REPORT TO:	**ADULT SOCIAL SERVICES REVIEW PANEL** **November 2017**
SUBJECT:	**The Learning Disabilities Mortality Review (LeDeR) Programme in Croydon**
LEAD OFFICER:	**Caroline Baxter, Assistant Director, Adult Social Care & All Age Disability**
CORPORATE PRIORITY/POLICY CONTEXT/AMBITIOUS FOR CROYDON: This report is for information only	

1. RECOMMENDATIONS

1.1 The Adult Social Services Review Panel (ASSRP) is asked to note the contents of the report

2. EXECUTIVE SUMMARY

2.1. 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. Work on the LeDeR programme commenced in June 2015 for an initial three-year period.

2.2. The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to guide improvements in the quality of health and social care service delivery for people over 18 with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities.

3. DETAIL

3.1. A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision.

3.2. The purpose of the LeDeR reviews is not to hold any individual or organisation to account. Other processes exist for that, including 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.

3.3. In order to do this in a timely manner and to avoid duplication, reviewers need to be clear where and how the LeDeR process links with other reviews or investigation processes.

3.4. 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), Serious Incident Reviews, Coroners' investigations and Child Death Reviews.

3.5. The LeDeR Programme will also collate and share 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.

3.6. A further part of the LeDeR programme is to conduct a series of additional projects. These are:

- Finding out more about the age and cause of death of people with learning disabilities in England by linking different data sets
- Finding out more about the provision of 'reasonable adjustments' for people with learning disabilities
- Providing better guidance so that the cause of death written on death certificates of people with learning disabilities is recorded in a consistent manner
- Establishing a collection of reports about people with learning disabilities from which we can learn more about commonly occurring problems.

3.7. The LeDeR programme in the London Borough of Croydon is being led and chaired by the Clinical Commissioning Group (CCG) in partnership with the Local Authority and other partners.
A Steering Group has been set up and will be chaired by Rachel Blaney from the CCG. Caroline Baxter, Assistant Director of All Age Disability is the Senior Responsible Officer in the Council. Once the Group has finalised its terms of reference there will be invitations to join offered to members of the local voluntary sector and the Learning Disability Partnership and parent carers.
Information has already been shared with the Voluntary Sector and Learning Disability

3.8. Partnership to ensure they are fully briefed as to progress and the scope of the programme. A presentation was delivered on the 9th of October.
Staff from the CCG, the Local Authority and Health Partners have attended training to become reviewers of any cases that should occur in Croydon.
Managers have also received training so that they can support reviewers.
As yet no deaths have been reported by Croydon but there is currently a review of deaths since April of this year to identify any cases that reach the criteria for the programme.

3.9. Data analysis of the Croydon population suggest that we can expect to review approximately 15 deaths per year.
Once a case has been reviewed the report will be sent to the University of Bristol to add to the data being collated nationally.
Locally the LeDeR Steering Group will review reports on cases and make recommendations, if appropriate on any themes identified.
Those involved in an LeDeR investigation process should not be involved in the direct care of those individuals affected and if possible not work directly with those involved in the delivery of that care.

3.10. When acting as a reviewer officers should act with impartiality – challenging the 'status quo' to identify system weaknesses and opportunities for learning while making decisions based on objective criteria.

3.11. The Reviewing Officer will inform the LeDeR Steering Group about each report that significantly impacts on or is affected by another investigation or review, sharing the agreed plan for data collection and providing the Steering Group with reports on progress and completion of the review.

3.12. The needs of the family and carers will be paramount and should receive careful consideration to avoid duplication of questioning and unnecessary upset.
The Croydon LeDeR Steering Group will report to Senior Officers locally and the Health and Well Being Board findings, themes and recommendations. Information will also be shared with other Boards or Committees that require updates.

3.13. There is a statutory requirement in the Children Act 2004 to review all deaths of children. More recently, the Department for Education document, 'Working Together to Safeguard Children' (2015) sets out the review process for the deaths of children, and requires Safeguarding Children's Boards to review the deaths of children who are normally resident in their area. Hence the LeDeR programme will only review cases of adults over the age of 18. There will though be the opportunity to share information around child deaths to track any themes that relate to adult deaths too.