NHS
Halton
Clinical Commissioning Group

NHS
Warrington
Clinical Commissioning Group

LeDeR Annual Report
2021-2022

NHS
LeDeR - Learning from Lives and Deaths Reviews

The Learning Disabilities Mortality Review (LeDeR) Programme

Document Version Control

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Audience	NHS HCCG, NHS WCCG, NHSE/I, HSAB, WSAB, Learning Disability Partnership Board.

Contents

NHS Halton Clinical Commissioning Group

NHS Warrington Clinical Commissioning Group

This report is about people with a learning disability who have died in Halton and Warrington during 2021-2022.

All details in this report have been anonymised, but the stories are those as told by families or paid carers to help us learn from the deaths.

In 2020 NHS Halton CCG and NHS Warrington CCG held a conference to share learning from LeDeR by telling peoples stories. A legacy video from the conference was produced and the link is below as the stories remain pertinent.

We politely ask that you watch the video along with reading this year's annual report to ensure the person's voice is paramount.

https://vimeo.com/430665513/9c96dc68c8

LeDeR Annual Report 2021-2022

1. Introduction

The Learning from Life & Death Reviews (LeDeR) programme is part of a national focus upon improving the lives and care of people with Learning Disabilities and Autistic people. It has derived as an outcome from a series of national reports that describe that whilst care in many instances has improved over the last decade, many aspects have not. There are still marked health inequalities for people with learning disabilities and autism, compared to that of the general population. To put this into context the life expectancy for people with learning disabilities today can be equated to what the rest of the public could have expected in 1940. Today, people with learning disabilities die, on average, 15-20 years sooner than other people in the general population.

Reviews of the deaths of people with a diagnosis of autism were added into the LeDeR programme in 2021. Autism is not a rare condition about 1–2% of England's population is autistic. Autism should not bar anyone from a happy, healthy, and long life; yet relative to their non-autistic peers, autistic people frequently experience the following:

- More mental ill-health. Autistic people have higher rates of almost all mental health conditions when compared with non-autistic people
- Greater likelihood of poor physical health and/or disabilities. Autistic people are more likely to have cardiovascular conditions, epilepsy, a physical disability, or a learning disability
- More and/or broader determinants of poor health. Autistic people are more likely to be under employed, live in inadequate housing, experience stigma and discrimination, be obese, be physically inactive, or to have restricted and undernutritious diets
- Greater difficulties accessing care autistic people often struggle to access general health services because of providers failing to accommodate their sensory sensitivities, communication difficulties, anxiety, or poor planning and organisational skills, further compounding their already poor outcomes
- Shorter life. Sadly, we now know that autistic people, on average, die younger than their non-autistic counterparts. For autistic people without a learning disability, a leading cause of early death is suicide with the highest rates among those not diagnosed until later life (Five Year NHS Autism Research Strategy for England 2022 Appendix 1).

These health inequalities are not inevitable, and progress can be achieved by preventative and/ or timely access to healthcare.

Reviewing the circumstances surrounding the deaths of people with a learning disability and autism provides a real opportunity to learn from the past to help prevent avoidable deaths and improve future care for others.

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

This is the third LeDeR Annual Report produced by HCCG/WCCG. This annual report focuses on Halton and Warrington in respect of activity and findings relating to Learning from Life & Death Reviews (LeDeR) for 2021-22. The report has been produced by HCCG and WCCG as required by the 'The NHS Long Term Plan January 2019'.

The report provides:

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

2. National LeDeR Programme

LeDeR is a unique national service improvement programme that aims to improve care, reduce health inequalities, and prevent premature mortality of people with a learning disability and (now) autistic people. It does this by reviewing information about the health and social care support that people have received, highlighting good practice and areas where improvements could be made. LeDeR forms part of the national deliverables for Transforming Care for People with Learning Disabilities.

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

The LeDeR programme was supported by the University of Bristol until May 2021 when its contract ceased and from June 2021 NHSE/I took it forward. The programme is a joint health and social care project, involving healthcare providers across the health economy, Local Authorities and Clinical Commissioning Groups until the implementation of Integrated Care Boards (ICB) from July 2022.

A national LeDeR policy was developed for the first time in March 2021, the key implications are:

- There is a stronger emphasis on the delivery of the thematic actions coming out of the reviews and holding local systems to account for that delivery, to ensure that there is evidence of service improvement locally.
- Launch of a new process for reviews to follow with 2 distinct levels of review, a new computer system ('web- based platform'), and new training for the LeDeR workforce.
- Local Integrated Care Boards (ICBs) will become responsible from 1 July 2022 for ensuring:
    1. that LeDeR reviews are completed for their local area
    2. that actions are implemented to improve the quality of all mainstream services for people with a learning disability to reduce health inequalities and premature mortality
    3. that recurrent themes and significant issues are identified and addressed at a more systematic level
    4. within the ICS reviewers will work in teams so that no reviewer will work alone, everyone will have the time they need to do reviews and support to do them.
    5. The policy introduced the need to commence reviewing the deaths of adults who have a diagnosis of autism but no learning disability. All reviews of people who are autistic without a learning disability will be focused reviews initially.

6. All people from Black Asian and Minority Ethnic communities (BAME) get a focused review because the evidence so far shows that the health inequalities experienced by people from these communities are very significant, and there is also under reporting of deaths from these communities.

The new policy requirements have been a major focus for 2021-2022, both as local delivery and for active future planning for the transition to the new model within the ICB. This is provided in more detail in the report.

Full details of the policy can be found at Appendix 2.

3. National Context

The LeDeR National Annual Report 2021-2022 has not been published at the time of writing the HCCG/WCCG Annual Report. Therefore, it is not possible to include any national comparison data within this report and this will be reviewed for learning at a later date.

4. Regional Context – Cheshire and Merseyside

A strategy and 3-year delivery plan has been developed for LeDeR for Cheshire and Merseyside that demonstrates how the Integrated Care Board (ICB) will act strategically to tackle those areas identified in aggregated and systematic analysis of LeDeR reviews and national findings including how the ICB will reduce the health inequalities faced by people from Black, Asian and Minority Ethnic communities who live locally who have a learning disability and /or Autism. The strategy can be found in full at Appendix 3.

HCCG/WCCG are active members of the Cheshire and Merseyside LeDeR Strategy Steering Group. Learning from across the region is shared and this informed a shared set of priorities for 2021-2022.

In Cheshire and Merseyside, the priorities for 2021-2022 broadly aligned to those identified nationally from previous learning. The priorities were agreed by the Cheshire and Merseyside LeDeR Strategy Steering Group as follows:

Management of medical conditions:

- Vaccination Programme (including seasonal flu and COVID vaccinations)
- Managing deterioration of health

Changing how we work:

- Developing the LeDeR processes and implementation of the new LeDeR policy including governance arrangements
- Integrating care between community and acute settings
- DNACPR
- Annual Health Checks (AHCs) uptake

5. Local Context

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

Systems were developed and implemented to support the panel and dedicated administration support identified.

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

The panel consists of an independent chair, and multi-agency representatives with a broad range of knowledge and skills in relation to learning disability and autism who meet regularly to review the circumstances surrounding a notified death to identify local learning.

Appendix 4 to this report provides a flowchart of the process from initial notification to completion of the review, including pathways to learning and the supporting governance arrangements.

Following the implementation of the LeDeR policy in March 2021, this resulted in the go live of the new LeDeR platform and amended review templates in June 2021. This presented significant challenges locally in adapting the panel methodology to meet the new review requirements. Reviews have been completed within the expected timescales and met the NHSE/I KPI requirements for 2021/22. Where a panel approach has not been possible the HCCG/WCCG Local Area Contact has worked closely with the LeDeR administrator to ensure completion of the reviews.

6.0 Local Activity

The changes to the LeDeR platform and the review templates have resulted in a reduced data set for initial reviews. Where comparative data is available this has been included below and supplemented with qualitative learning, observations and anonymised details from local reviews.

Locally across Halton and Warrington in the reporting period of April 2021 to the end of March 2022 there have been 25 new deaths notified to LeDeR for local review. 2 reviews were removed from LeDeR as they were found to be out of scope as the individuals did not have a learning disability or autism diagnosis.

In addition, within the reporting period 11 deaths were reviewed that had been notified late on in 2020-2021 and extended in 2021-22 until complete. 2 reviews from this cohort were also removed from LeDeR as they were out of scope.

There are 9 reviews that whilst notified within 2021-2022 remain ongoing and will be reported for learning in the ICB 2022- 2023 LeDeR report.

This leaves a total cohort of 25 reviews that have been subject to analysis as below to help inform local learning within the reporting period.

Reviews of deaths for people with a diagnosis of Autism were introduced towards the end of the reporting period. This has been communicated across the local system however there were no autism deaths reviewed within the analysis for this report.

There are currently 2 ongoing local reviews of deaths for people with a diagnosis of Autism and this learning will be part of the ICB LeDeR report for 2022-2023.

6.1 What we have learnt in 2021-2022

Demographic Data Comparisons
Table 1

Demographics	**Reviews 2021-22**	
	Halton	**Warrington**
% of reviews	**60%**	**40%**
Gender Male	**46%**	**10%**
Female	**54%**	**90%**
Age Under 55	**33%**	**20%**
55-64	**27%**	**10%**
65 and over	**40%**	**70%**
BAME	**0%**	**1 was not LD out of scope**

Observation.

For Warrington a high % of deaths are noted as female however as the actual numbers are low this may not be statistically significant however should be reviewed for 2022-2023.

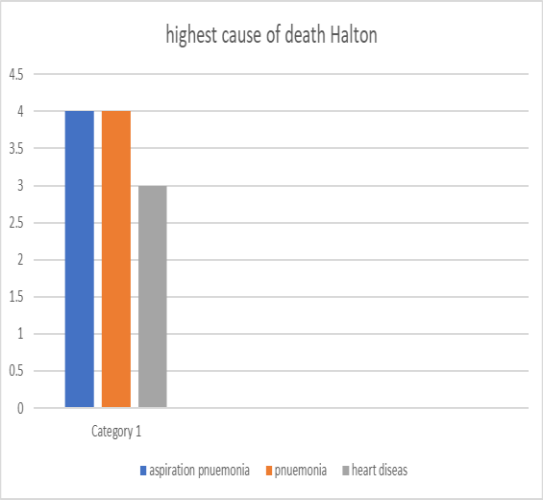
In 2021/ 2022 analysed reporting it is noted that there has been only **1** notification of a death for people with learning disabilities from the Black, Asian or Minority Ethnicities (BAME) and this was for Warrington however it was identified as part of the review process to not be LD and was out of scope. This correlates to the national picture of underreporting of BAME deaths and is picked up for targeted awareness raising of LeDeR with BAME communities and aligns to the national LeDeR Policy priorities.

1 BAME death has been notified for Halton but this remains ongoing and will be included in the learning for 2022-2023.

6.2 Cause of Deaths

Of the reviews conducted in 2021/22 the two most common recorded causes of death were:

Halton



Warrington

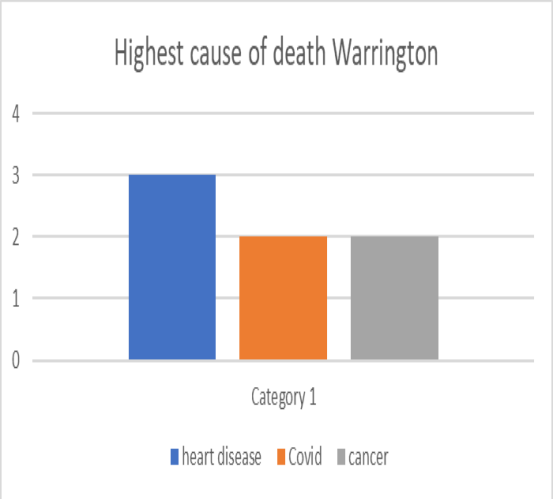
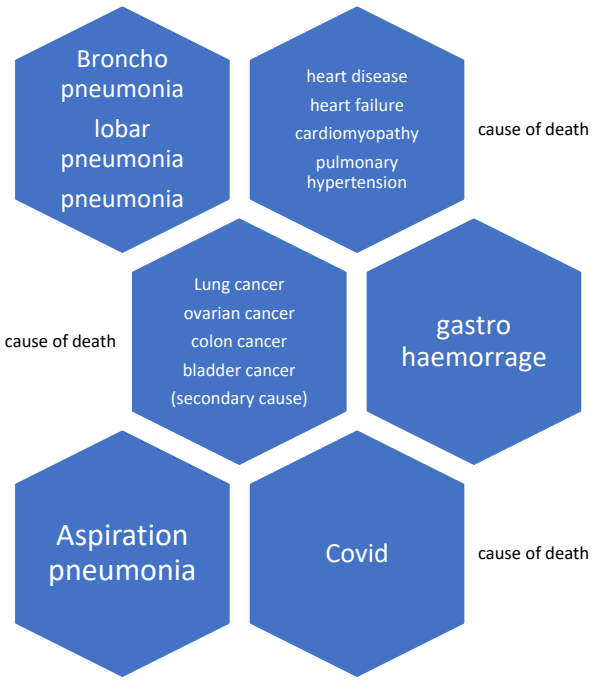


Table 5 -All recorded causes of death



Observation:
A range of causes of death were noted from the reviews. Cancer was frequently recorded on part ii of the death certificate but not as primary cause but has been detailed above as aligns with the continued need for quality AHC's and screening.
Aspiration pneumonia remains a frequently recorded cause of death and aligns to national learning.

6.3 Place of death

Table 2

Place of death	Reviews 2021 - 2022	
	Halton	Warrington
Hospital	47%	60%
Own home (inc. nursing home)	53%	40%

Observation:

The numbers of deaths in hospital do vary between the 2 boroughs and would be worth further exploration to identify if there are any underpinning contributory factors i.e., eol provision.

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

Table 3

Reviews 2021-22	
Halton	**Warrington**
78%	72%

Observation:

- The reviews did not indicate any areas of concern in relation to the DNACPR decisions in place, all were found on the evidence available to have been appropriate.
- For some reviews the information was not available in respect of a DNACPR
- A small number of deaths were recorded as unexpected and there had not been a need in advance to consider a DNACPR for the individuals.
- There was noted in a small number of reviews a lack of understanding re DNACPR's, the decision-making process and accountability for the decision, by families and carers. This could be an area for consideration by medical/clinical staff going forward.

7. 0 Covid 19

During 2021-22 for Halton and Warrington there were 2 deaths notified to LeDeR for Halton and Warrington with a confirmed Covid diagnosis. 1 death was in the out of scope cohort, and the other remains ongoing and the learning will go into the 2022-2023 ICB LeDeR report.

From the deaths notified late in 2020-2021 that were completed in this reporting period there were 3 confirmed deaths from Covid. This aligns with the observed increase in Covid deaths recorded over the winter period.

Within Halton and Warrington services continued to work collaboratively across the system partnership to manage the health and social care needs of people with a learning disability and adapt and respond to the continued effects of the pandemic upon capacity, business priorities and restrictions upon face-to-face contact.

Learning from 2020/21 was implemented and Learning Disability Nursing Teams and Health and Social Care Providers worked closely together to ensure:

1. All people with a learning disability and a known risk of respiratory conditions were flagged with acute providers due to an increased risk of admission.
2. Hospital passports were updated and shared with acute providers to support any admissions.
3. Consultations were maintained via virtual platforms or telephone consultations to ensure healthcare needs were managed in a timely manner.
4. System wide communications and resources were shared to raise awareness of the signs of deteriorating health in people with a learning disability.

Table 4

Known factors	HALTON	WARRINGTON
Number of Covid deaths	2	2
Male/female	M, F	F, F
Age	52, 24	70, 71
Long term conditions	Mental health Epilepsy	Respiratory condition Asthma
Covid symptoms	Breathlessness High temperature Reduced oral intake	Temperature Shortness of breath
Other:	DNACPR √	DNACPR – in place for one death
	One death BAME	Hospital passport √

7.1 Covid Impact upon LeDeR delivery for Halton and Warrington

During 2021-2022 the Covid restrictions, vaccinations then boosters and need for business prioritisation did continue to impact upon the LeDeR panel. The panels continued to run via a virtual platform to enable continuity however it was noted this still does bring some challenges to information sharing and review of the available information.

In addition, there was a noted impact upon the capacity of services to provide information towards the LeDeR reviews. HCCG/WCCG supported services where possible and ensured that NHSE/I was aware of the competing demands across the system. Whilst national business prioritisation plans were in place for services to enable the required Covid

response, the national LeDeR timescales remained unchanged throughout the pandemic. Reviews were maintained throughout this period and a flexible and pragmatic approach applied in respect of the information gathered for a review.

7.2 Good Practice examples from reviews (anonymised)

Well documented detailed discussion with patient's sister by Consultant

Throughout the pandemic he was screened regularly for COVID in his residence

With regards to healthcare provided, she had regular annual LD reviews including full medication reviews by the GP Practice

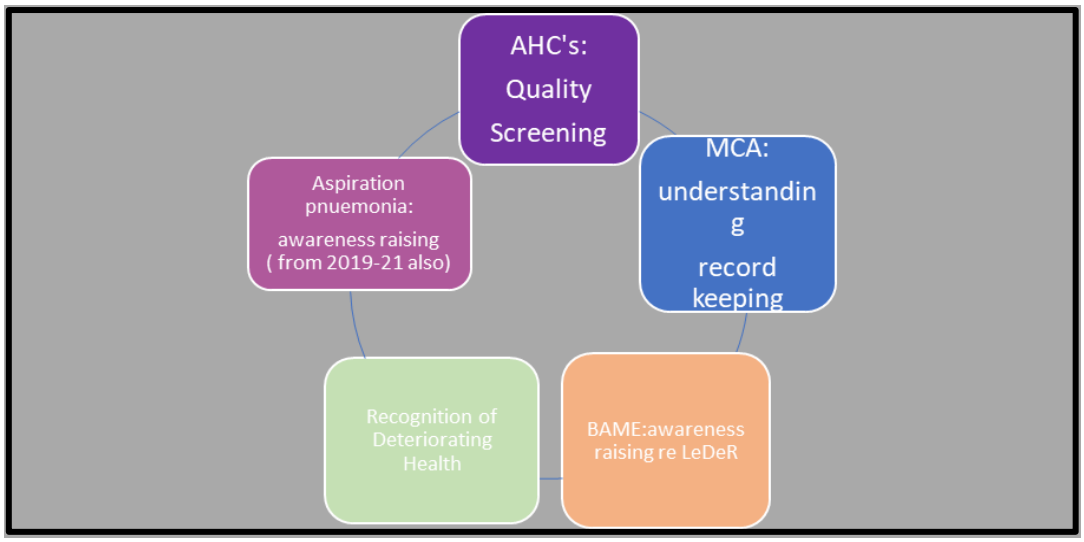
Brother's main concern was that he or a carer be allowed to stay in the hospital- this was accomodated

Her death was quite quick & she was not on her own as she was supported by the team of carers and friends

Best interest discussion by treating clinicians with family included and followed Mental Capacity Act

8.0 Local Learning into Action themes:

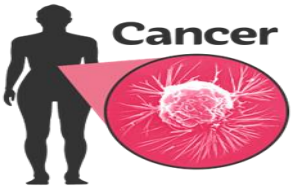
The most reported themes for 2021-2022 noted for targeted learning into action were reasonably consistent across both Halton and Warrington and relate to:



8.1 Workplan for the Local Learning into Action Group 2021-2022
The workplan for local learning into action was agreed as below:

Quarter	Focus Area- awareness raising and promotion	Deep dive topic for Learning into Action Group
Quarter 1	BAME groups- awareness of LeDeR	• Covid learning • Aspiration pneumonia
Quarter 2	Recognising deteriorating health- Speak up video. Z cards	• Recognition of signs of deteriorating heath in people with a learning disability
Quarter 3	Nursing Homes- awareness of LeDeR (from 2019-20)	• MCA - scoping
Quarter 4	LeDeR delivery in the ICS	• AHC and access to screening

The continued impact of Covid 19 upon business priorities, capacity and meeting restrictions did impact upon this work during 2021-2022. A flexible approach was taken to delivery through sharing of information, resources, and assurances of progress across the local system towards the focus areas as detailed below.



9.0 Halton and Warrington contribution to the CM Regional Priority Areas

HCCG/WCCG have actively supported the C/M strategy steering group and worked in collaboration to progress improvements against the priority areas. Detail in brief is provided below against each priority area for 2021-2022. Further updates from system partners are included in the report at section 10 and in Appendix 5.

Table 5

Priority Area	Actions- HCCG/WCCG and System Partners
Management of Medical Conditions	
Vaccination Programme	• HCCG- Covid vaccine Quality Assurance work is being undertaken with primary care practices to ensure capacity assessments have been completed for those individuals with LD not having had a first covid vaccine to ensure the correct health and care safety principles have been followed in accordance with the Mental Care Act. Covid vaccine • HCCG achieved an uptake rate for Covid vaccines in people with a LD: 1st vacc – 92.80% 2nd vacc – 89.45% Booster – 74.84% • Halton was one of three C&M CCGs to exceed 65% Influenza uptake among its LD population. • Training and resource packs provided to Primary care to support understanding of MCA (2005) • HCCG- Audit of patients with a learning disability and vaccine status undertaken to identify any areas for review and support for practices • HCCG/WCCG- SOP developed to support access to legal services and funding for primary care to progress any court of protection cases • Warrington CCG achieved an uptake rate for influenza vaccinations of 59.1% • WCCG achieved an uptake rate for Covid vaccines: • 1st vacc – 91.4% • 2nd vacc – 89.3% • Booster – 66.2% • Multi-agency targeted support offered to every GP practice to support understanding and implementation of the MCA re vaccination programme for people with a learning disability • Desensitisation work with people with LD supported by LD nursing teams. • BWCT- support people with learning disabilities to access covid vaccination and linking in with the local CCG to ensure anti-virals are delivered to vulnerable groups.

	• Halton LD nurses- LD nursing team supporting GP practices with MCA, BI, COP procedures for covid vaccinations • Warrington advocacy- production of easy read information re vaccinations
Managing deterioration of Health	• Resource pack re managing deteriorating health shared with system partners and LeDeR panel members • Z cards re spotting signs of deteriorating health shared with system partners for second year
Changing how we work	
LeDeR policy implementation	• Supported the development of the C/M strategy • membership of the LeDeR ICB transition group • implementation for Halton and Warrington of new LeDeR platform and review formats
Integrating care between community and acute settings	• local use of hospital passports • BWCHT- developed communication and partnership working with WHHFT and STHK hopspitals.This has improved the pathway with secondary care and supports a more effective pathway for service-users and their families and carers • STHK- positive Communication Links with Care Providers / Northwest CLDTs / Local Authority / GPs and STHK Health Professionals to ensure Reasonable Adjustments are offered and implemented • WHHFT- weekly meetings with LD partners to review and strengthen existing pathways • Halton LD Nurses- Closer working with LD leads within hospitals -setting up weekly meeting with local hospital safeguarding teams (Whiston and Warrington) to discuss patients and any issues • Merseycare- developed weekly updates with safeguarding team from WHHFT local acute hospital to discuss any issues/concerns each week with admissions or out-patient appointment.
DNACPR	• Learning from regional/national workstreams shared locally.
Annual Health Checks:	• HCCG -In 2021/22 the LD AHCs target was set to 75% by our C&M TCP. In total Halton achieved 82.66%. Halton was one of three C&M CCGs to have exceeded the 75% target. The CCG has plans in place to review the process and quality of the LD checks being carried out by Halton GP practices. • BWCHT- support to encourage individuals to complete their health check and provide the health check at home for some patients who struggle with mainstream access. supported service-users with elements of the

	health check e.g., taking bloods etc where they have been unable to access their GP. Breast awareness and raising awareness of breast screening for people with Learning disabilities and support with local and national screening programme. Cervical screening uptake- working directly with the primary care practices nurses Bowel cancer testing – proactively working with primary care via the practice nurses • Warrington advocacy- promotion of annual health checks and the five ways to wellbeing • WCCG: Warrington achieved 70% compliance for AHC's. Plans are in place to review the process and quality of the LD checks being carried out by Warrington GP practices.
Additional aligned work	
STAMP/STOMP	Halton LD Nurses: Stomp – we have had meeting and a presentation from Dave Gerrard (pharmacist/NHS England) we are meeting to develop a new Stomp pathway with Halton Council and CCG, linking in with medicines management and their data collection. PBSS will feature more prominently in the pathway. Will be sharing new pathway and educating GP practices and psychiatrists. WCCG: The Warrington Medicines Management team has completed the STAMP audit in all Warrington CCG practices in 2021/22. The audit has identified 210 patients on the LD/Autism register. 172 patients had received a medication review in the last 12 months.
Keyworker Project	In Spring 2022 Halton CCG commenced the Halton Keyworker Project for children and young people (CYP) with a LD and/or ASC with the most complex needs. Halton CCG leads on the monthly project group meetings to identify the requirements of the Halton Keyworker role. Planning is currently underway to support the co-production for this work with CYP with lived experience which will form a key part to the roles and responsibilities for the role. Warrington CCG is working with C&M Partnership to begin working on co-production for the above Keyworker offer as Warrington are not an Early Adopter but have been proactive in requesting additional funding to commence this piece of work.

10.0 Partner Updates

Key partner organisations across Halton and Warrington have shown commitment and support for the LeDeR programme in this reporting period.
Highlights and examples of the development work undertaken that aligns with LeDeR priorities, and supports reducing health inequalities, improving accessibility, quality, and the experience of services for people with a learning disability and/or autism is detailed below. Full details can be found at Appendix 6.

STHK

- LD specialist nurse in post
- Piloting use of wrist bands in A&E for patients who need reasonable adjustments

Halton LD Nurses

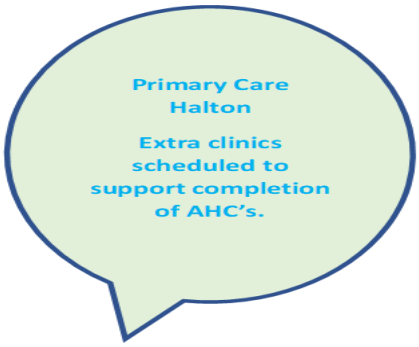
- Support to GP practices with MCA
- Diabetes work with Countess of Chester Hospital
- Run weekly walk in the park

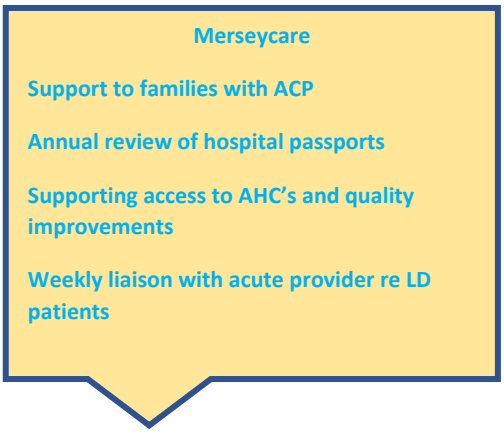
BWCHT

- Development of best practice guidance for working with people with LD/Autism
- Flagging for reasonable adjustments in electronic patient record
- Support LD awareness week with a range of events
- Support with AHC uptake

WHHFT

- LD link staff assigned to all clinical areas
- LD and Autism strategies in place
- Improved signposting in the Trust





11.0 Co-production and learning

To end the reporting period HCCG/WCCG worked with Warrington Speak Up Advocacy Service to commission a video co-produced with people with a learning disability. The video talks about LeDeR and the importance of looking after your health and engaging with health services. The video can be used across the health and social care partnership to raise awareness. A link to the video is below:

LeDeR video

12.0 Oliver McGown Report

The report and recommendations were reviewed at the end of 2020/21. An action plan was completed against the recommendations and agreed via the LeDeR panel.
The action plan has been reviewed for 2021-2022 with all actions completed. The report and action plan can be found at Appendix 6.

All commissioned health providers within Halton and Warrington have implemented learning disability and autism awareness training programmes.

Local advocacy groups have been proactive re supporting awareness raising of learning disability and autism and have worked closely with system partners where possible.

13.0 Progress from 2019-2022

In 2019-2020 the LeDeR panel was a new process, and the panel members were adjusting to the multi-agency approach. For 2020-2021 the LeDeR panel was now established and functioned well throughout the pandemic. The panel continued in 2021-22 and is well supported across the system from both Halton and Warrington with members from a range of providers and HCCG/WCCG. The reviews are subject to multi-agency scrutiny for every review, and this has on many occasions highlighted issues and learning that would not have been noted with the previous single reviewer process.

HCCG/WCCG remain committed to this approach for 2021-2022 until the move on 1st July 2022 to the Integrated Care Board model. LeDeR will become a shared ICB function with a dedicated team from July 2022.

All national learning and key messages have been cascaded during this reporting period via System Partners, Safeguarding Adult Boards, and local groups and specialist forums as appropriate.

Covid has impacted upon the system capacity to hold local learning into action groups however work has continued via virtual platforms where possible and through a flexible approach to system learning and information sharing

14.0 Next Steps in 2022-2023

Responsibility for ensuring the delivery of LeDeR reviews currently lies with clinical commissioning groups (CCGs) until 30th June 2022. As we move into new arrangements in the NHS through 2021 and into 2022, local integrated care systems (ICSs) will become responsible for ensuring that LeDeR reviews are completed for their local area and also, and very importantly, that actions are implemented to improve the quality of services for people with a learning disability and autistic people to reduce health inequalities and premature mortality. ICSs will be responsible for ensuring that LeDeR reviews are completed of the health and social care received by people with a learning disability and autistic people to reduce health inequalities and premature mortality.

15.0 Cheshire and Merseyside and Greater Manchester – Combined LeDeR Reviewer Workforce

From 1st July 2022, Cheshire and Merseyside ICB will host a dedicated reviewer LeDeR workforce, a combined reviewer team with Greater Manchester. The dedicated team will be led by a Senior Reviewer and will be supported by a LeDeR administrator.

A Local Area Contact will also be appointed, who will be independent and separate to the Review team.

16.0 ICB LeDeR Governance Arrangements

From 1st July 2022, Cheshire and Merseyside ICB will adopt a Cheshire and Merseyside ICB LeDeR Governance structure which will consist of the Cheshire and Merseyside ICB LeDeR Quality Assurance Panel. Reviewers will no longer make recommendations for each review, instead they will present areas of learning, good practice, and areas of concern to the panel. The panel will be responsible for signing off the quality of focussed reviews, in discussion with the reviewer, agree SMART (specific, measurable, achievable, realistic and timebound) actions which feed in to, and are cognisant of the strategic plan.

The panel will be integral to wider ICB quality governance arrangements as appropriate and will report into regional and national quality assurance meetings and processes as required.

The Regional and National team will hold the ICB to account assuring that the actions are robust, that they will address the issues identified and will achieve objectives required. At the time of writing this annual report ICB LeDeR Governance structures are in the process of being finalised and will be adapted as appropriate as ICB structures evolve.

The local governance group/panel will consist of people from across the ICB who have responsibility for the quality of services and can take action to improve services. The governance group/panel will continue to include people with lived experience.

17.0 Conclusion

2021-2022 has been a challenging year, with the effect of the pandemic being felt upon system capacity and business priorities at times impacting upon LeDeR local delivery. With support of the system partners HCCG/WCCG LeDeR panel has maintained oversight and delivery of LeDeR activity within the agreed standards and worked flexibly to ensure the learning from deaths continues.

The 2021-2022 LeDeR Annual Report provides an opportunity to express thanks across the local system to those whose efforts to drive forward the service improvements required to improve care and reduce health inequalities for people with a learning disability as noted within the report.

Leadership of the LeDeR programme will transfer to the ICB from July 2022 but supported by good local engagement.

The legacy video (Aftathought), and LeDeR film (Warrington Speak Up Advocacy) for people with a learning disability can continue to be accessed and highlight Halton and Warrington's commitment to LeDeR both as CCG's and forwards into the ICB.

18.0 Appendices:

Appendix 1

Autism Strategy

B1004-five-year-NHS -autism-research-stra

Appendix 2

Leder Policy

B0428-LeDeR-policy-2021.pdf

Appendix 3

Cheshire /Merseyside LeDeR Strategy

C&M ICS LDA 3 Yr LeDeR Strategic Plan.(

Appendix 4

HCCG/WCCG Leder Governance Flow Chart

Flow chart.docx

Appendix 5

System Partner updates

Partner Updates for LeDeR Annual Report

Appendix 6

Oliver McGowan

Oliver McGowan.docx