NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

# Learning Disabilities Mortality Review (LeDeR) Multi Agency Review (MAR) Policy

Shaping better health

| ***Please complete the table below:***<br>*To be added by corporate team once policy approved and before placing on website* | |
|---|---|
| **Policy ref no:** | |
| **Responsible Executive Director:** | Rosi Shepherd, Director of Nursing & Quality |
| **Author and Job Title:** | Lesley Le-Pine – LeDeR Programme Manager |
| **Date Approved:** | December 2020 |
| **Approved by:** | LeDeR Steering Group |
| **Date of next review:** | February 2023 |

**Policy Review Checklist**

| | Yes/ No/NA | Supporting information |
|---|---|---|
| Has an Equality Impact Assessment Screening been completed? | Yes | Appendix |
| Has the review taken account of latest Guidance/Legislation? | Yes | |
| Has legal advice been sought? | No | |
| Has HR been consulted? | N/A | |
| Have training issues been addressed? | Yes | Evaluation of MAR meetings |
| Are there other HR related issues that need to be considered? | No | |
| Has the policy been reviewed by Staff Partnership Forum? | No | |
| Are there financial issues and have they been addressed? | No | |
| What engagement has there been with patients/members of the public in preparing this policy? | Not required | |
| Are there linked policies and procedures? | Yes | LeDeR Policy and Guidance |
| Has the lead Executive Director approved the policy? | Yes | |
| Which committees have assured the policy? | | Not required already implemented |
| Has an implementation plan been provided? | NO | Included in section |
| How will the policy be shared with staff, patients and the public? | Staff will be able to access the policy via the BNSSG staff intranet and patients/public via our website. | |
| Will an audit trail demonstrating receipt of policy by staff be required; how will this be done? | Yes | Via the BNSSG LeDeR Steering group |

# Table of Contents

# Learning Disabilities Mortality Review (LeDeR) Multi Agency Review Policy

## 1 Summary

**1.1** The LeDeR programme was established in 2017 as a response to the recommendations from the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD, 2013). CIPOLD reported that people with learning disabilities are three times more likely to die from causes of death that could have been avoided with good quality healthcare. It is not a statutory process.

**1.2** Bristol, North Somerset, South Gloucestershire (BNSSG) CCG has an obligation to complete LeDeR reviews on all deaths of service users with Learning Disabilities notified to the CCG via the Local Area Contact (LAC).

1.3 The process for completing LeDeR reviews can be found in the BNSSG LeDeR Policy and Framework via https://bnssgccg.nhs.uk/library/learning-disabilities-mortality-review-leder-policy-framework/. The policy details the scope of the LeDeR review process and the responsibilities of those involved in the LeDeR programme.

**1.4** A diagram illustrating how the LeDeR process links with the Child Death Overview Process (CDOP) and the individual mortality review processes within individual organisations can be viewed in Appendix 4. More information about the programme and the review process can be found at: http://www.bristol.ac.uk/sps/leder/about/

**1.5** LeDeR reviews are completed by staff from organisations within the BNSSG ICP area who have volunteered to complete LeDeR review training and become a LeDeR reviewer.

**1.6** LeDeR Reviewers complete the LeDeR review by reviewing the case notes of the service user and speaking to relatives, carers and professionals who knew or cared for the person in the period prior to their death. Families of service users are central to the LeDeR process and in a MAR are offered full sight of all documents,

**1.7** The LeDeR Reviewer is asked to provide an indication on the level of care provided to the service user and makes recommendation on learning to be taken forward to improve access to health and social care services and reduce health inequalities for people with Learning Disabilities across the wider system.

**1.8** Multi Agency Review (MAR) meetings are initially identified as a requirement by LeDeR reviewers in completing a LeDeR review by scoring the level of care provided to the service user. (Appendix 1 shows the scoring categories used to identify a requirement for a MAR meeting).

**1.9** Where a score of 5 or 6 occurs, this indicates a need for further consideration of the care provided in the context of a MAR. At this point the LeDeR reviewer suggests the requirement for a MAR meeting to be convened.

**1.10** Where the reviewer identifies a MAR is indicated, the reviewer should discuss the circumstances with their Local Area Contact (LAC). The LAC will provide support and supervision for the review and preparation for the MAR.

**1.11** The LeDeR case identified by the LeDeR reviewer and LAC as requiring a MAR is quality assured at a LeDeR clinical case review panel held by Bristol, North Somerset and South Gloucestershire (BNSSG). The clinical case review panels are attended by the Local Area Contact (LAC), the CCG Clinical Lead GP, a Safeguarding Lead and colleagues from Bristol, North Somerset or South Gloucestershire's Local Authorities

**1.12** A MAR meeting will be convened where the BNSSG LeDeR clinical case review panel has scrutinised the review and upheld this recommendation. The panel will not overrule a reviewer's recommendation for a MAR, however, if they are in possession of additional information this will be discussed with the reviewer for their consideration prior to a final decision on the MAR is made.

**1.13** The clinical case review panel may also recommend a MAR is held if they feel further learning can be achieved even if the reviewer has not identified this. This decision will be discussed with the reviewer.

1.14 When the MAR is agreed the LeDeR administrator will support the reviewer with the paperwork for the MAR and liaise with the various agencies to arrange a meeting date. The LAC will provide support and supervision for the review and support the reviewer to prepare for presenting the MAR at the meeting for the MAR. The LAC will chair the MAR meeting.

**1.15** A key reason for convening a MAR meeting is that it will enable broader learning by bringing together the family and the health and care professionals who were involved in caring for the person and/or in coordinating their care. Reasons for holding a MAR meeting may vary and their focus may differ however the key principles for successful MAR meetings can be applied across any setting.

## 2. Purpose

**2.1** The purpose of this policy is to detail how the Learning Disabilities Mortality Review (LeDeR) programme Multi Agency Review (MAR) meetings are managed within the BNSSG STP area. This guidance aims to enhance the existing guidance available on the LeDeR platform.

**2.2** Best practice preparation and planning for MAR meetings contributes to their effectiveness.

**2.3** It is essential that those involved in planning a MAR meeting ensure that they and all attendees, including the family, are supported to be clear about the purpose of the meeting and its intended outcomes.

**2.4** This guidance aims to inform the preparations, completion and actions required following a MAR meeting to ensure each MAR meeting is held to best practice.

**2.5** This guidance is intended to inform the management of the MAR meeting process as a multi-agency approach that achieves effective learning into action outcomes to inform the wider system.

## 3 Definitions

**3.1** This Policy sets out how the LeDeR programme Multi Agency Review (MAR) meetings operate within BNSSG, and the individuals, teams and groups/committees key to the successful delivery of these meetings.

**3.2** This Policy aims to enable the BNSSG local health community to embed best practice MAR meetings, the aim of which is to achieve effective learning into action to reduce health inequalities for people with Learning Disabilities across the wider system

**3.3** To assist in achieving this aim, this policy outlines the governance structures that BNSSG links with and the management process for completing a MAR meeting.

## 4 Roles and Responsibilities

The roles and responsibilities of those involved in the completion of Multi Agency Review (MAR) meetings are shown below:

**4.1 University of Bristol**

LeDeR programme national support is currently delivered by a team based at the University of Bristol (UB). The UB has been commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England to provide this function. Its main role is to provide support and analysis of LeDeR reviews which is facilitated by an electronic portal.

**4.2 BNSSG Director of Nursing and Quality**

The BNSSG Director of Nursing and Quality holds Director-level responsibility for the LeDeR programme within BNSSG area. The Director of Nursing and Quality assigns the day-to-day operational management of the programme to the Local Area Contact (LAC).

**4.3 Local Area Contact**

The Local Area Contact (and their team) is the link between the UB LeDeR programme team, the South West NHSE/I Regional Steering Group and the locally delivered programme. The LAC will notify the LeDeR Steering Group of each MAR meeting held and its outcomes.

The LAC responsibilities in regard to MAR are:

- monitoring the progress and completion of reviews to ensure that they are of a consistent standard and completed in a timely and comprehensive way;
- providing advice and support for local reviewers as necessary;
- organising and chairing the quarterly Local Reviewers Support Group and discussing any issues as appropriate;

- chairing the monthly LeDeR Clinical Case Review Panel, receiving and signing off completed reviews and recommendations in agreement with the Panel members;
- Chairing the Multi-Agency Review (MAR) meetings and supporting the LeDeR reviewer to prepare for the MAR meeting, providing supervision and guidance.
- Reporting the outcome of the MAR meeting and recommendations to the LeDeR Clinical Case Review Panel to agree case closure and/or further referral/actions
- Anonymising and collating learning points and recommendations and sharing these with the Reviewers Support Group, LeDeR Steering Group, BNSSG providers and South West Regional Steering Group as appropriate

### 4.4 Local Reviewers

Local Reviewers are responsible for undertaking robust and high quality reviews of the deaths of people with learning disabilities and identifying the requirement for convening a MAR meeting through the grading of the case review.

The local reviewer must ensure that families are central to the process, and any family members involved are offered full sight of all documents and are invited to attend the meeting as they wish. Where family do not want to be involved in the MAR meeting the reviewer and the LAC need to agree and document how the family member would like feedback from the MAR

Local Reviewers, with support from the LeDeR administrator, are responsible for preparing the information required and preparing and liaising with the family, carers and provider leads for attendance at MAR meetings (full details of the preparation for MAR meetings responsibilities of the LeDeR Reviewer are detailed in section 7).

Local Reviewers, with the support of the LAC chair, are responsible for presenting the findings of their review at the MAR meeting.

### 4.5 Local Provider Leads

Local Provider Leads are responsible for attending and/or identifying the appropriate member of staff to attend a MAR meeting.

Local Provider Leads are responsible for ensuring that documentation requested for the MAR meeting is provided prior to the meeting.

Local Provider Leads are responsible for providing the collated learning from their organisations internal investigation processes related to the review being discussed. This is to enable contribution to the learning into action recommendations agreed at the meeting (full details of the preparation for MAR meetings are detailed in section 7).

Following the MAR meeting Local Provider Leads are responsible for disseminating the outcome and recommendations taken from the meeting across their organisation and ensuring learning is taken forward.

### 4.6 Relatives and Carers

Relatives and Carers are invited by the LeDeR reviewer to give consent to be involved in the completion of a LeDeR review and attendance or contribution to the MAR meeting.

The relative/carer will liaise with the LeDeR reviewer and agree any additional support and/or special requirement needed to attend the MAR meeting (full details of the preparation for MAR meetings are detailed in section 7).

**4.7 LeDeR Administrator**

The LeDeR administrator is responsible for supporting the LeDeR reviewer to book the date, time and venue for the MAR meeting.

The LeDeR administrator is responsible for supporting the LeDeR reviewer to send letter invitations to the MAR meeting and complete correspondence to attendees.

The LeDeR administrator is responsible for supporting the LeDeR reviewer and LAC to collate all documentation required for the MAR meeting (full details of the preparation for MAR meetings is detailed in section 7 and checklist in appendix 5).

## 5. BNSSG LeDeR Review Governance Structure and Reporting

**5.1** The reporting structure for completed Multi Agency Review (MAR) meetings are listed below. Full details of the groups and meetings included in this structure can be found in the BNSSG LeDeR Policy and Framework.

- **LeDeR Clinical Case Review Panel**
- **LeDeR Steering Group**
- **Quality Committee**
- **Governing Body**
- **Safeguarding Governance Group (where appropriate)**

**5.2** The LeDeR review is not a statutory process and its purpose is not to hold any individual or organisation to account. The purpose of a MAR meeting is to identify learning that improves access to health and social care services for people with learning disabilities and reduces health inequalities

**5.3** It is intended that MAR meetings, where possible, have access to the learning and recommendations from other statutory and organisational investigation processes. These include:

- Rapid Reviews and Safeguarding Practice Reviews (SPRs)
- Safeguarding Adult Reviews (SARs);
- Safeguarding Adults Enquiries (Section 42 Care Act);
- Domestic Homicide Reviews (DHRs);
- Mental Health Homicide Reviews (MHRs);
- Coroners' investigations;
- Child Death Reviews.

- Serious Incident Reviews;
- An organisation's internal Serious Incident investigations (including Structured Judgement Review and Mortality review).

**5.4** The outcomes, recommendations and learning from each completed MAR meeting will be reported to the LeDeR Clinical Case Review panel where the decision to close the case will be made.

5.5 It is completely acceptable for LeDeR reviews, where appropriate, to arrive at differing conclusions to other reviews or inquests. This is on condition that they have the evidence to support this determination and that the LeDeR itself was subject to correct governance processes.

**5.5** If the MAR meeting identifies a requirement for a statutory investigation (such as those listed in 5.3) the LeDeR Clinical Case Review panel is responsible for completing the necessary action in completing the referral.

**5.6** Outcomes, recommendations and learning from each MAR meeting will be shared by the LAC at the LeDeR Reviewers meeting, the BNSSG LeDeR Steering group and the South West NHSE/I Regional LeDeR Steering group as appropriate.

**5.7** The Local Area Contact will produce a quarterly report for the LeDeR Steering Group which will include the learning taken from the LeDeR reviews and MAR meetings. This learning will be escalated to the Quality Committee, detailing the key learning and themes. The Quality Committee reports to the CCGs Governing Body.

**5.8** Members of the LeDeR steering group are expected to take the recommendations and learning identified in the quarterly reports and disseminate this to the organisations they represent.

## 6 PREPARING FOR A MULTI-AGENCY REVIEW (MAR)

The following actions below are required to be completed in preparing for a Multi-Agency Review (MAR) meeting. The terms of reference for MAR meetings are detailed in Appendix 7.

All actions below are for completion by the named reviewer, supported by the LeDeR administrator and the Local Area Co-ordinator (LAC). In particular the LAC should check if the reviewer is comfortable and confident to present at the MAR meeting. If the reviewer has concerns the LAC should approach a reviewer who has more experience of presenting MARs to co-present. The LAC should provide supervision and guide discussion to help the reviewer prepare for the MAR.

**6.1 Arranging the MAR meeting**:

Contacting all agencies that were involved with the service user:

- The named reviewer should contact any family members, explain the purpose of a MAR and whether/how they would like to be involved

- If there is ever a breakdown of trust between family and reviewer it would be responsibility of the LAC to contact the family.

- The named reviewer should identify the individuals and agencies that have been involved in supporting the person who has died.

- The reviewer will send an initial letter to each provider/organisation advising that a MAR meeting has been agreed by the BNSSG Clinical Case Review Panel. The reviewer must follow the letter up with a phone/face to face conversation with the individuals and/or provider/organisation leads so that the provider/organisation lead can clarify the correct individuals to attend the MAR meeting. NB: This is to ensure that the individuals attending the MAR meeting are ones who knew the person and/or had provided care for them. If an individual has left the provider/organisation the provider/organisation lead will need to identify an appropriate individual to attend the MAR meeting in their place.

- The reviewer must have a phone/face to face conversation with provider leads where a structured judgement review and/or a mortality review has been completed to identify the learning actions and recommendations that have been agreed from these reviews.

- The reviewer must identify whether a safeguarding adult review has been completed and acquire the outcome of this review. This will include any recommendations and actions agreed.

- The reviewer/LeDeR administrator must send all attendees a draft copy of the service user's pen portrait, timeline, and description of the circumstances leading to the death and ask them to add any additional comments. NB all information must be sent by secure email. See uploading documents email link 6.3.

- If information/documents require sending by post the named LeDeR reviewer must discuss this with the LeDeR administrator who will arrange secure posting.

- Attendees' comments should consider:

  A. Initial diagnosis of the condition.
  B. On-going management of the condition from initial diagnosis to critical illness.
  C. Management and care received during final illness (including details and dates of any investigations, their results and any actions subsequently taken).

### 6.2 Contacting and involving family members

- The reviewer must identify if family members have been involved in the initial review. If they have been involved and consented to having feedback on the outcome of the review the reviewer will phone or write to the family offering them a meeting to complete a discussion on the review outcome, including that a MAR will be taking place and the MAR process.

- When the reviewer meets with the family, the reviewer should share and check the draft information with them (pen portrait, timeline, and description of the circumstances leading to death).

- As part of this multi-agency review, it may be helpful for the reviewer to ask the family some additional questions if they have not already been covered, such as:
    - Was there any particularly good practice in relation to this person's death?
    - Were there any contributory factors to the death that could have been avoided?
    - Is there anything about the person's death that has concerned them?

The reviewer should confirm whether the family would like to attend the MAR panel meeting, and how the family want the reviewer to help them to prepare for this. The reviewer will discuss the specific consideration points shown in section 6.6.6 below with the family.

The reviewer should consider any specific additional needs of the family member/s attending (bringing a friend/supportive person/access and mobility/seating/hearing loop etc.) and ask the LeDeR administrator to ensure these are arranged prior to the meeting.

### 6.3 Requesting documents

The reviewer, with support from the LeDeR administrator, should request a copy of any relevant notes and documents pertaining to the person, for example

- Acute Trusts – structured judgement review, mortality review, summary record of past attendances, notes from most recent hospital attendance, copy of DNACPR order, copy of most recent medication record, any advance directives.

- GPs – summary copy of GP records, copy of any correspondence, copy of DNACPR order, copy of most recent medication record, significant event audit review and/or any advance directives.

- Other services – records from the final year of person's life, summary of health and care/ support plans and most recent medication records.

- In order to upload case review notes, the individuals involved need to be contacted and asked to use the following link. When they click on this link they will be asked to identify themselves, and will then be able to upload files. These files will appear inside the case review window.

### 6.4 Arrange a Multi-Agency Review meeting

- The reviewer will ask the LeDeR administrator to arrange a date, time and venue for the multi-agency review meeting.

- Where there may be, or have been identified safeguarding concerns the named LeDeR reviewer should discuss with the LAC inviting a safeguarding representative to the meeting

- The LeDeR administrator will identify a date and time of the MAR meeting that the LAC (and/or Senior Manager i.e. Chair) and named reviewer can attend.

- The named LeDeR reviewer will confirm attendees names and contact details with the LeDeR administrator
- The LeDeR administrator will send an invite letter (see appendix 3) to each attendee. The letter will include enclosed copy of the service user's pen portrait and the timeline
- The LeDeR administrator will coordinate attendee's availability to agree a final date/time for the MAR.

**6.5 Prepare for the meeting**

The reviewer, with support from the administrator, will collate the information from the relevant case notes and responses. The reviewer will agree a meeting agenda with the LAC (using template in appendix 2).

The reviewer, LAC and LeDeR administrator will liaise to ensure the documentation pack for the meeting (including copies of case notes, additional information, agenda and outcome document) is available for the meeting.

The LeDeR administrator will print the agreed number of packs for the MAR meeting and provide packs to the LAC and named reviewer (and other attendees as agreed).

The checklist (appendix 5) can be completed to ensure all actions have been completed.

**6.6** **Pre meet**: The LAC/Senior Manager, the named reviewer and the LeDeR administrator need to undertake planning meeting by phone or face to face to finalise meeting detail and agree required outcomes. A brief agenda for this pre-meet to include: Finalising and clarifying meeting arrangements (e.g. documentation, time arriving, parking), agreement on agenda items, family member support and requirements and clarity on case (coroners outcome/SJR recommendations etc.)

- The meeting guidance in section 6 must be considered.
- The LAC or Associate Director will chair the meeting.
- The named LeDeR reviewer will present the case at the MAR meeting.
- The LeDeR administrator will take minutes of the meeting and support completion of the draft outcomes document.

**6.7 Meeting Guidance**

In order for this meeting to have a positive outcome and to allow all parties to contribute the Chair should inform the attendees of the purpose, the expected aims and outcomes of the MAR meeting and brief ground rules. The chair should explain that the MAR meeting is a review to gain learning and not an investigation and assure attendees that the MAR is intended to be a non-blame process as an open and transparent process for l earning. The chair should advise attendees that everyone has a valued contribution to make and that the meeting will consider personal confidential information about the person who died that should not be shared outside of the meeting.

Clear contingency plans need to be outlined by the chair providing clarity on the completion of the meeting and the actions and recommendations identified at the meeting. The contingency plans can include:

- Need for cancellation of the meeting (Quoracy/Terms of reference)
- Discussion and agreement on breaks/stops during the meeting and reconvening the meeting.
- Solution based discussion and recommendations during the meeting.

Ground rules can be discussed by the chair and adapted as required at each MAR meeting held. Suggested ground rules for discussion are:

- Attendees to stay for the full meeting.
- Keep discussion relevant to agenda.
- Be respectful to all attending the meeting.
- Agree breaks/time out plan at start of the meeting.
- Be solution focussed.
- Avoid using jargon or acronyms. These create a barrier to good communication.
- Be willing to/support recommendations and actions being taken forward.

The Chair will address the MAR meeting agenda and refer to the outcome document (appendix 8) during the meeting. All outcome document questions should be considered and answered in agreement with all attendees prior to ending the meeting.

I f safeguarding and/or other statutory investigation concerns are raised by information shared during the MAR meeting, those present must agree who and how the referral will be made and the urgency required.

**6.8 Family members attending the MAR meeting:**

The reviewer will have discussed the MAR meeting with the family in advance and the arrangements as laid out in the points below reviewed prior to the meeting:

- The reviewer will identify if the family are attending the whole meeting. If they are attending only part of the meeting, how they are to join the meeting, who will meet them and bring them in.
- The reviewer will identify if the family want to be introduced to the attendees before they go into the meeting or at the start of the meeting.
- The reviewer will identify if the family want someone to sit with the family before they come into the meeting.
- The reviewer will identify if there is a specific chair for the family at the table and who would it be most appropriate for them to sit next to.
- If the family are not able to attend, the reviewer will identify to the meeting how the views of the family will be sought during the meeting and will report the family's views as part of the agenda.
- The reviewer will provide a debrief to the family after the meeting and inform them of the closing process of the case (or when/how actions and recommendations will be completed and how they will receive the meeting outcome information).
- If there is ever a breakdown of trust between family and reviewer it would be the LAC's responsibility to contact the family.

**6.9 Attendees:**

- All attendees will be offered a briefing before the meeting and a debrief following the meeting by the chair as required.

- All attendees will be asked to evaluate and comment on their experience of the meeting process to enable the MAR meeting process to be developed effectively.

- All attendees will be sent a written summary (via email or letter) of the meeting outcomes.

## 7 Actions required following the MAR meeting

- The LeDeR administrator will meet with the reviewer, LAC and/or Chair following the MAR meeting and ensure the completed LeDeR outcome document in Appendix 8 (including recommendations and actions) is sent to the University of Bristol.
- The LeDeR administrator and LAC to ensure an outcome letter/email is sent to attendees.
- The reviewer will contact the family and offer a debrief/ensure the family understand the agreed outcomes.
- The case will be taken to the next Clinical Case Review Panel and outcomes discussed with recommendations and actions agreed including the decision to close the case.
- The case will be closed on the LeDeR platform.
- The case will be discussed at the LeDeR Steering group and South West NHSE/I Regional Steering group to share learning and recommendations, as appropriate

## 8 Evaluation

Each MAR meeting held will include evaluation. This evaluation will consist of the following:

- Feedback from debriefs held after each meeting with family members and all attendees will be collated.
- Collated feedback will be reviewed by the LAC and Reviewer to inform the development of best practice MAR meetings across BNSSG.
- Evaluation will be fed back to all attendees and to the LeDeR Steering group and South West NHSEI Regional LeDeR Steering group and via all governance reporting structures.

## 9 Training

9.1 The Local Area Contact, Secondary Local Area Contacts and all Reviewers have received on-line training from NHS England/University of Bristol on the requirements and responsibilities of their LeDeR roles.

9.2 Training requirements specific to the completion of MAR meetings have not been available as part of the national training but any emerging training needs identified from MAR meetings evaluation will be identified and addressed. This will include discussion and agreement with all LeDeR reviewers via the Peer Review group meetings.

## 10 Recommendation and Approval Process

The approval process for this LeDeR Multi Agency Review (MAR) Policy is via submission to the LeDeR Steering Group and the Quality Committee and subsequent approval of the Governing Body.

## 11 Communications/dissemination

Notice of issue of the first version, and any updated versions of this Policy will be communicated via the quarterly LeDeR activity report submitted to the LeDeR Steering group.

## 12 Implementation

12.1 As a Policy this procedural document summarises the current arrangements for the management of the LeDeR Multi Agency Review (MAR) meetings within BNSSG.

12.2 The aspects of the Policy that require implementation are:

- Quarterly LeDeR activity update to be submitted to the BNSSG Quality Committee;
- Implementing with the BNSSG reviewers via the BNSSG Peer reviewer group meetings and/or when a reviewer has recommended a MAR meeting.
- Annual assurance audit of implementation of MAR meeting recommendations and actions.
- The development of a dedicated LeDeR page is to be developed on the website of BNSSG CCG in 2020.
- Sending the quarterly report to a wide range of mortality/learning from deaths, end of life, safeguarding and risk meetings across BNSSG/STP.

## 13 Monitoring Compliance and Effectiveness

13.1 Identification of key learning themes, affecting change in practice for people with a learning disability and reporting progress are the key objectives of the LeDeR Multi Agency Review (MAR) meetings within BNSSG.

13.2 The assurance and oversight of the effectiveness of the LeDeR MAR meetings within BNSSG in achieving these objectives will be provided by the BNSSG Steering Group.

**APPENDIX 1**

# Guidelines for LeDeR Reviewers to allocating a grade to the care received by the person with Learning Disabilities before their death

## 1 Purpose:

This guideline is intended to provide a standard grading system for LeDeR Reviewers when determining the level of care provided in completing LeDeR reviews. The guideline includes a list of the care grade descriptions and a suggested rationale for selecting each grade.

## 2. The care grades:

Once the reviewer has completed the initial review they need to identify a grade for the care that the person received before their death.

The grading scores are shown below:

1. This was excellent care (it exceeded expected good practice).
2. This was good care (it met expected good practice in all areas).
3. This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the person's wellbeing).
4. Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death.
5. Care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death.
6. Care fell far short of expected good practice and this contributed to the cause of death.

## 3. Rationale for Reviewers to use in choosing a care grade:

From the information gathered and analysed the reviewer is required to grade the quality of care the person received. This needs to be based on the person's overall experience of services, not solely on one organisation's input.

The table below provides the grade, its description and a rationale for choosing each grade.

**Table 1: Care grades and rationale for choosing the grade**

| Grade | Description | Rationale for choosing this grade |
|---|---|---|
| **1** | This was excellent care (it exceeded expected good practice). Please identify in Q62 what features of care made it excellent and consider how current practice could learn from this. | • The total package of care appeared to meet the individual's needs with no gaps identified.<br>• There was evidence of good medical care from professionals with no gaps identified.<br>• There were no concerns expressed from family, carers, professionals or reviewer on the overall care provided.<br>• There was no evidence of confirmed safeguarding concerns.<br>• There is evidence of best practice found during the review. |
| **2** | This was good care (it met expected good practice). Please identify in Q62 any features of care that current practice could learn from. | • The total package of care appeared to meet the individual's needs with no or very minimal gaps identified.<br>There was evidence of good medical care from professionals with no or very minimal gaps identified.<br>• There were no concerns expressed from family, carers, professionals or reviewer on the overall care provided or where concern was expressed there was no evidence found to validate this.<br>• There was no evidence of confirmed safeguarding concerns. |
| **3** | This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the person's wellbeing). Please address these issues in your recommendations for service improvement in Q61, and identify in Q62 any features of care that current practice could learn from | • The total package of care appeared to meet most of the individual's needs with minimal gaps identified which had not significantly impacted on the person's wellbeing<br>• There was evidence of medical care from professionals with gaps identified which had not significantly impacted on the person's wellbeing<br>• There were no concerns expressed from family, carers, professionals or reviewer on the overall care provided or where concern was expressed there was no evidence found to validate this or what was identified had not significantly impacted on the person's wellbeing. |
| **4** | Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death. Please address these | • The total package of care appeared to meet most of the individual's needs with gaps identified which did impact on the person's wellbeing but was not evidenced/thought to have contributed to the cause of death<br>• There was evidence of medical care from professionals with gaps identified which impacted on |

| | | |
|---|---|---|
| | issues in your recommendations for service improvement in Q61, and identify in Q62 any features of care that current practice could learn from. | the person's wellbeing but was not evidenced/thought to have contributed to the cause of death.<br>• There were concerns expressed from family, carers, professionals or reviewer on the overall care provided which was evidenced and did impact on the person's wellbeing but was not evidenced/thought to have contributed to the cause of death. |
| **5** | Care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death. | • The package of care appeared not to meet the individual's needs with gaps identified which appeared to have significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death.<br>• There was evidence of medical care from professionals with gaps identified which appeared to have significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death.<br>• There was evidenced significant concerns expressed from family, carers, professionals or the reviewer on the care provided which appeared to have significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death. |
| **6** | Care fell far short of expected good practice and this contributed to the cause of death. | • The package of care did not meet the individual's needs with gaps identified which appeared to fall far short of expected good practice and this is thought to have contributed to the cause of death.<br>• The medical care from professionals appeared not to meet the individual's needs with gaps identified which appeared to fall far short of expected good practice and this is thought to have contributed to the cause of death.<br>• There was evidenced significant concerns expressed from family, carers, professionals or the reviewer on the care provided which appeared to fall far short of expected good practice and this is thought to have contributed to the cause of death. |

## 4. Further Advice and Guidance

If the reviewer identifies that there is insufficient information available and they are unable to grade their overall assessment of the care received by the person, further evidence should be gathered until they feel they have sufficient information.

If the reviewer remains unsure of what grade to give the care, they should discuss this with their Local Area Contact (LAC).

The reviewer must discuss with the LAC if the level of care is indicating a score of 5 or 6 and/or the care is indicating a requirement for a safeguarding referral. A grade of 5 or 6 indicates a multi-agency review (MAR) meeting is required.

The reviewer will submit the review to the LeDeR platform for LAC approval.

The LAC will submit the review to the next BNSSG Clinical Case Panel. The BNSSG Clinical Case Panel will quality assure the review including the care grade.

It is completely acceptable for MAR reviews, where appropriate, to arrive at differing conclusions to other reviews or inquests. This is on condition that they have the evidence to support this determination and that the LeDeR itself was subject to correct governance processes.

The Clinical Case Panel will agree to close the case or agree for the LAC to discuss the rationale for the care grade further with the reviewer if there is any discrepancy in the decision for the grade allocated.

Actions agreed at the Clinical Case Panel will support any further actions required by the LAC and/or reviewer. This may include providing further information, clarifying information, safeguarding referral or arranging a Multi-Agency Review (MAR) meeting

Please refer to the BNSSG MAR policy to support the setting up of a MAR meeting.

The review will be presented back to a BNSSG Clinical Case Panel for closure when the further required actions (including MAR meetings) have been completed.

**APPENDIX 2**

# LeDeR Multi-Agency Review Meeting Agenda

Date :
Time :
Venue :

## 1. Agenda

| | | Time | Attachment |
|---|---|---|---|
| 1. | **Introduction and apologies** | | |
| 2. | **Terms of Reference** | | A1 |
| 3. | **Family session** | | V |
| 4. | **Agree content of draft timeline and pen portrait**<br>- **Accuracy**<br>- **Comments** | | A2 |
| 5. | **Discuss potentially avoidable contributory factors relating to:**<br>- **The person and their environment**<br>- **Their care and its provision**<br>- **The way services are organised and accessed** | | V |
| 6. | **Was the death potentially avoidable?**<br>*"Potentially avoidable deaths are those where there are aspects of care and support that, had they been identified and addressed, may have changed the outcome and on balance of probability the person may have lived another year or more"* | | V |
| 7. | **Has any best practice been identified?** | | A2 |
| 8. | **What are the learning points (if any)?** | | |
| 9. | **What are the draft recommendations to:**<br>- **Local practice**<br>- **Wider recommendations** | | V |
| 10. | **Agree content of the outcome document and action plan** | | |
| 11. | **What happens next** | | |

A = Attached T = Tabled V = Verbal

## APPENDIX 3

ADDRESS

DATE

Dear.....

ADDRESS

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

As part of the national Learning Disabilities Mortality Review Programme and following our recent discussions, I am now writing to invite you to a multiagency review meeting to discuss the death of (anonymised).

The purpose of the meeting is for those involved with the care and support of..... to discuss and agree (where possible):

- The draft timeline and pen portrait;
- Issues arising or lessons that can be learned from his/her death;
- Examples of best practice in his/her support;
- Whether there are any potentially avoidable contributory factors relating to his/her death;
- Any recommendations to be made to local practice and wider recommendations;
- The content of an action plan based upon any identified recommendations.

I will be sending out further paperwork prior to the meeting.

The meeting will be held:

Date:

Time:

Location:

Please could you confirm your attendance to …….. on telephone number or email address.

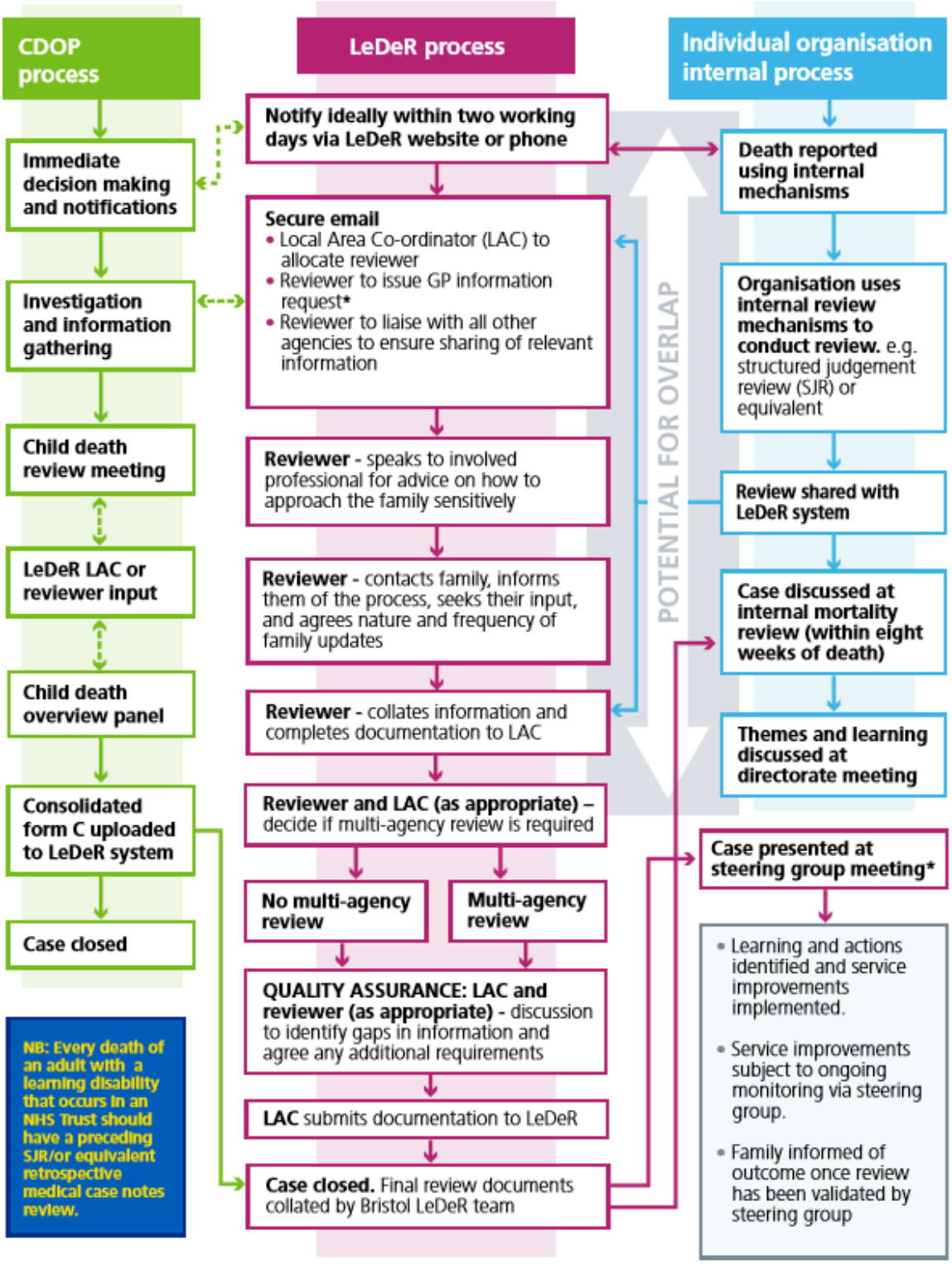
With thanks and best wishes .....

Named Reviewer

**APPENDIX 4**

# Notification and review of a death of an adult (18+) or child (age 4+) with a learning disability

NHS England




Please note: Parts of a process marked with an * may be subject to regional variation. If in doubt consult your regional co-ordinator

## APPENDIX 5

### CHECKLIST FOR PREPARING FOR MAR MEETING

1. **Have you identified all relevant individuals and agencies that have been involved in supporting the person who has died?**

Tick to confirm ☐

Please note the agencies involved here:

Details: Click here to enter text.

2. **Have you sent all relevant agencies and individuals a draft copy of the pen portrait, timeline, and description of the circumstances leading to death and asked them to add any additional comments?**

Tick to confirm ☐

Please note the agencies contacted here:

Details: Click here to enter text.

3. **Have you received replies from all relevant agencies and individuals with their additions/amendments to the pen portrait, timeline, and description of the circumstances leading to death?**

Tick to confirm ☐

Please note the agencies that have responded here:

Details: Click here to enter text.

4. **Have you requested a copy of case notes from all relevant agencies and individuals?**

Tick to confirm ☐

Please note the agencies contacted for case notes here:

Details: Click here to enter text.

5. **Have you received a copy of case notes from all relevant agencies and individuals?**

Tick to confirm ☐

Please note the agencies that have responded here:

Details: Click here to enter text.

6. **Have you arranged a date, time and venue for the multi-agency review meeting and invited all individuals, agencies and the family?**

Tick to confirm ☐

Please note the arrangements for the review meeting below:

Details: Click here to enter text.

7. **Have you collated the information from the relevant case notes and responses to prepare for the review meeting?**

Tick to confirm ☐

8. **Have you moved all submitted material to the case folder in the LeDeR web-based platform?**

Tick to confirm ☐

**APPENDIX 6**

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

# LeDeR Multi-Agency Review Meeting

## Terms of Reference

### Introduction

The Learning Disabilities Mortality Review (LeDeR) Programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It was established as a result of one of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD, 2013).

The LeDeR programme strives to ensure that reviews of deaths lead to learning which will result in improved health and social care services for people with learning disabilities. It is not an investigation nor is it aimed at holding any individual or organisation to account. If individuals and organisations are to be able to learn lessons from the past it is important that the reviews are trusted and safe experiences that encourage honesty, transparency and the sharing of information in order to obtain maximum benefit from them.

### Purpose

The purpose of this Multi-Agency Review Meeting is to ensure all aspects of the care provided to the deceased for the period leading up to their death are appropriately considered and that the panel and all contributors to the review are focused on shared learning, highlighting both good practice and potentially avoidable contributory factors, with any resulting recommendations being put into practice across the health and social care system.

The panel will take into account the factual evidence contained in the timeline, pen portrait and the noted identified good practice and learning points summary based on the information provided by family members and professionals involved in the deceased's care records.

### Focus

The focus of the multi-agency review will be to:

- Agree the comprehensive pen portrait and timeline
- Identify potentially avoidable factors that may have contributed to the person's death, specifically the person and their environment, provision of care and the way services are organised and accessed

- Identify and agree on good practice, learning points and any subsequent recommendations

- Develop plans of action that will guide necessary changes in health and social care services in order to improve the experience of care and reduce premature deaths of people with learning disabilities

## Membership

Membership of the Multi-Agency Review Panel will consist of:

- LeDeR Local Area Contact
- Associate Director Quality (Chair)
- LeDeR Reviewer
- LeDeR Administrator

## Attendance

In addition to the LeDeR Lead Reviewer/s who initiated the Multi-Agency review, representation from each individual/provider involved in the deceased's care, and the deceased's family, will be invited to attend and contribute to the review.

## Outcome

The draft recommendations and the subsequent content of the action plan will be provisionally agreed at the meeting and circulated to all involved in the review.

A completed report and agreed action plan will then be sent to the Local Area Contact for approval before being sent to the LeDeR Programme.

The LeDeR Programme will share anonymised learning points and actions with the BNSSG CCG BNSSG LeDeR Steering group, Safeguarding Governance Committee and Quality Committee to ensure learning is embedded within Provider organisations and actions are taken forward.

The LeDeR programme will also include this information in their annual summary report to the National Quality Board and NHS England

## APPENDIX 8

### FINAL REPORT FOLLOWING MAR

**Please use the outcomes of the Multi-Agency Review meeting to complete this form.**

#### 4.1.1 Please list below the name and role of those contributing to this Multi-Agency Review

To add rows click into the last row of the table, right click, and select Insert – Insert Rows Below.

| Name | Role | Method of contributing to review (in person / by phone / video conference / written submission / other) | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

#### 4.1.2 Pen Portrait

Please provide a short summary about the person who has died, drawing on the contributions of all individuals and agencies submitting information for the review, using the following headings:

**Please write a short paragraph about the person and their needs (e.g. their personality, how they communicated their needs or how they were feeling, their likes and dislikes, and their behaviour).**

Click here to enter text.

**Please write a short paragraph about the person's social history and activities (e.g. significant life events, their lifestyle, social activities, sense of belonging to the local community, family and other contacts).**

Click here to enter text.

**Please add any additional information about the person that may be relevant but has**

**not been covered elsewhere.**

Click here to enter text.

### 4.1.3 Timeline

Please provide a timeline of the circumstances leading to the person's death, drawing on the contributions of all individuals and agencies submitting information for the review. You can find guidance about completing the timeline in the 'Help' section.

To add rows click into the last row of the table, right click, and select Insert – Insert Rows Below.

N.B. The person's death should be the last line in the timeline.

| **Date**<br><br>**(from earliest to latest)** | **Reported by / where evidence obtained from** | **Circumstances** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

### 4.1.4 Best Practice

Has any particularly good practice been identified in relation to the person's death? N.B. 'Best' practice here refers to that which is over and above the standard of care that should be usually be expected.

☐Yes

☐No

If yes, please describe: Click here to enter text.

### 4.1.5 Surprise at Death?

**Is the Panel surprised that the person died at this time from this cause?**

☐Yes

☐No

If yes, please describe: Click here to enter text.

### 4.1.6 Potentially avoidable contributory factors in relation to the person and their environment

Have any potentially avoidable contributory factors relating to the person and /or their environment been identified? (e.g. overriding fear of medical interventions; family members don't feel listened to; housing inadequate for needs).

☐Yes

☐No

If yes, please describe: Click here to enter text.

### 4.1.7 Potentially avoidable contributory factors in relation to care

Have any potentially avoidable contributory factors relating to the person's care and its provision been identified? (e.g. the quality of pain relief, nutritional support, provision of reasonable adjustments).

☐Yes

☐No

If yes, please describe: Click here to enter text.

### 4.1.8 Potentially avoidable contributory factors in relation to services

Have any potentially avoidable contributory factors relating to the way services were organised and accessed been identified? (e.g. assessment processes, eligibility criteria, protocols between agencies).

☐Yes

☐No

If yes, please describe: Click here to enter text.

### 4.1.9 Was the death, on balance, potentially avoidable?

Potentially avoidable deaths are those where there are aspects of care and support that, had they been identified and addressed, may have avoided the person dying at this time from this cause.

☐Yes

☐No

☐Panel cannot reach a unanimous decision

Please describe the reasons given for this response: Click here to enter text.

### 4.1.10 As a result of this review, have any lessons been learned in respect of this person's death?

☐Yes

☐No

If yes, please describe lessons learned: Click here to enter text.

### 4.1.11 Changes to local practices

Should there be any changes made to local practices following this review?

☐Yes

☐No

If yes, please describe what changes should be made: Click here to enter text.

### 4.1.12 Are there any wider recommendations that should be considered?

☐Yes

☐No

If yes, please describe what recommendations should be considered:

Click here to enter text.

### 4.1.13 Additional comments

Please use this space to add any additional comments that you feel are relevant about the process or content of the multi-agency review.

Click here to enter text.

### 4.1.14 Comments about the LeDeR Review process and IT System

Please add any comments that you might have about your experience of the LeDeR Review process or IT System.

Click here to enter text.

### 4.1.15 Learning and Recommendations

Following your review, please now consider what you have learned from this individual's death that could lead to service improvements that could benefit others.

Please ensure that any issues, concerns or potential problems with care that have been identified in the review are addressed by a recommendation for service improvement.

| Identified Issue | Learning | Recommendation to address issue |
|---|---|---|
| *e.g. Zack was discharged from hospital without the care home staff being trained in catheter care which led to him having a UTI.* | *e.g. Nursing staff do not routinely assess specific skills of care home staff before discharge.* | *e.g. Hospital staff must be responsible for ensuring that the skills and capabilities of care home staff are such that they can provide appropriate care before the patient is discharged.* |
| | | |
| | | |

### 4.1.16 Positive Practice

Please identify any positive practice that could benefit other people if the same was available to them, and any recommendations for service improvements as a result of this.

| Positive practice identified | Recommendations from this |
|---|---|
| | |
| | |
| | |

# Appendix 7 - Equality Impact Assessment

Name of policy being assessed**: Learning Disabilities Mortality Review (LeDeR) policy framework)**

Does this Proposal relate to a new or existing programme, project, policy or service? **New Policy**

| | |
|---|---|
| Lead Officer completing EIA | Lesley Le-Pine |
| Job Title | Lead Quality Manager & LeDeR Programme Manager |
| Department/Service | Nursing Directorate |
| E-mail address | Lesley.le-pine@nhs.net |
| Lead Equality Officer | Sharon Woma |
| Key decision which this EIA will inform and the decision-maker(s) | Approval of LeDeR Multi Agency Review meeting policy |

## Step 1: Equality Impact Assessment Screening

**1. Does the policy affect service users, employees and/or the wider community?**

The policy sets out how, as a commissioning organisation, Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group will fulfil its statutory duties and responsibilities for Learning Disabilities Mortality Review (LeDeR) which includes where deemed necessary a multi-agency review meeting. The Policy operates in the context of all commissioned services for the population of Bristol, North Somerset and South Gloucestershire both within its own organisation and across the local health economy via its commissioning arrangements.

**2. Could the proposal impact differently in relation to different characteristics protected by the Equality Act 2010?**

This Equality Impact Assessment screening is undertaken to ensure that the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) LeDeR Multi Agency Review meeting policy meets statutory obligations under programmes previously known as confidential enquiries. It has approval from the Secretary of State under section 251 of the NHS Act 2006 to process patient identifiable information without the patient's consent. It will not impact differently in relation to protected characteristics.

| **Assessment of impact of policy on Protected Characteristics with analysis positive + /neutral N / or negative -** | | |
|---|---|---|
| Protected characteristic | Analysis; | Reasons for answer and any mitigation required |
| **Age*** [e.g.: young adults, working age adults; Older People 60+] | N | The policy applies to all people and therefore is consistent in its approach regardless of age. |
| **Disability**<br>Physical Impairment; Sensory Impairment; Mental Health; Learning Difficulty/ Disability; Long-Term Condition | + | The overall aim of the Learning Disabilities Mortality Review (LeDeR) programme is to drive improvement in the quality of health and social care service delivery and to help reduce premature mortality and health inequalities. |

| | | |
|---|---|---|
| **Gender Reassignment** [Trans people] | N | This policy is consistent in its approach regardless of gender reassignment. |
| **Race** [including nationality and ethnicity] | N | This policy is consistent in its approach regardless of race, nationality or ethnicity |
| **Religion or Belief** | N | This policy is consistent in its approach regardless of religion and belief. |
| **Sex** [Male or Female] | N | This policy is consistent in its approach regardless of sex. |
| **Sexual Orientation** | N | This policy is consistent in its approach regardless of sexual orientation. |
| **Pregnancy and Maternity** | N | This policy is consistent in its approach regardless of pregnancy and maternity. |
| **Marriage and Civil Partnership** | N | This policy is consistent in its approach regardless of marriage or civil partnership status. |

**3 Relevance to the Public Sector Equality Duty:**

The positive impact of the policy is that it has been developed to provide a clear process, and policy framework for the CCG, to fulfil LeDeR policy framework statutory obligations under programmes previously known as confidential enquiries.

**4. Health Inequalities:**

Does the proposal relate to an area with known Health Inequalities? **Yes**
The overall aim of the Learning Disabilities Mortality Review (LeDeR) programme is to drive improvement in the quality of health and social care service delivery and to help reduce premature mortality and health inequalities.

On the basis of this screening assessment do you consider this proposal to be relevant to the General Duty or to any particular protected characteristic? Disability **-** Health Inequalities.

**5. Conclusion:**

I am satisfied that this service/policy/function has been successfully equality impact analysed. There is no requirement to proceed to the Full Equality Impact Assessment.

| | |
|---|---|
| **Proceed to full EIA:** | No |
| **Quality Assured by:** | Quality and Patient Safety Team |
| **Date of Screening** | 8th December 2020 |
| **Action Plan** | N/A |
| **Signed** | Lesley Le-Pine |
| **Date** | 8th November 2020 |