NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Learning Disabilities Mortality Review (LeDeR) Policy Framework

Shaping better health

Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	44
Responsible Executive Director:	Rosi Shepherd – Director of Nursing
Author and Job Title:	Lesley Le-Pine – Quality Lead and LeDeR Programme Manager
Date Approved:	December 2020
Approved by:	LeDeR Steering Group
Date of next review:	September 2023

Policy Review Checklist

	Yes/ No/NA	Supporting information
Has an Equality Impact Assessment Screening been completed?	Yes	Appendix 4
Has the review taken account of latest guidance/ Legislation?	Yes	
Has legal advice been sought?	TBC	
Has HR been consulted?	N/A	
Have training issues been addressed?	Yes	
Are there other HR related issues that need to be considered?	N/A	
Has the policy been reviewed by Staff Partnership Forum?	N/A	
Are there financial issues and have they been addressed?	N/A	
What engagement has there been with patients/members of the public in preparing this policy?	N/A	
Are there linked policies and procedures?	Yes	linked in the document
Has the lead Executive Director approved the policy?	Yes	
Which committees have assured the policy?	Yes	Quality Committee
Has an implementation plan been provided?	YES	Included in section 14
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?	N/A	

Table of Contents

Learning Disabilities Mortality Review (LeDeR) Framework

1 Introduction

1.1 The LeDeR programme was established in 2015 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 The programme has developed and rolled out a review process for the deaths of people with learning disabilities. The programme aims to help:

- identify what works well to support people with learning disabilities to live long and healthy lives;
- identify factors which may have contributed to deaths of people with learning disabilities so that changes can be made to reduce the impact of these factors;
- develop action plans to make any necessary changes to health and social care services for people with learning disabilities.

1.3 The LeDeR programme collates and shares the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

1.4 Each local area has a designated 'Local Area Contact'. Within Bristol, North Somerset and South Gloucestershire the Local Area Contact is employed by BNSSG CCG. The role of the Local Area Contact is detailed within Section 5.

1.5 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 1. The local BNSSG review process is set out in Appendix 2. More information about the programme and the review process can be found at: http://www.bristol.ac.uk/sps/leder/about/

2 Purpose

2.1 The purpose of this policy framework is to detail how the Learning Disabilities Mortality Review (LeDeR) programme is managed within BNSSG area.

2.2 The LeDeR programme ensures that the deaths of people with learning disabilities aged four years and over are reviewed, irrespective of whether the death was expected, the cause of death or the place of death.

2.3 The LeDeR programme has been established to support local areas to review deaths of people with learning disabilities, and to use the lessons learned to make improvements to service provision. The LeDeR programme is not an investigation. If, during or after a review of a death, the Local Area Contact has concerns which have not or cannot be addressed within the scope of the LeDeR review process, the Local Area Contact or the local reviewer

will recommend to the appropriate organisations/bodies the need for a fuller investigation (e.g. Adult Safeguarding Review).

2.4 The LeDeR programme works closely with other existing mortality review processes. More details regarding can be found in Section 7.

2.5 A wealth of information regarding the LeDeR programme can be found on the LeDeR programme website: http://www.bristol.ac.uk/sps/leder/

2.5 This Framework does not seek to duplicate this information, but to:

- detail the governance and operational arrangements specific to BNSSG;
- provide 'signposting' to existing LeDeR information.

2.6 To assist in achieving this aim, this framework also outlines the governance structures that BNSSG links with, including adult and child safeguarding arrangements and Child Death Overview Panels (Section 6).

3 Roles and responsibilities

University of Bristol

3.1 The LeDeR programme is delivered by the University of Bristol. It is commissioned by NHS England. It is a support and analysis function.

Director of Nursing and Quality

3.2 The responsibility for oversight of ongoing structures that facilitate the review of deaths in BNSSG, sits with the Director of Nursing and Quality. The Director of Nursing and Quality assigns the day-to-day operational management of the programme to the Local Area Contact.

Local Area Contact

3.3 The Local Area Contact (and their team) is the link between the LeDeR programme team (in Bristol), the regional Steering Group and the locally delivered programme. Their role is to work in partnership with the Bristol-based LeDeR team and is responsible for:

- receiving notifications of deaths;
- identifying and organising the training of local reviewers;
- allocating cases to local reviewers;
- 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;
- attending the monthly BNSSG LeDeR Steering Group;
- organising and chairing the quarterly BNSSG Local Reviewers 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;
- anonymising and collating learning points and recommendations and sharing these with the Steering group and health and social care providers.

3.4 The national role description for the Local Area Contact can be found via this link; http://www.bristol.ac.uk/medialibrary/sites/sps/leder/Role%20description%20Area%20Contact_V2.pdf

Local Reviewers

3.5 Local Reviewers are responsible for undertaking robust and high quality reviews of the deaths of people with learning disabilities and are integral to the success of the BNSSG programme. It is the responsibility of the reviewer to declare a conflict of interest in regard to case to the LeDeR team.

3.6 The role description for Local Reviewers can be found via this link; http://www.bristol.ac.uk/media-library/sites/sps/leder/Role%20description%20Local%20Reviewer.pdf

4 BNSSG Governance Structure

4.1 Regional Steering Group

The Regional Steering Group for BNSSG is the South West LeDeR Steering Group. The Regional Steering Group meets monthly and attendance by a member of the BNSSG LeDeR team is required.

4.2 BNSSG LeDeR Steering Group

The group meets monthly and is chaired by the Independent Registered Nurse, who is a member of the Governing Body. It is attended by representative from all NHS Provider and Social Care organisations in BNSSG.

The role of the Steering Group is to monitor and develop the effectiveness of review processes across health providers in BNSSG, by bringing together representations from provider organisations and those with specific area of interest to share best practice, with the ultimate outcome to reduce avoidable deaths.

The Terms of Reference for the meetings are available from the BNSSG Local Area Contact and set out in appendix 3. This Group reports to the Quality Committee of the CCG.

4.3 Local Reviewers Peer Support Forum

All local reviewers will be invited to meet quarterly in an informal, supportive and educational environment.

4.4 BNSSG LeDeR Clinical Case Review Panel

The BNSSG LeDeR Clinical Case Review panel meets monthly to review and signs off completed reviews and provides assurance on the quality of the review process.

The panel can also request further investigation into certain aspects of reviews and/or further clarification prior to sign off.

During the sign off process, all reviews are graded a score by the reviewer as follows. There is full guidance for reviewers in regard to grading set out in appendix 5

Score	Score description
1	This was excellent care and met current best practice.
2	This was good care, which fell short of current best practice in only one minor area.
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 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.
6	Care fell far short of expected good practice and this contributed to the cause of death.

4.5 The panel members are as follows:

- Local Area Contact
- Lead Quality Manager/LeDeR Programme Manager;
- Safeguarding Team representative ;
- Clinical Lead GP for learning disabilities & mental health,
- Local Authority representative Bristol
- Local Authority representative South Gloucestershire
- Local Authority representative North Somerset

4.6 During the review closure process, the Local Area Contact and support team:

- complete the internal LeDeR assurance checklist;
- notify the reviewer that the review has been closed and thank them for their contribution to the LeDeR process **OR** feedback is given regarding the review and asked to add/amend any recommendations added during the Clinical Case Review panel, or further information to be gathered;
- ask the reviewer who they wish the findings from the review to be shared with, for example the family/relatives/carers, and others they spoke to whilst undertaking the review;
- share the learning with the individuals identified by the reviewer (as above);
- routinely contact the GP practice(s) where the individual was registered to share learning;

4.7 **Initial and Multi-Agency Reviews**
All deaths of people aged four years and over will receive an initial review. If any concerns are identified about the death, or it is felt that further learning could come from a fuller review of the death, a detailed, Multi Agency Review will be held.

4.8 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.

4.9 BNSSG recognises that in some cases an independent investigation (commissioned and delivered separately from the organisation(s) involved in caring for the patient) may be required in some circumstances. Any concerns about a case should be escalated by the LAC to the Director of Nursing, to agree the approach and potential commissioning of an Independent Review as outlined in the Serious Incident Framework

4.10 BNSSG will implement a local protocol for the triage, escalation and commissioning of independent reviews in line with the Serious Incident Framework to ensure the most appropriate level of investigation and governance is identified.

5 Links with other mortality review processes

5.1 The LeDeR review is not a statutory process and its purpose is not to hold any individual or organisation to account. Other processes exist for that, including safeguarding, criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation. It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them.

5.2 In order to do this in a timely manner, to avoid duplication and to ensure there is no additional distress to the relatives of the individual, reviewers need to be clear where and how the LeDeR process links with other reviews or investigation processes.

5.3 Other investigations or reviews may include, for example:

- Serious Case Reviews (SCRs);
- Safeguarding Adult Reviews (SARs);
- Safeguarding Adults Enquiries (Section 42 Care Act);
- Domestic Homicide Reviews (DHRs);
- Mental Health Homicide Reviews (MHRs);
- Serious Incident Reviews;
- Coroners' investigations;
- Child Death Reviews.
- An organisation's internal Root Cause Analysis investigations

5.4 Guidance from the LeDeR Programme on working with other investigation and review processes can be viewed via this link; http://www.bristol.ac.uk/media-library/sites/sps/leder/leder---briefing-papers/5.%20Briefing%20paper%20-%20Working%20with%20other%20investigation%20and%20review%20processes%20v1.pdf

5.5 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 1.

6 Additional Information/Resources

6.1 As stated in Section 2, a wealth of information regarding the LeDeR programme can be found on the LeDeR programme website. http://www.bristol.ac.uk/sps/leder/

6.2 Summary of some of the information available on the website;

Notifying LeDeR of a death

6.3 Anyone can notify LeDeR of a death, including people with learning disabilities themselves, family members, friends and paid staff. Notifications can be made online via this link https://www.bris.ac.uk/sps/leder/notification-system/
or by calling 0300 777 4774.

6.4 A poster about how to notify a death is available here; http://www.bristol.ac.uk/media-library/sites/sps/leder/notify_a_death_flyer_for_website.pdf
For printed copies, please contact the LeDeR team on leder-team@bristol.ac.uk or call on 0117 331 0686.

6.5 For Multi-Agency Reviews (MARS) the BNSSG reviewer develops Terms of Reference, which are tailored to each review on a case-by-case basis. These Terms of Reference are available from the BNSSG Local Area Contact.

Information for families and carers

8.7 Key to the review process is the involvement of family members and/or carers to find out more about the life and the circumstances leading up to the death of their relative or friend. The information available to family and carers can be viewed via this link;
http://www.bristol.ac.uk/sps/leder/resources/information-for-family-carers/

7. Learning

7.1 **Identifying learning**

As part of the assurance and sign off process, it is the responsibility of the BNSSG LeDeR Clinical Review Panel to ensure that identified learning from each review helps to achieve these aims. (example below from LeDeR review form)

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.*

7.2 **Sharing local learning**

The Local Area Contact collates and reports the recommendations of the reviews by 'theme' via the quarterly report. This report will be sent to a wide range of mortality/learning from deaths, end of life, safeguarding and risk meetings across BNSSG.

7.3 As an appendix of the quarterly report, cases which have scored '4', '5' or '6' (as per the scoring in 6.12) are shared as case studies with the associated learning. This can only be done in cases where consent has been given from the individual's family to share the learning in this way.

7.4 Assurance and oversight of local learning is provided by the BNSSG Steering Group. This group also provides support to the Local Area Contact and Reviewers Group to affect wider-scale change. This will also link to the Strategic Transformation Plan for wider local learning.

Sharing national learning

7.5 In addition to local monitoring and oversight of recommendations, the University of Bristol collate and analyse summaries of the reviews to create a national and regional picture of issues that have arisen. This anonymised information provides an overview of potentially avoidable contributory factors associated with deaths, outlines good practice in preventing early deaths, and enables local areas to compare their experiences with other areas. Such national data collection will also enable improvements in service provision to be monitored over time and the resulting impact on mortality of people with learning disabilities.

8. Reporting

Reporting to NHS England

8.1 The Local Area Contact is required to submit a quarterly report to NHS England detailing the progress against Key Performance Indicators.

Reporting within BNSSG

8.2 The Local Area Contact will produce a quarterly report for the Steering Group which will be escalated to the Quality Committee, detailing the progress of the programme and key learning. The Quality Committee reports to Governing Body.

8.3 Members of the steering group are able to use this report for their own assurance and for the organisations they represent.

8.4 To date, the University of Bristol programme team have produced annual reports each year, detailing the national actions and learning. These reports can be viewed via this link; http://www.bristol.ac.uk/sps/leder/resources/annual-reports/

8.5 The NHS Operational Planning and Contracting Guidance for 2019/2020 requires a local annual report to be submitted to the appropriate board/committee for all statutory partners, demonstrating actions taken and outcomes from LeDeR reviews. The first BNSSG report will be produced in April/May 2020.

9. Training

9.1 The Local Area Contact and Secondary Local Area Contacts have received on-line training from NHS England on the requirements and responsibilities of their role.

9.2 To undertake LeDeR reviews and become a 'Local Reviewer', specific online training (with face-to-face support as required) must be completed. Once this training has been completed, the individual will be given access to the LeDeR programme database through which reviews are managed.

9.3 No other LeDeR-specific training requirements have been identified. Work is on-going within BNSSG to raise awareness of the LeDeR programme and the process for notifying the LeDeR programme of the death of an individual with a learning disability. Any emerging training needs will be identified and addressed.

10 Recommendation and Approval Process

10.1 The approval process for this BNSSG LeDeR Policy and Framework is via submission and subsequent approval by the Governing Body.

11 Communications/dissemination

11.1 During 2019, a dedicated LeDeR page is to be developed on the website of NHS BNSSG CCG. A link to this Policy and Framework, and easy read information about LeDeR, will be available on this web page.

11.2 Notice of issue of the first version, and any updated versions of this Policy and Framework, will be communicated via the quarterly report.

12 Implementation

12.1 As a Policy and Framework, this procedural document summarises the current arrangements for the management of the LeDeR programme within BNSSG.

12.2 The aspects of the Policy and Framework that require implementation are:

- a quarterly LeDeR Programme update to be submitted to the BNSSG Quality Committee;
- the development of a dedicated LeDeR page is to be developed on the website of BNSSG CCG.
- Sending the quarterly report to a wide range of mortality/learning from deaths, end of life, safeguarding and risk meetings across BNSSG.

13 Monitoring compliance and effectiveness

13.1 The assurance and oversight of the effectiveness of the LeDeR programme within BNSSG in achieving these objectives will be provided by the BNSSG Steering Group which has responsibility to;

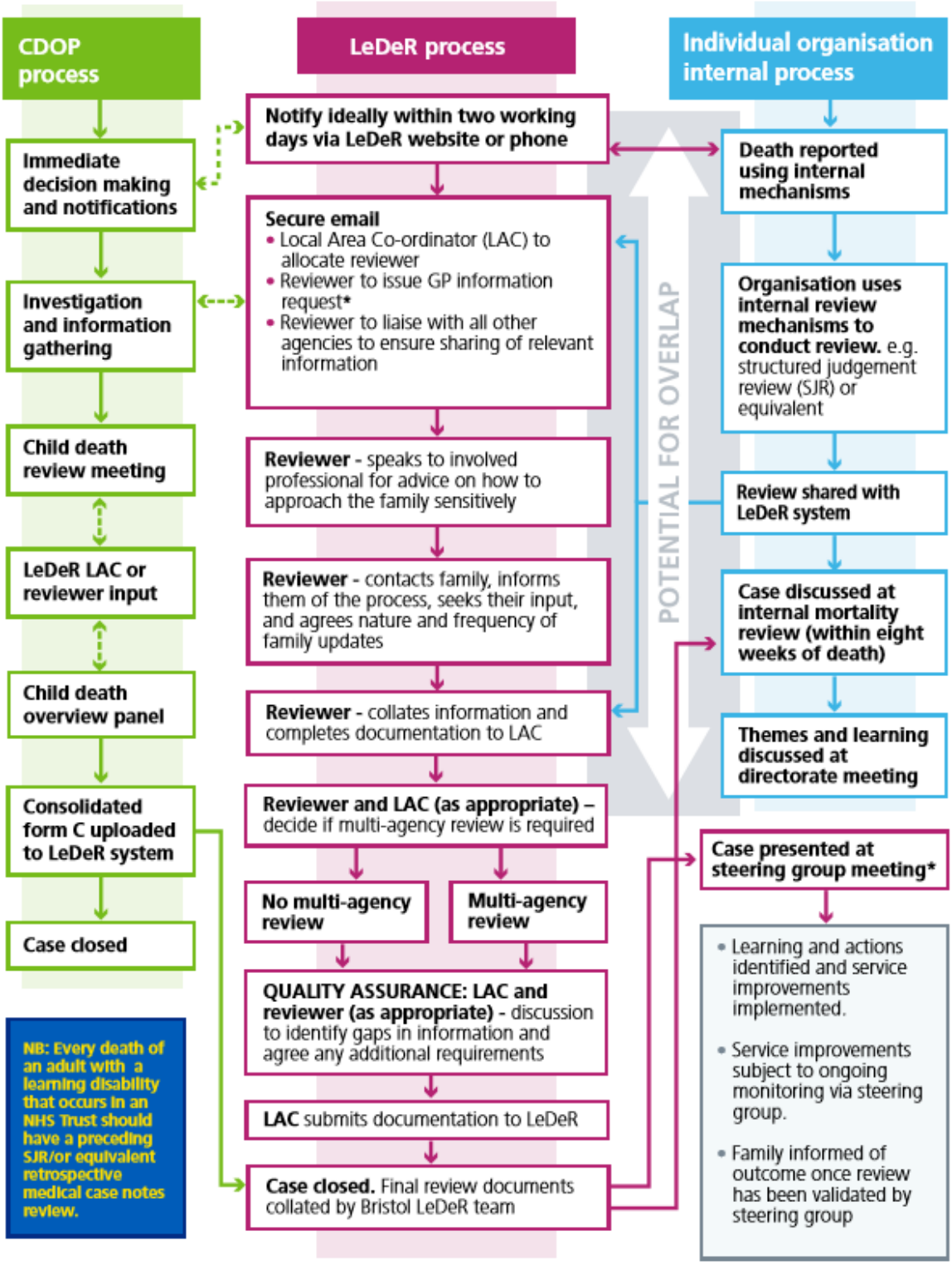
- ensure case reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur.
- ensure that mortality reporting in relation to LeDeR reviews, investigations and learning is regularly provided to the Governing Body in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting will be discussed at the public section of the meetings with data suitably anonymised;
- ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care in commissioned services;

13.2 Audit of the BNSSG LeDeR process and compliance with national LeDeR timeframes will be audited as part of the Internal Audit programme and reported to the Quality Committee.

Appendix 1

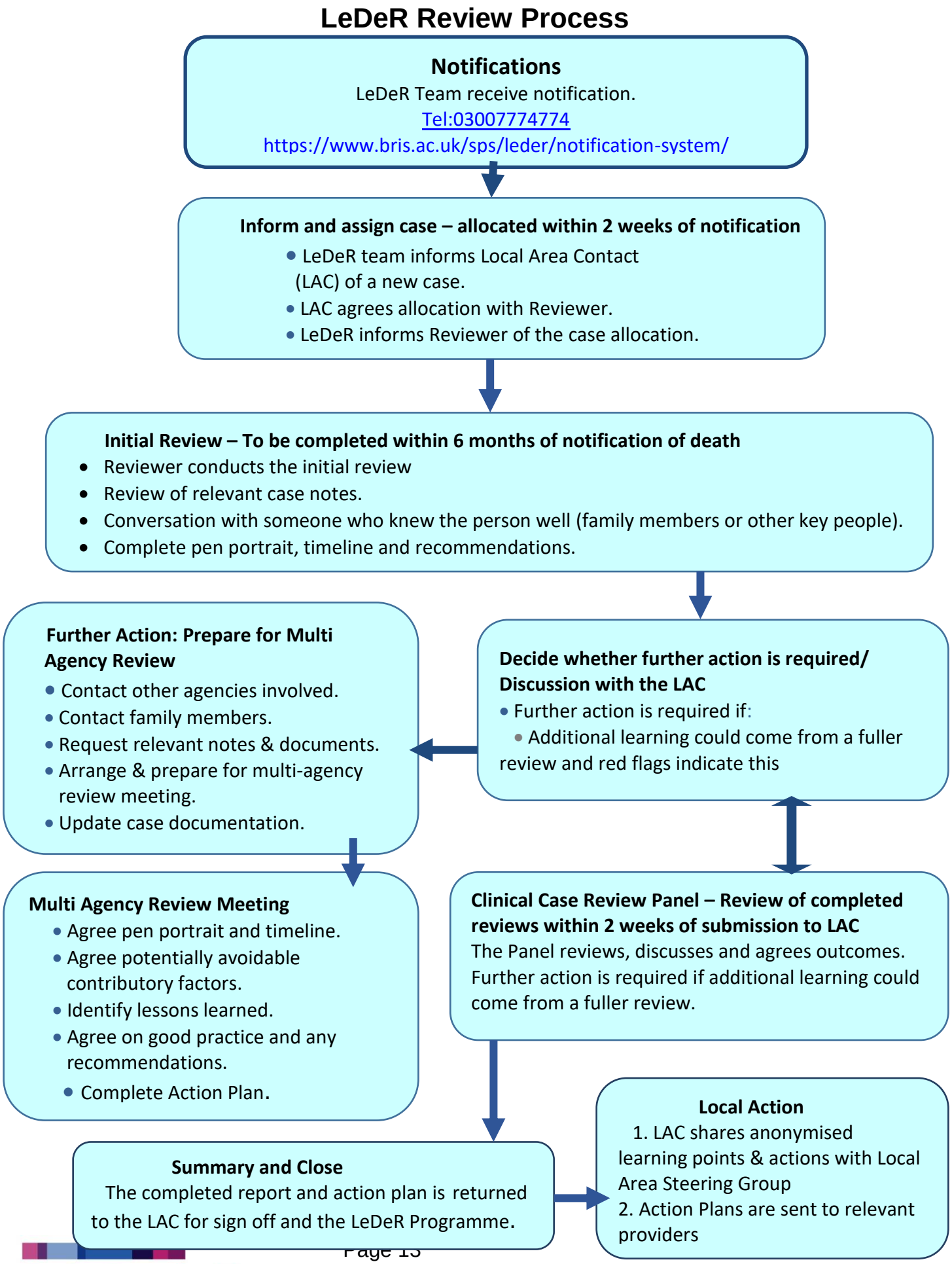
Notification and review of a death of an adult (18+) or child (age 4+) with a learning disability

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 2 – BNSSG Data Flow and Process Chart



Appendix 3

LeDeR Steering Group Terms of Reference

This document sets out the standard terms and background that will apply to all meetings of the Bristol, North Somerset & South Gloucestershire (BNSSG) Learning Disabilities Mortality Review (LeDeR) steering group.

1. Introduction

The LeDeR Programme, delivered by the University of Bristol, is commissioned NHS England.

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

The programme will complement and contribute to the work of other agencies such as the Learning Disability Public Health Observatory, academic research studies, NICE, the Care Quality Commission (CQC) inspection programme, Local Government Associations, The Transforming Care Improvement Programme, and Third Sector and voluntary agencies.

2. The scope of the local reviews of deaths

The LeDeR Programme will ensure reviews are carried out into the deaths of people with learning disabilities aged 4 years and upwards, who are registered with a GP in England at the time of their death, irrespective of the cause of death or place of death.

3. Purpose / role of the Steering Group

3.1 To guide the implementation of the programme of local reviews of deaths of people with learning disabilities in order to share learning and best practice.

3.2 To work in partnership with the Regional Lead for the work in order to gain and share wider learning and best practice.

3.3 In partnership with stakeholders to ensure that at least one appropriate person (Local Area Contact) is recruited for the BNSSG area. The Local Area Contact will have oversight of the programme activities in the local area.

3.4 To ensure the proportionate review of all deaths of people with learning disabilities in the BNSSG area, and more detailed reviews of those for whom it is indicated, and those subject to a rolling programme of priority themed review.

3.5 To receive regular updates from the Local Area Contact about the progress and findings of reviews.

3.6 To interpret and analyse the data submitted from local reviews, including areas of good practice in preventing premature mortality, and areas where improvements in practice could be made and make recommendations.

3.7 To monitor the action plans developed as a result of the reviews of deaths, and take or guide appropriate action as a result of such information.

3.8 To ensure agreed protocols are in place for information sharing, accessing case records and keeping content confidential and secure.

3.9 To share anonymised case reports pertaining to deaths or significant adverse events relating to people with learning disabilities for publication in the LeDeR Programme repository in order to contribute to collective understanding of learning points and recommendations across cases.

3.10 To receive assurance from the LAC regarding the quality of the reviews.

3.11 To ensure that the programme actively captures and shares local and national learning; aligned to The Learning from Deaths initiatives. In addition, the group will adhere to the LeDeR framework and national legislation.

4. Membership

The LeDeR programme recommends that Steering Groups should consider the following representation:

Role	Organisation
Independent Registered Nurse – Governing Body (Chair)	(BNSSG) Clinical Commissioning Group
Executive Lead/ Director of Nursing (deputy chair)	BNSSG CCG
Senior Quality Lead & LeDeR Programme Manager	BNSSG CCG
LeDeR Regional Coordinator	NHS England
LD Commissioning Manager	Bristol Local Authority
LD Commissioning Manager	North Somerset Local Authority
LD Commissioning Manager	South Gloucestershire Local Authority
LD Commissioning Manager	BNSSG CCG
LD Transformation Manager	BNSSG CCG
Children's Service Commissioning Lead	BNSSG CCG
Adult Safeguarding Lead	BNSSG CCG
Children's Safeguarding Lead	BNSSG
CQC Representative	CQC
Representative of people with LD and families	Representatives/Local Groups/ Advocacy organisation
LA LD Social Care Provider representatives	Bristol, NS & SG Local Authorities
Community Learning Disability Team manager	Sirona
Acute Provider senior LD representatives	UHB/ NBT/ WAHT
LeDeR administrator	BNSSG CCG
Communications Lead	BNSSG CCG
Primary Care Clinical Lead for MH/LD	BNSSG CCG
Primary care provider representative	

When members are not able to attend they should nominate a deputy to attend on their behalf. Members will be expected to represent the views of their organisations.

5. In attendance (as needed)

As appropriate and/or agreed as part of agenda

6. Role of the Members

Members will review the programme direction and make decisions to ensure that:

6.1 Partners work together to support the success of the programme and make sure that no single interest will undermine the programme.

6.2 All risks are assessed and managed, putting in place actions and contingency plans for all high impact risks.

6.3 The time and resources needed for the programme objectives are available.

6.4 Recording of programme information is accurate and coherent.

6.5 Support (engagement, cooperation and response with the programme) is available for the Local Area Contact.

6.6 The progress of the overall programme is monitored and any remediable action is undertaken.

6.7 Data sharing agreements are agreed and adopted by representative members of the Steering Group.

7. Administration

The LeDeR Steering group will be administered by the LAC coordinator/support. Papers will be circulated five working days prior to the meeting.

8. Quoracy

Quoracy will be achieved when the Chair and/or Deputy Chair, two Local Authority Members, 2 CCG Members and 1 Member from a health provider are present.

9. Frequency of meetings

9.1 Meetings to be held monthly for the first three months (April – June 2019) and then reviewed.

9.2 Among other matters, the meetings may establish time limited working groups to focus on specific issues, which may be delegated to resolve / approve pertinent issues identified by the Steering Group.

9.3 Meeting will be organised and chaired by BNSSG CCG.

10. Governance and Reporting Requirements

The Steering group will be a sub group of the BNSSG CCG Quality Committee will be submitted quarterly.

The Steering Group will provide escalation exception reports to:

- Safeguarding Board (adults and children)

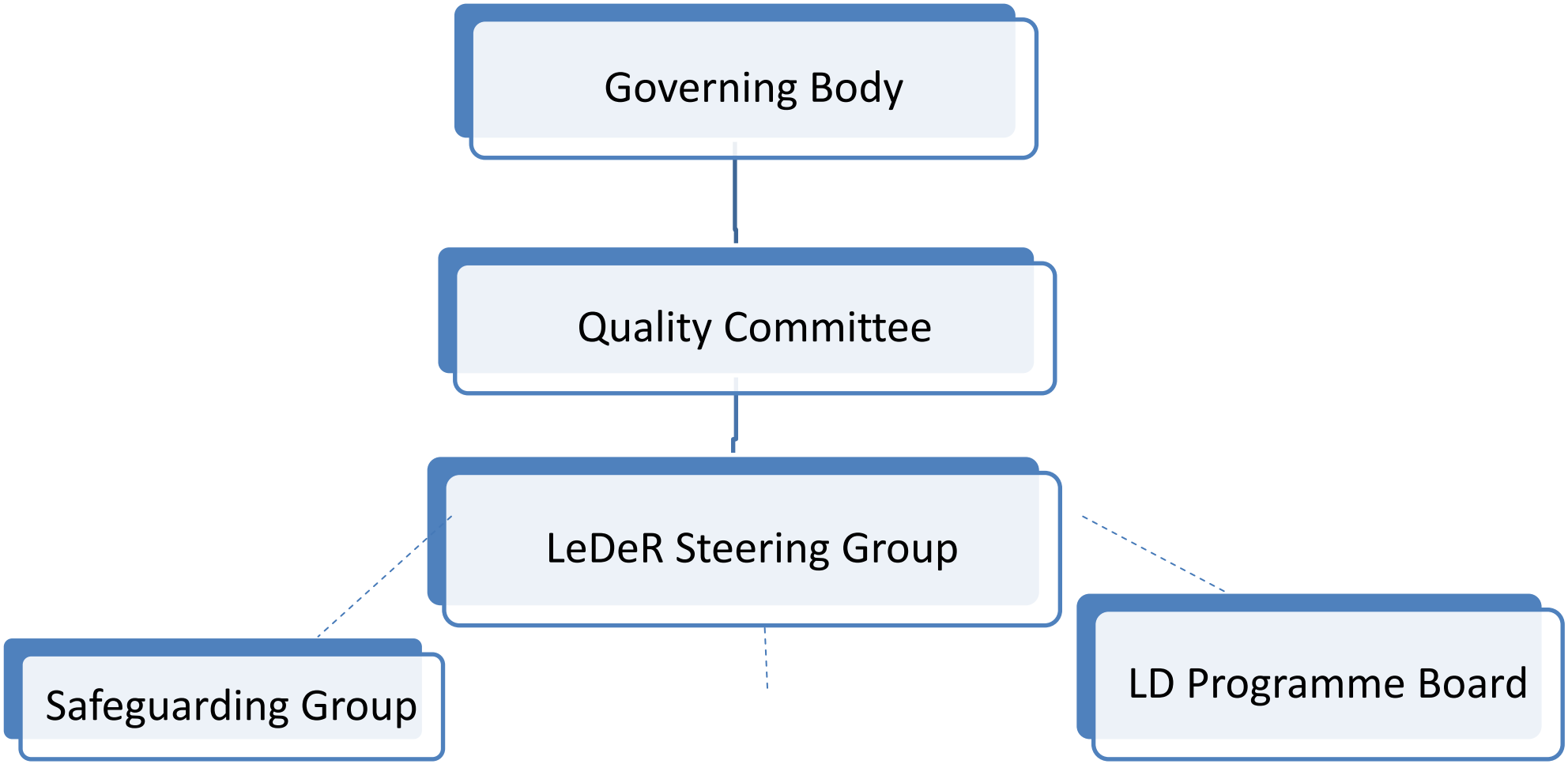
The group will produce an annual report for the Quality Committee.

Data Sharing Agreements will be used across the BNSSG CCG footprint, in accordance with associated governance processes

11. Review of Terms of Reference

The terms of reference will be reviewed in six months following their formal acceptance.

LeDeR Steering Group Governance Organogram



Appendix 4

Learning Disabilities Mortality Review (LeDeR) Policy Framework - Implementation Plan

Policy Owner: Associate Director of Quality

Target Group	Implementation objective	Method	Lead	Target start date	Target end date	Resources Required
A. BNSSG CCG Governing Body	Ensure GB is aware of LeDeR programme responsibilities and provide assurance that appropriate processes are established.	Cover paper plus policy to be presented to the Governing Body	Associate Director of Quality	Sept 2019	Sept 2019	Governing body time.
B. BNSSG Quality Committee	Ensure the Quality committee is aware of LeDeR programme responsibilities and provide assurance through quarterly reports that the processes are followed.	Quarterly report to be submitted to the Quality Committee	Associate Director of Quality	Sept 2019	Oct 2019 ongoing	Staffing for report production
C. CCG Staff	Launch and access to the LeDeR Policy Framework	Through the Voice and policy available via the Hub	Comms	Sept 2019	Sept 2019	Staff time
D. NHS Providers and Local Authorities within the STP	1. Distribute to providers/local authorities 2. Policy posted on CCG public website	Circulation of the policy to partner agencies system wide	Quality Support Manager	Oct 2019	Oct 2019	Staffing for circulation
E. BNSSG Public	In addition to making the policy available on the CCG website, develop a dedicated LeDeR page to b on the BNSSG CCG website	Develop web pages with informative, appropriate content about LeDeR for public website	Associate Director of Quality Head Of Insights & Engagement	Sept 2019	Dec 2019	Staffing to develop and create webpages

NHS
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Clinical Commissioning Group

APPENDIX 5

A Guideline for LeDeR Reviewers for 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. • There was evidence of good medical care from professionals with no gaps identified. • There were no concerns expressed from family, carers, professionals or reviewer on the overall care provided. • There was no evidence of confirmed safeguarding concerns. • 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. There was evidence of good medical care from professionals with no or very minimal gaps identified. • 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. • 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 • There was evidence of medical care from professionals with gaps identified which had not significantly impacted on the person's wellbeing • 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 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 gaps identified which did impact on the person's wellbeing but was not evidenced/thought to have contributed to the cause of death • There was evidence of medical care from professionals with gaps identified which impacted on the person's wellbeing but was not evidenced/thought to have contributed to the cause of death. • 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. • 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. • 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. • 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. • 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.

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 6

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	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 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). 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 policy framework 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* [eg: 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 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 December 2020