Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 5 September 2018 at 2.00 pm**

Location: **Sparkenhoe Committee Room - County Hall**

Contact: **Mr. E. Walters (0116 3052583)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Dr. R. K. A. Feltham CC (Chairman)

Mr. T. Barkley CC
Mr. D. C. Bill MBE CC
Mrs. A. J. Hack CC
Mr. D. Harrison CC
Dr. S. Hill CC
Mr. T. J. Pendleton CC
Mrs. J. Richards CC
Mrs. M. Wright CC

Please note: this meeting will be filmed for live or subsequent broadcast via the Council's web site at http://www.leicestershire.gov.uk – Notices will be on display at the meeting explaining the arrangements.

AGENDA

	Item	Report by	
1.	Minutes of the meeting held on 30 May 2018.		(Pages 5 - 16)
2.	Question Time.		
3.	Questions asked by members under Standing Order 7(3) and 7(5).		
4.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
5.	Declarations of interest in respect of items on the agenda.		

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6. Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.

7. Presentation of Petitions under Standing Order 36.

8. Learning Disabilities Mortality Review Programme. (Pages 17 - 64)

9. Section 106 of the Town and Country Planning Act 1990. (Pages 65 - 74)

10. Quality Innovation Productivity and Prevention (QIPP) Schemes. (Pages 75 - 80)

11. Winter Pressures. (Pages 81 - 90)

12. Suicide Prevention Campaign. Director of Public Health (Pages 91 - 98)

13. Dates of future meetings.

    Future meetings of the Committee are scheduled to take place on the following dates:

    7 November 2018 at 10:00am
    16 January 2019 at 2:00pm
    13 March 2019 at 2:00pm
    5 June 2019 at 2:00pm
    11 September 2019 at 2:00pm
    13 November 2019 at 2:00pm

14. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Public Scrutiny website www.cfps.org.uk.

The following questions have been agreed by Scrutiny members as a good starting point for developing questions:-

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

Leicestershire County Council

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 30 May 2018.

PRESENT

Mr. D. C. Bill MBE CC	Mrs. R. Page CC
Dr. R. K. A. Feltham CC	Mr T. Parton CC
Mrs. A. J. Hack CC	Mr. T. J. Pendleton CC
Dr. S. Hill CC	Mrs. M. Wright CC

In attendance
Mrs. P. Posnett CC – Cabinet Lead Member for Health, Public Health and Sport.
Micheal Smith – Healthwatch Leicester and Leicestershire representative.
Dr Chris Trzcinski, Deputy Chair, West Leicestershire CCG (minutes 10 and 11 refer).
Karen English, Managing Director at East Leicestershire and Rutland CCG (minutes 11 and 13 refer).
Paul Gibara, Chief Commissioning and Performance Officer (minute 11 refers).
Caroline Trevithick, Chief Nurse, Quality Lead and Governing Body Nurse at West Leicestershire CCG (minutes 11 and 12 refer).
Paula Vaughan, Deputy Chief Operating Officer, East Leicestershire and Rutland CCG (minute 13 refers).
Helen Thompson, LPT Divisional Director for Families, Young People and Children's Services (minute 14 refers).
Dr Fabida Noushad, Deputy Clinical Director for Adult Mental Health Services, Leicestershire Partnership NHS Trust (minute 14 refers).
Dr Saquib Muhammad, Consultant Psychiatrist, Leicestershire Partnership NHS Trust (minute 14 refers).
Vandna Gohil - Voluntary Action LeicesterShire (minute 15 refers).
Kevan Lyles - Voluntary Action LeicesterShire (minute 15 refers).
Kate Allardyce, NHS Midlands and Lancashire Commissioning Support Unit (minute 16 refers).

1. Appointment of Chairman.

That Dr. R. K. A. Feltham CC be appointed Chairman of the Health Overview and Scrutiny Committee for the period ending with the date of the Annual Meeting of the County Council in 2019.

(Dr. R. K. A. Feltham CC in the Chair)

2. Election of Deputy Chairman.

That Mrs. J. Richards CC be elected Deputy Chairman of the Health Overview and Scrutiny Committee for the period ending with the date of the Annual Meeting of the County Council in 2019.

3. Minutes of the previous meeting.

The minutes of the meeting held on 28 February 2018 were taken as read, confirmed and signed.

4. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 35.

5. Questions asked by members under Standing Order 7(3) and 7(5).

The Chief Executive reported that no questions had been received under Standing Order 7(3) and 7(5).

6. Urgent items.

There were no urgent items for consideration.

7. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

No declarations were made.

8. Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.

There were no declarations of the party whip.

9. Presentation of Petitions under Standing Order 36.

The Chief Executive reported that no petitions had been received under Standing Order 36.

10. Management Structure of Clinical Commissioning Groups in Leicester, Leicestershire and Rutland.

The Committee received a report of the Leicester, Leicestershire and Rutland Clinical Commissioning Groups which provided an update on the proposal to develop an integrated senior management team for the three clinical commissioning groups in Leicester, Leicestershire and Rutland. A copy of the report, marked ‘Agenda Item 10’, is filed with these minutes.

The Committee welcomed Dr Chris Trzcinski, Deputy Chair, West Leicestershire CCG to the meeting for this item.

Arising from discussions the following points were noted:

(i) The main purpose of the proposals was to improve efficiency and ensure the CCGs worked together more effectively, rather than saving money. For this reason a savings figure had not been given in the report. It was not proposed to introduce an additional layer of management to the CCGs; it was proposed to merge an existing layer of management. A benefit of an integrated management team was that managers would have more time to carry out other duties. Whilst it was proposed that the management team would be integrated it was still intended that there would be three separate Boards. Reassurance was given to Members that the single accountable officer model had operated successfully in CCGs in other areas of the country.

(ii) A management structure chart relating to the proposals had not been produced yet as it was expected that the single accountable officer when appointed would wish to have an input into the structure. Members raised concerns regarding the timescales for implementation given that it was proposed that the single accountable officer would be appointed by September 2018. Members also raised concerns regarding a lack of accountability until that appointment was made.

(iii) One of the reasons the CCGs gave for not integrating CCG functions with local authorities was the different priorities of the respective CCGs and local authorities, however members questioned whether in fact CCGs and local authorities had the same priorities with regard to health. It was noted that the demographics within the different authorities were different, for example Leicester City Council had a younger population.

(iv) Members stated that whilst the integrated management team model could be acceptable as an interim measure as part of a move towards a full merger, they had concerns about the model as a permanent solution.

RESOLVED:

(a) That the update on the proposal to develop an integrated senior management team for the three clinical commissioning groups in Leicester, Leicestershire and Rutland be noted but that the CCGs be advised that the Committee has concerns about using this model as a permanent solution;

(b) That officers be requested to produce a more detailed report and management structure chart for a future meeting of the Committee.

11. <u>Quality, Innovation, Productivity and Prevention Programme 2018/19</u>

The Committee received a report of West Leicestershire CCG and East Leicestershire CCG which provided an update on the 2018/19 Quality, Innovation, Productivity and Prevention (QIPP) programme for West Leicestershire CCG and East Leicestershire and Rutland CCG. A copy of the report, marked ‘Agenda Item 11’, is filed with these minutes.

Along with Dr Chris Trzcinski, the Committee welcomed Karen English, Managing Director at East Leicestershire and Rutland CCG, Paul Gibara, Chief Commissioning and Performance Officer and Caroline Trevithick, Chief Nurse, Quality Lead and Governing Body Nurse at West Leicestershire CCG to the meeting for this item.

In presenting the report the following information was given:

(i) The CCGs received approximately £932 million per annum to commission health services in Leicester, Leicestershire and Rutland. Due to growth and inflationary pressures the CCGs were forecast to have a £42 million shortfall during 2018/19 therefore this figure needed to be made up from efficiency savings within the CCGs while ensuring that clinical outcomes were not affected. The money generated would be put towards the priorities for the CCGs which were:

- ensuring primary care was safe and responsive;
- mental health services;
- ensuring waiting lists did not grow.

(ii) QIPP schemes were explained to members using the Musculoskeletal service as an example. Whilst there was a triage process for the Musculoskeletal service, work was being carried out with partners and providers to make the system more efficient and triage patients earlier. A single point of access was being developed for patients with musculoskeletal issues where they would be identified early by GPs and referred for physiotherapy. Improving the self-referral system was also being looked at.

Arising from discussions the following points were noted:

(iii) Before making changes to services Quality Impact Assessments were carried out and all schemes were signed off by the Chief Nurse to ensure they were safe.

(iv) Members raised concerns that the CCGs would not have an idea whether the required savings were going to be achieved until half way through the financial year and by this time it may be too late to make the necessary adjustments. In response reassurance was given that monitoring took place on a weekly basis and there were contingency plans in place should it appear that the required savings would not be made. Alternative schemes would be implemented should the QIPP plan not produce the desired results. Reserves could also be used if necessary.

(v) In response to a question from the Chairman it was explained that the CCGs had a fair amount of confidence that the savings could be achieved, however until the hidden implications were properly understood they could not have complete confidence. Usually the CCGs set themselves a higher savings target than was strictly essential therefore even if the target was not met it would not necessarily result in an overspend.

(vi) Members sought reassurance that the transformation process would not affect frontline services and it was confirmed that the management structure and other back office functions were the main areas targeted for savings.

(vii) A concern was raised regarding the housing growth particularly in the south Leicestershire area, the lack of equivalent growth in GP Surgeries and ineffective use of the process under Section 106 of the Town and Country Planning Act 1990. Members asked for reports on these issues for a future meeting of the Committee. The CCGs gave reassurance that they were fully engaged with the Strategic Growth Plan and were aware which areas of Leicester, Leicestershire and Rutland were to experience growth and therefore need to be prioritised by the CCGs.

(viii) In response to a question from a Member it was confirmed that the biggest difficulties the CCGs faced related to the workforce rather than estates and buildings.

(ix) A member raised concerns that patients were having difficulties returning Community Equipment to the NHS when they no longer needed it and that savings could be made if this equipment was reused. In response it was explained that contract penalties were in place if equipment was not collected and that the CCGs would look into this matter further.

(x) Clarification was given that West Leicestershire CCG was bidding for £8 million of capital funding to invest in the Hinckley area of Leicestershire and this was a separate budget to the £932 million referred to above. West Leicestershire CCG asked for support from members for any bids for capital funding.

(xi) In response to concerns regarding how the QIPP programme would apply to Continuing Healthcare where the aim was to support patients in their own homes as long as possible, it was explained that it was key to ensure that the National Framework for NHS Continuing Healthcare was applied correctly and people met the eligibility criteria. Liaison needed to take place with Local Authorities to ensure that the NHS was providing the elements of care that it was responsible for and not more. There were other efficiencies that could be made such as reviewing patients more regularly to ascertain whether the care they were receiving was still appropriate, and making sure that patients which had died were no longer being budgeted for.

RESOLVED:

(a) That the update on the 2018/19 Quality, Innovation, Productivity and Prevention (QIPP) programme for West Leicestershire CCG and East Leicestershire and Rutland CCG be noted;

(b) That officers be requested to produce a further report on the QIPP programme for the September 2018 meeting of the Committee.

12. A Review of Community Health Services in Ashby.

The Committee received a report of West Leicestershire Clinical Commissioning Group (WLCCG) which provided an update on the relocation of outpatient services following the Review of Community Services in Ashby in 2014/15 and the decision to close Ashby and District Community Hospital. A copy of the report, marked ‘Agenda Item 12’, is filed with these minutes.

Caroline Trevithick from West Leicestershire CCG was also present for this item.

In accordance with the procedures for making representations to the Committee a local resident Mr Frank Bedford spoke regarding the issue.

Arising from discussions the following points were noted:

(i) The Chairman reported the comments of the local member Dr. T. Eynon CC who was generally satisfied with the availability of medical services in the area following the closure of Ashby Hospital, though she had concerns regarding car parking capacity at Coalville Hospital and patients and visitors to the hospital parking on local streets. In response reassurance was given that Leicestershire Partnership NHS Trust who ran Coalville Hospital were aware of the car parking problems and that a local school was being inappropriately used by Coalville Hospital patients for car parking.

(ii) WLCCG had conducted analysis into the travel impact for patients as a result of moving the services to Coalville and Loughborough and found that there were good public transport links from Ashby to Coalville. They had also looked at the demographics of patients using the services to ensure that none of them were disproportionately affected. The Patient Transport Service would transport patients to community hospitals should they be too unwell to use public transport.

(iii) In response to concerns raised by Mr Bedford that WLCCG were no longer monitoring the impact of the change to the way the services were provided in Ashby, it was explained that WLCCG did not performance manage every service they provided however the CCG was a member of the Alliance Management Board where the monitoring did take place. The Alliance Management Board was responsible for ensuring that services were appropriate to patients' need. WLCCG reassured the Committee that they would continue to communicate with Mr Bedford regarding health service concerns in the Ashby area.

(iv) On behalf of North West Leicestershire District Council of which he was a member, Mr. T. J. Pendleton CC offered to work with WLCCG to establish suitable venues in the area for community health services to be provided from and in particular further develop Hood Park Leisure Centre for services such as pulmonary rehabilitation.

RESOLVED:

That the update regarding the relocation of outpatient services following the Review of Community Services in Ashby in 2014/15 be noted.

13. Improving Access to Primary Care.

The Committee received a report of East Leicestershire and Rutland CCG which explained their plans to improve access to primary care and urgent care services for patients out of hours. A copy of the report, marked 'Agenda Item 13', is filed with these minutes.

The Committee welcomed Karen English, Managing Director at East Leicestershire and Rutland CCG, and Paula Vaughan, Deputy Chief Operating Officer, East Leicestershire and Rutland CCG, to the meeting for this item.

Arising from discussions the following points were noted:

(i) The Committee endorsed the proposals particularly the procurement of a combined service for out of hours and urgent care.

(ii) ELRCCG reassured Members that County Councillors would be an important part of the engagement process and would be added to the list of consultees.

(iii) Members raised concerns regarding difficulties for patients in obtaining appointments at some GP Practices within 10 weeks which often lead to increased attendance at the out of hours service. Members asked that ELRCCG gave clear communication to GPs regarding the proposals and ensured that GP Practices adhere to the guidelines. It was noted that GP Practices could book patients into the out of hours service.

(iv) The timings for when GP Practices were open varied across the County and under the new proposals the timings would be standardised. All GP Practices would need to be open until 6:30pm under the new system.

(v) There was a direct correlation between areas which did not have an out of hours service (such as Blaby and Rutland) and high attendance at Accident and Emergency Departments from patients that lived in those areas. Consideration was being given to a suitable venue for an out of hours service in Blaby district.

(vi) In response to a question regarding the closure of Fielding Palmer hospital in Lutterworth it was confirmed that there were no plans to move the out of hours service away from Fielding Palmer.

RESOLVED:

That the plans to improve access to primary care and urgent care services be supported.

14. Response from Leicestershire Partnership NHS Trust to Healthwatch Leicestershire Report entitled 'Insights on the Bradgate Mental Health Unit'.

The Committee received a presentation from Leicestershire Partnership NHS Trust (LPT) regarding the Bradgate Mental Health Unit and actions taken in response to the Healthwatch Leicestershire report entitled 'Insights on the Bradgate Mental Health Unit. A copy of the presentation slides is filed with these minutes along with the Healthwatch Leicestershire report.

For this item the Committee welcomed to the meeting Helen Thompson, LPT Divisional Director for Families, Young People and Children’s Services, Dr Fabida Noushad, Deputy Clinical Director for Adult Mental Health Services, and Dr Saquib Muhammad, Consultant Psychiatrist.

As part of the presentation the following points were highlighted:

(i) All new staff at LPT were required to sign a pledge which explained the conduct LPT expected from staff and what staff could expect from LPT as an employer.

(ii) LPT was working on a document pack for patients at the Bradgate Unit which could be used to welcome them to the ward. LPT was also constructing a new public facing website regarding the Unit.

(iii) LPT was considering expansion of the Involvement Centre including redeveloping the cafeteria.

(iv) It was acknowledged that there were issues with the estate at the Bradgate Unit particularly as the Care Quality Commission had recommended that all rooms should have ensuite bathrooms. Consideration was being given to refurbishing the existing wards or whether to build new wards, and an outline business case was expected to be ready by July 2018. National support was also being sought for capital funding. The policy of central government was to move away from dormitory accommodation therefore LPT was cautiously optimistic that the capital funding would become available.

(v) There were still issues with the workforce specifically relating to recruitment and 30% of the qualified nurse roles were vacant. However, more than 20 apprentices had recently begun employment with LPT and the Trust was able to rely on well trained bank staff to ensure that all shifts were covered safely.

Arising from discussions the following points were noted:

(vi) In response to a question from a member regarding patients feeling unsafe in the Bradgate Unit, particularly perceiving a threat from other patients, it was explained that the wards were busier than they used to be and LPT accepted that the ward environment was not conducive to every patient’s needs. Reassurance was given that each patient was clinically assessed according to their needs on arrival and the clinical assessment process continued throughout their stay to ensure a patient was on the most appropriate ward. Wards were separated by gender and some wards were specially designed to be a low stimulus environment so that sensitive patients were more able to cope with their surroundings. Restraints were used if necessary. Patients would be moved wards if their clinical assessment changed. Each patient had a named nurse that they could discuss concerns with.

(vii) There were community mental health services in place which enabled patients to be treated earlier so that their health would not have deteriorated as much by the time they were admitted to hospital. In connection with this members were made aware of an initiative called ‘Are you ok?’ where the general public were stopped in the streets and asked about their mental health and referred to the Samaritans if necessary. Members asked for further information on this and it was noted that a report on suicide prevention would be presented to the Committee later in the year.

(viii) In response to a question from a member regarding gaining feedback on patient experience, it was explained that there were learning forums within the Trust, and senior doctors surveyed a random sample of patients about the services the Bradgate Unit provided. Additionally morbidity and mortality meetings took place, and staff shared their views with each other. It was agreed that further documents regarding the learning process would be circulated to Members after the meeting.

RESOLVED:

That the actions taken by Leicestershire Partnership NHS Trust in response to the Healthwatch Leicestershire Report on the Bradgate Unit be noted.

15. Healthwatch Leicestershire Annual Review 2017-18.

The Committee received a report of Voluntary Action Leicestershire which presented the Healthwatch Leicestershire Annual Report 2017-18. A copy of the report, marked ‘Agenda Item 15’, is filed with these minutes.

The Committee welcomed Vandna Gohil and Kevan Lyles of Voluntary Action LeicesterShire (VAL) to the meeting for this item.

Members thanked Voluntary Action LeicesterShire for the user friendly Annual Report and the willingness of Healthwatch Leicestershire, whilst VAL held the contract, to challenge the way health services were run.

Some members of the Committee expressed disappointment that the contract for Healthwatch Leicester and Leicestershire had now been awarded to an organisation based in Staffordshire - Engaging Communities Staffordshire (ECS). In response reassurance was given by Micheal Smith of Healthwatch Leicester and Leicestershire that whilst the Governance was scrutinised by ECS the priorities for Healthwatch Leicester and Leicestershire were still set locally. ECS held the Healthwatch contract for seven counties in the midlands which created a strong network.

Members requested that the Committee receive a Healthwatch Leicester and Leicestershire Report more frequently than on an annual basis.

RESOLVED:

(a) That the Healthwatch Annual Review 2017/18 be welcomed.

(b) That Voluntary Action Leicestershire be thanked for their work regarding Healthwatch Leicestershire whilst they held the contract.

16. Health Performance Update.

The Committee considered a joint report of the Chief Executive of the County Council and NHS Midlands and Lancashire Commissioning Support Unit, which provided an update of performance at the end of quarter four of 2017-18. A copy of the report marked ‘Agenda Item 16’ is filed with these minutes.

The Committee welcomed Kate Allardyce, NHS Midlands and Lancashire Commissioning Support Unit to the meeting to present the report.

In presenting the report it was highlighted that new Better Care Fund guidance was expected to be published soon and would inform future targets for the Better Care Fund Programme for 2018/19 onwards which would be included in the next Performance Report to the Committee if available.

Arising from discussions the following points were noted:

(i) Since the papers for the Committee meeting had been published, more up to date data on tooth decay in children had been released which showed that in 2016/17, the percentage of five year olds with one or more decayed, missing or filled teeth in Leicestershire was 22.3%. This was an improvement compared to the previous survey in 2014/15. Members were extremely happy to note this progress.

(ii) Members were very pleased with the reduction in days lost due to Delayed Transfers of Care (DTOC). It was noted however, that there had not been such an improvement for Delayed Transfers for people with Learning Difficulties and members questioned why this may be the case. It was noted that the Delayed Transfers of Care for University Hospitals of Leicester were low whereas those for Leicestershire Partnership NHS Trust (LPT) were much higher therefore the Committee may wish to investigate further the DTOCs relating to LPT and learning difficulties in particular.

(iii) Members were interested to learn about Metric 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, per month, and the reasons behind the non-improvement in performance for this Metric. It was suggested that Metric 4 performance could be an agenda item at a future meeting of the Committee.

(iv) The number of cancer screening referrals made by GPs had increased and it was speculated whether this was due to more public awareness of cancer causing more patients to visit their GPs regarding that particular health problem. There had not been a corresponding increase in numbers of patients being referred on for cancer treatment therefore it appeared that the amount of patients diagnosed with cancer was not increasing. The increased referrals for cancer screening would have an impact on the two week target for cancer screening however there would be no impact on the targets for cancer treatment given that there had been no change in the amount of patients that needed cancer treatment. The Director of Public Health informed that cancer screening was the responsibility of NHS England which was looking at creating a Task and Finish Group to address the issue.

RESOLVED:

(a) That the performance summary, issues identified and actions planned in response to improve performance be noted.

(b) That officers be requested to provide a report for a future meeting of the Committee on Metric 4: Total non-elective admissions into hospital per 100,000 population, per month.

17. Remodelling of Integrated Lifestyle Service Provision.

The Committee received a report from the Director of Public Health which sought the views of the Committee on the proposed new model for an integrated lifestyle service. A copy of the report, marked ‘Agenda Item 17’, is filed with these minutes.

In presenting the report Members were informed that the consultation would now open on 11 June 2018 and finish at the end of July 2018, and then the proposal would be taken to Cabinet in the autumn.

Arising from discussions the following points were noted:

(i) The present system relied on GPs to make referrals to the weight management programme. The Lead Member for Health and Wellbeing Mrs. P. Posnett CC stated that she had received positive messages from people who had undertaken the weight management programme however more needed to be done to make the service more easily accessible. The Director of Public Health explained that it was planned that the weight management service would be available out of normal working hours such as during evenings or Saturday mornings.

(ii) The proposed new system would enable patients to refer themselves to the weight management programme without seeing their GP. The First Contact Plus website contained a large amount of information regarding weight management. Should a person require further help they could complete an online form which would result in them receiving a telephone call from an advisor, or there was a telephone number which they could call themselves. The advisor would rely on the information given over the phone regarding the person's weight; no checking was done nor independent weighing process conducted. The callers would need to be self-motivated to follow the advice and monitor their own weight.

(iii) In response to a suggestion from a member the Director of Public Health agreed to give consideration to whether mobile phone applications could be used as part of the weight management scheme.

(iv) It was noted that many workplaces held their own schemes regarding weight management and the proposals from the Director of Public Health could link in with those schemes.

(v) Persons with drug or alcohol addictions were being referred to a separate service run by Turning Point. In response to a comment from a Member the Director of Public Health acknowledged that there may be people that were abusing substances such as alcohol and cocaine but were still functioning and maintaining full time employment and consideration needed to be given to whether Turning Point was the appropriate service for these people.

RESOLVED:

That the proposed new model for an integrated lifestyle service be supported.

18. Date of next meeting.

RESOLVED:

It was noted that the next meeting of the Committee would be held on 5 September 2018 at 2:00pm.

2.00 - 5.30 pm
30 May 2018

CHAIRMAN

Learning Disabilities Mortality Review
(LeDeR) Programme

Information pack for Leicestershire Health Overview and Scrutiny Committee

September 5th 2018

James Lewis
Local Area Contact for Leicester, Leicestershire and Rutland; Learning Disability Mortality Review
james.lewis@leicester.gov.uk
01164 544839 / 07956 563368

Learning Disabilities Mortality Review (LeDeR) Programme

Introduction

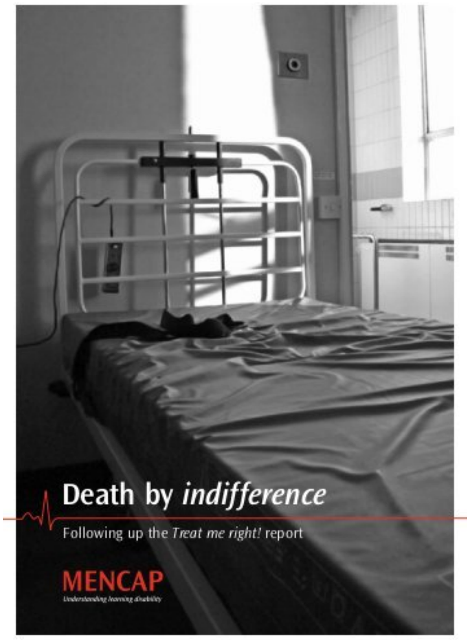
From the LeDeR Annual Report (2017)

The persistence of health inequalities between different population groups has been well documented, including the inequalities faced by people with learning disabilities (LD). Today, people with learning disabilities die, on average, 15-20 years sooner than people in the general population, with some of those deaths identified as being potentially amenable to good quality healthcare.

The Learning Disabilities Mortality Review (LeDeR) 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. It is being implemented at the time of considerable spotlight on the deaths of patients in the NHS, and the introduction of the national Learning from Deaths framework in England in 2017. The programme is led by the University of Bristol, and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

From Mencap to Southern Health – LeDeR's origins

For over 10 years there have been a series of investigations, reports and scrutiny placed on health and social care services delivered for people with learning disabilities. LeDeR aims to address the inequalities, inconsistencies, and what has been determined 'institutional discrimination' that these reviews and reflections have brought to national attention.

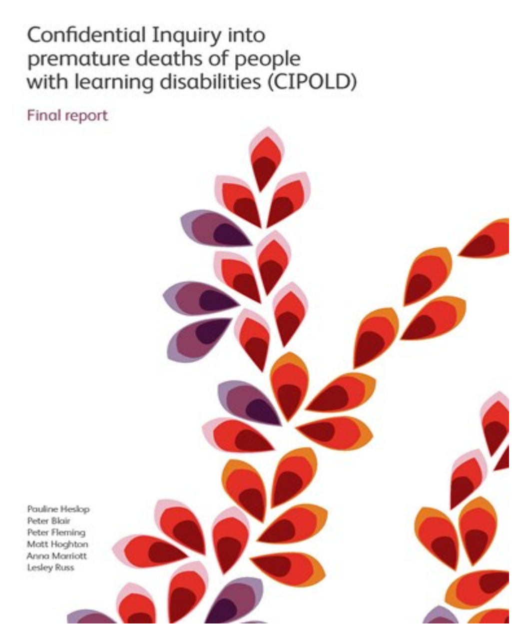


Death by *indifference*

Following up the *Treat me right!* report

MENCAP

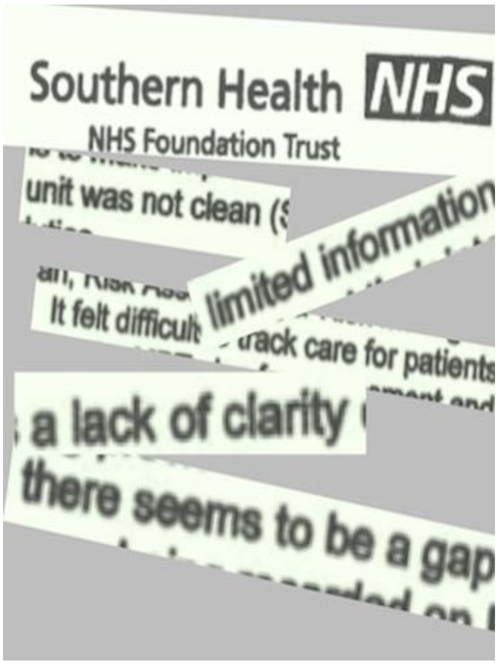
Understanding learning disability



Confidential Inquiry into
premature deaths of people
with learning disabilities (CIPOLD)

Final report

Pauline Heslop
Peter Blair
Peter Fleming
Matt Hoghton
Anna Marriott
Lesley Russ



James Lewis
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Learning Disabilities Mortality Review (LeDeR) Programme

The LeDeR Process

4 +

Anybody over the age of 4 years old with a diagnosed learning disability is required to have a review of their health and social care services after their death

A referral to the LeDeR programme is made either online or over the phone. Details can be found at http://www.bristol.ac.uk/sps/leder/

Referrals are then sent to the LLR local area contact for allocation to an available LeDeR reviewer.

For LLR LeDeR reviewers are usually Nurses from the two NHS Trusts or Social Workers from the three local authorities. They are specially trained in conducting LeDeR reviews.

The allocated LeDeR reviewer will discuss the person – their life, aspirations, what they enjoyed doing – with their family, friends, carers and involved professionals.

They will also review case records from all major organisations involved. This includes hospital records and local authority assessments and support plants.

They will use this evidence as the basis for their LeDeR review. This includes a pen portrait of the person and a timeline of their care leading up to death.

The review ends with a score of the person's care and an outline of any identified learning. If there were significant concerns a further multi-disciplinary review could be convened.

Once approved the reviews and recommendations are then passed to the LLR LeDeR Steering Group for discussion. This could lead to the development and implementation of Action Plans to improve services.

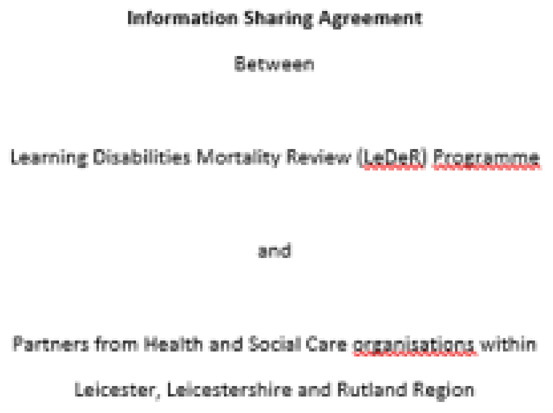
Leicester, Leicestershire and Rutland (LLR) LeDeR

Approximately 15,500	Estimated number of people with a learning disability across LLR*
October 1st 2017	LeDeR programme goes live across LLR
50	Indicative projection for LD deaths across LLR each year
50	Current projection for the number of deaths across LLR for LeDeR's first year
44	Number of referrals from LLR made to the LeDeR programme (since Oct. 1st 2017)
14	Trained LeDeR reviewers
20	Referrals allocated to a LeDeR reviewer
30	Referrals awaiting allocation
2	Reviews going through Quality Assurance process
3	Completed reviews

*Pansi data as cited by East Leicestershire and Rutland CCG 'LLR Transforming Care Plan' https://eastleicestershireandrutlandccg.nhs.uk/wp-content/uploads/2013/01/LLR-Transforming-Care-Plan-April-2016-2.pdf

Data Protection & Information Sharing

The LeDeR programme has undergone extensive work to ensure the people's data is protected in line with stipulations of contemporary legislation (including GDPR). In recognition of this work the LeDeR programme has obtained on a national level Section 251 approval from the Secretary of State to handle personal data without consent to conduct mortality reviews; on a local level an information sharing agreement signed by health and social care partners to this end. For more information visit http://www.bristol.ac.uk/sps/leder/ or contact James Lewis.



Information Sharing Agreement

Between

Learning Disabilities Mortality Review (LeDeR) Programme

and

Partners from Health and Social Care organisations within

Leicester, Leicestershire and Rutland Region

James Lewis
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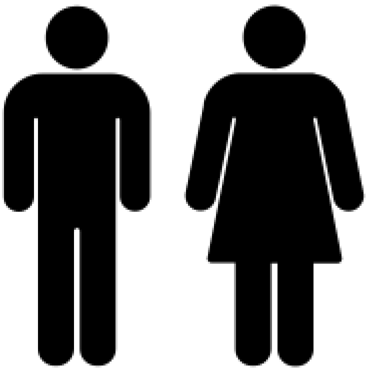
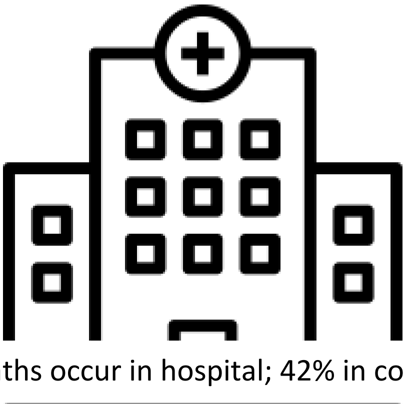
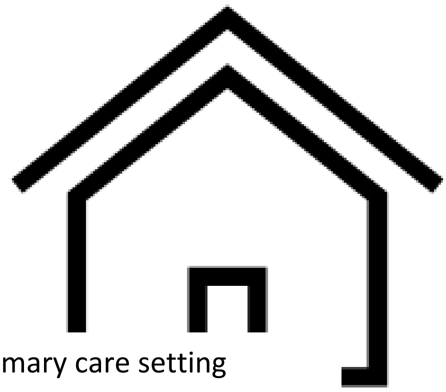
Learning Disabilities Mortality Review (LeDeR) Programme

Some indicative findings for LLR (as of 21.08.18)



Life expectancy (Leicester)		Ave. age of death (LeDeR referrals)	
Female	77	Mild LD	69
		Moderate LD	63
Male	81	Profound / Severe LD	48
		All LD	56

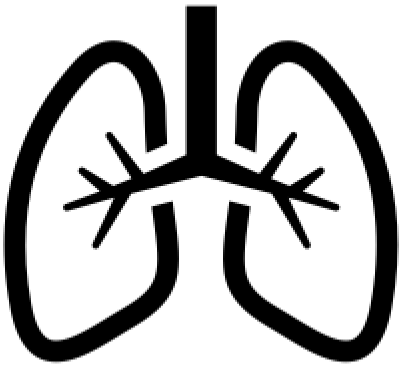




58% of deaths occur in hospital; 42% in community or primary care setting

Most prevalent causes of death
are respiratory related conditions
(COPD, Aspiration Pneumonia).

Other causes include cardiac
conditions, sepsis and cancer.



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Learning Disabilities Mortality Review (LeDeR) Programme

Leicester, Leicestershire & Rutland LeDeR's priorities

- Recruit further LeDeR reviewers
- Continue to raise awareness of the programme with stakeholders. Presentations have been delivered to health and social care professionals, the voluntary and community sector and service user participation groups; LeDeR correspondence sent to health and social care providers across Leicester, Leicestershire and Rutland.
- Begin to formulate Action Plans based upon the findings of completed LeDeR reviews
- Integrate LeDeR into LLR's programme of work to improve services for people with learning disabilities

How you can contribute to the LeDeR programme

- Refer the deaths of anyone over the age of 4 with a diagnosed Learning Disability to the programme (http://www.bristol.ac.uk/sps/leder/notify-a-death/ or 0300 777 4774)
- Provide information to a LeDeR reviewer if asked for it. All key health and social care organisations have signed up to the local information sharing agreement for the purposes of the programme.
- Become a LeDeR reviewer. We are in particular looking for those whom have experience in working with people with learning disabilities in a health or social care setting. For more information please contact James Lewis.

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The Learning Disabilities Mortality Review
(LeDeR) Programme

This information can be made available in formats such as easy read or large print, and may be available in alternative languages, upon request

Annual Report

December 2017

University of
BRISTOL

NHS
England

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP), on behalf of NHS England.

Contents

Executive summary

Introduction

The persistence of health inequalities between different population groups has been well documented, including the inequalities faced by people with learning disabilities. Today, people with learning disabilities die, on average, 15-20 years sooner than people in the general population, with some of those deaths identified as being potentially amenable to good quality healthcare.

The Learning Disabilities Mortality Review (LeDeR) 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. It is being implemented at the time of considerable spotlight on the deaths of patients in the NHS, and the introduction of the national Learning from Deaths framework in England in 2017. The programme is led by the University of Bristol, and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

The programme has developed a review process for the deaths of people with learning disabilities. All deaths receive an initial review; those where there are any areas of concern in relation to the care of the person who has died, or if it is felt that further learning could be gained, receive a full multi-agency review of the death. Deaths subject to the current priority review themes (aged 18-24years or from a Black or minority ethnic background) receive multi-agency review and expert panel scrutiny. At the completion of the review, an action planning process identifies any service improvements that may be indicated.

By the end of November 2017, all but two of the 39 LeDeR Steering Groups were operational. Key processes to deliver mortality reviews of people with learning disabilities have been established, and over 1,000 local reviewers have been trained in the LeDeR methodology. The LeDeR methodology itself has been refined with routine updates twice a year, matched with amendments to training and associated materials and the LeDeR IT systems.

The programme has developed a robust quality assurance process to ensure that training is of the highest standard, is fit for purpose and ultimately delivers high quality reviews. The programme team produces targeted reports for those involved with delivering the LeDeR programme, including NHS England leads, Steering Groups, Local Area Contacts and Regional Coordinators. These reports summarise notification data, and review progress and the learning and recommendations identified in completed reviews.

The most significant challenge to programme delivery has been the timeliness with which mortality reviews have been completed, largely driven by four key factors: a) large numbers of deaths being notified before full capacity was in place locally to review them b) the low proportion of people trained in LeDeR methodology who have gone on to complete a mortality review c) trained reviewers having sufficient time away from their other duties to be able to complete a mortality review and d) the process not being formally mandated.

The programme team has been resolving these challenges in a number of ways, including the use of Key Performance Indicators; the appointment of Regional Coordinators to work with local Steering Groups; additional funding from NHS England to support local recovery plans; and the commissioning of NHS Sustainable Improvement to help address and support a reduction in the number of un-reviewed deaths, and develop a more streamlined process for the delivery of mortality reviews.

Deaths notified to the LeDeR programme

From 1st July 2016 to 30th November 2017, 1,311 deaths were notified to the LeDeR programme. The most frequent role of those notifying a death was Learning Disability Nurse (25%), most commonly working in a Community Learning Disabilities Team.

Key information about the people with learning disabilities whose deaths were notified to the LeDeR programme includes:

- Just over half (57%) of the deaths were of males
- Most people (96%) were single
- Most people (93%) were of White ethnic background
- Just over a quarter (27%) had mild learning disabilities; 33% had moderate learning disabilities; 29% severe learning disabilities; and 11% profound or multiple learning disabilities.
- Approximately one in ten (9%) usually lived alone
- Approximately one in ten (9%) had been in an out-of-area placement.

The proportion of people with learning disabilities who died in hospital was greater (64%) than the proportion of hospital deaths in the general population (47%). Younger people with learning disabilities were more likely to die in hospital than were older people (76% of those under 24 years of age compared with 63% of those aged 65 and over); those with profound or multiple learning disabilities were more likely to die in hospital (71%) than other people with learning disabilities (59%).

The median age at death[1] of people with learning disabilities (aged four years and over) was 58 years (range 4-97 years). For males it was 59; for females 56. More than a quarter (28%) of deaths were of people aged under 50 years. People with profound or multiple disabilities had a median age at death of 41 years; those with mild or moderate learning disabilities had a median age at death of 63 years.

Less than half (44%; n=576) of deaths notified to the LeDeR programme stated a cause of death. For the remainder of the deaths notified, the exact cause of death will be confirmed to the LeDeR programme during the mortality review process itself. It is also the case that some of the preliminary causes of death given at notification, could subsequently change if, for example, a post-mortem indicates a different cause.

Almost a third of the deaths (31%) had an underlying cause related to diseases of the respiratory system. These were distributed across all age groups from aged 18 years onwards, but were more commonly given as the underlying cause of death in people between ages 25-44. The second most common category of deaths was of diseases of the circulatory system (16%). These were also distributed across all age groups but were more common in the oldest. Men were slightly more likely than women to die from circulatory disorders (18% vs. 14%).

Analysis of the individual ICD-10[2] codes of reported underlying causes of death indicates a significant proportion of deaths from pneumonia (16%) and aspiration pneumonia (9%).

Analysis of any conditions cited in Part I of the Medical Certificate of Cause of Deaths (MCCD) suggests causes of death broadly similar to underlying causes of death, plus sepsis (11%). People aged 25–34 were more likely to have aspiration pneumonia listed in Part I of their MCCD than were other age groups (37% vs. 24%).

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[1] The median age at death is the age at which exactly half the deaths were of people above that age and half were of people below that age

[2] ICD-10 codes are based on the International Classification of Diseases version 10. The codes in ICD-10 classify all medical diagnoses, symptoms and procedures.

Completed reviews of deaths of people with learning disabilities

By 30 November 2017, 103 reviews had been completed and approved by the LeDeR quality assurance process. Reviewers indicated that in13 (13%) the person's health had been adversely affected by one or more of the following: delays in care or treatment; gaps in service provision; organisational dysfunction; or neglect or abuse. For example:

- A person was discharged home with a catheter, although the care staff had never received any training about catheter care. The person was later readmitted to hospital with possible urinary sepsis.
- For one person there was evidence of several delays in their hospital care and treatment. The patient was not monitored in terms of Modified Early Warning System (MEWS) measurements. Blood tests were not taken during their brief stay in hospital. It was also noted that there was no justification or explanation in the medical or nursing records about the course of treatment the patient received.
- For one person who could not speak up for himself, there was no professional co-ordination in relation to his long term conditions. Treatment for the patient's weight loss took months; the identification of kidney stones also took months with limited pain relief being given. Identification of a urinary infection and treatment for it with antibiotics towards the end of the patient's life could and should have been sooner; and there was no recognition before he died of pyelonephritis which was the cause of death.

The deaths of 13 people received a full multi-agency review. Three of these met the criteria for Priority Themed Review.

Learning points and recommendations from completed reviews

From the 103 completed reviews, there were 189 learning points or recommendations identified. In each review that identified one or more learning points, the average number of learning points and/or recommendations was 2.8. Thirty-six reviews (35%) did not identify any learning.

The most commonly reported learning and recommendations were made in relation to the need for:

a) Inter-agency collaboration and communication
b) Awareness of the needs of people with learning disabilities
c) The understanding and application of the Mental Capacity Act (MCA).

Most of the learning to-date echoes that of previous reports of deaths of people with learning disabilities, and the importance of addressing this cannot be over-estimated. We have a responsibility to families and others to ensure that any learning points at individual level are taken forward into relevant service improvements as appropriate.

As a result of the reviews completed, some actions have already been taken to improve service provision for people with learning disabilities. These have included, for example, strengthening discharge planning processes, and the provision of reasonable adjustments for people with learning disabilities.

National recommendations made based on completed local reviews of deaths in 2016-2017 are as follows:

1. Strengthen collaboration and information sharing, and effective communication, between different care providers or agencies.
2. Push forward the electronic integration (with appropriate security controls) of health and social care records to ensure that agencies can communicate effectively, and share relevant information in a timely way.
3. Health Action Plans, developed as part of the Learning Disabilities Annual Health Check should be shared with relevant health and social care agencies involved in supporting the person (either with consent or following the appropriate Mental Capacity Act decision-making process).
4. All people with learning disabilities with two or more long-term conditions (related to either physical or mental health) should have a local, named health care coordinator.
5. Providers should clearly identify people requiring the provision of reasonable adjustments, record the adjustments that are required, and regularly audit their provision.
6. Mandatory learning disability awareness training should be provided to all staff, and be delivered in conjunction with people with learning disabilities and their families.
7. There should be a national focus on pneumonia and sepsis in people with learning disabilities, to raise awareness about their prevention, identification and early treatment.
8. Local services must strengthen their governance in relation to adherence to the Mental Capacity Act, and provide training and audit of compliance ‘on the ground’ so that professionals fully appreciate the requirements of the Act in relation to their own role.
9. A strategic approach is required nationally for the training of those conducting mortality reviews or investigations, with a core module about the principles of undertaking reviews or investigations, and additional tailored modules for the different mortality review or investigation methodologies.

The future focus of the LeDeR programme will be to move beyond ‘learning’ into ‘action’ to support improved service provision for meeting the health and care needs of people with learning disabilities and their families.

Chapter 1:

Introduction

Health inequalities in relation to people with learning disabilities

The persistence of health inequalities between different population groups has been receiving renewed attention recently. Focusing on trends in population mortality and life expectancy, Marmot (2017) has reported that not only have improvements in life expectancy at population level stalled, but that inequalities within and between local authorities, and between areas with different deprivation indices have persisted.

In addition, each of the six domains that are key contributors to health inequalities as identified in the Marmot Review (2010) (early child development; education; employment and working conditions; minimum income for healthy living; healthy and sustainable places to live and work; and taking a social determinants approach to prevention) are described as raising cause for concern in 2017 (Institute of Health Equity, 2017).

Health inequalities faced by people with learning disabilities have also been highlighted in recent years. Emerson and his colleagues in 2016 reported markedly poorer health for people with learning disabilities than their non-disabled peers, whilst in 2017 Osugu and colleagues concluded that in addition to having a high prevalence of diagnosed health problems, adults with learning disabilities also have a four-fold disparity in signs and symptoms that are medically unexplained.

Inequalities in mortality of people with learning disabilities

The higher mortality rate in England for people with learning disabilities is both an outcome of health inequalities, and a health inequality itself. An overview of key reports relating to mortality of people with learning disabilities was presented in Appendix 1 of our 2015-2016 annual report (http://www.bristol.ac.uk/sps/leder/resources/annual-reports/). It is more than 10 years since Mencap published Death by Indifference (2007) highlighting ‘institutional discrimination’ leading to the deaths of six people with learning disabilities whilst in the care of the NHS. In 2018 it is a decade since Sir Jonathan Michael’s (2008) report ‘Healthcare for all’ in which he expressed shock at the ‘disturbing’ findings of the inquiry, and concern that the experiences of the families described in Mencap’s report were by no means isolated.

Over the past few years, statistical evidence about inequalities in mortality of people with learning disabilities has been accumulating. Using data from the Clinical Practice Research Datalink database for April 2010 to March 2014 (CPRD GOLD, September 2015), Glover and colleagues at Public Health England, with the LeDeR programme, reported an all-cause standardised mortality ratio of 3.18 for people with learning disabilities (Glover et al., 2017). Their life expectancy at birth was 19.7 years lower than for people without learning disabilities. Drawing on data from the same source, Hosking et al. (2016) reported that more than a third of deaths of people with learning disabilities were potentially amenable to health care interventions. A summary of the key issues over time that have been associated with premature mortality in people with learning disabilities is presented on p.3-4 of our 2015-2016 annual report (http://www.bristol.ac.uk/sps/leder/resources/annual-reports/).

National policy in relation to learning from deaths

National policy in relation to learning from deaths has been strengthened following publication of the Care Quality Commission (CQC) report ‘Learning Candour and Accountability’ in 2016. The report describes what the CQC found when it reviewed how NHS Trusts identify, investigate and learn from the deaths of people under their care. The report authors indicated that there was a ‘common’ level of acceptance and sense of inevitability when people with learning disabilities or mental illness died, and that the lack of a single framework for NHS Trusts that sets out what they need to do to maximise the learning from deaths that may be the result of problems in care was problematic. The report concluded that learning from deaths was not being given enough consideration in the NHS and opportunities to improve care for future patients were being missed.

National Guidance on Learning from Deaths was published by the National Quality Board in March 2017. It provides a framework for NHS Trusts and NHS Foundation Trusts in England for identifying, reporting, investigating and learning from deaths of people in their care. The guidance emphasises the importance of learning from reviews of the care provided to patients who die, and that this should be integral to a provider's clinical governance and quality improvement work. It requires providers to have a clear policy for engagement with bereaved families and carers, and an updated policy on how they respond to, and learn from, deaths of patients who die. From April 2017, Trusts have been required to collect and publish on a quarterly basis specified information on deaths.

A driver for the CQC report in 2016 was the death of Connor Sparrowhawk, a young man with learning disabilities, who was under the care of Southern Health NHS Foundation Trust. A review into the circumstances at the Trust where he died revealed a very low number of investigations or reviews of deaths at the Trust (Mazars, 2015). The deaths of people with learning disabilities were therefore a particular focus of the CQC report, which is also reflected in the national guidance on Learning from Deaths. Here, it is acknowledged that the lives of people with learning disabilities often involve a complex array of service provision with multiple care and support staff. A single agency review of their death would likely fail to identify the complex interplay of circumstances leading to a person's death, and the wide range of potentially avoidable contributory factors to their death. A cross-sector approach to reviewing deaths of people with learning disabilities is underpinned in the Learning from Deaths guidance, which states that all deaths of people with learning disabilities aged four years and older should be subject to review using LeDeR methodology.

Chapter 2:

The LeDeR programme

About the LeDeR programme

The LeDeR programme is delivered by the University of Bristol, and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015 for an initial three-year period. The overall aims of the LeDeR programme are to support improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities.

A key part of the LeDeR programme is to support local areas in England to review the deaths of people with learning disabilities aged four years and over. The programme has developed and rolled out a review process for the deaths of people with learning disabilities. By the end of 2017, the LeDeR programme was fully rolled out across England, with local Steering Groups in place, and the deaths of people with learning disabilities being reviewed in all regions.

The LeDeR programme also collates and shares anonymised information about the deaths of people with learning disabilities nationally, so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements. These are reported in the following chapters of this report.

Core principles and values of the programme

- We value the on-going contribution of people with learning disabilities and their families to all aspects of our work.
- We take a holistic perspective looking at the circumstances leading to deaths of people with learning disabilities and don't prioritise any one source of information over any other.
- We aim to ensure that reviews of deaths lead to reflective learning which will result in improved health and social care service delivery.
- Our aim is to embed reviews of deaths of people with learning disabilities into local structures to ensure their continuation.

LeDeR methodology

The LeDeR methodology is described in a flowchart in Appendix 1, a brief summary in Appendix 2, and on the LeDeR website at www.bristol.ac.uk/sps/leder/

Delivery of the LeDeR programme

In our Annual Report 2015-2016, we reported on the progress made in establishing the programme in its first year, between 1st June 2015 to 31st May 2016. This covered details about the 'set up' activities for the programme and the ways in which we worked through the challenges faced in establishing a process for local reviews of deaths. We will not repeat this information here; rather we will provide an update from June 2016 about further developments in the programme delivery.

In June 2016, a NHS England National Operational Steering Group was established, and each NHS region appointed an NHS England Regional Coordinator to guide the roll out of the LeDeR programme, across their geographical region. Each of the four NHS England regions of England established a pilot site for the LeDeR programme in 2016. The pilot sites were as follows:

- NHS England North: Cumbria and the North East
- NHS England Midlands and the East: Leicestershire, Leicester City and Rutland
- NHS England South: Wessex, Gloucester and Oxford
- NHS England London: Lambeth, Richmond, Kingston, Camden, Islington and Tower Hamlets

The lessons learnt from the pilot sites were shared at regional 'learning and sharing' events prior to the development of regional plans to deliver the wider roll-out of the programme.

By the end of November 2017, all but two of the 39 Steering Groups were operational. Key processes to deliver mortality reviews of people with learning disabilities have been established, and over 1,000 local reviewers have been trained in using the LeDeR methodology. The LeDeR methodology itself has been refined with routine updates twice a year, matched with amendments to training and associated materials and the LeDeR IT systems. The programme has developed a robust quality assurance process to ensure that training is of the highest standard, is fit for purpose and ultimately delivers high quality reviews. The programme team produces targeted reports for those involved with delivering the LeDeR programme, including NHS England leads, Steering Groups, Local Area Contacts and Regional Coordinators. These reports summarise notification data, the progress of reviews, and the learning and recommendations identified in completed reviews.

It is to be expected that a programme of this size and complexity, requiring the input and support from a range of stakeholders, would face challenges to its delivery. The most significant challenge has been the timeliness with which mortality reviews have been completed, largely driven by four key factors:

- large numbers of deaths being notified before full capacity was in place locally to review them
- the low proportion of people trained in LeDeR methodology who have gone on to complete a mortality review
- trained reviewers having sufficient time away from their other duties to be able to complete a mortality review and
- the process not being formally mandated.

Some participating NHS and social care organisations have made it clear that, because of their present overstretched budgets and the pressures on staff time, contributing to LeDeR could not be prioritised as we would all like. Nevertheless, NHS Trust level participation is expected and quarterly dashboards will be published as described in the National Guidance on Learning from Deaths - the implementation of which is overseen by NHS Improvement.

The programme team has been assessing progress in resolving these challenges with four key performance indicators, as follows:

1. The proportion of those receiving training who then collect their password to the LeDeR IT system (indicating that they are likely to be conducting a review of a death).
2. The proportion of notifications of death that are awaiting allocation from the Local Area Contact to a reviewer.
3. The proportion of deaths which have been in the LeDeR review process longer than six months.
4. The proportion of trained reviewers not aligned to a Steering Group.

Additional measures taken have been the appointment of Regional Coordinators to work with local Steering Groups; additional funding from NHS England to support local recovery plans; and NHS Sustainable Improvement has been formally commissioned to help address and support a reduction in the number of un-reviewed deaths, and develop a more streamlined process for the delivery of mortality reviews.

Chapter 3:

Demographic characteristics and information about the deaths of people with learning disabilities

This chapter describes the demographic characteristics of the people with learning disabilities whose deaths were reviewed as part of the LeDeR programme from 1st July 2016 – 30th November 2017. It also describes information relating to their deaths.

DEATHS NOTIFIED TO THE LeDeR PROGRAMME

Number of deaths notified to the LeDeR programme

From 1st July 2016 to 30th November 2017, 1,311 deaths were notified to the LeDeR programme. Just under half of these (48%) were from the North of England, unsurprisingly so as the LeDeR programme was first introduced in the North. Table 3.1 presents the number of notifications of deaths of people with learning disabilities by NHS England region. Figure 1 (over-page) shows that the number of deaths notified to the programme has generally been increasing each month.

Table 3.1: Number of notifications of deaths of people with learning disabilities by NHS England region

Region	Number	%
North	631	48
Midlands and East	241	18
South	261	20
London	178	14
Total notifications	1311	100

Those notifying deaths

To-date, 668 different people have notified deaths to the LeDeR programme. The most frequent role of those notifying a death was Learning Disability Nurse (25%; n=168). Only three-quarters (78%; n=523) of those notifying a death included details of their employing organisation. Of these, the largest proportions worked in a Community Learning Disability Team or Community NHS Trust (38%; n=199), or in secondary or acute care (26%; n=136).

Figure 3.1: The number of deaths notified to the LeDeR programme each month

Demographic characteristics and information about the deaths of people with learning disabilities

The rest of this chapter describes the demographic characteristics of the people with learning disabilities whose deaths were reviewed as part of the LeDeR programme. It also describes information relating to their deaths.

Gender

Of the people with learning disabilities whose deaths were notified to the LeDeR programme, over half (57%; n=741[3]) were men.

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[3] The gender of six people was not recorded at the time of notification.

Marital status

Marital status was reported for 1,073 people. Of these, most people who died were single (96%). Women were more likely to have been married, divorced, widowed or separated than were men (6% vs. 2%).

Ethnicity

The person's ethnic background was reported for 1,145 deaths notified. Almost all of these (93%) were from a White ethnic background, 4% were from an Asian background, and 4% were from other backgrounds. The proportion of people whose ethnic group was described as 'White' was higher than the 86% recorded for England and Wales as a whole (ONS, 2011).

Severity of learning disabilities

At the point of notifying a death, the severity of a person's learning disabilities was reported for 828 people. Just over a quarter (27%) of these were known to have had mild learning disabilities; 33% had moderate learning disabilities; 29% severe learning disabilities; and 11% profound or multiple learning disabilities.

Living alone, or away from home

Of the 1,158 people for whom the information was available at the notification of their death, 9% usually lived alone. Information about out-of-area placements was available for 1,107 deaths: of these 101 people (9%) had been in an out-of-area placement.

Place of death

In England in 2016, 47% of deaths of the general population occurred in hospital (National End of Life Intelligence Network, 2017). Table 3.2 shows the place of death, where known at the point of notification, for deaths notified to LeDeR. As can be seen, the proportion of people with learning disabilities who died in hospital (64%; n=801) was considerably greater than that of the general population. Younger people with learning disabilities were more likely to die in hospital than were older people, with 76% of those aged 24 and under dying in hospital (n=86) compared to 63% (n=260) of those aged 65 and older.

Table 3.2: The place of death of people with learning disabilities

Place of death	Number	%
Hospital	801	64
Usual place of residence[1]	373	30
Hospice / palliative care unit	27	2
Other[2]	43	3
Total	1244	100%

[1] Includes own or family home, and residential or nursing home that was the person's usual address

[2] Includes home of relative or friend, and residential or nursing home that was not usual address

Of the 828 people for whom the severity of their learning disability was recorded at notification, those with profound or multiple learning disabilities were more likely to die in hospital (71%; n=61) than other people with learning disabilities (59%; n=412), and less likely to die at their usual place of residence (23%; n=20) compared to other people with learning disabilities (35%; n=249).

Age at death

Figure 3.2: Median age at death by severity of learning disabilities

Cause of death

Less than a half (44%; n=576) of deaths notified to the LeDeR programme stated a cause of death at the time of notification. For the remainder of the deaths notified, the exact cause of death would be confirmed during the mortality review process itself. However, it is also the case that some of the causes of death given at notification, and presented in this section, may be preliminary causes which could subsequently change if, for example, a post-mortem indicated a different cause.

Medical certificates of cause of death (MCCD) are divided into two sections, Parts I and II. Contained in Part I is the immediate cause of death, tracking the sequence of causes back to any underlying cause or causes. The World Health Organisation (WHO, 1967) defines the underlying cause of death as the disease or injury which initiated the train of events leading directly to death, or the circumstances of the accident or violence which produced a fatal injury. Part II of the MCCD is used to list other significant conditions, diseases or injuries that contributed to the death, but were not part of the direct sequence leading to death4.

Underlying cause of death

Table 3.3 presents the underlying cause of death, as categorised by ICD-10 chapters. Almost a third of the deaths (31%; n=177) had an underlying cause related to diseases of the respiratory system. The second most common ICD-10 chapter was that of diseases of the circulatory system (16%; n=95).

Table 3.3: Underlying cause of death by ICD-10 chapter

Underlying cause of death	Number	%[1]
Diseases of the respiratory system	177	31
Diseases of the circulatory system	95	16
Neoplasms	55	10
Nervous system	46	8
Diseases of the digestive system	38	7
Mental and behavioural disorders	38	7
Congenital malformations, deformations and chromosomal abnormalities	33	6
Diseases of the genitourinary system	30	5
Other underlying causes	64	11
Total	576	100

[1] Percentages add to more than 100% due to roundin

Figure 3.3 shows that diseases of the respiratory system were distributed across all age groups from aged 18 years onwards, but were more commonly given as the underlying cause of death in people between ages 25-44. Diseases of the circulatory system were also distributed across all age groups, most commonly amongst the older age groups, but also amongst those aged 35 - 44.

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4 The information from the MCCD is coded using the latest International Classification of Disease (ICD) codes, to form national statistics on the causes of death of a population. The LeDeR programme has applied to NHS Digital for the ICD-10 codes of all causes of death in Parts I and II of the MCCD for those whose deaths have been notified to LeDeR. This will provide a richer, and more accurate source of information about the deaths of people with learning disabilities over time.

Figure 3.3: Broad category of underlying cause of death by age group

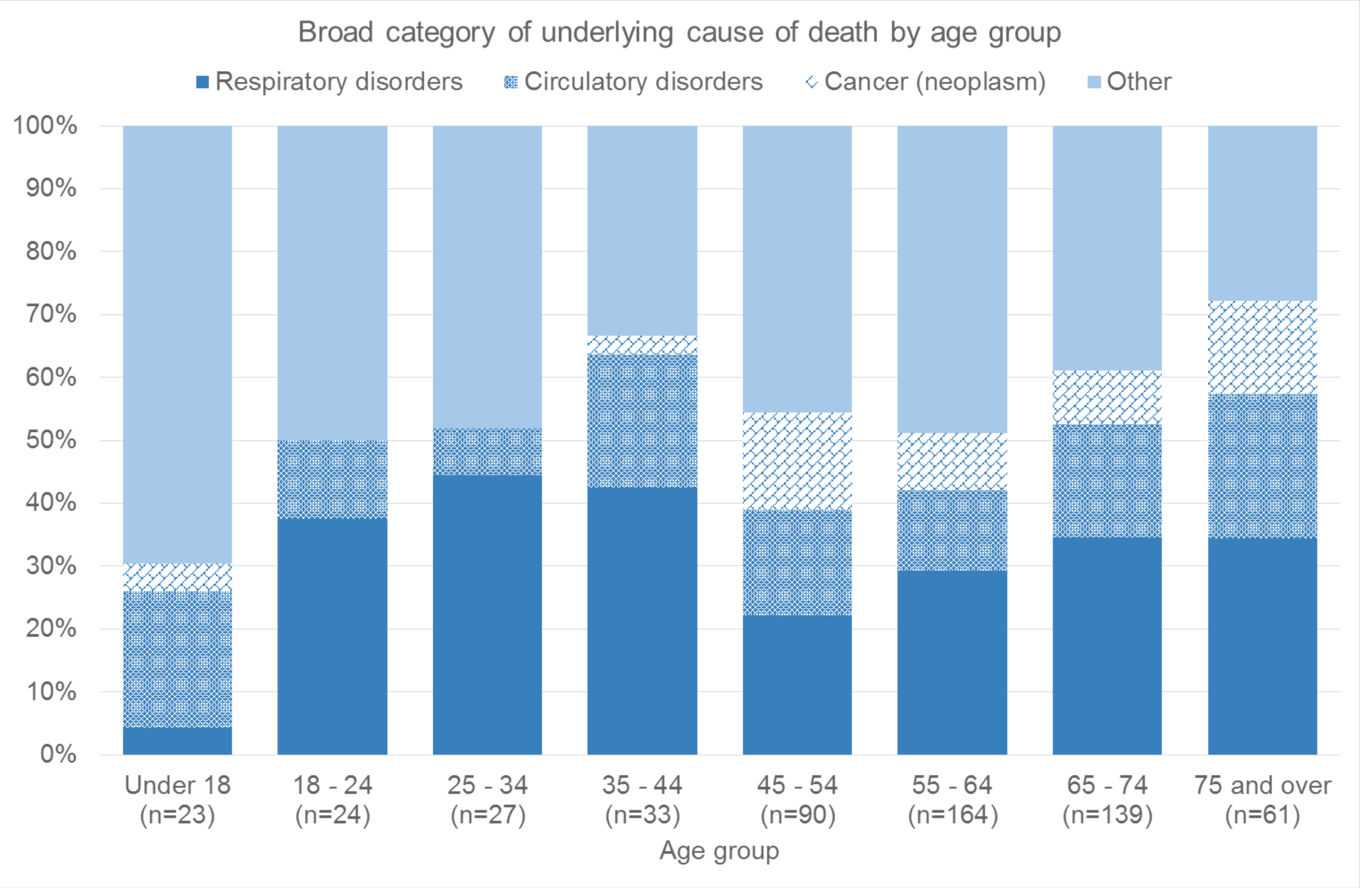

Figure 3.4 shows underlying cause of death by gender. Men were slightly more likely than women to die from circulatory disorders (18% vs. 14%), while women were slightly more likely to die from cancer (11% vs. 9%).

Figure 3.4: Underlying cause of death by gender

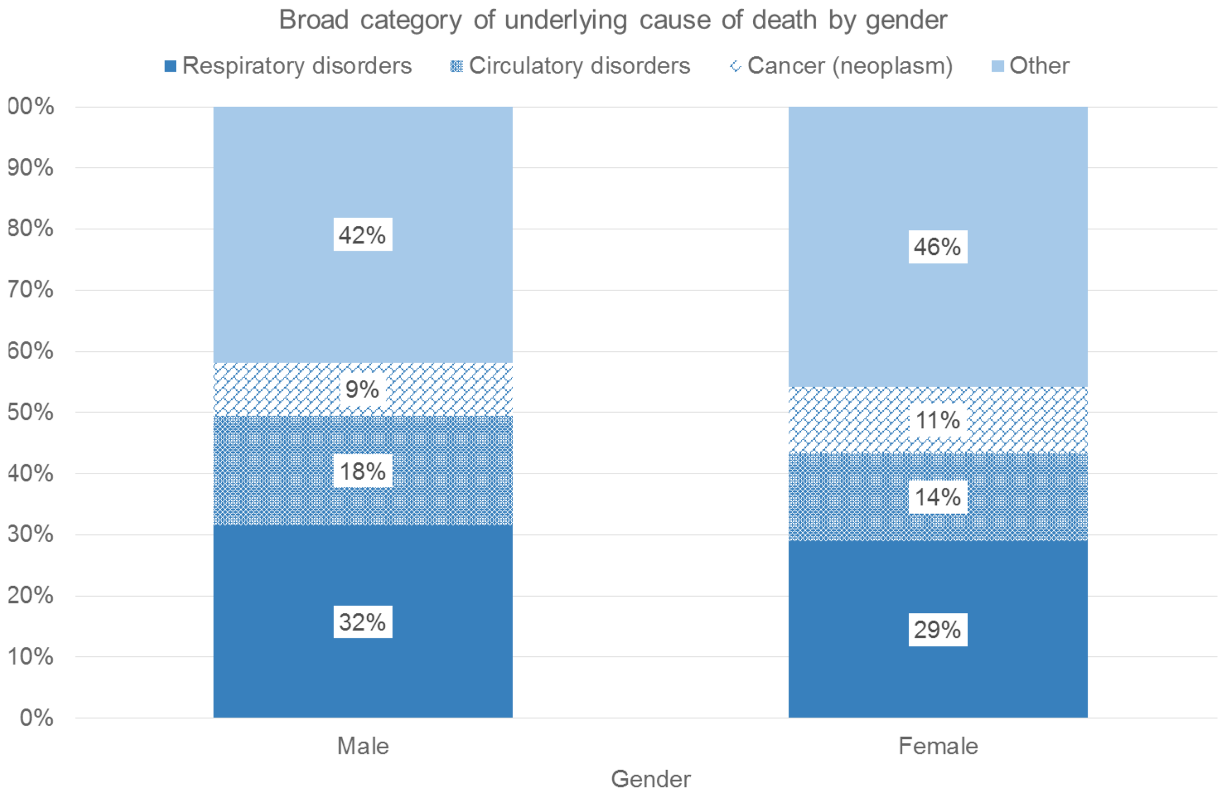

Table 3.4 provides analysis of the individual ICD-10 codes for the most commonly reported underlying causes of death. It indicates a significant proportion of deaths from pneumonia (16%; n=93) and aspiration pneumonia (9%; n=51).

Table 3.4: Most common individual underlying causes of death by ICD-10 code

Underlying cause of death	No.	%
Pneumonia – unspecified	93	16
Aspiration pneumonia	51	9
Epilepsy	25	4
Dementia	24	4
Down syndrome[1]	23	4
Total (where cause of death is reported at notification)	576	n/a

Other causes of death recorded in Part I of the MCCD

Although the underlying cause of death is the most commonly reported and used in vital statistics, it is instructive to also consider other conditions identified in the sequence from the immediate cause of death tracking back to the underlying cause of death. In part, this is because it is important to bring to light those conditions for which service improvement initiatives may be indicated, but which are not described as the underlying cause of death. In part, it is also because there is a growing body of evidence to suggest that inconsistencies and inaccuracies frequently occur in recording the cause of death of people with learning disabilities on the MCCD (Tyrer and McGrother, 2009; Glover and Ayub, 2010; Landes and Peak, 2013; Hosking et al., 2016; Trollor et al., 2017).

The conditions most frequently cited in Part I of the MCCDs of people notified to the LeDeR programme are shown in Table 3.5. While they were broadly similar to underlying causes of death (Table 3.4), the fact that sepsis is mentioned on 11% (n=66) of MCCDs is of note, given the current NHS England national sepsis action plan[5].

Table 3.5: Most common conditions identified as causes of death anywhere on Part 1 of MCCD

Most frequent causes of death	No.	%
Pneumonia – unspecified	140	24
Aspiration pneumonia	96	17
Sepsis	66	11
Dementia	34	6
Epilepsy	28	5
Down syndrome	25	4
Cardiac arrest	24	4
Respiratory infection	22	4
Total (where cause of death is reported at notification)	576	n/a

There were no significant differences between males and females in the conditions mentioned on Part 1 of the MCCD. However, people aged 25–34 were more likely to have pneumonia listed in Part I of their MCCD than were other age groups (37% vs. 24%). Other than dementia occurring in older age groups, there were no other differences in conditions listed by age group.

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[5] https://www.england.nhs.uk/wp-content/uploads/2017/09/second-sepsis-action-plan.pdf

COMPLETED REVIEWS OF DEATHS OF PEOPLE WITH LEARNING DISABILITIES

By 30th November 2017, 103 reviews had been completed and approved by the LeDeR quality assurance process. This section outlines some of the key findings from completed reviews.

Involvement of someone who knew the person well

All but five reviews were completed with the assistance of someone who knew the person who had died well. Over half (56%; n=58) obtained information from staff at the home where the person lived; over a third (38%; n=39) from a family member; and a fifth from a member of a community learning disability team (19%; n=20). Other sources of information included GP practices (17%; n=18) and social services staff (15%; n=15).

Other investigations taking place

Reviewers reported that post-mortems were carried out on 12% (n=12) of the deaths that had completed the review process, and there was to be a Coroner's inquest into 5% (n=5) of the deaths. A further 19% (n=19) were to be subject to another investigation or review, most commonly an internal (NHS Trust) mortality review.

Reviewers' overall assessment of the care received by the person

At the end of the review, having considered all of the information available to them, reviewers are asked to provide an overall assessment of the care provided to the individual. As Table 3.6 shows, in the majority of completed mortality reviews (79%; n=81) the care was assessed as either Grade 1 (excellent) or Grade 2 (good). A further 12% (n=12) were assessed as 'satisfactory' (Grade 3). The care received by five people (5%) was assessed as Grade 5 (falling short of best practice with the potential for learning from a fuller review of the death). The care received by one person was assessed as Grade 6 (having the potential for, or actual, adverse impact on the person).

Aspects of care or service provision considered to have demonstrated the provision of excellent care

Almost a half (44%) of reviewers (Table 3.6) assessed the care provided to the person who had died as being 'excellent'. 'Excellent' care is described as being better than the good quality care that any patient should expect to receive. Reviewers were asked to detail any aspects of care or service provision that they considered to have demonstrated the provision of excellent care. Generally, however, there was a lack of detail about why care was considered excellent, rather than of a good quality. For example, one reviewer commented that excellent care had been provided because 'there were numerous experts involved' in the person's care, without specifying exactly what it was that made this excellent care. Another commented that the sister of the person who had died described her care as 'exemplary' and that it had supported her sister to have 'a dignified and happy end of life', but had not explained what it was that made the care 'exemplary'.

Similarly, other examples of excellent care were related to the provision of reasonable adjustments that health services have a duty to provide under the Equality Act 2010. One reviewer described excellent care as being related to the support provided to the brother and sister-in-law of a person who died, noting that both were partially sighted and were encouraged to stay in hospital with their relative in her final weeks; the relatives had told the reviewer that they had felt well supported during and after their relative's death. Another reviewer described

Table 3.6: Reviewers' overall assessment of the care received by the person

	Overall assessment	No.	%
1	This was excellent care and met current best practice	45	44
2	This was good care, which fell short of current best practice in only one minor area	36	35
3	This was satisfactory care, falling short of current best practice in two or more minor areas, but no significant learning would result from a fuller review of the death	12	12
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 could result from a fuller review of the death	1	1
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	5	5
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	1	1
	No grading given	3	3
	Total	103	100%

excellent care as being provided by the hospital learning disability liaison nurse, reporting that 'when Gerald[6] was not able to be safely supported at home, they worked with him to find out what was most important to him (his wife and football on TV) and ensured he had both of these with him on the ward. Gerald found this very reassuring and it greatly improved his experience'.

Additionally, a few reviewers described excellent care in relation to the home environment in which the person had lived, one reviewer noting that 'the care home went above caring', and describing it as a 'family' where the person appeared to be 'loved as well as cared for.'

Moving forward, we are hopeful that reviewers will be able to identify more tangible examples of excellent care that can be shared with all agencies, and adopted and implemented as appropriate.

Aspects of care or service provision which may have adversely affected the person

Reviewers indicated that 13 (13%) people's health had been adversely affected by one or more of the following: delays in care or treatment; gaps in service provision; organisational dysfunction; or neglect or abuse. For example, in relation to one person the reviewer noted:

Discharged home with a catheter and the care staff had never had any training on catheter care. Nick was later readmitted to hospital with possible urinary sepsis. The failure to liaise with carers about their knowledge and skills in catheter care contributed to an unsafe discharge, readmission and rapid decline in health.

Another reviewer noted:

> *'There was evidence to indicate several omissions occurred within the hospital, which caused delays in care and treatment provided to Marlon. He was not monitored in terms of Modified Early Warning System (MEWS) measurements, and no blood tests were taken during his brief stay in hospital - there was no documentation in the medical or nursing records to justify these courses of action.*
>
> *Marlon was extremely distressed due to his skin condition and the pain associated with this. He was given analgesia and subsequently slept for long periods of time, during which he was not disturbed to be offered diet and fluids. It is likely the staff thought they were acting in his best interest by not disturbing him. While it was unlikely that even with optimal management this death could have been prevented, it should be noted that i) the omission of one dose of [medicine] is unlikely to have prevented the fatal pulmonary embolism, although it may have done so and ii) sepsis or dehydration could have contributed to the development of a pulmonary embolism in this patient. A lack of investigations performed on admission meant that these conditions, if present, were not diagnosed or treated.'*

In relation to another death, the reviewer commented:

'This was a gentleman who could not advocate for himself. He was under the care of a urologist when a child, this stopped at age 18. For 8 years he had no follow up care and during this time he developed a large kidney stone which was the main cause of his death. There was no professional co-ordination in relation to his long-term conditions; the treatment of his weight loss took months; the identification of his kidney stones took months; limited pain relief was given, the identification of urinary infection and commencement on antibiotics towards the end of his life could have been done sooner; and there was no recognition of pyelonephritis which was the cause of death.'

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[6] All names have been changed to protect confidentiality

Progression to multi-agency review

If there are areas of concern identified about the death, or if it is felt that a fuller review could lead to improved practice, a more in-depth or multi-agency review takes place. This involves the range of agencies that have been supporting the person who has died, (e.g. health and social care staff). Multi-agency reviews are also undertaken when people who died meet the Priority Themed Review criteria (Appendix 2).

The deaths of 13 people received a full multi-agency review: three of these met the criteria for Priority Themed Review.

Actions taken in relation to learning and recommendations from completed reviews are described in the following chapter.

Chapter 4:

Learning and recommendations from completed reviews

The LeDeR programme's success will be determined by the ability of commissioners and providers of services to convert learning and recommendations from completed reviews into service improvements. As such, at the end of the initial and multi-agency review forms there is space for reviewers to identify learning and recommendations (from initial reviews) and action points (from multi-agency reviews). These are collated by the LeDeR team, and reported back to Steering Groups, Regional Coordinators and Regional Leads via the routine reporting systems of the programme.

Overall themes identified as learning points or recommendations

Of the 103 completed reviews, 67 identified a total of 189 learning points[7]. Thirty-six reviews (35%) did not explicitly identify any learning, the remainder identified between 1-21. Overall, the average was 2.8 learning points in each review.

The most commonly reported learning and recommendations were made in relation to the need for:

a) Inter-agency collaboration, including communication

b) Awareness of the needs of people with learning disabilities

c) The understanding and application of the Mental Capacity Act (MCA)

It should be noted that two learning points referred to evidence of good practice and the opportunity for others to learn from positive experiences, both in relation to inter-agency communication.

Inter-agency collaboration, including communication

The largest category of learnings or recommendations related to collaboration and communication between agencies and, while some elements of good practice were identified, concerns about a lack of coordination and sharing of information between care providers were apparent.

Good practice identified included one reviewer reporting[8]:

'The family actively participated in discussions with the multidisciplinary team and in planning Jenny's end of life care. This was facilitated by a high level of communication between the many acute, critical care, palliative care and community professionals involved in her care as well as by a clear and organised plan for managing her transfer back to the care home and her management there.'

Another reviewer commented:

> *'There was excellent use of the traffic light assessment tool and full involvement of the LD Liaison Nurses, to ensure Frank's needs were met. All referrals within the hospital were accepted promptly and all the teams within the hospital appeared to work well together to provide consistent and timely care for him.'*

Reviews of other deaths, however, identified considerable scope for improvements in inter-agency collaboration and communication, particularly in relation to communication involving residential or care homes and health professionals. For example, one reviewer commented:

> *'A shortfall was liaison between the GP, community teams, and the residential home staff. None of the care home staff were involved in Best Interest decision meetings, so there were delays in getting the right information and sharing expertise.'*

Another reviewer reported that although the person with learning disabilities relied on those who knew his individual and communication patterns well in order identify his needs, they had no way of sharing this key knowledge with others supporting and caring for him.

A range of recommendations was made in relation to improving interagency collaboration and communication. These included:

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[7] For simplicity, 'learnings' and 'learning points' are used in this chapter to cover learning points, recommendations and action plans.

[8] Learning and recommendations have been edited from the originals submitted by reviewers.

- Ensuring that a health passport is created if a person with learning disabilities does not already have one when admitted to hospital.
- A&E department to improve signage about expected waiting times and what to do if condition deteriorates whilst waiting to be seen.
- Poor or unsafe discharges from hospital to be addressed at quality review group meetings.
- Address the need for good healthcare co-ordination for people with learning disabilities.
- GP practices to follow-up the reason for non-attendance at Annual Health Checks, and inform the Community Learning Disabilities Team about those known to the service and not responding to invitations.

Awareness of the needs of people with learning disabilities among health and social care providers

The second largest category of the learning and recommendations related to raising awareness about the needs of people with learning disabilities. Training needs across a spectrum of roles were noted, including those working in A&E, the local authority, acute services, care providers and primary care.

Recommendations for training included general awareness about the health needs of people with learning disabilities. Several reviewers commented on the importance of health care staff being aware of behaviour as a means of communication, for example:[9]

> *'Acute services need to be supported in recognising the needs of patients with learning disabilities in their care, particularly people with communication difficulties who may present with certain behaviours as a mechanism to communicate.'*

Another reviewer notes the need to:

> *'Ensure that front line practitioners are aware that changes in behaviour and mood can be a sign of an underlying medical condition.'*

Reviews of deaths also identified the need for a greater awareness of the health needs of people with learning disabilities to be embedded within the healthcare system, with one reviewer commenting:

> *'GPs may benefit from a reminder of the system within Community Learning Disability Teams which identifies people who have Down's Syndrome and their need to be assessed for early onset dementia.'*

Another reviewer noted that:

> *'There is still a need for GP practices and clinical leads to be made aware of the importance of full annual health checks for people with learning disabilities.'*

Raising the awareness of paid care staff about supporting people receiving palliative care was also identified as a learning point, with one reviewer recommending a discussion with the local contract monitoring team about supporting end of life awareness training in residential and supported living services.

Some of the lack of awareness of the needs of people with learning disabilities was underpinned by staff not being able to easily access a record of their specific needs. One reviewer noted that the person with learning disabilities had had anxieties about accessing services where there were stairs, and as a consequence attendance at appointments was not consistent. They felt that had this been recorded, reasonable adjustments could have been made. Another reviewer recommended that

> *'If a patient who is flagged on a register does not attend their appointments, they should be followed up to establish if reasonable adjustments are required, and not discharged first.'*

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[9] Learning and recommendations have been edited from the originals submitted by reviewers.

Better understanding and application of the Mental Capacity Act

The third largest category of the learning and recommendations related to the need for a better understanding and application of the Mental Capacity Act (MCA). Reviewers identified problems with the level of knowledge about the MCA by a range of professionals, and concerns about capacity assessments not being undertaken, the Best Interests process not being followed, and Deprivation of Liberty Safeguards (DOLS) not being applied. For example, in relation to one person, the reviewer noted:

> *'Several references to lack of capacity in hospital records but no evidence of a capacity assessment in records. A consent form for the procedure did indicate a lack of capacity through a tick system but was not backed up with a full capacity assessment - a capacity assessment form was on file but not completed.'*
>
> *'Additionally, there is evidence of close and continuous supervision at times during Ashley's admission to hospital whilst awaiting the procedure, but no evidence of a consideration for DOLs authorisation, despite a number of entries in the notes identifying that she did not have capacity. Without a formal assessment it is difficult to identify what the statement 'lacks capacity' relates to.'*

The learning and recommendations from the review related to the need for improved training about all aspects of the Mental Capacity Act and DOLS.

In the review of another death, the reviewer noted concerns about the validity of a tenancy agreement for a person's supported living accommodation as the person had not had a capacity assessment and was thought unlikely to have understood the terms of the agreement. A recommendation was made for social care annual reviews to consider the validity of tenancy agreements as part of a check on adherence to the MCA.

From 'learning' to action

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 families and others to ensure that any learning points at individual level are taken forward into relevant service improvements as appropriate.

Several examples of actions resulting from the reviews of deaths of people with learning disabilities have been given.

For example, a couple of reviews reported concerns about unsafe discharges of people with learning disabilities. Actions taken include one hospital trust reviewing safeguarding procedures in relation to discharge planning for patients with learning disabilities, and another hospital adding a 'catheter prompt' on their discharge planning forms to ensure that any changes to the level of support that may be required for a person are identified early, and carers properly trained in any new aspects of the person's care.

In relation to the provision of reasonable adjustments for people with learning disabilities in hospital, one trust has now raised this with ward staff to ensure that 'reasonable adjustment care plans' are in place for all patients with learning disabilities.

To address poor inter-agency communication, one area has been discussing with the Clinical Commissioning Group the need to fund specialist support for people with learning disabilities when admitted to hospital in an emergency. In relation to another death that highlighted concerns about inter-agency communication, a multiagency meeting was held to review joint working arrangements.

More general learning disability awareness training has also been delivered to a range of professionals following the findings of the LeDeR review. In addition, one reviewer recorded that a hospital had now identified two members of staff to be learning disability, autism and 'hidden' disability champions, and that a folder containing advice and support about caring for people with learning disabilities is kept at the nursing station on the ward.

The need for further action

There is, at present, a raft of initiatives in place to raise awareness of the needs of people with learning disabilities, and improve the delivery of health and care services. Some of these are:

- NHS Improvement is developing Improvement Standards for Learning Disability. The four key standards relate to improving the workforce, improving the provision of reasonable adjustments, improving specialist learning disability NHS services, and improving inclusion and engagement with people using services and their family carers.
- NHS Digital is developing a nationally available flag to be placed on a person's Summary Care Record that will indicate if the person has been identified by a care provider as being potentially eligible for reasonable adjustments, and what reasonable adjustments in care should be considered.
- The NHS England Transforming Care programme is working to improve health and care services so that people with learning disabilities can live in the community, with the right support, close to home.
- The Royal College of General Practitioners has developed a toolkit to help GPs and practice nurses carry out learning disability annual health checks to a high standard.
- NHS England is developing practice guidance for supporting people with learning disabilities who have poor outcomes in some long-term conditions, including diabetes, epilepsy, heart disease and dysphagia. The diabetes guidance is now available at https://www.england.nhs.uk/rightcare/products/pathways/diabetes-pathway
- NHS England is supporting the STOMP project to stop the over-use of psychotropic medicines. Resources to support this are available at https://www.england.nhs.uk/learning-disabilities/stomp/

However, most of the learning from mortality reviews presented in this annual report echoes that of previous reports of deaths of people with learning disabilities, with the same issues repeatedly identified as problematic over the past decade or so. For example:

- Mencap's Death by Indifference (2007) reported that many healthcare professionals 'do not understand much about learning disability' (p.19), and 'do not understand the law around capacity and consent to treatment' (p.21).
- In 2008, Sir Jonathan Michael concluded that 'the evidence shows a significant gap between policy, the law and the delivery of effective health services for people with learning disabilities' (Michael 2008, p.53), and recommended 'improve[d] data, communication and cross-boundary partnership working' (p.54).
- In 2013, CIPOLD recommended 'Clear identification of people with learning disabilities on the NHS central registration system and in all healthcare record systems'; 'Reasonable adjustments required by, and provided to, individuals, to be audited annually'; and 'Mental Capacity Act training and regular updates to be mandatory for staff involved in the delivery of health or social care' (Heslop et al. p.108).

These same issues are being raised as problematic in LeDeR reviews some 10 years after coming to public attention in Death by Indifference.

A model that can be helpful when thinking about the development of expertise in supporting people with learning disabilities is that of 'Conscious Competence', developed in the 1970s. According to the model, we move through four stages as we develop expertise (see Figure 4.1):

- Unconsciously incompetent – we don't know that we don't have this expertise, or that we need to learn it.
- Consciously incompetent – we know that we don't have this expertise.
- Consciously competent – we know that we have this expertise.
- Unconsciously competent – we don't know that we have this expertise (it just comes naturally).

People do not usually make an effortless, smooth transition from one stage to another: different strategies are needed in the move between stages, and in making recommendations from the completed LeDeR reviews we need to bear this in mind. For example, delivering training about the requirements of the Mental Capacity Act may be necessary for those who are 'unconsciously incompetent', but other professionals may benefit more from the opportunity to apply the learning to their work setting, and develop their skills and expertise through joint working and reflecting on their practice.

Recommendations for action

Based on the evidence from completed LeDeR mortality reviews, we make a number of important and key recommendations. These are summarised in Table 4.1 and more fully explained below.

Inter-agency collaboration and communication

Evidence suggests that in general, interagency collaboration is perceived by professionals, those using services and their families, as having a beneficial impact and outcome (Cooper et al., 2016). Facilitative factors for interagency collaboration and communication are:

- ✓ Good working relationships, including a commitment from all staff to work together, trust and mutual respect across agencies, and shared understandings
- ✓ Transparent and constant communication between agencies
- ✓ Adequate funding, staffing and time, and the presence of a key worker or care co-ordinator
- ✓ Strong leadership and clear lines of accountability.(Atkinson et al. 2007).

Table 4.1: Summary of recommendations

	Recommendation	Responsible agency
1.	Strengthen collaboration and information sharing, and effective communication, between different care providers or agencies.	Commissioners
2.	Push forward the electronic integration (with appropriate security controls) of health and social care records to ensure that agencies can communicate effectively, and share relevant information in a timely way.	NHS England
3.	Health Action Plans, developed as part of the Learning Disabilities Annual Health Check should be shared with relevant health and social care agencies involved in supporting the person (either with consent or following the appropriate Mental Capacity Act decision-making process).	NHS England Commissioners Providers
4.	All people with learning disabilities with two or more long-term conditions (related to either physical or mental health) should have a local, named health care coordinator.	Commissioners
5.	Providers should clearly identify people requiring the provision of reasonable adjustments, record the adjustments that are required, and regularly audit their provision.	Providers
6.	Mandatory learning disability awareness training should be provided to all staff, delivered in conjunction with people with learning disabilities and their families.	Commissioners Providers
7.	There should be a national focus on pneumonia and sepsis in people with learning disabilities, to raise awareness about their prevention, identification and early treatment.	NHS England
8.	Local services strengthen their governance in relation to adherence to the MCA, and provide training and audit of compliance 'on the ground' so that professionals fully appreciate the requirements of the Act in relation to their own role.	Commissioners Providers
9.	A strategic approach is required nationally for the training of those conducting mortality reviews or investigations, with a core module about the principles of undertaking reviews or investigations, and additional tailored modules for the different mortality review or investigation methodologies.	NHS England

Our first recommendation is therefore to **strengthen collaboration and information sharing, and effective communication, between different care providers or agencies.** There may be a number of ways of addressing this, but one approach could be for health and social care agencies to appoint a person with leadership responsibility for interagency collaboration and communication. As a matter of priority, this role-holder should develop, monitor and audit the effectiveness of their policy and procedures for interagency collaboration and communication; and train all staff members about good practice in interagency communication.

Our second recommendation is to **push forward the electronic integration (with appropriate security controls) of health and social care records to ensure that agencies can communicate effectively, and share relevant information in a timely way.** People with learning disabilities are often in touch with several health and care providers, but the records are usually siloed in different systems, or in multiple sets of paper records. We suggest that NHS England work with NHS Digital and the Professional Records Standards Body to develop information standards relating to the multi-agency care of people with learning disabilities, and others, that will enable professionals to share high quality digital care records and promote their widespread use in health and social care systems.

Our third recommendation is that **Health Action Plans developed as part of the Learning Disabilities Annual Health Check should be shared with relevant health and social care agencies involved in supporting the person (either with consent or following the appropriate Mental Capacity Act decision-making process).** The learning disabilities annual health check scheme is a voluntary reward programme for primary medical services. Under the scheme for 2017-18, GP practices are encouraged to produce a register of all patients aged 14 years or over with learning disabilities; offer all the patients on this register an annual health check and perform the health check where the patient agrees to this; and offer all the patients on the register a Health Action Plan and produce the Health Action Plan where the patient agrees to this. A National Electronic Health Check clinical template for people with learning disabilities is currently under development (see: https://www.england.nhs.uk/wp-content/uploads/2017/05/nat-elec-health-check-ld-clinical-template.pdf); we feel that a strong steer is required from NHS England for this to be shared (with patient consent) across relevant health and social care agencies involved in supporting the person.

Our fourth recommendation is that **all people with learning disabilities with two or more long-term conditions (related to either physical or mental health) should have a local, named health care coordinator.** The National Institute for Clinical Excellence (NICE) quality standard (QS142) for people with learning disabilities and a serious mental illness, is that they should have a key worker to improve care coordination and help services to communicate clearly with people with learning disabilities and their family members and carers. Current NHS England recommendations are that commissioners should extend the offer of a named local care coordinator to all people with learning disabilities and/or autism who have a mental health condition or behaviour that challenges (LGA, ADASS, NHSE, 2015; Public Health England, 2017). In the light of the extent to which potentially avoidable contributory factors leading to death are related to poor inter-agency collaboration and communication, we do not believe that this is sufficient. Rather, we suggest that parity is upheld between the impact of physical and mental health conditions, and that any person with learning disabilities with two or more long-term conditions, of whatever nature, is supported in managing their overall healthcare needs with a local, named health care coordinator.

Awareness of the needs of people with learning disabilities

Our fifth, sixth and seventh recommendations focus on improving an awareness about the needs of people with learning disabilities. As already mentioned above, there is already positive work in progress to raise awareness of the needs of people with learning disabilities, and improve the delivery of health and care services; when fully introduced and implemented, these will make a positive contribution.

Our **fifth recommendation is that providers clearly identify people requiring the provision of reasonable adjustments, record the adjustments that are required, and regularly audit their provision.** The mortality reviews provided patchy evidence about the provision of reasonable adjustments for people with learning disabilities, although this is a statutory requirement for health and care services.

Our sixth recommendation is that mandatory learning disability awareness training should be provided to all staff, delivered in conjunction with people with learning disabilities and their families. Evidence from the mortality reviews suggested that the influence of all staff, not just ‘front line’ staff providing health or social care, was important and could make a difference to the outcomes for people with learning disabilities. Office secretaries, outpatient booking clerks, cleaners and meal attendants could all be influential, and it is equally important that they receive learning disability awareness training.

Our seventh recommendation is for a national focus on pneumonia and sepsis in people with learning disabilities, to raise awareness about their prevention, identification and early treatment. The issue of the high rate of deaths potentially amenable to good quality care also deserves attention. Here, bacterial pneumonia, aspiration pneumonia and sepsis are key contributors. Identifying the early signs of illness is essential, and carers must be alert to how these diseases may present, take all preventative measures, and be proactive in seeking timely medical attention.

The understanding and application of the Mental Capacity Act (MCA)

Our eighth recommendation is that **local services strengthen their governance in relation to adherence to the MCA, and provide training and audit of compliance 'on the ground' so that professionals fully appreciate the requirements of the Act in relation to their own role.** The findings from the LeDeR mortality reviews echo the House of Lords post-legislative scrutiny of the Mental Capacity Act conclusion that there is a lack of awareness and understanding about the MCA, principally within the health and social care sectors. They commented:

> *'For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives…the prevailing cultures of paternalism (in health) and risk-aversion (in social care) have prevented the Act from becoming widely known or embedded….The duties imposed by the Act are not widely followed.' (p.6).*

The process of undertaking mortality reviews

Our ninth recommendation is that **a strategic approach is taken nationally for training those conducting mortality reviews or investigations, with a core module about the principles of undertaking reviews or investigations, and additional tailored modules for the different mortality review or investigation methodologies.** This supports, but extends, the Department of Health and Social Care (DHSC) mandate to Health Education England (HEE) which states the requirement for HEE to work with the Healthcare Safety Investigation Branch and providers to develop approaches to ensuring that 'staff have the capability and capacity to carry out good investigations of deaths and write good reports, with a focus on these leading to improvements in care.' (DHSC p.16).

The future focus of the LeDeR programme

The focus of the LeDeR programme over the coming year will be to follow-up on the actions that are proposed in mortality reviews. We need to ensure that we move beyond 'learning' into a more proactive approach to meeting the health needs of people with learning disabilities, which requires targeted action and commitment to improve service delivery where required.

A model for how this could be realised was shared by Emily Lauer, the lead for mortality reviews of people with learning disabilities at Massachusetts USA. She spoke at a series of workshops for LeDeR Steering Group members in England in June 2017, to share some of the actions that have been implemented in various States in the USA and how their effectiveness is being monitored. Her presentations can be viewed at: https://www.youtube.com/watch?v=Iw-   coxPOI and https://www.youtube.com/watch?v=nBnjwi-5sEk

References

Atkinson M, Jones M, Lamont, E. (2007) Multi-agency Working and its Implications for Practice. CfBT Education Trust, Reading.

Care Quality Commission (2016) Learning, candour and accountability. https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

Cooper M, Evans Y, Pybis J. (2016) Interagency collaboration in children and young people's mental health: a systematic review of outcomes, facilitating factors and inhibiting factors. Child: Care, Health and Development, 42, 3, 325–342.

Department of Health and Social Care (2018) The Department of Health and Social Care mandate to Health Education England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/674419/HEE_mandate_2017-2018.pdf

Emerson E, Hatton C, Baines S, Robertson J. (2016) The physical health of British adults with intellectual disability: cross sectional study. International Journal for Equity in Health (2016) 15, 11. https://equityhealthj.biomedcentral.com/track/pdf/10.1186/s12939-016-0296-x?site=equityhealthj.biomedcentral.com.

Glover G, Ayub M. (2010) How people with learning disabilities die. Durham: Improving Health and Lives Learning Disabilities Observatory.

Glover G, Williams R, Heslop P, Oyinola J, Grey J. (2017) Mortality in people with intellectual disabilities in England. Journal of Intellectual Disability Research, 61, 1 62-74.

Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Mallett R, Russ L. (2013) The Confidential Inquiry into premature deaths of people with learning disabilities. University of Bristol: Bristol.

Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Mallett R, Russ L. (2014) The Confidential Inquiry into premature deaths of people with intellectual disabilities in the UK: a population-based study. The Lancet 383, 9920, 889 – 895.

Hosking FJ, Carey IM, Shah SM, Harris T, DeWilde S, Beighton C, Cook DG (2016) Mortality among adults with intellectual disability in England: Comparisons with the general population. American Journal of Public Health 106, 8, 1483-1490.

House of Lords (2015) Mental Capacity Act 2005:post-legislative scrutiny. The Stationery Office: London.

Institute of Health Equity (2017) The rise of life expectancy in the UK is slowing. http://marmot-review.blogspot.co.uk/

Landes SD, Peak CW. (2013) Death by mental retardation? The influence of ambiguity on death certificate coding error for adults with intellectual disability. Journal of Intellectual Disability Research 57, 12, 1183–1190.

LGA, ADASS, NHSE (2015) Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

Marmot M. (2010) Fair society, healthy lives. http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

Marmot M. (2017) Marmot Indicators 2017. http://www.instituteofhealthequity.org/resources-reports/marmot-indicators-2017-institute-of-health-equity-briefing/marmot-indicators-briefing-2017-updated.pdf

Mazars (2015) Independent review of deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015. https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

Mencap (2007) Death by Indifference. https://www.mencap.org.uk/sites/default/files/2016-06/DBIreport.pdf

Michael J. (2008) Healthcare for all. http://webarchive.nationalarchives.gov.uk/20130105064756/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_106126.pdf

National End of Life Intelligence Network (2017) Data Sources. Place of death. http://www.endoflifecare-intelligence.org.uk/data_sources/place_of_death

National Quality Board (2017) National Guidance on Learning from Deaths. A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

NHS Digital (2017) Learning disabilities health check scheme, England, 2017-18. Supporting information.

ONS (2011) Ethnicity and national identity in England and Wales: 2011. http://webarchive.nationalarchives.gov.uk/20160107112033/http://www.ons.gov.uk/ons/dcp171776_290558.pdf

ONS (2012) Mortality in England and Wales: Average life span, 2010 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/mortalityinenglandandwales/2012-12-17

Osugo M, Morrison J, Allan L, Kinnear D, Cooper SA. (2017) Prevalence, types and associations of medically unexplained symptoms and signs. A cross-sectional study of 1023 adults with intellectual disabilities. Journal of Intellectual Disability Research 61, 7, 637–642.

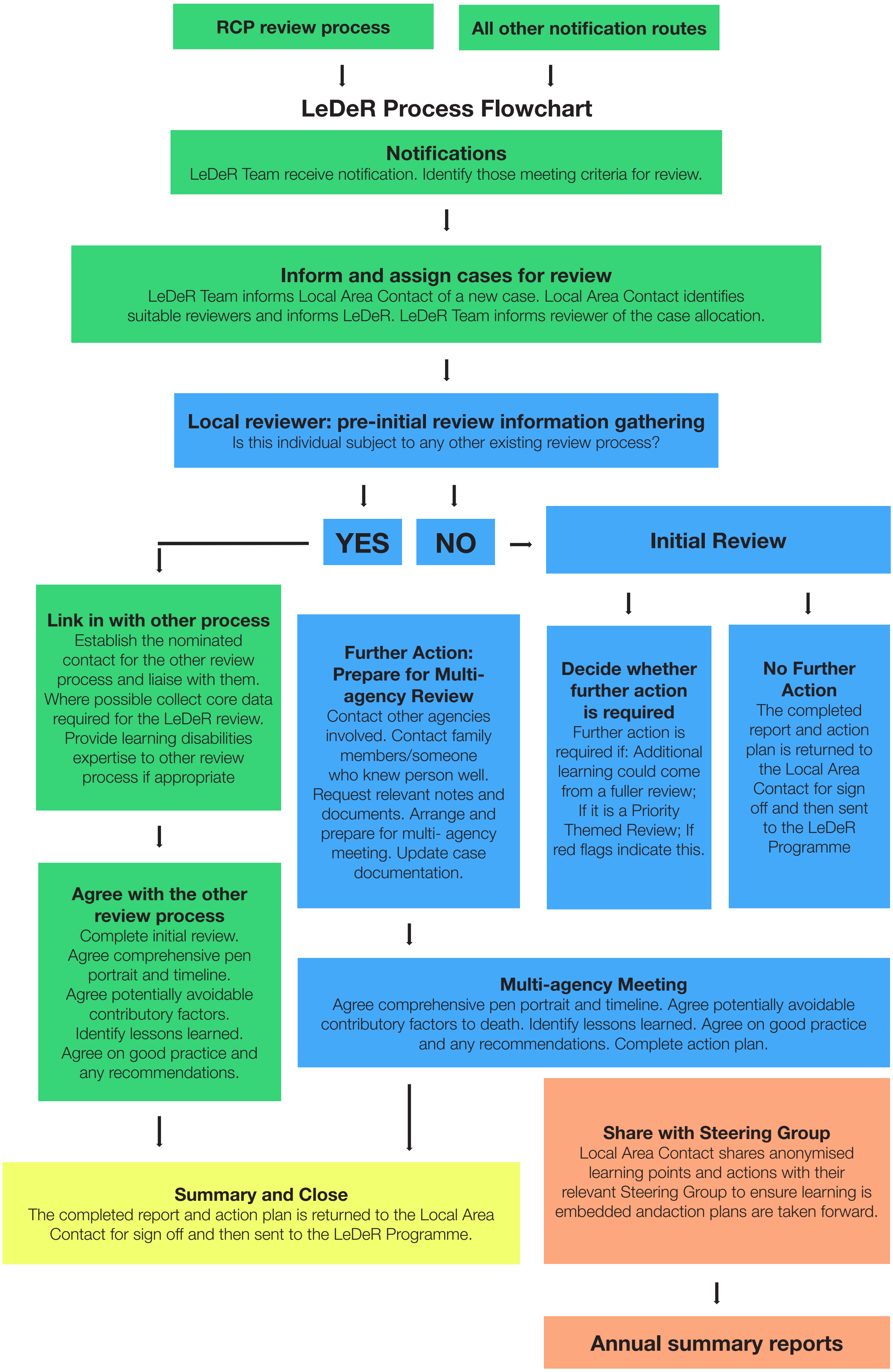
Public Health England (2017) Prevention Concordat for Better Mental Health: Prevention planning resource for local areas – Summary. https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-planning-resource

Trollor J, Srasuebkul P, Xu H, Howlett S. (2017) Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data. BMJ Open 2017;7:e013489.

Tyrer F, McGrother C. (2009) Cause-specific mortality and death certificate reporting in adults with moderate to profound intellectual disability. Journal of Intellectual Disabilities Research 53, 898–904.

Appendices

Appendix 1: LeDeR process flowchart



RCP review process

All other notification routes

LeDeR Process Flowchart

Notifications
LeDeR Team receive notification. Identify those meeting criteria for review.

Inform and assign cases for review
LeDeR Team informs Local Area Contact of a new case. Local Area Contact identifies suitable reviewers and informs LeDeR. LeDeR Team informs reviewer of the case allocation.

Local reviewer: pre-initial review information gathering
Is this individual subject to any other existing review process?

YES

NO

Initial Review

Link in with other process
Establish the nominated contact for the other review process and liaise with them. Where possible collect core data required for the LeDeR review. Provide learning disabilities expertise to other review process if appropriate

Agree with the other review process
Complete initial review. Agree comprehensive pen portrait and timeline. Agree potentially avoidable contributory factors. Identify lessons learned. Agree on good practice and any recommendations.

Further Action: Prepare for Multi-agency Review
Contact other agencies involved. Contact family members/someone who knew person well. Request relevant notes and documents. Arrange and prepare for multi- agency meeting. Update case documentation.

Decide whether further action is required
Further action is required if: Additional learning could come from a fuller review; If it is a Priority Themed Review; If red flags indicate this.

No Further Action
The completed report and action plan is returned to the Local Area Contact for sign off and then sent to the LeDeR Programme

Multi-agency Meeting
Agree comprehensive pen portrait and timeline. Agree potentially avoidable contributory factors to death. Identify lessons learned. Agree on good practice and any recommendations. Complete action plan.

Summary and Close
The completed report and action plan is returned to the Local Area Contact for sign off and then sent to the LeDeR Programme.

Share with Steering Group
Local Area Contact shares anonymised learning points and actions with their relevant Steering Group to ensure learning is embedded andaction plans are taken forward.

Annual summary reports

Appendix 2: LeDeR methodology

Notification of a death

The person reporting the death is asked to provide relevant core information. The information provided is checked by the LeDeR team to ensure that the death meets the inclusion criteria for the LeDeR programme. Once confirmed, the death is allocated to a reviewer under the guidance of the Local Area Contact.

Initial review

An initial review is completed for all deaths of people with learning disabilities that 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 that would contribute to improving practice.

Multi-agency Review of a death

A multi-agency review of a death involves the range of agencies that had been supporting the individual who had died. It considers:

- Any good practice that has been identified in relation to the person's death
- Any potentially avoidable contributory factors to the death.
- If there were any aspects of care and support that may have changed the outcome, had they been identified and addressed.
- If there have been any lessons learned, as a result of the review of the death.
- If there should be any changes made to local practices, as a result of the findings of the review.
- If there are any wider recommendations that should be made.

Action planning process

At the end of the initial and multi-agency review forms there is space for reviewers to identify learning and recommendations (from initial reviews) and action points (from multi-agency reviews). Copies of completed reports are sent to the local LeDeR Steering Group, which agrees relevant actions, and oversees their implementation in conjunction with relevant partners and health and social care agencies in their area.

Priority Theme Reviews

The Priority Theme Review aspect of the LeDeR programme examines the deaths of a subset of people with learning disabilities in more detail. Two themes are currently under scrutiny:

- Deaths of people aged 18 to 24 years
- Deaths of adults and children from a Black or Minority Ethnic group.

  Deaths subject to Priority Themed Review receive an initial and full multi-agency review. The review documentation is anonymised by the LeDeR team, and then sent to Priority Themed Review panel members for further comment. Comments from the panels are collated by the LeDeR team and incorporated into the completed review documentation.

The LeDeR quality assurance process

The Quality Assurance process involves a small panel of LeDeR team members looking at recently submitted reviews, to work to ensure national consistency in the quality of mortality reviews. Quality assurance enables the LeDeR team to give constructive feedback to reviewers to enrich their future reviews. It also gives the LeDeR team invaluable insight into training needs: themes picked up in quality assurance are incorporated into training improvements on an ongoing basis.

Appendix 3: Acknowledgements

There are many people whom we would like to thank for their support and help with implementing the LeDeR programme. In particular, we would like to thank:

- NHS England, particularly Dr Dominic Slowie, Matthew Fagg, Crispin Hebron, John Trevains and Kevin Elliott
- HQIP
- The Regional Coordinators: Maria Foster, Emily Handley, Robert Tunmore, and Louisa Whait
- Members of the Independent Advisory Group chaired by Dr Dominic Slowie
- Members of the LeDeR Programme Steering Group chaired by Professor Peter Fleming
- Members of the LeDeR Programme Advisory Groups
- The National Valuing Families Forum
- All of the family members and people with learning disabilities who have attended any of the LeDeR consultation events
- Those working to implement the LeDeR programme as Steering Group members, Local Area Contacts, and reviewers

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Thank-you for reading this report.

For more information about the LeDeR programme, please contact us:

Phone: **0117 3310686**
Email: **leder-team@bristol.ac.uk**

Or visit our website at
www.bristol.ac.uk/sps/leder

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You can find more information at
bristol.ac.uk

University of
BRISTOL

NHS
West Leicestershire
Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 5 SEPTEMBER 2018

REPORT OF WEST LEICESTERSHIRE AND EAST LEICESTERSHIRE & RUTLAND CCGS

SECTION 106 OF THE TOWN AND COUNTRY PLANNING ACT 1990

Purpose of Report

1. The purpose of this report is to provide an overview of how Section 106 healthcare contributions are managed by the NHS and the process followed to ensure that all possible funding is received from developers.

Background

2. Planning obligations under Section 106 of the Town and Country Planning Act 1990 (as amended), commonly known as Section 106 agreements, are a mechanism which make a development proposal acceptable in planning terms, that would not otherwise be acceptable. They are focused on site specific mitigation of the impact of development. Developers applying for planning permission can be asked to contribute financially and in other ways to the infrastructure needed to support the new development, including health infrastructure, and to mitigate any impacts arising from the development.

3. NHS England held the remit for the management of primary care estates and the facilitation of Section 106 healthcare contributions until January 2016; with the responsibility transferring to CCGs at this point under co-commissioning delegation.

4. The CCGs have maintained close links with NHS England and have established effective working relationships with Borough and District Council teams to maximise the Section 106 healthcare contributions requested and spent to benefit patients within the Leicestershire and Rutland area.

Current Process

5. Please refer to appendix A, Section 106 Healthcare Contribution Process – West Leicestershire CCG. WLCCG developed and implemented this process to support the management of Section 106 contributions; which has since been adopted by ELRCCG.

6. The CCG review the detail of any proposed development and assess the potential impact of the increased population on local healthcare services. The CCG uses a clear methodology for allocating practices and applying for healthcare contributions, taking into account; general practice boundaries, size of the proposed development, current practice capacity/resilience, commitment in principle from the practice and existing Section 106 agreements.

7. Following consultation with identified practices, the CCG will respond to the Council. Our response may;
    - Recommend refusal of the planning application on the grounds of insufficient healthcare capacity in the area. In this instance a Section 106 healthcare contribution would be requested if the application is subsequently approved;
    - Request a Section 106 healthcare contribution to increase clinical capacity to meet the demand of the proposed increased population;
    - Request that occupancy trigger points are carefully considered where premises investment is required to increase capacity before patients register at the identified practice.

8. The CCG regularly checks the status of planning applications through the Borough and District Council planning portals. Where a planning application has been approved and a Section 106 healthcare contribution has been agreed, the legal agreement is downloaded and saved on file for information.

9. The CCG meets with Borough and District Councils on a quarterly basis to discuss new healthcare contributions received by the council, progress with GP practice projects and to seek approval for newly identified projects.

10. The CCG GP Contracts and Quality team maintains an effective engagement relationship with its member practices and is familiar with the premises needs of each. Practices will approach the CCG for advice in planning how Section 106 monies can be effectively utilised and teams work closely to ensure all available funds are spent in accordance with the obligations as set out in the relevant section 106 agreement.

Notable Projects to Date

11. Please refer to Appendix B, West Leicestershire CCG S106 Healthcare Contributions Spend and Appendix C, East Leicestershire & Rutland CCG S106 Healthcare Contributions Spend. WLCCG has been actively working with its member practices, and the Borough and District Councils, to ensure that Section 106 healthcare contributions are spent in a timely manner and in accordance with conditions as outlined in the legal agreements.

12. Since taking responsibility for the facilitation of Section 106 healthcare contributions in January 2016, WLCCG has achieved a spend totalling around £1.5m to support the improvement and expansion of primary medical healthcare facilities, and has a further £1.4m committed to premises improvement projects.

13. To date, S106 healthcare contributions have supported a number of premises projects locally, including;
    - The internal refurbishment of clinical consulting rooms at Measham Medical Unit, Highgate Surgery, Anstey Surgery and Forest House Surgery;
    - Premises extensions at Castle Donington Surgery, Ibstock House Surgery, Heath Lane Surgery and The Burbage Surgery. Please refer to Appendix D, Heath Lane Surgery Extension Project – Mini Case Study;

- Internal reconfiguration and refurbishment of Pinfold Medical Centre and the two branch surgeries of Charnwood Medical Group;
- The purchase of clinical equipment for Barrow Health Centre, Anstey Surgery, Quorn Medical Centre, Highgate Surgery, Station View Health Centre.

14. East Leicestershire and Rutland CCG have secured £1.6m in Section 106 healthcare contributions from Blaby County Council and £306k from Harborough District, Charnwood Borough and Melton Borough Councils.

15. Larger sums of Section 106 healthcare contributions have been allocated to Countesthorpe Health Centre, Hazlemere Medical Centre, Forest House, The Limes Medical Centre, Wycliffe and Masharani. Three practices will be using funds for extensions to current premises and one for general refurbishments.

Officer to Contact

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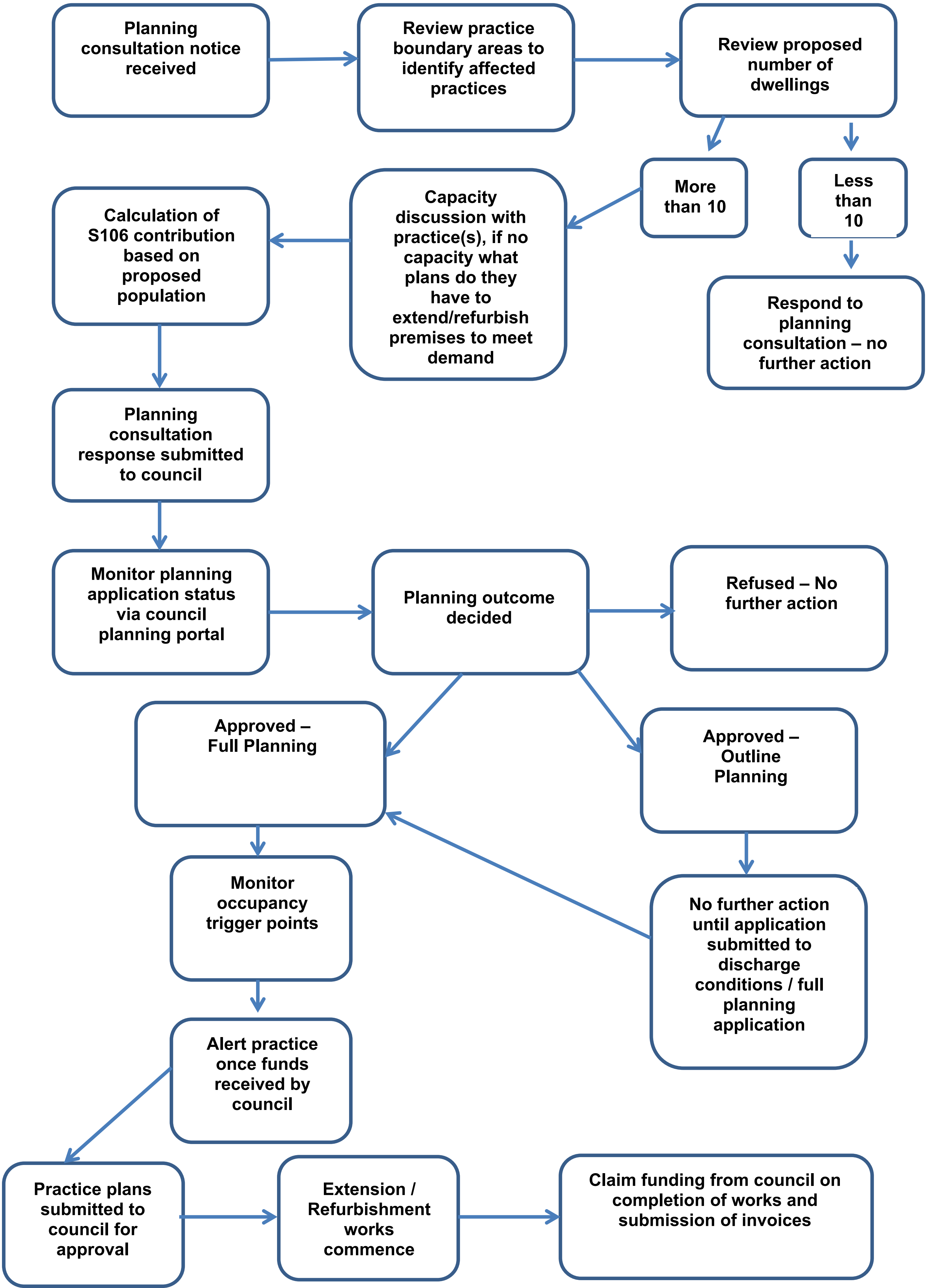
List of Appendices

Appendix A: Section 106 Healthcare Contribution Process – WLCCG
Appendix B: West Leicestershire CCG S106 Healthcare Contributions Spend
Appendix C: East Leicestershire & Rutland CCG S106 Healthcare Contributions Spend
Appendix D: Heath Lane Surgery Extension Project – Mini Case Study

APPENDIX A

Section 106 Healthcare Contribution Process – West Leicestershire CCG



S106 Healthcare Contributions – Spend by WLCCG

	S106 funding spent in General Practice since January 2016 to August 2018	S106 healthcare contributions held by the council as at August 2018	Projects identified by practices and approved for completion - £ value as at August 2018	Projects under development by practices - £ value as at August 2018
Charnwood Borough Council	£628,063.88	£702,555.45	£303,742.52	£398,812.93
North West Leicestershire DC	£663,920.42	£1,010,842.12	£917,712.86	£93,129.26
Hinckley & Bosworth BC	£254,085.12	£363,278.91	£185,312.71	£177,966.20
Blaby District Council	£10,799.97	£570,868.88	£55,501.00	£518,814.88
Harborough District Council	£0.00	£443,850.76	£0.00	£443,850.76
	£1,556,869.39	£3,091,396.12	£1,462,269.09	£1,632,574.03

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S106 Healthcare Contributions – Spend by ELRCCG

	S106 funding spent in General Practice since January 2016 to August 2018	S106 healthcare contributions held by the council as at August 2018	Projects identified by practices and approved for completion - £ value as at August 2018	Projects under development by practices - £ value as at August 2018
Harborough District Council	£81,617.24	£165,488.70	£28,971.04	£136,517.66
Melton Borough Council	£0.00	£59,963.00	£0.00	£59,963.00
Charnwood Borough Council	£0.00	£93,812.60	£0.00	£93,812.60
Blaby District Council	£232,992.85	£1,012,639.90	£622,944.52	£389,695.46
Oadby & Wigston Borough Council	£0.00	£0.00	£0.00	£0.00
	£314,556.09	£1,331,904.20	£651,915.56	£679,988.72

Appendix D: Heath Lane Surgery Extension Project – Mini Case Study

Heath Lane Surgery, Earl Shilton - Extension Project (West Leicestershire CCG)

Heath Lane Surgery is situated within the Hinckley & Bosworth Locality and has a registered list size of 14650 patients (1/7/2018 capitation). The area has attracted several new housing developments in recent years and the accumulative growth in the area has placed pressure on clinical capacity within the practice premises. A further 1400 houses are under consideration within the local Sustainable Urban Extension plan by 2032;

The practice had adopted a proactive approach in planning for the increasing population growth, and submitted a detailed business case to NHS England in 2017 applying for NHS capital funding under the Estates & Technology Transformation Funding Scheme (ETTF). Under this scheme the NHS will fund up to 60% of the overall project. The practice proposal incorporated the Section 106 healthcare contributions available, in addition to practice investment. This proposal was supported by West Leicestershire CCG and was approved by NHS England as it was seen as an opportunity to support current and future growth in the area.

The extension project is underway and nearing completion; providing a much needed additional 4 clinical consulting rooms, minor surgery procedure facilities, extended waiting area and additional administration areas.

West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 5TH SEPTEMBER 2018

REPORT OF WEST LEICESTERSHIRE CCG AND EAST LEICESTERSHIRE AND RUTLAND CCG

QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION PROGRAMME 2018/19

Purpose of Report

1. The purpose of this report is to:

    a) Provide information regarding CCG QIPP (Quality, Innovation, Productivity and Prevention) Savings Schemes in 2018/19 including reference to associated quality processes to ensure appropriate implementation of savings programmes.

    b) Provide information in relation to CCG assurance ratings received from their regulator, NHS England, in relation to 2017/18.

Background

2. A report was provided to the HOSC in May 2018 outlining high level QIPP plans developed for 2018/19. This report provides an update on progress and the expected financial outturn for QIPP for 2018/19.

3. Further information has also been requested by HOSC in relation to quality processes linked to QIPP Savings and the CCG assurance ratings.

QIPP Progress and forecasts as at Month 4

4. QIPP is monitored internally within the CCGs with the support of PMO (programme management office) arrangements which operate across the 3 Leicestershire CCGs to keep a close view of progress. Senior responsible officers are in place for each QIPP scheme; responsible for development and implementation of plans alongside clinical leads supported by finance, contracting and other support staff. Monitoring and escalation of any issues takes place at the QIPP Assurance Group (QAG), which is an executive level LLR meeting which meets twice monthly. Formally, the outcome of PMO

and QAG processes is reported into the Collaborative Commissioning Board and also Individual CCG formal committees on a monthly basis.

5. Activity and financial information as at Month 4 has confirmed that both Leicestershire County CCGs are currently exceeding their planned levels of savings year to date (April to July) – this shown in the table below.

Table 1: Year to Date (YTD) QIPP Performance by CCG

CCG	Plan YTD £000	Actual YTD £000	Variance YTD £000
ELR	-4,475	-5,117	-642
WL	-5,505	-6,060	-555
Grand Total County CCGs	**-9,980**	**-11,177**	**-1,197**

Information in relation to performance in August will be available in early September and hence we have been unable to include that within this paper given timescales for submission of papers.

6. Initial indications of the level of forecast savings for the year from existing schemes based on progress made in the first few months of the year have indicated a level of risk in achieving the full target for the year. As a result CCGs have worked together to develop QIPP recovery schemes/mitigations during August for further development, approval and implementation from September onwards.

7. As a result of work undertaken in reviewing areas of expenditure, benchmarking and consideration of QIPP schemes in place in other health economies, the CCGs have been able to prioritise some schemes for development for future years' QIPP programmes.

8. In developing recovery schemes for 2018/19 the CCGs have also considered and dismissed a range of options due to their potential detrimental impact on patient care (such as reducing Better Care Fund investment below the mandated level and schemes which would result in lengthening waiting times for necessary patient care).

9. The full year forecast including delivery of QIPP Recovery schemes is shown in the tables below; by Programme Area first and then by CCG.

Table 2: QIPP Forecast Delivery by Programme Area

Program Area	Annual Planned Savings £000	Existing Schemes Forecast £000	Recovery Actions Forecast £000	Final Forecast Savings £000
Acute	-3,616	-1,116	-804	-1,919
CHC	-4,337	-4,903		-4,903
Community Services	-2,813	-1,315	-94	-1,409
Corporate	-4,258	-4,670	-3,445	-8,115
ILT	-1,304	-805		-805
LD	-1,495	-1,321	-1,000	-2,321
Mental Health	-2,236	-814	-1,282	-2,096
Non-Acute	-1,464	-978		-978
Planned Care	-4,283	-2,370	-207	-2,577
Prescribing	-7,843	-8,202		-8,202
Primary Care	-4,621	-6,132	-50	-6,182
Urgent Care	-1,875	-534	-193	-727
Grand Total	**-40,145**	**-33,161**	**-7,075**	**-40,236**

CCG Schemes	Annual Planned Savings £000	Existing Schemes Forecast £000	Recovery Actions Forecast £000	Final Forecast Savings £000
ELR	-19,647	-16,388	-3,275	-19,662
WL	-20,498	-16,773	-3,800	-20,573
Grand Total	**-40,145**	**-33,161**	**-7,075**	**-40,236**

Quality Processes supporting QIPP

Quality Impact Assessments

10. East Leicestershire and Rutland CCG and West Leicestershire CCG are committed to ensuring that commissioning decisions, business cases and any other business plans are evaluated for their impact on quality.

11. A Quality impact assessment (QIA) is undertaken to assess the qualitative impact of commissioning, QIPP plans, business cases and any other plans for change. The

process starts with the project lead undertaking a Quality Impact Assessment (QIA), to ensure a robust assessment from a quality and risk perspective.

12. There is then a local process for scrutiny and challenge of the proposed scheme by a group of multi-professionals which includes the quality lead within the CCG. The QIAs are embedded as business as usual within CCG commissioning processes.

13. The QIA tool is broken down into the 3 domains of Quality as outlined by the Darzi principles:
    - Safety – Rating the impact of the proposal on patient safety;
    - Effectiveness – Rating the impact of the proposal on the clinical effectiveness of patient care;
    - Experience – Rating the impact of the proposal on the patient experience of care delivery.

14. The QIA tool also assesses additional contributory factors such as; organisational reputation, evidence base and resources.

15. The QIA tool is a continuous process to ensure that possible or actual business plans are assessed and the potential consequences on quality are considered, with mitigating actions outlined in a uniformed way

Quality Impact Assessment process

16. The Quality Impact Assessment process is as follows:

    - 1. The project lead undertakes a Quality Impact Assessment (QIA), to ensure a robust assessment from a quality and risk perspective to identify any risks of the proposed Business case / QIPP;
    - 2. The QIA is then reviewed by a group of multi-professionals which includes the quality lead within the CCG for scrutiny and challenge of the proposed scheme. This provides a robust confirm and challenge process to each proposal presented ensuring a thorough multi-professional review of services is undertaken. Detailed risk assurance and mitigating actions are confirmed and an agreed overall risk score is set for the scheme;
    - 3. The final sign off of the QIA is undertaken by the Chief Nurse and Quality Officer and the CCG Clinical Chair.

17. The QIA is an integral part of CGG business and forms part of a process of a wider piece of work that the CCG undertakes in order to carry out its statutory responsibility to ensure safe, cost effective services are commissioned for the health needs of the population that it serves within the financial envelope and is used to ensure the impact on quality is understood and considered as part of decision making.

CCG Assurance Ratings

18. The CCG annual assessment for 2017/18, carried out by NHS England (NHSE), provides each CCG with a headline assessment against the indicators in the CCG

improvement and assessment framework (CCG IAF). The IAF aligns key objectives and priorities as part of delivering the Five Year Forward View.

19. The CCG IAF used to determine CCG ratings comprises 50 indicators selected to track and assess variation across policy areas covering performance, delivery, outcomes, finance and leadership.

20. CCGs are rated in one of four categories: ‘Outstanding’, ‘Good’, ‘Requires Improvement’ and ‘Inadequate’.

21. Each CCG receives a letter detailing the assessment by NHSE and confirming the annual assessment, as well as a summary of any areas of strength and where improvement is needed from a year-end review.

22. The 2017/18 annual assessments were published on the CCG Improvement and Assessment page of the NHSE websites’ in July 2018. At the same time, they were published on the MyNHS section of the NHS Choices website. The full letter is also published on the CCG’s website.

23. For 2017/18, West Leicestershire CCG and East Leicestershire and Rutland CCGs were rated ‘Requires Improvement’ having been assessed as ‘Outstanding’ and “Good” respectively in 2016/17. NHSE state that the main reason for the downturn in ratings is the financial position faced by the CCGs locally.

24. Key areas of strength/areas of good practice highlighted by NHSE are the leadership provided to the Urgent and Emergency Care programme, the further development of the LLR Sustainability and Transformation Plan, improved performance in dementia diagnosis, increased oversight of Continuing Health Care and recognition of the leadership given to the GP 5 year forward view transformation programme.

25. NHSE also acknowledge the establishment of collaborative commissioning arrangements in LLR.

26. The performance assessment highlights challenges in the following service areas:
    - delivery against emergency care standards - particularly during the winter period;
    - Lack of progress with Cancer performance despite additional transformational funds being allocated;
    - Failure to deliver Transforming care trajectories;
    - IAPT performance has remained significantly below the expected standard particularly in respect of access; and
    - improving Referral To Treatment performance requires a robust plan to be developed to ensure effective demand management and sufficient elective capacity available to meet the needs of patients.

27. NHSE highlights the financial position of the CCGs as the primary reason for the 2017/18 assessment. The CCGs recorded a year end deficit of £1.6m (West) and £5.2m (East) despite both organisations achieving their highest ever level of savings through QIPP programmes and also developing financial recovery plans during the year to reduce the level of deficit – plans which were overseen and agreed with NHS

England. Both CCGs achieved the revised forecast outturn position which was agreed with NHSE prior to the end of the financial year.

Summary of Key Points

28. This report outlines progress made during the financial year 2018/19 with respect to QIPP savings delivery for ELR and WL CCGs, showing over delivery for both organisations year to date. Following the development of recovery schemes during August to mitigate emerging QIPP risks, both CCGs are expected to deliver savings in line with QIPP targets by the end of the financial year.

29. The report also shows how there is a robust QIA process in place for any QIPP schemes implemented to ensure that CCGs can effectively comply with statutory duties.

30. This report also outlines how the CCG assurance ratings are developed by the regulator (NHSE) and that financial pressure experienced in 2017/18 is the root cause in the deterioration in rating for both CCGs.

Circulation under local issues alert procedure

None.

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Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 5 SEPTEMBER 2018

REPORT OF LLR HEALTH AND SOCIAL CARE SYSTEM

LLR URGENT AND EMERGENCY CARE RESILIENCE PLANNING WINTER 2018/19

Purpose of report

1. The purpose of this report is to provide an overview of the ongoing work to prepare for the 2018/19 winter period across the Leicester City, Leicestershire and Rutland (LLR) Urgent and Emergency Care system. The paper includes a reflection of performance last winter, what was learnt, plus the actions being taken and the expected impact to ensure we have more resilient health and social care services this coming winter.

System Performance Winter 2017/18

2. Patients are living longer in light of advances in medical treatment and health, alongside an aging population with resident growth into the area and lifestyle factors; all of which increase the demand for public services including health and social care.

3. The winter of 2017/18 saw the local urgent and emergency care (UEC) system under intense pressure, resulting in poor patient experience and weak performance against national targets. Accident & Emergency department performance against the targets is known to drop in Dec, Jan & Feb each year, however last winter this deterioration started in November and continued through to March; it was particularly intense from February to April.

4. Hospital A&E 4-hour performance overall was below standard with an annual position of 77.7% (79% the previous year), and A&E waiting times performance deteriorated sharply from October onwards, dipping to a low of 66.9% in March with primary clinical focus on major conditions.

Major Causes of Pressure

5. Not surprisingly, in such a complex system, there were several factors that contributed to the pressures:

   - Pressure was felt across all parts of the system – in GP practices, GP Primary Care Hubs, Urgent Care Centres, 111 calls, Clinical Navigation Services, Ambulances Services, ED and within the hospitals. Although hospital activity levels overall and emergency admissions were not as high as in past years, there were changes to the *type* of patient, and how sick they were, with very high numbers of cardio-respiratory cases in particular. Analysis confirms the pressures were not caused only by the number of admitted patients, but by how unwell they were and how long they needed to be in hospital. Many of these were older or frail patients. Generally across Leicestershire and Rutland, older people make up approximately 20% of the population, yet at the height of the pressures, 80% of hospital beds were occupied by this group.

- There was a mismatch between the number of patients coming into the hospital and the ability to discharge them quickly and efficiently, causing delayed flow of patients through the hospital.

- Due to the number of emergency surgical cases exceeding normal levels, critical care / intensive care units were often full, which resulted in high numbers of cancelled surgical cases, some of which were regrettably cancer cases. Occasional staff sickness/absence impacted upon the ability to maintain full use of critical care beds.

- Bed occupancy was high throughout much of the winter period. This means a lack of free beds, which has a knock-on effect on internal patient flow from admissions areas, often resulting in long trolley waits. Many working days started with patients waiting for beds to become free (often termed “negative bed capacity”).

- High numbers of medical “outliers,” (medical patients in a bed not designated for medical patients e.g. on a surgical ward) which only started to improve towards the end of March. Delivering care to patients spread across a number of wards is less efficient for clinical teams. The length of stay for medical patients at LRI increased by nearly two days from January to March 2018.

- Higher than average “non-admitted breaches” (patients who were in the Emergency Department for more than 4-hours (i.e. breached the standard) but were not admitted into hospital. Delays for such patients are often due to the demand on diagnostic services, although preventing an unnecessary admission can often reflect a better outcome for the patient.

- Patients with Norovirus and/or flu resulted in many closed beds on a regular basis, at both University Hospitals Leicester and Leicestershire Partnership NHS Trust.

- There was a higher number of elective (i.e. planned care) cancellations last winter in comparison with 2016/2017 following a national instruction to all acute Trusts, as well as exceptional levels of cancellations of urgent and cancer operations.

- Activity in out-of-hospital services, including Urgent Care Centres, Primary Care Hubs, Home Visiting and Clinical Navigation services, was higher than forecast and higher than in winter 2016/17. This at times created significant pressure in these services but they were successful in preventing a significant increase in Emergency Department attendances.

- NHS111 demand rose significantly, dealing with 30% more calls than we had planned for in the period of January to March 2018.

- Ambulance services remained stretched and were regularly at a high escalation level during winter; patient handover times were higher than expectation (within 15 minutes), particularly from November through to March, although there were fewer 1 hour+ waits than in 2016/2017, and fewer total 'lost hours.'

- Staffing levels were particularly challenged over winter across all providers. In particular, medical and nurse staffing levels in hospital were variable with a higher than average sickness/absence rate during peak periods of demand.

- Although a flu jab campaign was marketed and communicated, the uptake of flu jabs by members of the public and staff was not as high as it could be.

- Processes vary across providers which influences local decision making, and there are benefits to more standardisation.

Lessons Learnt – National

6. As well as reflecting on the lessons that the local system learnt, our actions for the future are also informed by national learning on improved Emergency Department performance. One such example is the "Patient Flow Standards" which were issued nationally and against which the system compliance is tested by the regulators. These are shown at Appendix A.

Lessons Learnt - Local

7. The lessons learnt locally are as follows:

- Effective communication across the system often began to break down as pressure was building, resulting in increased "silo" working as partners tried to sort out the problems in their own areas.

- Joint forward planning / forecasting of the likely activity levels and responses to them was not undertaken.

- Skills in forecasting were not shared across the system.

- More could have been done to protect beds for emergency activity by planning how to deliver both elective and emergency activity across the year.

- Workforce and staffing challenges were seen across several of the organisations, due to scheduling issues and staff sickness such as flu.

- There was an inability to maintain flow across the system once pressure built.

- Patients were still presenting at ED with conditions that could have been treated in primary care or via self-care, despite there being slots available in Hubs and urgent care centres.

Actions and Steps to avoid similar issues in Future

8. Focused review and revise the system Escalation Plan. The Leicester City, Leicestershire, and Rutland (LLR) Urgent and Emergency Care Resilience Plan 2018/19 is currently under development in collaboration with key stakeholders across the city and county, and is due to be published during September/October 2018 following simulation exercises. This will reflect a 'one plan approach' and sets out the features / signs of increasing levels of pressure for each organisation and what the response from themselves and other partners will be as a consequence. An effective and well-managed plan is key to ensuring we all take the right steps to manage the pressure but also ensures that the system can recover quickly ("bounce back") once pressure begins to decrease. The plan will be tested through simulation exercises that will involve all partners, so that we are clear how the actions interact and to test whether everything has been considered. This improved communication and collaboration will be a main contributing factor to improved performance, and will help establish the necessary regimented discipline amongst the people and professionals who will be working within periods increasing pressure.

9. The second part of the Emergency Department development at University Hospitals Leicester (UHL) is now open, which provides improved patient assessment areas. This allows more investigations to be carried out to reach an early diagnosis, give rapid treatment and ideally prevent the need for admission to a ward. In addition, UHL has re-aligned their bed capacity overall and created additional ward capacity to meet the expected increase in medical patient demand.

10. When agreeing the contracts for 2018/19, the Clinical Commissioning Groups (CCGs) and UHL have worked together as a first step to forecast in detail how much emergency capacity is required. We have then agreed how and when the elective (planned) activity will be delivered through the year, including how many operations may need to be delivered by other providers, so that we can protect and maximise the number of emergency beds.

11. We are working to increase the access to IT systems so that clinicians are able to see the patient's clinical record (where permission has been given) to improve decision-making. This is through an increase in the number of patients who have agreed for their Summary Care Record to be seen, which in turn supports more informed clinical assessments and treatments.

12. New, improved protocols are agreed between UHL and East Midlands Ambulance Service (EMAS) to manage better the handover of emergency patients when they arrive at hospital via ambulance.

13. Improved communication systems developed between consultants and GPs to give advice and guidance about patients' care and whether or not they need hospital.

14. We are working with Public Health and NHS England to deliver a proactive response to seasonal flu. There will be a publicity campaign raise awareness and encourage uptake of flu vaccines with the public, and a campaign to encourage uptake of the vaccine within eligible groups and frontline staff.

15. We are introducing a “Red Bag scheme” for care homes, which has been shown to work elsewhere. The bag will be used to keep all the patient’s essential items together including medication, personal items etc. and which can be transported with the patient if they are admitted. The scheme also helps the discharge process.

16. We are supporting more patients to understand and manage their conditions. For instance with respiratory patients, we will be ensuing that they are accurately identified on the clinical systems, that they have a care plan setting out their condition, treatment and what to do if it worsens and to ensure they have “rescue packs” i.e. antibiotic prescriptions etc. to allow them to start treatment and prevent admission. We will ensure that they receive cold weather warnings, pollution alerts, are flagged with EMAS in the event of 999 calls and are supported by a dedicated community specialist team and ongoing education programme for professionals, patients and carers.

17. There are improved discharge pathways which aim to get patients out of hospital and either back home or into a suitable care setting for assessment of their future needs. Evidence shows that this is really important for maximising recovery. We are working collaboratively with hospitals and providers to better communicate options for older people and their families, including where end of life choices can be better made. We are also strengthening the approach to promote general health and wellbeing when patients access services, as well as what alternative services exist outside of hospital.

Focusing on Frail Patients

18. Over the past few years, Better Care Fund (BCF) funding has supported the development of services that focus upon particular groups of patients for whom an increased level of support can prevent hospital admission. As time has gone on, we have learnt more about where this focus has the greatest impact. Moving on from this work, we are now collaborating system-wide to design a new pathway for frail patients based upon local needs and national standards, alongside other interventions to help battle ‘isolation’ and engage carers and voluntary organisations. There are 16 high impact actions that we are focusing on, prior to winter 18/19. The points below summarise the frailty work that is in progress:-

- Patient (and Risk) Identification -
    - Better understanding of patients through data analysis has highlighted patients who would be deemed a medium to high risk of a fall or health need, and likely need hospitalisation if not managed in primary care.
    - Improving community support for complex/frail/multi-morbid patients – CCG’s are adopting a population health management approach to identify the cohort of patients who will be most amenable to the range of interventions as part of the frailty programme.

- Care Plans -
    - Design and implement a system to enable each part of the system to access and enact a “care plan” through IT systems. The care plan sets out the key information about the patient, their condition, their care, their wishes and what to do if the condition worsens.
    - Establish a feedback loop whereby the quality of care plans can improve through better communication between doctors and patients.
    - Working to establish a single, GP-led care plan.

- Patient Discharge –
    - Revise discharge letters to identify specific actions which can prevent readmissions through better communication of patient needs in the community and primary care (and ambulance services).

- Frailty Checklist in Practice -
    - Design and implement a standardised checklist of interventions (the “frailty checklist”) which each provider can access and use consistently.

- New Ambulatory Care Pathway –
    - Implement the ‘diagnose to admit’ model (as opposed to “admit to diagnose”) which is known as both a national and local challenge, and pilot and assess a care home module – New ambulatory care pathways could reduce the number of bed-based admissions into the Trust if a ‘diagnose to admit’ model was implemented.

- Frailty Evaluation/Scoring -
    - Embed the use of the Rockwood Clinical Frailty Score in A&E and the emergency floor to identify patients who are likely to require support.

- Coordinated discharge from hospital (with monitoring) -
    - Ensure patients have the full range of health and social care response on discharge and also to reduce the risk of readmission. The current Integrated Discharge Team function started this process.

- Implement standardised daily interventions in all clinical areas for frail patients-
    - Improving flow and decreasing the numbers of patients who stay too long within acute and non-acute beds will be vital for winter, and is a major national initiative. Although UHL is one of the better Trusts in the country in this area, standardising processes and the actions expected across LLR to enable flow is a key action pre-winter.

- Hospital Readmissions -
    - Implementation of a new system of reviewing readmissions that happen within 30 and 90 days of discharge to understand what could be improved.

Assessment of Readiness

19. Planning winter preparedness across dozens of stakeholder organisations is challenging, technical and complex. The plan is being developed with input from the Clinical Commissioning Group, Leicester City Council, University Hospitals of Leicester (UHL), Primary Care, Community and Mental Health Care

Providers, Independent Sector Providers, patients and carers, Healthwatch, NHS England and NHS Improvement, as well as members of the local Leicester Resilience Forum, including the police, fire service, Public Health England, Health Protection, Health Education, utility companies, and several voluntary and charitable organisations. The plan will be approved by the LLR A&E Delivery Board which comprises of senior leaders across Leicestershire and Rutland.

20. Steady progress is being made to produce the plan by the end of September 2018, for submission to the regulators. There remains some work to engage members of the public through marketing and campaigns to ensure patients are aware of services available to them and to help manage expectations recognising that patient experience can be poor if the expectation is different to what is available to patients. Individual health and social care organisations have each been asked to review and submit their plans which will be shared and consolidated into one. They will also incorporate demand and capacity plans, business continuity plans, flu and infection control preparedness and adverse weather protocols. This will be checked and practiced via simulation exercises to ensure the system is clear on arrangements, contingencies, and to test for any gaps that exist ahead of winter.

21. The A&E Delivery Board will monitor progress of the plan production and more importantly, will ensure that any learning as we go through winter is incorporated into updated versions for continuous improvement.

Conclusions

22. Planning winter preparedness across dozens of stakeholder organisations is challenging, technical and complex. The plan is being developed with input from the Clinical Commissioning Group, Leicester City Council, University Hospitals of Leicester (UHL), Primary Care, Community and Mental Health Care Providers, Independent Sector Providers, patients and carers, Healthwatch, NHS England and NHS Improvement, as well as members of the local Leicester Resilience Forum, including the police, fire service, Public Health England, Health Protection, Health Education, utility companies, and several voluntary and charitable organisations. The plan will be approved by the LLR A&E Delivery Board which comprises of senior leaders across Leicestershire and Rutland.

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Background papers

Report to Health Overview and Scrutiny Committee 28 February 2018:
http://politics.leics.gov.uk/documents/s135758/HOSC%20winter%20plan%20report%20Feb%202018.pdf

Report to Health Overview and Scrutiny Committee 8 November 2017:
http://politics.leics.gov.uk/documents/s132917/Winter%20Pressures.pdf

Circulation under the Local Issues Alert Procedure

The report reflects impact across the entire county.

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List of Appendices

Appendix A – Patient Flow Standards

APPENDIX A

Patient Flow Standards

These core principles will have specific measures to demonstrate progress and where rapid improvement can be targeted during periods of increased demand, and include:

- Patients arriving by ambulance enjoy a seamless handover to the Emergency Department (ED) without delay, supported by the transfer of patient information from the ambulance service to the hospital;

- Patients attending Emergency Departments with conditions more suited to assessment and treatment in Primary Care are streamed to co-located Primary Care services;

- All patients to receive timely assessment and clinically appropriate, high quality care in the Emergency Department;

- Patients presenting to EDs or on inpatient wards with mental health and related physical conditions receive compassionate care from all staff;

- Patients who can be discharged following a short period of observation, investigation or treatment are managed in appropriate short stay areas outside ED;

- Patients being considered for emergency admissions are rapidly assessed and where appropriate are streamed to Ambulatory Emergency Care;

- Patients with acute medical conditions are assessed and their treatment begun by a multi professional acute medical team. Patients are referred from the ED or Primary Care;

- Acute medical, surgical and speciality assessment;

- Frail patients are identified as they present to the ED or directly to assessment services and are discharged without delay when acute care is complete;

- Patients are discharged as soon as they no longer benefit from acute hospital care.

Source: National priorities for acute hospitals 2017 Good practice guide: Focus on improving Patient flow; NHS Improvement, 13 July 2017.

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 5 SEPTEMBER 2018

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

SUICIDE PREVENTION CAMPAIGN

Purpose of report

1. The purpose of this report is to provide the committee with updates on:
   (i) the ‘STOP suicide Leicestershire, Leicester and Rutland’ campaign and website and
   (ii) the ‘RUOKToday?’ programme.

Policy Framework and Previous Decisions

2. At the Health Overview and Scrutiny Committee meeting in November 2018, the Director of Public Health appraised the committee of actions carried out by Public Health and wider partners in Leicestershire aimed at preventing and reducing the burden of suicide. These actions sit under the 2017-20 Leicester, Leicestershire and Rutland Suicide Prevention Strategy and Action Plan.

3. The actions included the development of a programme of suicide prevention called ‘STOP Suicide’ Leicestershire, Leicester and Rutland which was initiated in the autumn of 2017. Today’s report provides an update on that programme.

4. The report also briefly covers a separate local programme aimed at improving general mental health and wellbeing and helping people who are struggling with mental health issues: called ‘RUOKToday?’

Background

5. The background is as follows:

(i) The ‘STOP Suicide Leicestershire, Leicester and Rutland’ campaign and website (now referred to as ‘Start a Conversation’. ‘Suicide is Preventable’)

The evidence

- Over the last decade there has been a steady rise in the number of suicides in Leicestershire and across the UK;
- Suicide is the biggest killer of men under 50 as well as being the leading cause of death in young people;
- Three-quarters of suicides are among men, with those aged 45-49 most at risk

- People living in the most deprived areas are at higher risk of suicide;
- The effects of suicide can reach into every community and have a devastating impact on families, friends, colleagues and others;
- For each suicide approximately 135 people suffer intense grief or are otherwise affected.

6. After Public Health came back to local government in 2013, suicide prevention became a local authority led initiative working closely with the police, clinical commissioning groups (CCGs), NHS England, coroners and the voluntary sectors.

7. The Council Leader in Leicestershire identified suicide prevention as a high priority action area for Leicestershire in autumn, 2017 and tasked Public Health with developing a concerted suicide prevention programme across Leicestershire.

8. The Public Health team has since worked with key partners in the Leicester, Leicestershire and Rutland Suicide Audit and Prevention Group and across our local communities to develop the ‘STOP Suicide Leicester, Leicestershire and Rutland’ programme, campaign and website (now called ‘Start a Conversation’. ‘Suicide is Preventable).

9. Due to potential overlap and confusion with a similar programme in Cambridgeshire and Peterborough, the campaign’s title has been changed to ‘Start a Conversation’, ‘Suicide is Preventable’. This title has been chosen to capture the essential ethos behind the campaign i.e. that people in distress and with mental health problems benefit from a listening ear and from getting the right support in times of crisis. The campaign also aims to tackle stigma around mental illness and suicide by stimulating open and honest conversations about these issues more widely in our local population.

Key Developments

10. As described above, the campaign is now called ‘Start a Conversation’, ‘Suicide is Preventable’.

11. The campaign has been overseen by a Task and Finish Group which is a sub-group of the Leicester, Leicestershire and Rutland Suicide Audit and Prevention Group. The group meets monthly to offer expert advice and guidance to the development of the campaign (see **Appendix A** for membership and partners).

12. Initial focus has been on developing a website to anchor the campaign. Cuttlefish Multimedia has been commissioned to build a website for the campaign.

13. The Task and Finish group has worked alongside the Leicestershire County Council design and digital team on website content and a name for the campaign. The main areas of content for the website include:
    - Maintaining mental health and wellbeing;
    - In crisis support and response;
    - Training and resources;
    - Bereavement support;
    - A suicide prevention pledge for individuals and organisations.

14. Following a soft launch, the website has been finalised and is due to be officially launched on 10th September to coincide with World Suicide Prevention Day. The launch event takes place in the Council Chamber, Leicestershire County Council, County Hall, 12-2 pm on 10th September.

15. Funding has been secured for a 0.5.FTW suicide prevention coordinator post within the public health team. This will provide sustainability for the delivery of the campaign (and will include day to day maintenance of the website).

16. Additional support has been sourced using a grant arrangement for joint working with the Rural Communities Council (RCC). This also helps provide sustainability in terms of delivery of the campaign into our communities. RCC will also help co-ordinate and deliver relevant training

17. Joint working with the Office of the Police and Crime Commissioner and Leicester City Council is taking place to develop a support service for those bereaved or affected by suicide. It is hoped to have the service in place by 1st April, 2019

(ii) RUOKToday? programme

18. Launched in 2015, the RUOKToday? programme is a multi-agency programme and campaign of events to raise awareness of how a kind word or quick conversation can help lift the mood of someone who might be feeling low. The campaign is supported by NHS, police, rail services, local government, voluntary and third sector and other organisations. Details on membership of the partnership can be found in **Appendix B**

19. Events are organised at public venues during which scores of volunteers help by mingling with e.g. passengers at a designated railway station or individuals at a range of other locations. The aim is to engage people in 30-second conversations.

20. The campaign has already engaged with more than 7,000 people over the course of five events at Leicester railway station and in the city centre. More than 40 people have received specific one-to-one support on the day and many individuals have made a personal pledge on the pledge wall to help support mental wellbeing. The most recent event took place on 10th of March 2018 in Leicester Haymarket Shopping Centre. Further events are planned.

21. Information on the campaign can be found on the RUOKToday? Website: http://ruoktoday.co.uk/

Proposals/Options

22. The Health Overview and Scrutiny Committee is asked to note the contents of this report and to recognise the important role of the committee in supporting and championing both the ‘Start a Conversation’ and ‘RUOKToday? programmes.

23. The Health Overview and Scrutiny Committee is asked to note and support the launch of the ‘Start a Conversation’ website on 10th September.

Resource Implications

24. Partners involved in ‘Start a Conversation’ and ‘RUOKToday? campaigns invest their professional time and expertise into the programmes. Additional funding for specific aspects of ‘Start a Conversation’ has already been identified and committed as indicated earlier in the report.

Conclusions

25. Both the ‘Start a Conversation’ and RUOK?Today programmes are important developments in our efforts to both improve mental health and wellbeing and to reduce the burden of suicide across Leicestershire, and Leicester City and Rutland.

26. The Health Overview and Scrutiny Committee has an important role in overseeing and
27. supporting efforts to improve general mental health wellbeing and with reducing the burden of suicide in Leicestershire.

Background papers

Suicide Prevention, a report from the Director of Public Health, Leicestershire County Council Health and Overview Scrutiny Committee, 8th November, 2017

Circulation under the Local Issues Alert Procedure

None. The issue is County wide.

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List of Appendices

Appendix A: Partners in the ‘Start a Conversation’. ‘Suicide is Preventable’ campaign

Appendix B: Partners in the RUOKToday? Campaign

Relevant Impact Assessments

Equality and Human Rights Implications

Suicide disproportionately impacts on socially excluded groups and overall approaches to suicide prevention must ensure that this health inequality is targeted and addressed.

Crime and Disorder Implications

People and groups who experience social disadvantage are more likely to be victims of suicide and of crime. This reinforces the need to address social inequality across society.

Environmental Implications

None of significance

Partnership Working and associated issues

Tackling suicide requires concerted action and collaboration amongst services, communities, individuals and across society as a whole.

Appendix A

Partners in Leicester, Leicestershire and Rutland Suicide Audit and Prevention Group

- Leicestershire County Council
- Leicester City Council
- Rutland County Council
- Blaby District Council
- Charnwood Borough Council
- Harborough District Council
- Hinckley and Bosworth Borough Council
- Melton Borough Council
- North West Leicestershire District Council
- Oadby and Wigston Borough Council
- Leicestershire Police (including Office of police and crime commissioner)
- West Leicestershire CCG
- East Leicestershire and Rutland CCG
- Leicester City CCG
- University Hospitals of Leicester NHS Trust
- Leicestershire Partnership NHS Trust
- Rural Community Council
- Turning Point
- Samaritans
- East Midland Ambulance Service
- Public Health England (representing Leicestershire Prisons and Leicestershire Probation Services)

Appendix B

Organisations working together for the RUOK Today? programme

- Leicestershire Partnership NHS Trust
- Leicestershire Police, Network Rail
- British Transport Police
- Railway Mission
- Leicestershire Fire and Rescue Service
- Samaritans
- LAMP
- Leicester City Council
- Leicestershire County Council
- Richmond Fellowship
- R2care
- NHS England,
- CLASP
- Healthwatch Leicester
- Support for Carers and 2Care