of the service improvement cycle, and we have a responsibility to local families and others to ensure that any learning points or cases where care fell short at individual level are taken forward into relevant service improvements as appropriate. Equally, where good care is identified, this should be shared and celebrated.

FUTURE PLANS

Future plans – CCG

1. The CCGs will explore effective and meaningful ways to engage people with learning disabilities in the LeDeR processes and reporting.
2. With Blackpool Teaching Hospitals NHS Foundation Trust, there will be further consideration regarding how the Structured Judgement Review of deaths process aligns, complements and identifies root cause issues with LeDeR, for deaths in the acute hospital setting
3. A quarterly health inequalities group is being established to ensure quality assurance of the process; inform reviewers and direct commissioning intentions and plans
4. The CCGs commissioning and quality leads will consider local themes from LeDeR reviews, alongside regional and national themes and will work with contracted service providers to audit and review services to evidence improvement in these themed areas, including staff training.

Funding - Regional

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