Thurrock - An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future

Health and Wellbeing Board

The meeting will be held at **10.00 am** on **8 October 2020**

Virtual - Microsoft Teams

Membership:

Councillors James Halden (Chair), Tony Fish, Robert Gledhill and Allen Mayes

Jane Foster-Taylor, Executive Nurse Thurrock NHS Clinical Commissioning Group
Karen Grinney, HM Prison and Probation Service
Roger Harris, Corporate Director of Adults, Housing and Health
Kristina Jackson, Chief Executive Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
Dr Kallil, Chair Thurrock NHS Clinical Commissioning Group
Nigel Leonard, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)
Andrew Millard, Director of Place
Anthony McKeever, Interim Joint Accountable Officer for Mid & South Essex CCGs
Sheila Murphy, Corporate Director of Children's Services
Andrew Pike, Executive Member Basildon and Thurrock Hospitals University Foundation Trust
Ann Radmore, Director Level Executive NHS England Midlands and East of England Region
Julie Rogers, Chair Thurrock Community Safety Partnership Board / Director of Environment and Highways
Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust (NELFT)
Preeti Sud, Executive Member Basildon and Thurrock Hospitals University Foundation Trust
Mark Tebbs, Interim Deputy Accountable Officer: Thurrock NHS Clinical Commissioning Group
Ian Wake, Director of Public Health
Chair of the Adult Safeguarding Partnership or Senior Representative, Chair Thurrock Local Safeguarding Children's Partnership or Senior Representative

Agenda

Open to Public and Press

Member's papers to support this item

9	**Work Programme**	**123 - 126**

Queries regarding this Agenda or notification of apologies:

Please contact Darren Kristiansen, Business Manager - Commissioning by sending an email to DKristiansen@thurrock.gov.uk

Agenda published on: 30 September 2020

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PUBLIC Minutes of the meeting of the Health and Wellbeing Board held on 31 July 2020 10.30am-12.39pm

Present:	Councillor James Halden (Chair) Councillor Tony Fish Councillor Allen Mayes Roger Harris, Corporate Director for Adults, Housing and Health Ian Wake, Director of Public Health Sheila Murphy, Corporate Director for Children's Services Julie Rogers, Chair Thurrock Community Safety Partnership Board/Director of Environment and Highways Jane Foster-Taylor, Executive Nurse, Thurrock NHS Clinical Commissioning Group Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust (NELFT) Kim James, Chief Operating Officer, Healthwatch Thurrock Kristina Jackson, Chief Executive, Thurrock CVS Anthony McKeever, Interim Joint Accountable Officer for Mid and South Essex CCGs
Apologies:	Councillor Robert Gledhill Mark Tebbs, Deputy Accountable Officer, Thurrock NHS Clinical Commissioning Group Andy Millard, Director for Place Karen Grinney, HM Prison and Probation Service Preeti Sud, Executive Member of Basildon and Thurrock Hospitals University Foundation Trust Michelle Stapleton, Interim Director of Operations, Basildon and Thurrock University Hospitals Foundation Trust Tom Abell, Deputy Chief Executive and Chief Transformation Officer, Basildon and Thurrock University Hospitals Foundation Trust Andrew Pike, Executive Member, Basildon and Thurrock Hospitals University Trust
Guests:	Maria Payne, Strategic Lead for Public Mental Health & Adult Mental Health Systems Transformation Catherine Wilson, Strategic Lead Commissioning and Procurement Jane Itangata, Associate Director of Mental Health Commissioning, Mid and South Essex Health and Care Partnership Jo Cripps, Programme Director, Mid and South Essex Health and Care Partnership

Did not attend: Dr Anil Kallil, Chair of Thurrock CCG
Nigel Leonard, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)

1. Welcome, Introduction and Apologies

- Apologies were noted.
- The Chair welcomed members to the meeting and advised that this was his first Health and Wellbeing Board meeting as Chair within his new role as Cabinet Member and Portfolio Holder for Children and Adult Social Care.
- The Chair explained that this was a virtual Health and Wellbeing Board meeting and explained the etiquette to members for contributing to the meeting. New members of the Health and Wellbeing Board were welcomed and introduced by the Chair. The Chair also provided thanks to Council Officers, partners and the public for all of their hard work and commitment in responding to the COVID-19 pandemic, ensuring the most vulnerable residents of Thurrock received the necessary support and critical services remained operational.
- The Chair acknowledged the potential adverse financial impact of COVID-19 on the Council, Local Businesses, Partners, and the residents of Thurrock.

2. Minutes

The minutes of the Health and Wellbeing Board meeting held on 31 January 2020 were approved as a correct record.

3. Urgent Items

There were no urgent items raised in advance of the meeting.

4. Declaration of Interests

There were no declarations of interest.

5. Annual Director of Public Health Report (APHR) Violence and Vulnerability

This item was presented by Ian Wake, Director for Public Health. Key points included:

- The World Health Organisation has conceptualised youth violence as a communicable disease. Youth violence can be likened to a pandemic, which often starts with a single source and spreading within communities. As with a pandemic, youth violence can be treated and controlled with the appropriate interventions and requires a whole system approach.

- Data shows that younger people are becoming involved or associated with gangs. Black Asian and Minority Ethnic (BAME) young people are over represented for both weapons possession offences and violent offences; this requires further investigation. There is also an increase in the number of white young people being involved with gangs. Structural inequalities and gang involvement impact on a young person's life opportunities.
- It was noted specific ward deprivation is a very poor predictor of violence. The Director for Public Health (DPH) explained the crime paradox whereby a number of offenders come from deprived backgrounds, however many young people from disadvantaged areas do not commit crime.
- There are a number of risk factors linked to youth violence and gang involvement, these are:
    - Individual – this is the key risk factor and can include displaced aggressive traits.
    - Family – poor parental supervision and delinquent siblings.
    - School – frequent truancy and low academic aspirations.
    - Peer group – the influence of peers, particularly delinquency.
    - Community – community norms and values.
- A Public Health approach to tackling violence focuses on 4 steps:
    - Surveillance – identifying and defining the problem
    - Identify risk and protective factors – establishing the causes
    - Develop and evaluate interventions – establishing what works and why
    - Implementation – scaling-up of effective policy and programmes.
- The DPH explained that the report comprises 33 recommendations:
    - Surveillance and data integration.
    - Primary prevention through 'inoculating' the population to protect them from violence.
    - Secondary prevention through earlier intervention to support young people most at risk.
    - Tertiary prevention through intervention with perpetrators and victims of youth violence or gang membership.

During discussions the following points were made:

- Members welcomed the comprehensive report and agreed that a more coordinated, whole system approach is required to tackle youth violence.
- Members agreed the report should be presented to the Police and Crime Commissioner's Violence and Vulnerability Strategic and Executive Group.

- It was acknowledged that colleagues within the VCS are key partners who often work with young people at risk.
- Members recognised that improvements could be made to data sharing protocols between partners including the police.
- Members recognised the impact of positive deviants and how mentors inspire and assist young people. Further consideration will be provided to the merits of establishing mentor schemes within Thurrock.
- Members considered the role of social media and how it can be used by gangs to glamorise gang involvement. Members acknowledged that this is a relatively new phenomenon and agreed that further consideration should be given to creating a Thurrock Social Media Strategy which mitigates the impact of social media activity that promotes gang behaviour.
- Members noted the Violence and Vulnerability Unit will be holding a conference in Thurrock this year whereby this repot will be presented as part of a workshop. Further information will be circulated to colleagues as and when this is received.
- Members agreed that consideration should be provided to the merits of creating a local area coordinator approach which supports young people in Thurrock.
- Members were advised about the recently established Economic Vulnerability Group which will consider the impact of economics on young people and the vulnerability it might create. The vulnerability of young people will be further discussed during the meeting scheduled for September.

RESOLVED: The Health and Wellbeing Board members noted the content and recommendations of the report and considered how these can best be implemented and used to influence broader council strategy.

6. Mental Health Review

This item was introduced by Roger Harris, Corporate Director of Adults, Housing and Health. Key points included:

- A report had previously been endorsed by Thurrock Cabinet in March 2019 and the current report provided an update on significant improvements and transformation initiatives. It is acknowledged COVID-19 has impacted on certain areas however these work streams will be taken forward when it is practical to do so.
- It has been recognised the production and improvement within adult mental health services has been a joint approach across the Local Authority and external partners.
- Thurrock's social work and social care mental health services are provided through a Section 75 agreement between Thurrock Council and EPUT. This involves social care staff being placed on secondment to EPUT. Staff are based at Grays Hall which

enables an integrated offer to be provided to patients. A fundamental review of this offer is underway in order to strengthen managerial oversight of services. It is proposed that the Section 75 agreement is not be renewed in March 2021.

The Mental Health Transformation report was presented by Maria Payne, Public Health and Jane Itangata, Mid and South Essex Health and Care Partnership. Key points included:

- The report outlines the initiatives that have been implemented to address the under-diagnosis of mental health problems. These include the development of a depression screening protocol and the Thurrock Healthy Lifestyle Service embedding a short form of screening into the NHS Health Check.
- There has been improvement to the quality of information held on GP systems at a practice level. A specialist Mental Health Profile Card for each GP practice has also been created. This contains data on mental health diagnoses and treatment of mental health conditions, usage of emergency mental health care services and general recommendations for practices to follow.
- The access to mental health treatment has been improved by using 'Stretched QOF' as an incentive to ensure patients receive the right level of treatment and MPFT – Inclusion Thurrock providing more tailored talking therapies for those experiencing depression and anxiety. All therapists are currently working with patients via an enhanced digital offer to ensure treatments remain accessible during COVID-19.
- The Local Authority has employed a Senior Mental Health practitioner on a year's secondment from the Essex Partnership University Trust (EPUT) to join the Housing Solutions Team to upskill staff across the Housing directorate in mental health awareness and to undertake specialist mental health assessments.
- In addition, new models of care have been developed. The successful pilot of an evidence based programme to support individuals with Personality Disorders is continuing to be monitored.

During discussions the following points were made:

- Members noted clinical pathways have been developed, particularly the 24/7 mental health crisis support, launched on 1 April. This service facilitates individuals to receive the support they require as early and quickly as possible when experiencing a mental health crisis.
- Members were advised of transformation across the place and system levels and the need to embed mental health within Primary Care Networks. Significant progress had been made pre-COVID-19, however the pandemic has adversely impacted on this.

- Members welcomed the joint approach of colleagues in strengthening the crisis care pathway and integrating with other community assets, along with the introduction of specific services such as the School Wellbeing Team.
- It was recognised further discussions are required with EPUT colleagues as to when Open Dialogue will resume as this had been put on hold due to COVID-19.
- Members agreed that the Section 75 agreement should not be renewed until a review has been undertaken.
- Members acknowledged the benefits of joint appointments and how they support knowledge sharing and integration.

RESOLVED: The Board noted the progress made with relation to adult mental health system transformation and endorsed the next steps as detailed in the paper.

Members also agreed to establish a member led body, chaired by Cllr Allen Mayes to receive progress reports on the development of the joint mental health transformation plan.

7. Outbreak Control Plan

This item was presented by Ian Wake, Director for Public Health. Key points included:

- In response to the COVID-19 pandemic, it is a national requirement for Outbreak Control Plans to be developed by top tier Local Authorities.
- Thurrock's Outbreak Control Plan was published on 30 June 2020 and has received positive feedback nationally.
- There are 3 key objectives within the Outbreak Control Plan:
    - Understanding COVID-19 through surveillance.
    - Prevention of outbreaks and ensuring these are dealt with swiftly.
    - Participating in Test and Trace to prevent onward spread of infection.
- The Plan has a complex structure which spans national, regional and local levels. On a local level, the Plan sets out roles and responsibilities of key partners and governance arrangements, for example a Health Protection Board has been established which meets fortnightly and the development of a Member Engagement Board which is due to be held every 6 weeks.
- The Surveillance and Intelligence Cell meets daily to consider data and monitors this data to ascertain threat levels. Thurrock's threat level is currently at 0 and is rated green.
- The Plan outlines testing arrangements and a comprehensive Communication Engagement Plan.

- There are various protocols that underpin the Plan, for example Care Homes, Primary Care and Workplaces. There are 4 responsible Hubs for developing and overseeing the protocols and the action and implementation that sits underneath these.
- The Care Homes protocol was established in May 2020 and has recently been refreshed to incorporate developing government guidance.
- There have been a number of challenges experienced with Test and Trace. This is due in part to the availability of national data at a local level. A possible solution may have been found through linking data manually however this is ongoing.
- A paper has been produced in relation to governance and powers which highlight the functions of the Health Protection Board, the Member Engagement Board and the relationship with the SCG and wider NHS. The Local Authority has additional powers to close premises, public spaces and events, along with the ability to restrict their use. These powers sit with the Director for Public Health, the Chief Executive and the Head of Environmental Health.
- For a local lockdown within Thurrock, colleagues would need to liaise with the Health Protection Board and then this will be escalated to the SCG.
  The Regional Assurance Team, Public Health England and the Joint Bio Security Centre would also review before further action could be taken.
- A variety of powers have been retained by government ministers, for example, they will be able to instruct residents to stay at home and will be able to close non-essential retail establishments.

During discussions the following points were made:

- Colleagues were advised the Members Engagement Board have proposed to compare Thurrock's response to Essex in order to refine the Local Authority's approach further.

RESOLVED: Members noted the contents of the Outbreak Control Plan.

8. Health and Wellbeing Strategy – a new approach in a post Covid world

This item was introduced by Darren Kristiansen, Business Manager for Adults, Housing and Health. Key points included:

- The Health and Wellbeing Board is a key statutory partnership body in Thurrock that is responsible for creating and overseeing Thurrock's Statutory Health and Wellbeing Strategy.
- The current 5 year Strategy was launched in July 2016 and was developed following extensive consultation with system partners and the residents of Thurrock.

- The Strategy is live and organic which has been updated to reflect policy developments and emerging challenges ensuring that it has remained fit for purpose.
- Further evidence has emerged on the wider determinants of health and wellbeing since the launch of the current Strategy and potential new priorities cannot be incorporated into the current framework. This includes the nationally driven changes made to local health structures and the creation of the Mid and South Essex Care Partnership, the impact of housing on health, safety/feeling safe, economic development, regeneration and wider mental health challenges.
- During initial system partner consultation, colleagues welcomed the opportunity for the Strategy to be embedded into the day to day work streams of system partners, therefore ensuring a level of accountability. In addition, the refreshed Strategy should be strengthened via the governance processes and build on existing arrangements.
- The refreshed Strategy should reflect lesson's learned from COVID-19, such as the importance of technology and collaboration through strong, trust based partnership arrangements, while addressing some of the potential challenges it has posed.
- Colleagues agreed that many of the existing priorities should remain in the refreshed Strategy along with additional priorities.
- The first 4 proposed 'domains' within the new framework reflect the current and existing priorities, and domains 5 and 6 focus on the wider determinant elements of housing, community safety and the environment.
- A number of Joint Strategic Needs Assessments (JSNAs) were reviewed as part of the extensive literature review conducted and where these products have already highlighted a need and made recommendations for action, have also be considered in the rationalisation of priorities.
- A narrative is being developed to underpin the draft framework domains and priorities and a Task and Finish Group will be established to drive forward progress, which was subject to member's approval. Opportunities for residents of Thurrock to co-produce the Strategy proposals are being considered but members were asked to note the challenges created by COVID-19 and many forums remain inactive at present.
- It is proposed a wider public consultation will take place during early 2021, which will inform the final Strategy priorities.

During discussions the following points were made:

- Members recognised the challenges in developing a wide ranging Strategy however it is a significant document which is a statutory requirement. The Strategy sets the framework for development of people based services over the next 3-5 years and is a whole system production.

- Colleagues were advised during partner consultations, there have been recommendations for the membership of the Task and Finish Group therefore this will be finalised as soon as possible and the Terms of Reference produced.

RESOLVED: The Board agreed the Thurrock Health and Wellbeing Strategy 2016-2021 is refreshed along the lines of proposed outlined within the report.

Members agreed that a Task and Finish Group is established to drive forward the refresh of the Strategy.

In addition, the Board will consider how the Strategy is resourced post September 2020 to support the delivery of the refresh and continued oversight, engagement and implementation of the Strategy when launched in July 20201.

9. Mid and South Essex Health and Care Partnership update to confirm the MOU. Board to endorse.

This item was presented by Jo Cripps, Programme Director for the Mid and South Essex Health and Care Partnership. Key points included:

- The Memorandum of Understanding has been developed to formalise and build on existing partnership arrangements and relationships.
- It is built on a number of principles such as supporting the place agenda within Thurrock and providing a mutual accountability framework.
- The critical work of Health and Wellbeing Boards and Health and Wellbeing Overview and Scrutiny Committees has been recognised.
- The Memorandum of Understanding is not a legal document and does not override existing partner governance arrangements.
- The Partnership Board approved the Memorandum of Understanding in June 2020 and is presented to Thurrock's Health and Wellbeing Board for approval.

During discussions the following points were made:

- Members welcomed the Memorandum of Understanding as it links explicitly with the work of the Thurrock Integrated Care Partnership and strengthens the place based agenda, including working with communities and third sector organisations.
- Members recognised the positive work undertaken as part of the COVID-19 response including the ability to expedite a whole system response to the Pandemic.
- Members noted ongoing discussions with Ann Radmore in relation to jointly appointed posts to ensure Children's Services priorities are embedded into the work of partners at a system, place and locality levels.

- Members agreed the Memorandum of Understanding is a starting point for the partnership to build on and will ensure accountability across all partners.

RESOLVED: The Board endorsed the Memorandum of Understanding.

10. Creation of Thurrock Integrated Care Partnership – a sub-group of the Health and Wellbeing Board

This item was presented by Roger Harris, Corporate Director for Adults, Housing and Health. Key points included:

- The Thurrock Integrated Care Partnership, previously known as the Alliance, is a key strategic partnership comprising key partners.
- Some of the successful initiatives of the Partnership to date include the establishment of the pooled Better Care Fund of over £40m, the development of the 4 Integrated Medical Centres and the integration of key local services and development of joint leadership arrangements.
- The Partnership has driven forward the transformation programme which has included the commissioning of a social prescribing service within Thurrock, the expansion of the Local Area Coordinators and the development of wellbeing teams.
- The Thurrock Integrated Partnership focuses on the place based structure and the local health and care system.

RESOLVED: Members endorsed the Thurrock Integrated Care Partnership as a sub-group of the Board and agreed that minutes from this meeting will be considered by members as a standing agenda item.

11. Initial Health Assessments for Looked After Children

This item was presented by Janet Simon, Strategic Lead for Children's Services. Key points included:

- The papers sets out action completed by the Local Authority in partnership with Health colleagues to meet the needs of Looked After Children by ensuring they receive their initial health assessments within statutory timescales.
- During the Ofsted Inspection in November 2019, the delay in completing timely Initial Health Assessments was highlighted. Ofsted acknowledged the work between Social Care and Health colleagues to resolve the delay but that the pace of change was too slow and said the timeliness of initial health assessments when all children come into care needed to improve.
- It was noted Health colleagues have experienced some challenges in completing the assessment in a timely manner due to some staff being redeployed for the COVID-19 response.

Currently there are no breaches in timeliness reported, however they are reported a month in arrears.

During discussions the following points were made:

- Members acknowledged and reinforced the importance of completing initial health assessments in a timely manner.
- Members considered the merits of jointly appointed roles and the sharing of responsibilities between agencies, particularly given the clear link between Children's Services and Health services.
- Members welcomed the opportunity to work closely with both Children's Services and Health colleagues and to consider the role of wider Health professions in completing assessments; this is being reviewed at a national level.
- It was agreed a collaborative progress update will be provided at the next Board meeting.

ACTION: Secretariat to include Initial Health Assessments to the Board work plan for the next meeting.

- Members agreed that the proposed target of 90% of initial health assessments completed on time will be further reviewed at a Board meeting in 2021 to ensure it is both a realistic and stretching target.

ACTION: Secretariat to include Initial Health Assessments performance to the Board work plan for a meeting in 2021.

RESOLVED: The Board noted the efforts made by Health and Children's Services to improve the timeliness of Initial Health Assessments for Children Looked After and noted progress.

12. Work programme

- Members agreed to provide feedback for potential agenda items to the secretariat for future meetings.
- Members agreed a work programme for the Health and Wellbeing Strategy Refresh will be developed for the Task and Finish Group. This will consider resources, Terms of Reference and time frames for progression.

13. AOB

- Members noted Better Care Together have been shortlisted for an award by the HSJ Value Awards. The winner of the award will be announced on 4 September 2020.
- It was also acknowledged Thurrock Council have been shortlisted for Local Authority of the Year for the second year running.

The meeting finished at 12:39pm.

CHAIR……..

DATE……

8 October 2020	ITEM: 5
Thurrock Health and Wellbeing Board	
Basildon University Hospital Maternity Services	
Wards and communities affected: All	**Key Decision:** Not applicable.
Report of: Diane Sarkar, Chief Nursing Officer, Mid and South Essex NHS Foundation Trust.	
Accountable Head of Service: Not applicable – report produced by Council Partner	
Accountable Director: Not applicable – report produced by Council Partner	
This report is Public	

Executive Summary

The Care Quality Commission (CQC) carried out an inspection of maternity services at Basildon University Hospital on Friday 12 June 2020. Following this inspection, and a review of Trust incident reports, the CQC published its report on Wednesday 19 August 2020. This rated the service as Inadequate.

The Trust is extremely disappointed, but fully accepts the findings of the report and has taken urgent and significant action to improve the service. Mothers should feel safe when giving birth, and it is vital that staff are able to provide the best care to women and babies. The Basildon Maternity Unit remains safe, but did not keep pace with the increasingly complex demands being placed upon the service.

A number of changes have already been implemented and the CQC highlights this in its report. These include investing £1.8million in recruiting 29 more midwives and two additional consultants, improved security and a restructuring of ward facilities, plus we have increased bed capacity on the Delivery Suite and Cedar Ward.
We have learned from these incidents, with immediate leadership changes. The changes already made will be embedded, putting in place enhanced robust processes so that our Maternity Unit can deliver at the very highest standards.

1. Recommendation

1.1 For the Health and Wellbeing Board to note and comment on this report.

2. Introduction and Background

2.1 The CQC inspected maternity services at Basildon University Hospital on Friday 12 June 2020. The inspection was unannounced and focused on maternity services. It was carried out in response to concerns raised by a whistleblower about safety in the department. Alongside this, a review of incident reports provided by the Trust showed that in March and April 2020, there were six serious incidents where babies were born in a poor condition and transferred for cooling therapy.

2.2 There is a safe maternity service at Basildon University Hospital, with lower-than-average neo-natal deaths and stillbirths. However, the service did not keep pace with the increasingly complex demands being placed upon it, with more higher-risk women using the service and a greater prevalence of obesity and diabetes, leading to increased risks of complications for these women.

3. Issues, Options and Analysis of Options

3.1 The report was published on 19 August 2020. It found the following issues:

- Poor multi-disciplinary working
- Training was not always up to date
- Staff shortages
- Safety concerns were not always identified and escalated
- Junior medical staff were not supported sufficiently
- High-risk women were giving birth in a low-risk area
- Incidents were not always graded correctly
- Lessons learnt were not always implemented
- Care records were not always securely stored.

3.2 The report found the following areas of good practice:

- Recognised issues are being addressed, but not yet embedded
- Good control of infection risk
- Staff managed medicines well
- Women protected from abuse
- Staffing levels and skill mix reviewed and adjusted
- Bank and agency staff given full inductions.

3.3 The Trust has already made the following improvements:

- New leadership team in place
- Mandatory training back on track following COVID-19
- Consultants given bleeps to respond to emergencies
- New processes and procedures in place

- £1.8million invested to recruit 29 additional midwives and two consultants
- Foetal Surveillance Lead Midwife and Better Births Lead Midwife recruited
- Three more delivery beds opened for high-risk women and four more post-natal beds
- Creation of a 24-hour triage service
- Two Continuity of Care Teams launched
- Bereavement room restructured and refurbished to provide a self-contained suite
- Birthing pool to be provided in delivery suite
- Dedicated drugs rooms built on all three ward areas
- Improved security for women and their babies: controlled entrance and exit to all ward areas
- Safe staffing and escalation policy updated and implemented
- Central monitoring for CTG
- All staff have had CTG refresher training
- Educational update for instrumental deliveries
- Strengthened delivery suite handover and huddles.

Learning will be shared across all of our hospitals.

3.4 This has already led to positive results:

- Number of perinatal deaths is below expected levels
- Number of still-births is below expected levels
- Number of complaints down on previous years and in line with national average

4. Reasons for Recommendation

4.1 This report provides an overview of the changes made and planned to the maternity services at Basildon University Hospital.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Consultation has taken place with Health and Care system partners. There have been extensive opportunity for local stakeholders to engage with management at the Trust to discuss these issues.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The recommendations of the report as set out in 1.1 have implications for users of the maternity services Basildon University Hospital. There are also implications for stakeholders including the NHS.

7. Implications

7.1 Financial

Implications verified by: **Not Applicable**

Not applicable – externally produced report

7.2 Legal

Implications verified by: **Not Applicable**

Not applicable – externally produced report

7.3 Diversity and Equality

Implications verified by: **Not Applicable**

Not applicable – externally produced report

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Inspection Report of the CQC: Basildon University Hospital, Wednesday 19th August 2020.

9. Appendices to the report

- None.

Report Author:

Diane Sarkar

Chief Nursing Officer

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Basildon University Hospital

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Date of inspection visit: 12/06/2020
Date of publication: 19/08/2020

Ratings

Overall rating for this hospital

Are services safe?	
Are services effective?	
Are services well-led?	

Summary of findings

Overall summary of services at Basildon University Hospital

Basildon University Hospital is operated by Mid and South Essex NHS Foundation trust. The maternity unit at Basildon University Hospital provides a comprehensive range of services including; ambulatory care assessment, prenatal diagnostic screening, antenatal care services, perinatal mental health and counselling service, midwife led birthing unit, delivery suite and home birth service.

The maternity unit offers women the following birth options:

- Home birth: around 3% of all trust births are home births.
- Midwife-led birthing unit: Located on the Willow suite, consists of five delivery rooms (including two pool rooms) and four postnatal beds.
- Delivery suite: eight birthing beds and four enhanced care beds. There are two dedicated maternity theatres.

The maternity unit also includes Cedar Ward, a 33-bedded postnatal ward that also provides antenatal care and the Mulberry Suite, which is a seven-bedded ambulatory care assessment unit for all women from 14 weeks gestation.

From April 2019 to March 2020 there were 4,304 deliveries at Basildon University Hospital.

We last inspected the maternity service at Basildon Hospital in February 2019. The service was rated requires improvement overall; safe and well led were rated requires improvement, effective, caring and responsive were rated good.

During the 2019 inspection, we identified a number of concerns in the maternity service. As a result, requirement notices for breaches of regulation 12 and 17 of the health and social care act (2014), were issued against the trust. The requirement notices informed the action the trust must take to comply with its legal obligation, and we requested an action plan from the trust, outlining steps that had been taken to address the concerns we raised. The trust submitted an action plan following publication of the inspection report in July 2019. The trust submitted regular updates on the progress of the action plan and in February 2020, the actions relating to the maternity service were all signed off as completed by the trust.

In May 2020 we received information from an anonymous whistle-blower, raising safety concerns at Basildon Hospital maternity services. The information received and a review of the trust's incident reporting data highlighted a cluster of six serious incidents where babies were born in poor condition and subsequently transferred out for cooling therapy from March and April 2020. Cooling therapy is a procedure which can be offered as a treatment option for newborn babies with brain injury caused by oxygen shortage during birth. It involves bringing baby's temperature from the normal body temperature of 37°C to a temperature between 33°C and 35°C soon after birth and for a few days afterwards.

In response to the information we carried out a focused inspection on 12 June 2020 to follow up on the concerns raised.

During this inspection we:

- Spoke with 16 staff members; including service leads, matrons, midwives, doctors, midwifery care assistants and administrative staff.
- Checked 12 pieces of equipment.
- Reviewed 12 medical records.
- Reviewed five prescription charts.

Summary of findings

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. We carried out a focused inspection related to the concerns raised, this does not include all of our key lines of enquiry (KLOEs). As a result of this inspection we rated safe, effective and well-led as inadequate, and overall the service was rated inadequate.

We found some improvements from our last inspection. There were continued concerns in relation to requirement notices we served to the trust at our inspection February 2019. Following the focused inspection, we undertook enforcement action in relation to the maternity service, and told the trust it must improve. We issued a warning notice, on the 23 June 2020, under Section 29A of the Health and Social Care Act 2008. This identified specific areas that the trust must improve and set a date for compliance as 14 August 2020. The trust initiated an immediate action improvement plan.

The link below is our report published following our last inspection:

https://www.cqc.org.uk/location/RDDH0/reports

Maternity

Inadequate

Summary of this service

We rated it as inadequate because:

- Staff did not always complete training in key skills, they did not identify and escalate safety concerns appropriately. The service did not always have enough staff keep women safe and to provide the right care and treatment. Multidisciplinary team working was dysfunctional which had impacted on the increased number of safety incidents reported. Incidents were not always graded correctly according to the level of harm and lessons learnt were not being implemented. High risk women were inappropriately giving birth in the low risk area (Midwifery Led Birthing Unit - MLBU). Staff collected safety information, but it was not routinely shared with staff, women and visitors. Care records were not always stored securely. Most of these concerns were raised at our previous inspection February 2019, the service had not improved.
- The service did not make sure staff were competent for their roles. Senior medical staff did not support, supervise and mentor junior medical staff effectively. Staff did not always work well together. Some staff did not feel able to approach some colleagues which was not to the benefit of women and babies. There was poor multidisciplinary presence and structure to the safety handover on the delivery suite and postnatal ward.
- Leaders did not have the skills and abilities to effectively lead the service and did not operate effective governance processes throughout the service. The service did not have an open culture where staff could raise concerns without fear. There had been a lack of learning from previous incidents and actions put in place were not embedded. We were not assured the vision and strategy of the service was achievable with the current standard of multidisciplinary working within the service.

However:

- The service controlled infection risk well. Staff understood how to protect women from abuse. Staff managed medicines well.

Is the service safe?

We rated it as inadequate because:

- Staff did not always complete training in key skills, they did not identify and escalate safety concerns appropriately.
- Multidisciplinary team working was dysfunctional which had impacted on the increased number of safety incidents reported.
- The service had a comprehensive training programme to provide staff with the training they required, however the trust target for attendance at training was not met by the service.
- The service had enough consultant cover although presence on the delivery suite was poor and responses to emergencies had been inconsistent.
- The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.
- High risk women were inappropriately giving birth in the low risk area (Midwifery Led Birthing Unit - MLBU).

Maternity

- Staff did not always record and monitor women's carbon monoxide levels in line with the trust policy and saving babies lives (2016).
- The design, maintenance and use of facilities, premises and equipment were not always suitable. The delivery suite birthing rooms were not in line with national guidance.
- Care records were not always stored securely.
- The service did not always manage safety incidents well. Staff recognised incidents and near misses but did not always report them appropriately according to grading and level of harm. Lessons learnt from past incidents were not being implemented by the whole team and the wider service.
- The service did not use monitoring results well to improve safety. Safety information was not shared with staff, women and visitors.

However, we also found:

- The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff managed clinical waste well.
- The service used systems and processes to safely prescribe, administer, record and store medicines an improvement from our last inspection February 2019.
- Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Is the service effective?

We rated it as inadequate because:

- We were not assured that the service made sure staff were competent for their roles. There were no effective systems in place to ensure competencies of medical staff.
- Processes to manage staff competency of interpreting cardiotocography (monitoring the fetal heart) had been completed was poor
- Middle grade doctors' competencies were not reviewed, and consultant obstetricians did not support and mentor middle grade doctors appropriately.
- Doctors, midwives and other healthcare professionals did not always work well together to benefit women and babies. They did not support each other to provide good care.
- The longstanding poor staff culture had created an ineffective multidisciplinary team.
- Annual appraisals had not identified that medical staff had not been competency assessed.

Is the service well-led?

We rated it as inadequate because:

Maternity

- The service leaders did not have the skills and abilities to run the service. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved safety culture within the organisation. However, staff were positive about the arrival of the interim clinical lead.
- We were not assured the vision and strategy of the service was achievable with the current standard of multidisciplinary working within the service.
- Leaders did not operate effective governance processes to continually improve the quality of its service and safeguarding standards of care. Whilst governance processes were in place these were not fully effective, there remained a lack of oversight and acknowledgment of risk and cultural concerns from the maternity senior leadership team.
- The service did not have an open culture where staff could raise concerns without fear. Staff were very aware of the long standing poor culture and safety concerns.
- There had been a lack of learning from previous incidents and actions put in place were not embedded

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service had a comprehensive training programme to provide staff with the training they required, however the trust target for attendance at training was not met by the service.

The trust set a target of 85% for completion of mandatory training, with the exception of information governance, safeguarding and mental capacity training for which the target was 95%.

A breakdown of compliance for mandatory training courses as of March 2020 for qualified midwifery staff in maternity is shown below:

Training Module name	Eligible Staff	Staff trained	Completion rate
Conflict Resolution	193	175	91%
Mental capacity Act	47	41	87%
Dementia Awareness	193	167	87%
Equality & Diversity	193	126	65%
Fire Safety Yearly (eLearning)	193	153	79%
Fire Safety (Face to Face)	193	123	64%
Information Governance	193	74	90%
Learning Disabilities	159	140	88%
Manual Handling	193	76	39%
Recognition and management of Sepsis - eLearning	192	137	71%
Record keeping - eLearning	190	170	89%

Risk management & incident reporting	193	187	97%
Venous Thromboembolism	174	148	85%
Infection prevention and control	193	178	92%
Adult Basic Life Support	191	127	66%
Neonatal Basic Life Support	190	187	98%

For the reporting period April 2019 to March 2020, the training target was met for eight of the 16 mandatory training modules for which qualified midwifery staff were eligible.

A breakdown of compliance for mandatory training courses as of March 2020 for medical staff in maternity is shown below:

Training Module name	Eligible Staff	Staff trained	Completion rate
Conflict Resolution	19	16	84%
Mental capacity Act	26	21	81%
Dementia Awareness	30	18	60%
Equality & Diversity	30	21	70%
Fire Safety Yearly	30	17	57%
Fire Safety (Face to Face)	30	11	37%
Information Governance	30	27	80%
Learning Disabilities	8	6	75%
Manual Handling	30	24	80%
Recognition and management of Sepsis - eLearning	13	8	62%
Record keeping - eLearning	8	3	38%
Risk management & incident reporting	30	27	90%
Venous Thromboembolism	17	7	41%
Infection prevention and control	30	26	87%
Adult Basic Life Support	19	5	26%
Neonatal Basic Life Support	29	29	100%

For the reporting period April 2019 to March 2020, the training target was met for three of the 16 mandatory training modules for which medical staff in maternity were eligible.

Non-compliance with completion of mandatory training in line with the trust target was a breach identified at the February 2019 inspection and a trust wide requirement notice was issued.

During this focused inspection, mandatory training for staff in the maternity unit did not always meet the trust targets. Following the inspection, the trust executive team acknowledged that there were a number of concerns regarding training compliance within the maternity services and actions were already in place to improve compliance. Due to the

COVID-19 pandemic, all statutory and mandatory training was cancelled for three months in order to release staff to front line clinical duties. The senior leadership (SLT) team told us this had compounded the situation and the improvements the service had planned did not take effect. Following our focused inspection, the SLT informed us that statutory and mandatory training programmes had recommenced to address the poor training compliance.

We raised our concerns and were told that senior leaders were meeting with medical and midwifery staff to ensure that any outstanding training was completed by 17 July 2020. Additional dedicated adult basic life support (BLS) training sessions were specifically arranged for the service to ensure all staff receive an update by the end of August 2020.

Data provided by the service on 20 July 2020 showed 72% of midwifery and 41% of medical obstetric staff had completed their BLS training. The remaining 51 midwifes and 17 medical staff were set to complete their training by the 14 August 2020.

The mandatory training programme was comprehensive and met the needs of the maternity service. Training was provided online learning and at face to face sessions.

The service used nationally recommended 'Practical Obstetric Multi-Professional Training' (PROMPT) to deliver some of the maternity mandatory training. The delivery of PROMPT training was introduced following our inspection February 2019. The topics covered by the PROMPT training included: fetal monitoring, inverted uterus, human factors, sepsis, Modified Early Obstetrics Warning Score (MEOWS) use to identify deterioration in a woman's condition, obstetric haemorrhage (excessive bleeding), shoulder dystocia (an emergency where the baby's shoulders are difficult to birth), breech (baby is birthed bottom presenting), eclampsia (seizures during pregnancy), twin birth and cord prolapse (the baby's cord slips down in front of the baby after the waters have broken). The training was delivered by a multidisciplinary team and involved a mixture of skills and live drills sessions and presentations.

From April 2019 to March 2020, 98% of midwives and 100% of medical staff including obstetric and anaesthetic medical staff completed the PROMPT training.

Data from 18 June 2020 showed that 44% of midwifery and 24% of medical obstetric staff had completed the 'Gestation Related Optimal Weight' (GROW) e-learning, a recommendation from Saving Babies' Lives 2019. Following the inspection, we were told by senior leaders that staff were required to complete the GROW e-Learning by the 31 March 2020. However due to the Covid-19 pandemic a decision was made to suspend the learning. On the 9 June 2020 GROW e-learning training was reinstated and all staff have been given until the 19 July 2020 to complete the training. As of 20 July 2020, 94% of midwifery and 45% of medical obstetric staff had completed the GROW e-learning. The remaining 28 midwifery and medical obstetric staff were set to complete by 30 July 2020.

The trust employed three practice development midwives (PDMs) who were responsible for developing and delivering the mandatory training programme and recording midwifery attendance.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training attendance was monitored electronically, and staff received reminders to complete training. Training compliance remained poor, therefore we were not assured that oversight was robust.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Medical staff had not all completed training on how to recognise and report abuse, however they knew how to apply it.

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

Maternity

A breakdown of compliance for safeguarding training courses as of June 2020 for qualified nursing and midwifery staff in maternity is shown below:

Name of course	Number of staff eligible	Number of staff trained	Completion rate
Preventing Radicalisation Basic	193	174	90%
Preventing Radicalisation Awareness	189	165	87%
Safeguarding Adults Level 1	192	181	94%
Safeguarding Adults Level 2	188	119	63%
Safeguarding Children Level 1	241	235	98%
Safeguarding Children Level 2	224	214	96%
Safeguarding Children Level 3	206	196	95%

The trust compliance target was met for five of the seven safeguarding training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for safeguarding training courses as of June 2020 for medical staff in maternity is shown below:

Name of course	Number of staff eligible	Number of staff trained	Completion rate
Preventing Radicalisation Basic	19	19	63%
Preventing Radicalisation Awareness	19	11	58%
Safeguarding Adults Level 1	15	12	80%
Safeguarding Adults Level 2	30	16	53%
Safeguarding Children Level 1	30	27	90%
Safeguarding Children Level 2	30	27	90%
Safeguarding Children Level 3	23	20	87%

The trust compliance target was not met for any of the safeguarding modules for which medical staff were eligible. The maternity senior leadership team told us that due to the COVID-19 pandemic, all statutory and mandatory training was cancelled for three months in order to release staff to front line clinical duties. Medical staff had been allocated to the next available training sessions.

Midwifery and medical staff received safeguarding training specific for their role on how to recognise and report abuse. The safeguarding training staff received included child sexual exploitation (CSE) and female genital mutilation (FGM).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The staff we spoke with could confidently inform us of what a safeguarding concern would be and their process for reporting this. For example, domestic violence cases were some of the issues that had been identified and reported by maternity staff. Staff used the trust intranet safeguarding page to access contact details for further advice or support with safeguarding referrals.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were familiar with the process of escalation and referral to the safeguarding specialist midwife for extra support and understood the reporting system for women presenting with FGM. Staff told us they were always able to get support from the lead safeguarding midwife if they needed advice.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well maintained.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. The service had housekeeping staff who were responsible for cleaning wards and public areas, in accordance with daily and weekly checklists.

Staff cleaned equipment after each contact and labelled equipment to show when it was last cleaned. We saw that there was a system in use throughout the service to identify clean equipment by using 'I am clean' stickers.

Infection prevention and control (IPC) audits were undertaken and the results were used to improve IPC practice where needed. From December 2019 to May 2020, the service scored 100% for all elements of the cleaning and decontamination monthly audit.

The service audited hand hygiene and displayed the results in the entrance to the ward area. Data from December 2019 to May 2020 showed that all areas of the service scored 100% in the monthly hand hygiene audit, with the exception of Cedar Ward scoring 90% for December 2019.

The service followed current guidance for infection prevention and control when assessing and caring for women with possible or confirmed cases of COVID-19.

Women with possible or confirmed COVID-19 were cared for in a side room away from other women. We saw good practice when staff attended to these women, they were cared for in single side rooms with appropriate IPC signage and staff wore the correct personal protective equipment (PPE) before making contact.

Staff followed infection control principles including the use of appropriate PPE. We observed staff using PPE which was readily available, such as disposable gloves, masks and aprons.

We observed staff adhered to the trust's 'bare below the elbows' policy to enable effective hand washing and reduce the risk of spreading infections. We observed staff performed hand washing before and after episodes of direct care. Hand sanitising units and handwashing facilities were available throughout the unit and handwashing prompts were visible for staff, women and the public.

Women were screened for Methicillin resistant Staphylococcus aureus (MRSA) at booking. Where inpatient women had a known or suspected infection, they were cared for in single side rooms. There had been no cases of Clostridium difficile (C Diff) or MRSA bloodstream infections in the maternity service from September 2019 to November 2019.

Environment and equipment

The service mostly had suitable premises to care for women. Staff managed clinical waste well.

During our focused inspection the Midwife Lead Birthing unit (MLBU) was closed following an assessment due to escalation of staffing issues, this was in line with the trust policy, therefore we did not visit this area.

The birthing rooms on the delivery suite did not have en suite facilities, which meant women in the delivery suite had to walk past other women, visitors and staff to use any toilet or shower facilities. This was not in line with national guidance (Department of Health (DH), Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities (2013)). The service had plans for the future to improve services however this work was in its infancy.

The service had two dedicated obstetric theatres and recovery area. The neonatal unit was close by if a baby's condition deteriorated and they required an urgent transfer.

Maternity

In February 2020 the service started a capital build project to increase bed capacity and support care of women in the appropriate setting. This included work to the delivery suite, postnatal ward, the development of the bereavement facilities and a birthing pool on the delivery suite.

Due to COVID-19 pandemic, the suspension of building works had led to some delay with completing the work. However, at the time of our focused inspection six extra beds had been opened, four on the postnatal ward and two on delivery suite.

We were told that work on the bereavement suite improvements would recommence on the 8 June 2020 and would be completed by the end of June 2020 and that work on the birthing pool would commence by the end of June 2020.

During our focused inspection a number of staff told us that they were not involved or consulted in the redesign and layout of the ward area. This was particularly highlighted about the redesign of Cedar Ward. Staff felt the new layout was not workable, for example the desk and administrative space was much smaller and located further away from where the bedded bays were. This meant staff had to either write their notes just outside the bay which did not offer any privacy or take the notes to the desk area some distance away from the women and babies they were caring for.

All areas of the maternity units had card swipe in access for staff and visitors had to ring the buzzer to gain entry or exit. This was an improvement from the last inspection in February 2019 where we were not assured that staff were monitoring who was accessing the ward to mitigate the risk of a baby abduction.

The entrance to each ward was manned by a ward clerk between 9am and 5pm each day and after hours ward staff were responsible for ensuring the correct entry and exit procedure was adhered too. A camera monitor was positioned at the midwifery station which showed who was at the door awaiting entry or exit.

The service had enough suitable equipment to help them to safely care for women and babies. We checked 12 items of equipment and saw that they had up to date safety testing including resuscitaires, weighting scales and sonicaids, which are used to monitor the fetal heartbeat.

Staff carried out daily safety checks of specialist equipment. Staff checked adult and neonatal emergency equipment daily. We reviewed daily checklists for the emergency equipment from 15 April to 12 May 2020 which were all completed.

Staff disposed clinical waste safely. Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed in sharps containers which were dated and labelled with the hospital's details for traceability purposes. This was in line with national guidance (Health and Safety Executive Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: Guidance for employers and employees (March 2013)).

Arrangements for the control of substances hazardous to health (COSHH) were adhered to. Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials. Staff disposed of clinical waste safely.

Assessing and responding to risk

Staff did not always fully complete risk assessments for each woman. Risk was not always acted upon appropriately.

The Mulberry assessment unit had a designated four-bedded bed and three triage rooms. This provided 24-hour assessment, review and care planning for pregnant women from 16 weeks gestation. Women who visited the assessment unit were triaged by midwives using a traffic light RAG (red, amber, green) rating to see a midwife and/or doctor based on the symptoms they had. We reviewed the notes of seven women who visited the assessment unit, and all were seen within the appropriate time for their RAG rating. This was in line with national guidance (National Institute for Health and Care Excellence (NICE), Safe midwifery staffing for maternity settings overview (September 2019)).

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff took all observations required and scored correctly on the 'Modified Early Obstetric Warning Score' (MEOWS) charts. We reviewed 19 MEOWS charts in women's records on the day assessment unit, delivery suite and postnatal ward, we found all observations were completed and scored correctly.

Staff used a nationally recognised tool the 'Newborn Early Warning Score' (NEWS) to identify new born babies at risk of deterioration. At the time of our inspection we reviewed the two available NEWS charts, which were both completed and scored correctly.

Managers told us audits had recently started to assess compliance with the MEOWS guideline. We requested the last three audits and received the audit results and action plans for only one audit in June 2020 the month we inspected. The results showed out of 50 sets of healthcare records which were randomly selected from women who delivered in April 2020; 100% had a MEOWS assessment undertaken on maternity triage and 79% on antenatal admission. The audit also showed that MEOWS assessment was undertaken 12 hourly in only 52% of antenatal admissions and in 66% following birth. However, in postnatal ward, 12 hourly MEOWS assessments were undertaken in 93% of cases. The audit also showed that, nearly 50% of cases were not actioned in accordance with guidance when a MEOWS triggered a score of one or two, the majority of observations were repeated between two or three hours when they should be reassessed every hour. The action plan that was submitted consisted eight actions for the service to complete. The action plan had just been developed in June 2020 the month of our inspection and was yet to be implemented.

Staff used a buddy system to review cardiotocography (CTG) interpretation. This was in line with national recommendations (NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)). The service used the 'fresh eyes' approach. This meant a second midwife was required to review the CTG recording hourly during the woman's labour, to ensure it had been interpreted and classified correctly and escalated when needed. We reviewed 12 maternity records which showed CTG peer reviews were performed hourly and were escalated appropriately.

During the focused inspection the maternity senior leadership team told us, in response to the findings from the review of six serious incidents, themes had been identified with misinterpretation of CTGs and where abnormalities had been identified this had not been appropriately escalated. The SLT told us they had taken immediate action, which included; only senior midwives signed off CTG fresh eyes, classifications, and discontinuation. However, staff told us that some senior midwives were not up to date with their CTG training and competencies but signed off CTGs. We escalated our concerns to the maternity senior leadership team and following the inspection we received confirmation that all senior midwives had completed training and been assessed and were competent for CTG interpretation.

Staff did not always complete screening for specific risk issues. For example, we found that carbon monoxide screening which is part of the 'saving babies lives 2016' initiative was not always performed in line with trust guidance. We reviewed 12 records for carbon monoxide monitoring and found that all 12 women's records showed that they were not monitored in line with the trust's policy. Information provided post inspection stated that an electronic system for all antenatal bookings had been introduced in September 2019 and that this had replaced the antenatal booking handheld maternity records. Data provided demonstrated that compliance with testing of carbon monoxide ranged between 90% in November 2019 and 86% in February 2020. This meant the target within the trust guideline that "all women be offered a carbon monoxide screen" was not being met. In addition, having two systems duplicating the same information meant a potential risk of inconsistent and incomplete documentation.

Staff completed booking risk assessments for each woman at their initial booking appointment which included social, medical, obstetric and mental health assessments. This enabled staff to decide if the woman was a high or low risk pregnancy, staff updated them throughout pregnancy, labour and the postnatal period as needed. We reviewed 12 maternity care records which confirmed these details.

Maternity

Women who were assessed as high-risk and unsuitable for the midwife led birthing unit (MLBU) were referred to an obstetrician for review and management. However, following our inspection we reviewed the midwifery led birthing unit births report for April and May 2020 and found high risk women were inappropriately giving birth in the MLBU low risk area. There were three cases in April 2020 and four cases in May 2020 which showed high risk women had given birth in the MLBU. This was an area of concern highlighted in the February 2019 inspection and a requirement notice was issued. We escalated our concerns to the trust executive leadership team and received information that a review of all of the cases in April and May 2020 had taken place. Of the seven cases, three were confirmed as high-risk women and the service had developed an action plan to address the immediate concerns. However, this was yet to be embedded.

Staff completed venous thromboembolism (VTE) assessments of in line with the service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein.

We attended a delivery suite safety handover. This was not multi-disciplinary (MDT) attended, there was no representation from the neonatal unit (NICU) or theatres. The format of the handover was not effective, the anaesthetist arrived late, there were several interruptions and on some occasions two conversations were happening at the same time. The handover from the postnatal ward did not follow situation, background, assessment, recommendation (SBAR) format. SBAR is a tool used to facilitate prompt and appropriate communication between wards/services. Senior staff had to prompt staff to give more information regarding the women's history and care plan. Women were referred to by their room number and not their name, which posed a risk if the woman moved rooms or wards.

We reviewed the delivery suite safety handover daily register for week commencing 8 June 2020; on the 8 and 11 June there was no junior doctor present and, on the 10 June 2020, there was no anaesthetist present at the handover. The afternoon medical staff board round from the 8 June 2020 to 10 June 2020 was blank therefore we were not assured that the medical board round was actually held on these dates.

During the morning safety handover, there was no mention of staffing levels, acuity or escalation. On the day of the focused inspection, the Midwifery led birthing unit (MLBU) was closed but this information was not shared. We raised our concerns and following the focused inspection, we were told that the MLBU lead midwife would attend the delivery suite safety huddle at every shift change to update the delivery suite coordinator with regards to all women present on the MLBU.

Midwives did not receive a full handover of all the activities within the delivery suite at the beginning of their shift. Staff told us when they were allocated a woman to care for or if they had to cover for a colleague's break time, they would receive a one to one handover from their colleague. If there was an emergency and urgent cover was needed, the midwife would not have full knowledge of all of the risks and plans of care for all women or the activity on the delivery suite. They would also not be present for the daily safety briefings. This was yet to be embedded and audited as compliant.

There was a pathway for the management of sepsis. Staff we spoke with described what actions they would take if a woman was admitted with suspected or known sepsis including the prompt use of the sepsis six tool, administration of fluids and antibiotics.

Swabs used for vaginal birth and perineal suturing were counted for completeness by two members of staff. This was in line with national recommendations (NSPA, Reducing the risk of retained swabs after vaginal birth and perineal suturing: 1229 (May 2010). We reviewed 12 records and saw two members of staff had verified the swab count.

The World Health Organisation (WHO) surgical safety checklist 'Five Steps to Safer Surgery' was used in maternity theatres. The service carried out observational audit to demonstrate compliance in all sections of the checklist utilised in maternity theatre. The audit measures whether all sections of the checklist are verbalised, exceptions noted and that all relevant staff are fully involved in the process. The WHO surgical checklist maternity observational audit report

showed compliance for the anaesthetist sign out from October 2019 to December 2019 was 36.2% and compliance from January 2020 to March 2020 was worse at 18.3%. Anaesthetist sign out compliance was identified at the February 2019 inspection as poor and a requirement notice was issued. Processes of monitoring improvement have not been effective to mitigate or reduce the omissions.

The service shared an action plan that had been developed to improve compliance. The service planned to re-audit completion of surgical safety checklists in June 2020. During the focused inspection we reviewed seven WHO checklists and found they were fully completed.

Midwifery and nurse staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, to mitigate the risk of harm managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough midwifery staff to keep women and babies safe. Staff told us the delivery suite coordinator was not always supernumerary which meant that in the event that a high number of women attended the delivery suite then they would be providing one to one care for a woman and not facilitating the communication between professionals and overseeing the risk and appropriate use of resources. This was not in line with the 'Safer Childbirth recommendations, October 2007, which states that each delivery suite must have a rota of experienced senior midwives as delivery suite shift coordinators, supernumerary to the staffing numbers required for one-to-one care.'

The service used an acuity tool to identify if the it had the correct number of midwives employed to match the acuity of women accessing the service. Acuity is the measurement used to decide the level of care needed by a woman when in labour and giving birth. The service had conducted a staffing review in 2019 which indicated there was a shortfall of 15.39 whole time equivalent (WTE) registered midwives and 10.98 WTE for maternity support staff. The maternity senior leadership team told us the service was in the process of recruiting midwives.

The managers told us they adjusted staffing levels daily according to the needs of women. The service had an escalation policy which all staff we spoke with were aware of. The policy included calling in community midwives or closing the MLBU in the event of high levels of activity or staff shortages. Staffing was reviewed by managers within the service four times a day.

We saw staffing levels were displayed publicly in all clinical areas for midwives and maternity care assistants. On the day of our focused inspection we found planned staffing levels were mostly met. Although there were staffing shortages managers filled vacancy with bank or agency midwives. The service tried to use midwives familiar to the service all bank or agency midwives had received an induction.

Planned vs actual

The trust reported the following numbers for qualified midwifery staff for June 2020 below for maternity services:

	Planned WTE staff	Actual WTE staff	Fill rate
Qualified nursing and midwifery staff	193.78	169.18	87.3%

Vacancy rates

As of June 2020, the trust reported an overall vacancy of 20.32 WTE which equated to 10.49% of qualified midwifery staff in maternity. The trust told us that they had recruited 20 WTE midwives who were due to commence their role in September 2020.

Turnover rates

Maternity

From June 2019 to May 2020 the trust reported an overall turnover rate of 6.41% for qualified midwifery staff in maternity. This was lower than the trust target for turnover of 12%.

Sickness rates

From June 2019 to May 2020 the trust reported an average sickness rate of 5.6% for qualified midwifery staff in maternity. This was higher than the trust target of 4%.

Bank staff usage

The service used bank staff to fill gaps in midwifery staff. Bank staff completed an induction programme before working in the service. Ward managers told us they tried to use the same staff to promote continuity of care for women.

From January to March 2020 the service reported 6427 hours were covered by bank midwives.

Medical staffing

The trust informed us that medical staff worked across maternity and gynaecology. For this reason, the data below includes medical staff that work in both core services.

Planned vs actual

The trust reported the following numbers for medical staff for June 2020 below for maternity and gynaecology services:

	Planned WTE Staff	Actual WTE Staff	Fill rate
Gynae Clinical Services	1.00	0.00	
Obstetrics Clinical Services	34.75	30.80	88.6%
Total	35.75	30.80	88.6%

The service had sufficient consultants to cover presence on the delivery suite in line with national guidance 'Labour Ward Solutions (Good Practice No. 10) 2010'. Monday to Friday, consultants were rostered from 8am to 8pm and from 8pm to next day 8am on call off site. At weekends the consultants were rostered for five hours each day and when required to provide offsite on call cover.

During the focused inspection the maternity senior leadership team (SLT) and staff told us there was lack of consultant body support to junior doctors and midwives. Staff told us consultant presence was very poor. The junior members of staff were not comfortable asking consultants for support. In addition, the maternity SLT stated that the consultant body did not feel that it was part of their role to support and teach the junior members of staff. Following the identification of themes from the cluster of six serious incidents the executive team had appointed a new interim maternity clinical director and general manager to ensure clinical presence on the delivery suite improved. Staff spoke highly of this change; however, this had just been actioned in May 2020, we were not assured that this was an embedded practice.

Staff told us that there was a lack of response by consultants to emergencies which meant delays in treating women. An action had been put in place for all consultants to carry bleeps in May 2020. The SLT were monitoring this action, however, this was yet to be embedded and response times were not yet audited.

We escalated our concern to the executive leaders and following our inspection, we received confirmation that a number of changes had been implemented to increase consultant presence on the delivery suite. This included the SLT meeting with the consultant body, reviewing competencies of junior medical staff and supporting them with training. Utilising senior locum medical staff to support the service. All elective caesarean sections would be performed by a

consultant dedicated to an all-day list and not on call for emergencies. This meant that there would be a dedicated consultant that covered delivery suite. In addition, gynaecology and antenatal triage emergencies were going to be managed by a separate consultant from 9 am to 6 pm Monday to Friday. All of these actions had been implemented May 2020, therefore we were not assured that these were embedded, and practices had changed.

Vacancy rates

As of June 2020, the trust reported an overall vacancy of 5.55 WTE, which equated to 15.27% of medical staff working across maternity and gynaecology. The trust reported that the vacancies were in middle grade medical staff posts. Senior leaders for the service told us that they were conducting interviews in July 2020 to recruit into the vacant posts. There were no vacancies in consultant roles.

Turnover rates

From June 2019 to May 2020 the trust reported an overall turnover rate of 2.40% for medical staff working across maternity and gynaecology. This was lower than the trust target for turnover of 12%

Sickness rates

From June 2019 to May 2020 the trust reported an average sickness rate of 2.74% for medical staff working across maternity and gynaecology. This was lower than the trust target of 4%.

Bank and locum staff usage

Locum staff were employed to complete any rota gaps and staff confirmed locum doctors were regularly employed within the service. The service had an induction process to ensure locum doctors understood the process and protocols and to familiarise them with the environment.

From January to March 2020 the service reported 767 hours were covered by bank and 1807 hours covered by locum doctors.

Records

Staff kept detailed records of women's care and treatment, but records were not always completed in line with good practice. Information that was recorded in records was clear, up-to-date and easily available to all staff providing care. Records were not always stored securely.

Staff could access women's records easily. The service mainly used paper-based records, with some information held on the trust's electronic patient record system.

We viewed 12 care records of women who had used the maternity service in the previous 48 hours or whom were still on the ward at time of inspection. The records related to all of the episodes of care during their pregnancy. The records were mostly completed in line with records management code of practice for health and social care. However, records did not always include time of the woman's antenatal appointment this was not in line with the national Nursing and Midwifery (NMC) record keeping guidance (January 2019). This was an issue identified at our February 2019 inspection and a requirement notice was issued to the trust. In addition, staff did not always complete carbon monoxide screening in line with trust guidance. We have provided further detail in the assessing and responding to risk to women and babies section.

During our inspection in February 2019, the completion of women's records in line with trust policy and national guidance was an area identified as a concern and a requirement notice was issued. During this focused inspection some improvements had been made. For example, fetal movements, date of the observation and signature of the member staff undertaking the review were all completed in line with trust policy.

Records were not always stored securely. On the postnatal ward the records were kept in lockable mobile storage trolleys, at the end of each bedded bay. On two occasions during our focused inspection these were left unlocked and accessible to women and unauthorised personnel. Staff we spoke to also stated that this was an issue especially since the changes to the layout of the postnatal ward. Therefore, we were not assured that the service kept women's records secure at all times.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Medicines were stored securely in all clinical areas we visited. Since the February 2019 inspection Cedar and Willow Wards medicine rooms were moved into purpose built rooms which were compliant with medicine management standards. This was an improvement from our last inspection February 2020.

Controlled drugs (medicines subject to additional security measures) were stored correctly in locked cupboards and stock was checked by two qualified members of staff twice a day.

We found medicine storage areas were well organised and tidy, with effective processes in place to ensure stock was regularly rotated. All medicines we checked were within their use by date, including intravenous fluids (fluid given through a vein).

We saw that staff kept records of medicines fridge temperatures and ambient room temperature of their medicine rooms on the delivery suite and postnatal ward.

Secure bedside storage was provided for women's own medicines, which meant women's own medications were stored securely on the wards. This was an improvement from the February 2019 inspection

Staff reviewed women's medicines regularly and provided specific advice to in relation to options of pain relief during and following the birth of their baby. The service had access to pharmacy staff to support the maternity areas.

We reviewed the medicine records for five women and found prescriptions were readable and signed, allergies were clearly documented, and administration and route of administration were also clearly recorded. However, women's weight was not documented in three prescription charts. This is important because the correct dose of some medicines are determined by a woman's weight, such as anti-clotting medicine.

Women at risk of developing a blood clot were prescribed anti-clotting medicine to reduce this risk; the correct dose of which was determined by the woman's weight. However, staff told us they used the woman's booking weight to determine the correct dose which was in line with national guidance (RCOG, Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium: Green-top Guideline No. 37a (April 2015).

Incidents

The service reported safety incidents, staff recognised incidents and reported them. However, we were not assured that incidents were always graded correctly according to the level of harm and if lessons learnt from past incidents were being shared with the whole team and the wider service.

Staff we spoke with knew what incidents to report and how to report them. The trust used an electronic reporting system which all grades of staff had access to. Staff we spoke with said they were encouraged to report incidents.

From January 2019 to December 2019, staff reported 1,697 maternity incidents through the National Reporting and Learning System (NRLS). The incidents were graded as having caused no harm (88%), low harm (11%), moderate harm (0.5%), severe harm or death (0.1%). The most common themes for incidents reported were related to treatment and/or procedure (41%), access, admission, transfer, discharge (including missing patient) (13%) and other (22%).

Never events

Maternity

From April 2019 to March 2020 the service had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy. All potential serious incidents were reviewed by the trust's serious incident panel which met three times a week. If an incident was declared as a serious incident the panel appointed an appropriate senior member of staff to lead the investigation and conduct a root cause analysis (RCA). Incidents which met the reporting criteria were referred to the Healthcare Safety Investigation Branch (HSIB) for independent investigation. The HSIB's maternity investigation programme is part of a national action plan to make maternity care safer. They investigate incidents that meet the 'Each Baby Counts' criteria and maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from April 2019 to December 2019.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Maternity/obstetric incident meeting SI criteria:		
baby only (this include foetus, neonate and infant)	11	85%
Maternity/obstetric incident meeting SI		
criteria: mother only	2	15%
Total	13	100%

We reviewed the root cause analysis for nine of the 13 serious incidents reported between April 2019 to December 2019. The themes identified included; incorrect interpretation of CTGs and failure to escalate risk from midwife to middle grade doctors and from middle grade doctors to consultants.

The service had a maternal death in February 2019, which was investigated and an action plan produced. The issues identified from the investigation related to: incorrect interpretation of CTGs; failure to escalate risk from the midwives to medical staff; and failure to escalate risk from middle grade doctors to consultants. There were a further six serious incidents reported between January 2020 and April 2020. These serious incidents identified the same failings of care. This demonstrated a lack of learning from previous incidents and actions put in place were not embedded. Therefore, we were not assured that lessons were being learnt to prevent similar incidents from occurring.

We observed that incidents were not always graded correctly. For example, incidents reported on NRLS by the trust from January 2020 to April 2020, a post-partum haemorrhage (PPH) with blood loss of 3000ml, a maternal transfer to intensive therapy unit (ITU) and term babies admitted to the neonatal unit were graded as no or low harm. This meant that there was a risk that women were not informed of the significance of harm caused to them or their baby, or that appropriate action was taken to prevent further occurrences. This was an area that was identified at the February 2019 inspection and a requirement notice was issued.

The trust had an up to date duty of candour policy which staff could access through the trust's intranet. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of

the person using the service or severe, moderate or prolonged psychological harm. Staff we spoke with were aware of the importance of being open and honest with women and families when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened. However, where incidents were not graded correctly there was a risk woman may not receive the correct response, duty of candour and support from staff.

Safety thermometer

Staff collected safety information, but it was not routinely shared with staff, women and visitors.

Safety thermometer data was not displayed on wards for staff and women to see. While managers collected data for the maternity safety thermometer, the results were not displayed.

Managers submitted data monthly to the national maternity safety thermometer. The safety thermometer was designed to support improvements in women's care and experience. Harms associated with maternity were recorded such as perineal trauma, infection and babies with an apgar score less than seven at five minutes. An apgar score is a tool to assess the condition and wellbeing of a baby following birth.

The maternity safety thermometer data from August 2019 to October 2019 showed the service achieved an average of 81.3% harm free care. This was higher than the England average of 76.3%.

Is the service effective?

Competent staff

We were not assured that the service made sure staff were competent for their roles.

At the time of the focused inspection there were no effective systems in place to ensure competencies of staff to interpret cardiotocography (CTG) had been completed. There was poor audit and recognition of staff CTG training compliance and competency assessments following repeated themes identified from serious incidents of misinterpretation of CTG traces.

As a result of the six serious incidents reported between January to April 2020, the service review highlighted concerns about incorrect CTG classifications and lack of escalation which resulted in harm to some mothers and babies. The service decided that only senior midwives were allowed to sign off classifications, discontinuation and hourly reviews of CTG traces.

We raised our concerns with the trust executive team that the senior oversight and staffing on delivery suite could be compromised due to the senior midwives leaving the delivery suite to review CTGs in other areas of the unit.

During our inspection staff told us there were midwives and junior midwives that had completed CTG training and competency assessments, who were no longer allowed to utilise their skills to classify, discontinue or perform a fresh eyes hourly reviews of CTG traces. This decision was based on seniority and not competence of staff and posed potential delays for senior midwives to be able to leave the delivery suite to review CTGs in other areas.

Following the inspection, the trust notified us that actions had been taken to manage and mitigate immediate risk of harm. A masterclass had been booked for all staff to attend and a new competency work book would be completed by all staff. Not all staff had been allocated to attend, we raised our concerns and the executive team responded that more sessions had been arranged and staff in high risk areas would be prioritised to attend first. Training was due to be fully completed September 2020.

The maternity senior leadership team (SLT) told us during our focused inspection that there had been a lack of consultant body support for junior medical staff. Consultant response to an emergency was inconsistent and consultant

presence on the delivery suite was very poor. The junior medical staff were not comfortable asking the consultants for support as they were made to feel incompetent. The maternity SLT said that following a meeting with the consultants in May 2020, the consultants felt it was not their role to support and teach the junior staff. An action plan to address the lack of junior staff supervision and support had been developed by the SLT and was implemented in June 2020. However, the action plan was dependent on the interim clinical director checking consultant presence on the delivery suite daily. In addition, the interim clinical director telephoned the delivery suite every evening to ensure consultant presence at the evening board round and handover; they also checked if the midwives and middle- grade medical staff were happy with the plan of care for women overnight whilst the consultant was on call from home. These actions have only just been put in place, therefore were not yet embedded and audited as compliant.

The SLT told us middle grade doctors' competencies were not reviewed and that the consultant obstetricians did not support and mentor middle-grade doctors appropriately. Following the focused inspection, the executive team informed us that processes were in place to review all middle grade doctors' competencies. As a result, six middle grade doctors had been placed under supervision by senior locum middle grade doctors to ensure they met all of their competencies.

In addition, senior leaders told us that the training director and trainee medical staff had devised an action plan to improve supervision of the junior medical staff, and encouraged the junior medical staff to speak out and raise concerns. This was only implemented in June 2020 and therefore is yet to be embedded.

Staff told us the clinical educators supported the learning and development needs of staff. The service had three practice development midwifes (PDM). The PDM's role included organising mandatory training, inductions for new staff and band five midwives' (junior midwives) preceptorship training. A preceptorship is a period to guide and support all newly qualified practitioners to make the transition from student to develop their practice further.

Professional midwifery advocates (PMAs) supported midwifery staff to develop through regular, constructive clinical supervision of their work. The PMAs provided group clinical supervision sessions. Staff could also contact a PMA for advice and support when needed, such as if they had been involved in an incident.

The service had staff members who were trained to deliver the Practical Obstetric Multi-Professional Training (PROMPT) approach to obstetric emergency training. The PROMPT team consisted of consultant obstetricians, anaesthetists and midwives.

Appraisal rates

The service met the trust's target of 90% for appraisals between June 2019 and May 2020. Appraisal compliance data for midwifery and medical staff in maternity is below:

Staffing group	Appraisals required	Appraisals Complete	Completion rate	Target met
Qualified Midwifery Staff	192	177	92%	Yes
Medical Staff	30	29	97%	Yes

However due to the concerns raised regarding middle grade doctors' competencies, we were not assured how comprehensive appraisals had been.

Multidisciplinary working

Doctors, midwives and other healthcare professionals did not always work well together to benefit women and babies. Staff were not always supportive of each other to provide good care.

Staff did not hold regular multidisciplinary handover meetings to discuss women and babies and improve their care. Not all staff necessary in assessing, planning and delivering women's care and treatment were present.

Maternity

We observed the delivery suite morning safety huddle. This was not attended by all members of the multidisciplinary team. There was no representation from the neonatal unit or theatres. There was some confusion at the beginning of the handover who was leading the discussions. The 'sharing concerns' bulletin was not discussed, a folder was referred to if staff wanted to read them. We raised our concerns to the trust executive leadership team and following our inspection we were informed that neonatal staff and theatre staff would attend, and the sharing concerns bulletin would be read out loud for the multidisciplinary team to discuss.

Staff told us that consultant presence had been inconsistent and that senior medical oversight and supervision and support for the delivery suite team was poor. This history had affected team work and led to difficulty with multidisciplinary decisions being made with high risk cases and emergencies. Following the review of the cluster of incidents from January 2020 to April 2020, a theme identified was there had been a team lack of awareness and appreciation of the roles and responsibilities of others.

Some staff told us that not all consultants and midwives were approachable and accepting of new initiatives and guidance, they were resistant and wanted to continue old practices. Since the appointment of the clinical director May 2020 there had been actions agreed and some improvement, staff welcomed this change. However, this had been recently implemented and was yet to be embedded in practice,

The service held multidisciplinary clinics for women to attend, such as, diabetes clinic which included the diabetic team support.

The anaesthetists held an antenatal clinic for women determined as needing an anaesthetic review. However, staff told us that the clinics were double booked and felt they couldn't give women enough time. Staff told us, since the interim clinical lead started a dedicated anaesthetist was assigned to the elective caesarean section lists on Tuesdays and Thursdays.

There was an enhanced care area within the delivery suite for women requiring extra observations and care. Staff could call for the outreach critical care team for support if they were required. Women who needed level two care (support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care) were transferred to the intensive care unit.

Staff we spoke with said that mental health referrals were dealt with efficiently, in an emergency they would call the obstetric team and mental health team to attend. The service had a vulnerable women midwife to support midwives, women and their families.

Is the service well-led?

Leadership

We were not assured that the service leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved safety culture within the organisation.

Maternity services were within the women's and children's division in the trust's structure. There was a head of midwifery, clinical director and general manager.

At the time of our focused inspection, following the cluster of serious incidents from January 2020 to April 2020 the trust's group clinical director for the three hospitals maternity services had stepped in as an interim clinical director for Basildon hospital. In addition, the service had an interim general manager. Following the inspection, we were informed the trust was reviewing the operating model to bring together management and leadership of services across the three sites. This would then determine any subsequent recruitment.

Maternity

The head of midwifery (HOM) and the clinical director met with the chief nurse but did not present regularly to the board in line with Spotlight for Maternity 2016. The 'Spotlight on Maternity' March 2016 states 'to ensure that there is a board-level focus on improving safety and outcomes in maternity services, organisations should provide the opportunity for the Medical Director for maternity and the Head of Midwifery to present regularly to the board.' This was an area of concern that was raised at the February 2019 inspection for which a requirement notice was issued.

During our focused inspection, the HOM told us that in the last 12 months she had only presented once to the board. We were told that the chief nurse met monthly with the HOM and clinical director to discuss performance, operational capacity and any concerns. We asked for copies of the last three meeting minutes and found these meetings were held every two months and not monthly. We also noted that the clinical director did not attend two out of the three meetings. The chief nurse also met monthly with all three of the HOM across the trust. We requested minutes of these meetings; however, none were received.

Information provided post inspection outlined that as part of the integration of the corporate governance structures across the group principle assurance committees would meet in common only and retain oversight of performance at individual site level.

We were provided with information that demonstrated papers relating to the maternity service were regularly submitted to the monthly 'quality committees in common', 'site governance forum' and quarterly 'boards in common' meetings. However, direct presentation by either the director and / or head of midwifery was less frequent, occurring quarterly. In the absence of the maternity leadership team presenting to the board the chief nurse would present. However, due to the infrequency of meetings between the chief nurse, head of midwifery and clinical director, where all were in attendance, and lack of minutes from the meetings between the chief nurse and all three HOM we were not assured that concerns were being escalated to the board in a timely manner.

The executive team, maternity senior leadership team, managers and staff reported a longstanding poor culture over a number of years, which had resulted in a deterioration of the safety of the service, and as a result governance and oversight for improved progress and change was not robust. We raised our concerns to the executive team regarding the length of time maternity senior leadership team (SLT) had allowed the culture to continue and were provided with a change in the maternity SLT structure with the appointment of an interim clinical director and general manager from another hospital within the trust and an action plan to address the SLT issues.

Following our focused inspection, the executive leaders acknowledged that culture in the maternity unit needed to be improved and that they had been addressing this since the last inspection in February 2019. In May 2020, concerns for the safety of women and babies were raised by a whistle-blower to the CQC. During our focused inspection, the SLT told us the poor culture had been present for numerous years. Therefore, we were not assured sufficient steps had been taken to address the culture issues prior to the interim clinical director and general manager's appointment. Whilst actions and change of processes to improve culture were implemented in May 2020, this was still in its infancy and yet to be embedded.

The new SLT also told us that there had been a lack of leadership oversight of the consultant body's support for junior medical staff. The junior medical staff found it difficult to approach and escalate risk to some of the consultants for support as they were made to feel incompetent. An action plan to address the lack of junior staff supervision and support was developed by the maternity senior leadership team and was implemented in June 2020. However, the action plan was dependent on the interim clinical director checking consultant presence on the delivery suite daily. In addition, the interim clinical director telephones the delivery suite every evening to ensure consultant presence at the evening board round and handover; they also checked if the midwives and middle grade medical staff were happy with the plan of care for women overnight whilst the consultant is on call from home. At the time of our focused inspection, these actions had only been put in place, therefore were not yet embedded.

Staff spoke positively about the arrival of the interim clinical director. The head of midwifery and interim clinical director told us that they worked well together and were supportive of each other. However, we were not assured around the long-term sustainability and impact of the action plan as it appeared heavily dependent on one person checking behaviours. Following the inspection, the executive team told us that substantive changes were being made including the appointment of a director of midwifery, and the implementation of a revised group model for maternity risk and governance management for long term sustainability.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust developed a five year strategic plan following the recent merger of Basildon University Hospital with Mid Essex and Southend University Hospitals to form Mid and South Essex NHS foundation Trust. The maternity service strategy was included with the trust's five year strategy.

The maternity service's strategy detailed the service's ambitions for the next five and was aligned to the local maternity board (LMB) strategy. The strategy spoke of close collaborative working with the LMB throughout. We did not see an action plan in place with actions assigned to individual staff members, to achieve the strategy.

The maternity service has its own vision of "working in partnership with women, empowering them to make informed decisions about their care, ensuring that it is personalised to meet their individual needs." Staff did communicate and plan care with the women individually, however, due to the concerns raised throughout our inspection we not assured that this was always achievable with the current standard of multidisciplinary working within the service.

Culture

The service did not have an open culture where staff could raise concerns without fear.

All staff we met during our inspection were welcoming, friendly and helpful. It was evident that staff were concerned about the recent cluster of serious incidents and wanted to improve the care they provided to women and babies. However, staff were very aware of the longstanding poor culture and safety concerns. They expressed to us the impact the longstanding poor culture had impacted on women and babies care and staff morale. Staff told us that some of the consultants and longer serving midwives were difficult to approach and support from medical staff was a struggle.

In May 2020, concerns for the safety of women and babies were raised by a whistle-blower to the CQC. During the focused inspection both staff and maternity senior leadership team (SLT) told us the poor culture had been present for a number of years. Although a new maternity SLT were in place from May 2020 actions to improve the long-term history of poor culture and ineffective multidisciplinary team working which had impacted on safety in the maternity unit, were in their infancy and not yet embedded. Therefore, we were not assured sufficient steps had been taken to address the culture issues prior to interim clinical director's appointment and our focused inspection.

All NHS trusts are required to nominate a freedom to speak up guardian (FTSUG). The role of the FTSUG supported staff who wished to speak up about a concern or issue and ensured that any issue raised was listened to and the feedback was provided to them on any actions or inactions because of them raising an issue. Most staff we spoke with were aware the trust had a FTSUG service and how to report their concerns if required.

In the last 12 months, FTSUG service had received three enquiries in relation to the maternity service. We were told that none of the concerns raised were in relation to safety. The SLT told us that following our inspection they will be raising staff awareness of the FTSUG service.

The trust executives told us that in May 2020, it was decided to bring in a new leadership to the maternity unit to support and develop an action plan to address the safety culture. The interim clinical director initiated daily safety calls on delivery suite and weekly meetings with the consultants.

Following our concerns raised to the executive team we received an action plan to improve the culture which contained the following for example: establishing regular staff forums, the development of a communication strategy to encourage staff to escalate concerns and involving external stakeholders for cultural support. However, these are all in their infancy and are not yet embedded.

Governance

Leaders did not operate effective governance processes to continually improve the quality of its services and safeguarding standards of care.

Whilst governance processes were in place these were not fully effective, there remained a lack of oversight from the senior leadership and executive team. A number of the issues identified during our focused inspection, were pre-existing issues that had already been highlighted at the February 2019 inspection. Requirement notices were issued in relation to these breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust developed an action plan in response to these breaches, submitted regular updates and closed the actions, however, we found at our focused inspections the concerns were still present. The actions put in place did not address or remedy the issues and the maternity governance did not identify issues with the quality of care being provided. The systems and processes that were in place to address the concerns from February 2019 had still not been embedded within the service.

The maternity service had a maternal death February 2019, which was investigated by HSIB and an action plan produced. The issues identified related to: incorrect interpretation of CTGs; failure to escalate risk from the midwives to medical staff; and failure to escalate risk from middle grade doctors to consultants. There were a further six serious incidents reported between January 2020 and April 2020. Five of these serious incidents identified the same failings of care. This demonstrated there had been a lack of learning from previous incidents and actions put in place were not embedded. Therefore, we were not assured that the governance and oversight of lessons learnt was robust enough to prevent similar incidents from occurring.

The head of midwifery (HOM) did not have direct access to the board and did not present to them regularly in line with 'Spotlight on Maternity' 2016. This was an area of concern that was raised at the February 2019 inspection for which a requirement notice was issued. The governance systems were not effective to ensure appropriate escalation, scrutiny and overall responsibility at board level.

We found concerns relating to the governance processes of incident grading and appropriate review. This was an area that was identified at the February 2019 inspection, for which a requirement notice was issued. Incident data reported by the trust from January to April 2020, demonstrated that incidents were not always graded correctly in accordance to moderate harm as stated in Regulation 20 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

The service had a formal governance structure in place. The maternity service was within the

women's and children's division. The clinical maternity governance and risk manager held responsibility for managing risk within the maternity services, including monitoring incident reports, compliance with learning outcomes, and actions resulting from serious incident reviews.

At our focused inspection we found a number of areas of concern within the structure of the maternity governance and risk management team. The clinical governance lead role was vacant. As an interim measure the clinical governance lead from paediatrics and gynaecology had been providing support to maternity and at the time of our focused inspection they had returned to their substantive role.

Maternity

At the time of the focused inspection there were a number of overdue investigation reports, action plans and open incidents. Information received from the trust following the focused inspection showed three serious incident investigations that were overdue (over 60 days), nine internal root cause analysis overdue, 11 external report recommendations overdue to be developed into action plans and/implemented, and 27 serious incident action plans overdue for closure. This meant the governance systems and processes in place were not robust to ensure timely review of incidents and sharing of lessons learnt.

Following the focused inspection, we were told that a group wide maternity governance and risk management structure had been developed. This was subject to a staff consultation, before it could be implemented.

The service held monthly clinical governance meetings. We requested the last three meeting minutes and we were provided with the minutes from November 2019, January 2020 and May 2020. We were not assured on the frequency and regularity of these meeting to monitor risk and governance within the service. In addition, the minutes showed that the head of midwifery was not present at any of the meetings and the risk lead for maternity was only present at the November 2019 meeting. We reviewed the meeting minutes which confirmed governance matters such as incidents, risks, performance, guidance, audits and complaints were discussed, however not all actions were clearly assigned to a member of staff with a deadline for completion.

The service held perinatal mortality and morbidity meetings. Following our focused inspection, the executive team told us that the interim clinical director had reviewed some of the cases discussed by the perinatal review group and had raised concerns about the decisions made by the group and sometimes the group was not quorate and hence the discussions and decisions would not be valid. Senior leaders confirmed that they had taken urgent actions and put new measures in place to address the concerns raised; by reviewing all the cases discussed since January 2020, and a review of the terms of reference of the perinatal mortality and morbidity review group.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively.

There were some processes in place to identify risk. The maternity service had a risk register and we saw that risks within the service were on the risk register. Risks were recorded and managed using the trust's electronic risk reporting system. All risks on the register were allocated to a member of staff responsible for reviewing and monitoring them. We observed the risk register and risks were in date and had been reviewed.

The service had reported compliance to the board and NHS resolution for safety action six compliance with the saving babies lives initiative 2016. However, from our review of the 12 maternity handheld records the service were not always monitoring carbon monoxide in line with the trust guidance in all of the records. Therefore, they were not compliant with the saving babies lives initiative 2016. Information provided post inspection stated that an electronic system for all antenatal bookings had been introduced in September 2019 from which reports were generated to monitor compliance. Data provided demonstrated that between November 2019 and February 2020 compliance was 90%, 86%, 88% and 86% respectively. Carbon monoxide testing should be offered to all pregnant women at the antenatal booking appointment with the outcome recorded (Saving babies Lives Care Bundle Version 2 2019). We were not provided with any additional evidence to provide assurance that this was regularly audited and reviewed or that actions had been taken to improve compliance.

Daily handovers included a briefing of any issues highlighted by managers. However, we observed that the handovers were not detailed, and qualified midwives did not attend the whole handover. Therefore, not all would not be aware of the risks discussed.

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The dashboard was not displayed in clinical areas, this meant that staff and the public were not informed of the outcomes and risks of the maternity service.

Maternity

We saw that the services dashboard was reviewed as part of the women's health clinical governance & risk group meeting. We requested the meeting minutes for these and reviewed three sets from November 2019, January and May 2020. We saw that the meetings also discussed incidents, complaints, guidelines, the risk register, and audits, however not all actions were clearly assigned to a member of staff with a deadline for completion.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations.

- The service must complete carbon monoxide screening in line with trust policy. Regulation 12 (2) (a)
- The service must ensure staff completed mandatory and safeguarding training with the trust target. Regulation 12 (2) (a)
- The service must ensure that the delivery suite daily handover is fully attended, situation, background, assessment, recommendation (SBAR) format is used for all women, they are referred to by name and the afternoon board round is attended and documented. Regulation 12 (2) (b)
- The service must ensure the delivery suite coordinator is always supernumerary. Regulation 12 (2) (b)
- The service must ensure multidisciplinary team working is improved. Regulation 12 (2) (b)
- The service must ensure that the medical staff competencies are reviewed and up to date. Regulation 12 (2) (c)
- The service must ensure that appraisals are comprehensive and assess staff competencies. Regulation 12 (2) (c)
- The service must ensure that all records are kept securely. Regulation 17 (2) (c)

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

- The service should ensure weights are documented on prescription charts.
- The service should display safety information.

Our inspection team

The team that inspected the service comprised an of inspection manager, a lead inspector and specialist advisor. The inspection team was overseen off site by Mark Heath, interim Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Section 29A HSCA Warning notice: quality of health care

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8 October 2020	ITEM: 6
Thurrock Council Health & Wellbeing Board	
SEND Inspection Outcome - Written Statement of Action Update	
Wards and communities affected: All	**Key Decision:** Key
Report of: Michele Lucas, Assistant Director, Education and Skills	
Accountable Assistant Director: Michele Lucas, Assistant Director, Education and Skills	
Accountable Director: Sheila Murphy Corporate Director Children's Services	
This report is Public	

Executive Summary

This report sets out an overview of the work regarding the Written Statement of Action (WSoA) around SEND to the Health & Wellbeing Board. The report also provides evidence in relation to outcomes as a result of the work that has been undertaken to address the areas of concern, as well as an update on our ambitious stretch SEND targets.

Whilst the report will focus on the WSoA, a wider system approach is being adopted, to ensure that we are listening to parents/carers and young people in the delivery of SEND services and providing learning opportunities that meet the needs and aspirations of our children and young people.

Outlined below are the WSoA Ofsted identified:-

- Inaccurate and incomplete records and ineffective oversight mean that leaders did not know the whereabouts of some children and young people and what provision they have.

- Quality assurance is not rigorous enough to ensure effective governance and oversight across the provision and services for 0 to 25-year-olds with SEND. Leaders are reliant on working relationships rather than processes. Leaders are over reliant on the limited information given to them by educational providers about the quality of the provision they purchase.

- EHC plans and the annual review process are of poor quality. The local authority has no system in place to make sure that relevant professionals and services are notified when EHC plans need reviewing or updating.

Professionals are not routinely informed of requests to submit written information within specified timescales. Too often, EHC plans are out of date and do not accurately reflect the needs or views of children and young people, or the views of the families. The information from EHC plans and annual reviews is not used to inform the commissioning of services, particularly, but not exclusively, for young people between the ages of 19 and 25 years.

1. Recommendation(s)

1.1 Health & Wellbeing Board to scrutinise the work that has been undertaken during this period and offer challenge and support.

2. Introduction and Background

2.1 This report outlines the work that has been undertaken in addressing the areas of concern within the SEND WSoA.

2.2 The SEND Improvement Board, chaired by the Portfolio Holder for Education, is overseeing both the WSoA and the wider issues identified within the inspection outcome letter. The SEND Operational Group provides regular updates to the SEND Improvement board, which in turn reports back to Children's Overview & Scrutiny and the Health & Wellbeing Board.

2.3 As a result of COVID 19, we have reported to the SEND Improvement Board, some areas of the plan that will not be met within the timescales. The Ofsted Inspection programme was suspended for six months. Ofsted have reintroduced inspections, although these are focussed on safeguarding and do not include currently include the full inspection framework. At this point it is difficult to predict when our reinspection will take place, however we remain focussed on addressing the areas of weakness.

3. Issues, Options and Analysis of Options

3.1 The Council has a statutory duty to support SEND children and young people and as such we are working on ensuring that the whole system approach is taken to ensure smooth transition pathways for children. One of the key areas that was identified by Ofsted, related to systems and how they worked together. Phase one of the systems work has been completed and we now have a single view of education and skills data.

3.2 A number of key actions and outcomes are reported below:-

- Phase one of the data integration project has been completed this will enable a single view of education and skills data to be viewed. The Synergy system will support routine data reporting to support data clean up and performance management.
- Phase 2 of this development will support development off an electronic EHCP that can be accessed via a portal, this transformational piece of work will enable

us to meet some of our stretch targets. We are working closely with the provider to develop a project action plan with timelines and implementation.

- All specialist provision providers have been through a quality assurance framework a report has been represented to the SEND Improvement Board. This work is being used to inform discussions with the providers and changes to the educational offer where necessary.
- An EHCP Quality assurance process has been introduced so that a sample of plans are audited monthly and the learning is shared with contributors to the plan to support continued improvement and inform the training to both our SEND team and SENCO's in schools to ensure continuous improvement.
- 16-18 year olds Not in Education Employment or Training/Unknown is currently at 4.8% which is significantly below the Eastern Region of 7.9% (March 2019 is the latest comparative data) and National of 10% (March 2019 is the latest comparative data)
- 16-25 year olds Not in Education Employment and Training is currently at 7.5%.
- Work around participation and engagement has been challenging due to a number of reasons these include COVID 19 and the recent decision by CaPa to dissolve the parent partnership. We are working closely with Contact the national infrastructure organisation to support the development of a new parent/carer forum. We have continued to work closely with parents around our preparing for adulthood strategy and this group have informed some of the work we have committed to around transition into adult services.
- 79% of EHCPs were finalised within statutory timescales. Due to Covid, some EHCPs could not be finalised within timescales. The Government temporarily changed the law to give local authorities more flexibility around timelines for EHCPs due to the redeployment of health colleagues, schools partial closures and the inability for meetings to take place. The temporary changes to the law will expire on 25 September.
- During the partial school closures, children with EHCP could attend school. however, many parents chose not to send their children to school
- All SEND caseworkers have continued to receive bi-weekly training via MS Teams. We have also delivered face to face induction and training for the recently appointed caseworkers and they now have their own case-loads. The additional staff has allowed us to redistribute case-loads. Each full-time caseworker now has a caseload of 150 cases, which is significantly lower than at the time of the inspection. This will result in an improved service.
- There was only one stage 1 complaint reported this quarter and two compliments were received.
- Analysis of the feedback gathered via the EHCP feedback portal and random telephone survey, demonstrates that there is improved satisfaction in parents, children and young people with the EHCP process

Stretch Targets

Thurrock is ambitious and has set some additional targets these are outlined below:-

1. Reduce number of weeks for EHCP process to 16 weeks in 2021 – this timescale will need to be reviewed in lighted of COVID 19 and is linked to the

work around the on line EHCP portal which will not be fully operational until the end of 2021.

2. Responding to calls within 48 hours – the significant investment in both staff and telephone systems has meant we have met this target and this has led to a decrease in the number of complaints to the service.
3. Completing annual review paper is linked to the on line portal and as such the stretch target will be reviewed as we develop the project and implementation plan for the EHCP portal.

4. Reason for Recommendation

4.1 The Health & Wellbeing Board have a clear and accountable governance responsibility around supporting children with additional needs, and agreement was made to bring an annual report to the board. We are asking for the support of the Health & Wellbeing Board to enable us to progress with our improvement journey. We would ask committee member to consider how they would like us report back on progress.

5. CONSULTATION (including Overview and Scrutiny, if applicable)

5.1 Children's Overview and Scrutiny Committee

6. IMPACT ON CORPORATE POLICIES, PRIORITIES, PERFORMANCE AND COMMUNITY IMPACT

6.1 This report contributes to the following corporate priorities:
- create a great place for learning and opportunity

7. IMPLICATIONS

7.1 Financial

Additional resources have been identified to ensure that we implement the change programme that is being developed to support children with special needs. This will be monitored alongside the written statement of action to ensure that they have been targeted in the appropriate place to see improved outcomes for children and young people.

In addition, the Dedicated Schools Grant has prioritised resources to support the improvement plan and respond to the increase demand in EHCP.

Implications verified by: David May Strategic Lead Finance
dmay@thurrock.gov.uk

7.2 Legal

The Committee is asked to note the report content under the remit of the Committee's terms of reference and powers.

Implications verified by: Lindsey Marks, Deputy Head of Legal
Lindsey.marks@lbbd.gov.uk

7.3 Diversity and Equality

Supporting our children and young people who have special education al needs is a key strategic priority for Thurrock Council. We have recently redesigned our work around how we engage with children young people and parents/carers who require additional support. To support with this work we have recently recruited an engagement officer who will be working with local stakeholders to enable us to gain feedback and how we can ensure it is linked to the service transformation that we are undertaking.

Implications verified by: Becky Lee, Team Manager – Community Development and Equalities
rlee@thurrock.gov.uk

7.4 **<u>Other implications</u> (where significant) – i.e. Section 17, Risk Assessment, Health Impact Assessment, Sustainability, IT, Environmental**

None

APPENDICES TO THIS REPORT:

None.

Report Author Contact Details:

Michele Lucas
Assistant Director, Education and Skills

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8 October 2020	ITEM: 7
Thurrock Health and Wellbeing Board	
Economically Vulnerable Task-Force	
Wards and communities affected: All	**Key Decision:** None
Report of: Cllr Halden, Portfolio Holder for Children and Adult Social Care and Chair, Thurrock Health and Wellbeing Board	
Accountable Head of Service: Roger Harris, Corporate Director, Adult's Housing and Health	
Accountable Director: Roger Harris, Corporate Director, Adult's Housing and Health	
This report is Public	

Executive Summary

Following the initiative of the Portfolio Holder for Adult and Children Social Care an officer task force was established to ensure that those groups who may be described as economically vulnerable did not get overlooked as Thurrock addresses the problem of the economic downturn caused by COVID.

This group, chaired by Cllr Halden, has met on three occasions and has focussed on care leavers and adults close to the adult social care system (whether through a learning disability or mental health need) who have traditionally found it difficult to access paid employment.

The group has started by looking at the statistics and what support there is out in the community currently and where it could be strengthened. It has worked closely with the Economic Regeneration team and the Department for Work and Pension (DWP) initially.

At the same time, Thurrock has been working on its wider strategy to support the local economy recover and the report attached at Annex A: "**Backing Thurrock A Five Year Strategy for Economic Recovery, Resilience and a Return to Growth"** was agreed at Cabinet on 16th September.

This will also feature as one of the key work streams in the development of our new Health and Well-Being Strategy 2021–26, the work for which has just got underway.

Finally, we have worked closely with the community and voluntary sector – principally "The World of Work Project" run by Thurrock Community Network to ensure we understand the full picture from their perspective.

1. Recommendation(s)

1.1 It is recommended that Board members note the content of this report and agree to a further progress report in six months' time.

2. Introduction and Background

2.1 An officer task force has been established to ensure that those groups who may be described as economically vulnerable did not get overlooked as Thurrock addresses the problem of the economic downturn caused by COVID.

2.2 The task force has identified:

Claimant Count for Thurrock

2.3 The Claimant Count for Thurrock is provided at Annex B. Headline figures include:

- The claimant count rate (for 16-24 year olds) rose by 0.4% in Thurrock between July and August 2020, compared to a 0.2% national rise.
- The Thurrock male claimant rate rose by 0.4% between July and August 2020, compared to a 0.2% national rise.
- The Thurrock female claimant count rate rose by 0.3% between July and August 2020, compared to a 0.2% national rise. The 1.1% gap is the widest over the whole two year period.
- The Thurrock and national claimant count rates rose by 0.1% between July and August 2020.

Support for Adults

2.4 Adult Social Care are acutely aware of the challenges that are facing the wider population and more specifically vulnerable people regarding economic vulnerability. Under the Care Act 2014 we have a duty to offer information and advice together with ensuring that early intervention and prevention support is available. The Economically Vulnerable Taskforce has afford the opportunity to raise the profile of meaningful occupation for those who receive our services and for those in the wider community.

2.5 We have ensured that information and advice is available for those who contact adult social care, we have worked with our Local Area Coordinators who are at the centre of our communities to support vulnerable people before they come to services making sure that information and support is available. Our lead for Micro Enterprise development has actively shared information and will offer support to any vulnerable person considering setting up their own Micro Enterprise business. Our Community Led Support Social Work Teams are now based within their local areas and as such are able to offer more locally focused information and advice.

2.6 A great deal of work has been undertaken with unpaid carers who often struggle to maintain employment or return to work. We have developed an App to support both carers and employers to assist with employment, this is just about to be launched. We are also identifying those who access services and are either in paid employment or undertaking volunteering. We have 41 people in paid employment excluding mental health and within mental health services we have 28 people in paid employment and 11 people actively seeking work. Small numbers but when we consider that those who receive adult social care services in the main have high levels of need these are really positive figures.

World of Work

2.7 The World of Work is a service provided by Thurrock Centre for Independent Living to support people with learning disabilities and mental health challenges. They provide courses to prepare people for employment or volunteering, individual support with CV writing and interview preparation together with job coaching. The service is very highly valued and has had very positive success. Through the Economically Vulnerable Taskforce we were able to identify additional one off funding for this provider to increase the services available which has been positively received and increased the provision.

Support for young people and care leavers. The Inspire Youth Hub - Skills Offer

2.8 Inspire is our integrated youth hub that support vulnerable young people including Care Leavers, SEND and the YOS – the offer if outlined below:-

- Provides a drop in careers service for young people in Thurrock aged 16 to 18 and up to 25 with Special Education Needs and Disabilities (SEND). The service is delivered by Career advisers who additionally provide a traded careers service to 80% of schools in the borough.
- Houses employability Programme ‘Gaps’ run by TCHC for NEET young people in Thurrock
- Delivers Functional Skills tuition to NEET and at Risk of NEET Looked after Children and Care Leavers.
- Offers mentoring and young people focussed activities.
- Offers outdoor earning programmes at Grangewaters.

2.9 In response to current government advice, Inspire Youth Hub will modify its delivery model to provide:

- An alternative careers provision via digital means and telephone one to one interviews. All NEET young people have been contacted to update them on the new method of delivery. During the following weeks all NEET young people have been contacted by a Careers Adviser individually to provide support in seeking employment, education or training, a detailed Career Action Plan will be produced. Career

advisers are responding to new Labour Market Information whereby new employment opportunities are emerging in the logistics, distribution and food retail sectors offering instant employment to young people.

2.10 Additionally, Career Advisers have been assisting Preparing for Adulthood obligations. The meetings have been conducted over the phone, health Advisers contacting the 398 16+ Year old young people with an EHCP to ensure we have updated their intended destinations, complete a Preparing for Adulthood Action Plan and produce a review of their Annual Education, Health and Care Plan (EHCP) in line with statutory and social care input will be added – this methodology will ensure all vulnerable young people have had an education setting in place for September 2020 and all necessary support secured.

2.11 TCHC 'Gaps' provision has moved to an online offer in response to DfE advice and provision of tuition has moved to digital platforms. Learners without access to computers have been provided with laptops.

2.12 Functional Skills Tuition to NEET and at Risk of NEET Looked after Children and Care Leavers will moved to digital platforms. Where possible; home tuition packs have been prepared and self-addressed envelopes obtained to aid the process of homework marking where digital means are not viable.

2.13 Headstart Housing has continued to offer high quality accommodation with the additional benits around the integrated youth offer. The Headstart Housing team have visited young people and provided help and support where required. A key strand of this work relates to skills and young people have been in regular contact with the Personal Advisors who support them with developing the confidence and skills base to Access College or employment.

2.14 Employment will be a key challenge and to address this we are looking at the new government scheme Kick Start to ensure that we can offer opportunities to our vulnerable groups.

2.15 Emotional wellbeing is a key strand of our integrated approach and we have developed an on line resource this task was undertaken by our school wellbeing service and has been sent to vulnerable young people.

2.16 Grangewaters has offered a new Programme for SEND learners – the programme was designed by young people and initial feedback is positive.

3. Next Steps

3.1 Next steps will include:

a. Continuing the work of the sub-group.
b. Working alongside Economic regeneration team;
c. Build stronger links with DWP;
d. Reporting progress to the Board in 6 months' time, subject to the Board's approval.

4. Reasons for Recommendation

4.1 To ensure Thurrock Health and Wellbeing Board members remain sighted on progress and provided with opportunities to influence the work of the Taskforce.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Not applicable

6. Impact on corporate policies, priorities, performance and community impact

6.1 None at this stage given this is an early report on the work of the Economically Vulnerability Taskforce

7. 7. Implications

7.1 **Financial**

Implications verified by: **Roger Harris, Corporate Director, Adult's Housing and Health**

None at this stage given this is an early report on the work of the Economically Vulnerability Taskforce

7.2 **Legal**

Implications verified by: **Roger Harris, Corporate Director, Adult's Housing and Health**

None at this stage given this is an early report on the work of the Economically Vulnerability Taskforce

7.3 **Diversity and Equality**

Implications verified by: **Roger Harris, Corporate Director, Adult's Housing and Health**

None at this stage given this is an early report on the work of the Economically Vulnerability Taskforce

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- None

9. Appendices to the report

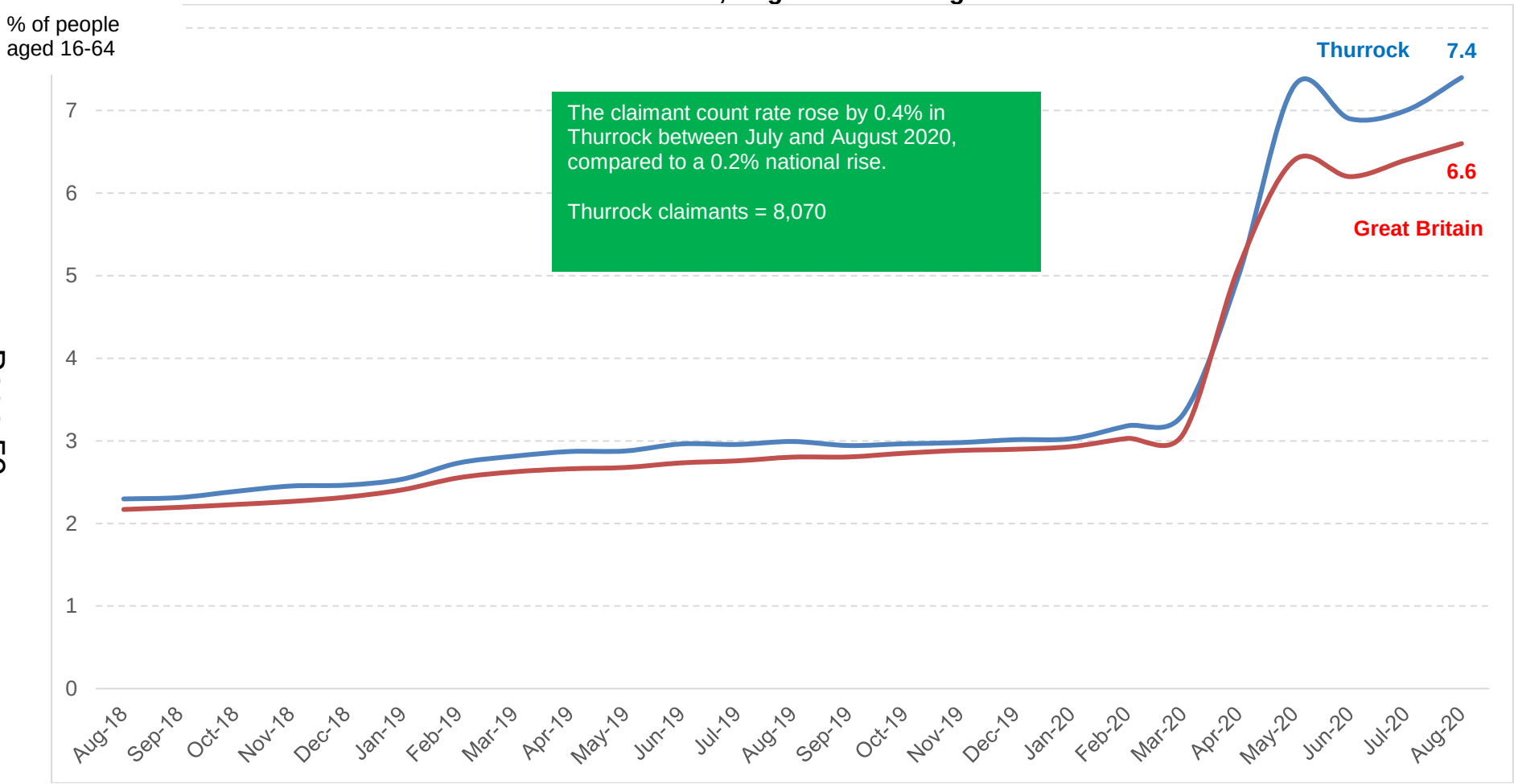
- **Annex A** – Thurrock Claimant Count
- **Annex B** - Backing Thurrock A Five Year Strategy for Economic Recovery Resilience and a Return to Growth (attached separately)

Report Author/Coordinator:

Darren Kristiansen
Business Manager, Adult's Housing and Health

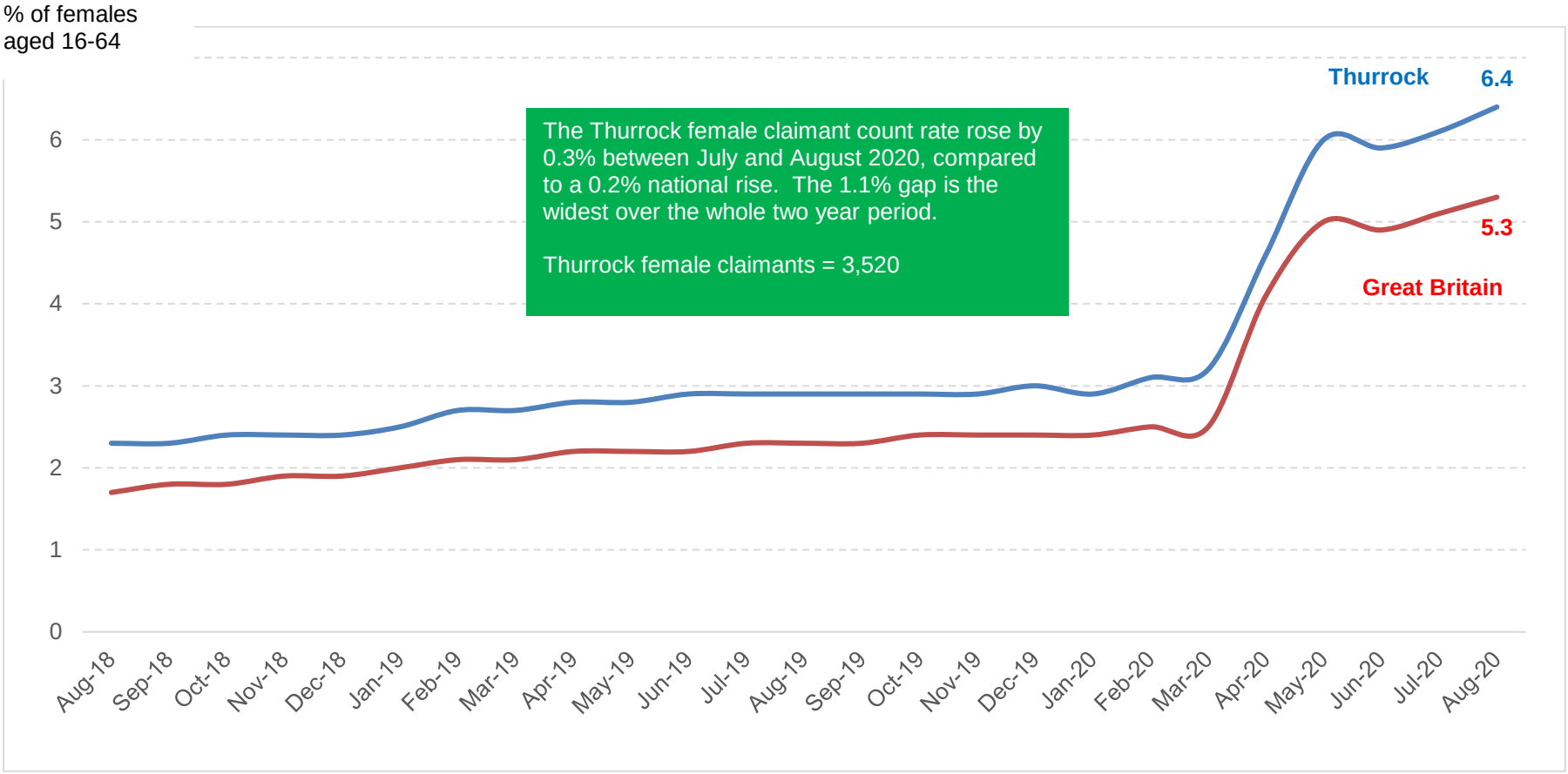
Annex A

Claimant count, August 2018 – August 2020

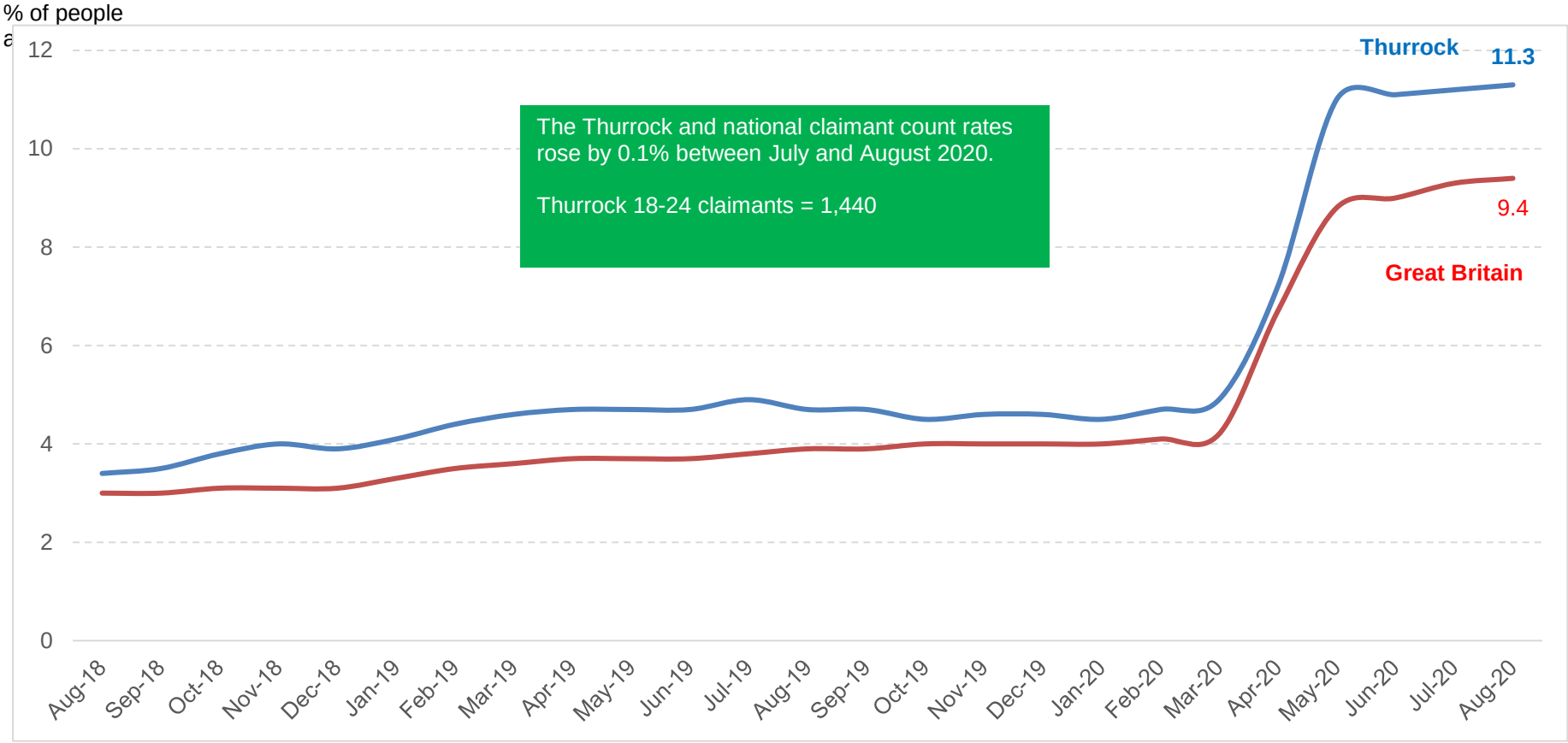


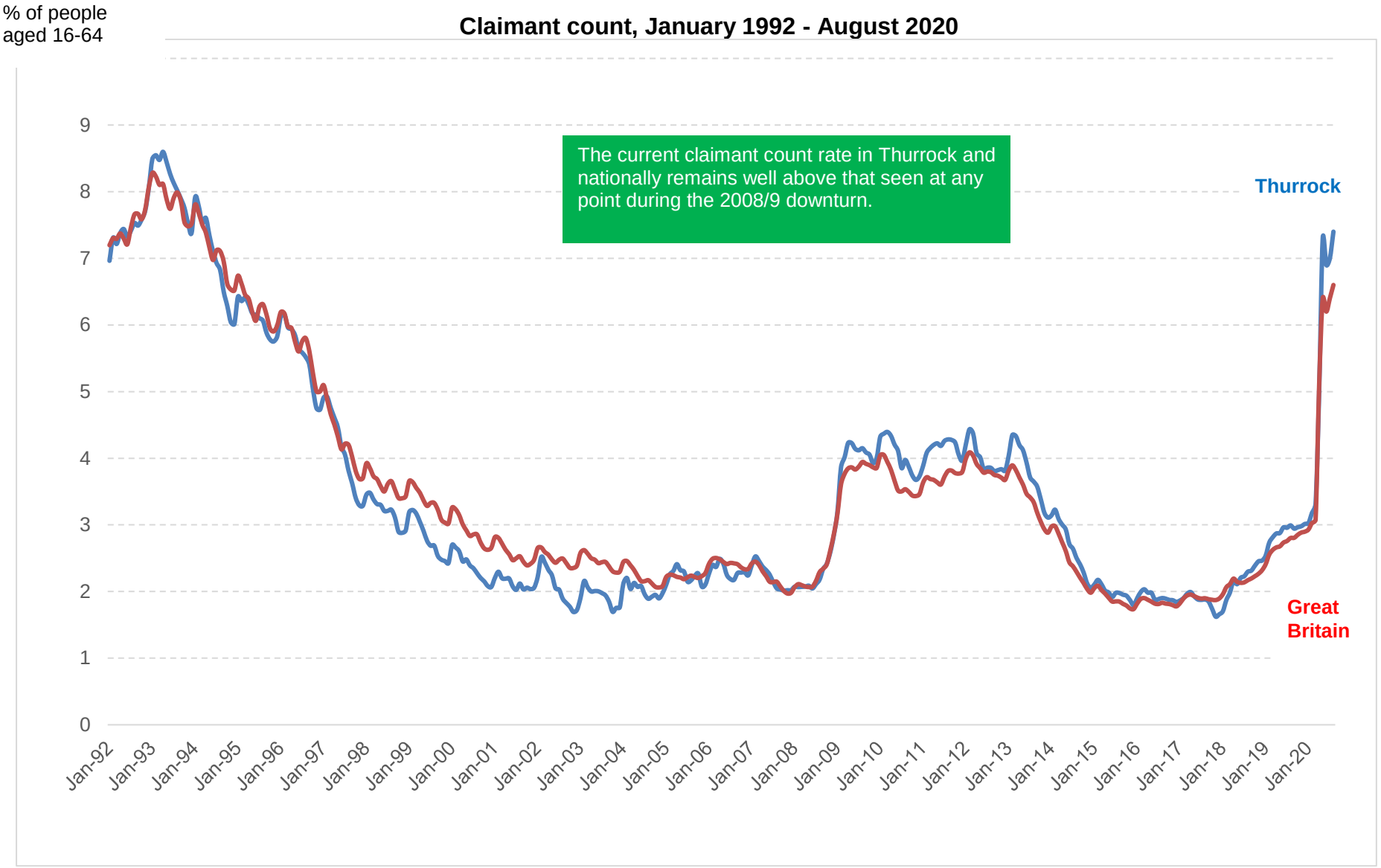
Claimant count - male, August 2018 – August 2020

Claimant count - female, August 2018 – August 2020



Claimant count – 18-24 year olds, August 2018 - August 2020




% of people aged 16-64
Claimant count, January 1992 - August 2020
The current claimant count rate in Thurrock and nationally remains well above that seen at any point during the 2008/9 downturn.
Thurrock
Great Britain
9
8
7
6
5
4
3
2
1
0
Jan-92
Jan-93
Jan-94
Jan-95
Jan-96
Jan-97
Jan-98
Jan-99
Jan-00
Jan-01
Jan-02
Jan-03
Jan-04
Jan-05
Jan-06
Jan-07
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Jan-10
Jan-11
Jan-12
Jan-13
Jan-14
Jan-15
Jan-16
Jan-17
Jan-18
Jan-19
Jan-20

Claimant count numbers, Thurrock (Aug 2018–Aug 2020)

Month/year	N	%
August 2018	2,500	2.3
September 2018	2,520	2.3
October 2018	2,600	2.4
November 2018	2,670	2.5
December 2018	2,685	2.5
January 2019	2,760	2.5
February 2019	2,975	2.7
March 2019	3,065	2.8
April 2019	3,125	2.9
May 2019	3,135	2.9
June 2019	3,225	3.0
July 2019	3,220	3.0
August 2019	3,260	3.0
September 2019	3,205	2.9
October 2019	3,230	3.0
November 2019	3,245	3.0
December 2019	3,280	3.0
January 2020	3,295	3.0
February 2020	3,465	3.2
March 2020	3,585	3.3
April 2020	5,470	5.0
May 2020	7,975	7.3
June 2020	7,565	6.9
July 2020	7,685	7.0
August 2020	8,070	7.4

Note: Figures for the last month are provisional and subject to revision. The July Thurrock claimant figure was revised down by 90, with the rate revised down by 0.1%. along with the August release.

There was a provisional rise of 385 claimants between July and August 2020.

Claimant count by ward, August 2020

Rank by rate	Ward	Claimant count - N	Claimant count - % 16-64 year olds
=1	Belhus	790	11.5
=1	Tilbury St Chads	480	11.5
3	Tilbury Riverside and Thurrock Park	525	11.2
4	Chadwell St Mary	525	8.7
5	Grays Riverside	790	8.6
6	West Thurrock and South Stifford	740	8.0
7	Ockendon	545	7.4
=8	East Tilbury	330	7.3
=8	Grays Thurrock	455	7.3
=10	Aveley and Uplands	470	7.2
=10	Stanford East and Corringham Town	355	7.2
12	Little Thurrock Blackshots	245	6.4
13	Stifford Clays	240	6.1
14	Stanford-le-Hope West	265	5.9
15	Chafford and North Stifford	300	5.3

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Economically Vulnerable Task-Force
Snapshot of minutes and discussion points from meetings

September 2020 meeting

Item 2 - Feedback on advice, reaching out to edge of care people and Corporate Comms
Aspire is open for the most vulnerable
Why not fully open – front door not open – will look at satellites hosted in different borough schools
OT very well embedded with Aspire
Ot attendance 90% - 20% above national
Adults refocusing on supporting micro enterprises
App for unpaid careers to support them
LD services returning well

Item 3 - The YOS and how we protect the vulnerable from gangs etc in a recession.
YOS has "Red balloon" service commissioned, using police data to identify areas of high need.
Working with Aspire. OT to link in.
OT to report back about how young people's perception is changing about their economic opportunities as they get to the end of their time at the PRU.

Item 4 - Olive Trust and how we can work with the PRU to support those most at risk in a recession
Further update to be given at the next meeting.

Item 5 - DWP and recovery plan
Dwp has done a care survey – will share data
DWP data sharing is good. Need more specific data in different sectors.
Key risk is there are a lot of programs, need to make sure they link.
Kickstart is a big opportunity for SEND.
DWP committed to attend ASB.

August 2020 meeting

Item 2 Update on outreach lists, feedback on advice offered

- More working has been done to support caregivers as a new work stream.
- More outreach is being done to offer respite for adults and children's, but more needs to be done.
- GCSE and A-Level result issues have caused real issues. Aspire has offered one to one support here. Vital to protect Aspire funding in the budget round.

Item 2.1 Expanding the "edge of care" and care provider list

- Working with local area coordinators to increase their knowledge base etc, as well as Thurrock First. More to be done in Sept/Oct. CW trying to do more to quantify numbers here.
- Youth teams working with young people based on school referrals. Aspire reopening for face to face work.
- CW and ML to link LAC's and Youth Teams.

Item 3 "World of work funding" and needed capacity

- WOW funding restored to March 2021. RH meeting to talk about targeting. Capacity needs still emerging.
- CCG funding their own plan. Still information on this.

Item 4 and item 5 DWP Data sharing

- Still no DWP attendance. Not good enough! S Taylor missing, so not update on recovery plan with regards to the vulnerable. ML to chase for next meeting.

Item 4.1 Corporate communications of advice

- RH to action. Need to ensure corp comms reflects this agenda.

Item 6 Emerging housing breakdown data

- With housing protection extended, we have little data to indicate scale of issue.
- Head Start housing only has 10% capacity, but we do have some additional covid housing. More work is being done to look at cross departmental commissioning for high end placements.
- Need to make sure all of these housing options are captured within the transition plan. CW and ML to engage with Joe Tynan.
-

Item 7 Adult training budget issues / getting younger people into care profession

- Adult college reshaping Sept offer. Looking at how we can support the creation of care jobs.

Item 8 Concerns from Safeguarding Boards

- No specific concerns coming up.

July 2020 meeting

Item 2 Update on outreach lists and feedback on advice and support offered

- We have 630 care leavers, SEND and NEET young people we are reaching out to
- Feedback remains limited
- Mental health info now being issued
- 850 service using adults being reached out to
- Feedback limited at the moment, mainly via LAC's
- Need to consider care givers – Michele and Catherine
- Need data on quality jobs and opportunities, not just quantity
- Need to ensure people are aware of there entitlements i.e. UC

Item 3 Finding / reaching out to "edge of care" people

- Still have a gap in terms if data / info sharing with DWP – S Taylor to chase
- Corporate communications (email and paper) are vital. Need to make sure the advice is getting out. Roger Harris to action.

Item 4"World of work funding" and other support for adults

- Will fund "world of work" via remaining covid funds. Need to asses if this is enough with the increased demands – Roger to action.

Item 5 Enhanced recruitment for jobs in adult and child social care

- Concerns are with the adult training and skills budget – Michele to look into
- Course in adult colleges to increase interest in care jobs is key – Michele to look into

Item 6 How wider recovery work can support care leavers and the vulnerable

- Refreshed economic development plan must contain clear intentions towards care leavers, SEND, and learning disabled – S Taylor to action.
- Future meeting (maybe Sept) should include regen colleagues in terms of bringing local plan / housing plans forward for job creation

Item 7 Emerging housing / employment breakdown data

- No info yet on EVT cohort presenting to the council for housing.
- August 23rd key due to housing protections ending. Must review – Roger.
- Head start housing 79% occupied – scale up? – Michele to review

Item 8 Concerns from Safeguarding Boards

- No concerns from children board
- Written comments from Jim are as follows –
    - 1. Despite a general reduction in recorded crime levels, incidents of domestic abuse have started to increase, with further rises anticipated. This is true in Thurrock as well as wider Essex and the Region.
    - 2. We are concerned about the possible increase in the level of drug-related activity during the lockdown, including County Lines and cuckooing. I have

asked police if they still maintain indications of price/purity of key drugs such as heroin and cocaine. You will appreciate that these are good indicators of the sufficiency of supply for these main drugs. It used to be the case that Thurrock had a significant under-use of these Class A drugs, but that is no longer the case.

- 3. Whilst not seen in Thurrock, in Southend and in parts of London, victims of modern slavery have been “released” by their captors as they haven’t been able to generate any income for them. They have been picked up roaming the streets, having been made homeless. As you know we maintain a vigilant approach to modern slavery.
- 4. We are also concerned about the activities of scammers and have some limited anecdotal evidence of scams being conducted on a pan-Essex basis. You will be interested to know that the Board has funded a project which provides suitable individuals in Thurrock with a free service to get registered with Lasting Powers of Attorney, which can be seen as a preventative response for the more vulnerable.
- Roger suggested the EVT work go to O&S

June 2020 meeting

Full group in attendance

Item 2 Pulling together the list of those care leavers, soon to be care leavers, and other vulnerable adults ie LD

- Need report at next meeting on a separate adults list (over 25) - MH, Drug, LD, LAC –. Catherine to own.
- NEET groups to be added to Micheles list.
- Edge of care issues is the biggest risk. Michele and Catherine to cast a wide net and feed back.
- A big issue is the "world of work funding" – we want it. £30,000 loss from the CCG. Roger to consider with JH.
- Duplication risk with economic group of Steve Taylor's. Ask Steven to attend the next meeting. Cllr Halden to own.
- Catherine and Michele to link and jointly report at next meeting.

Item 3 The advice emails and monitoring feedback

- Focus groups for up to 25 year olds being held to consider the quality of advice. Report for next meeting. Michele to own.
- Need to check employment advice is considered alongside care act obligations. Roger / Catherine to own.
- Ask Steven Taylor to outline what we can do with the apprenticeship levy to support people / focus on retraining. Possibly lobby government. Cllr Halden to own.

Item 4 Any information on National figures and planning assumptions for economically at risk children and young adults

- Claimant count increase very alarming. Must focus our own apprentice's opportunities at the most at risk where possible. Michele to own.
- Care market is an option. Enhanced recruitment is needed. Possibly targeted work based on higher claimant count wards. Should work with DWP. Roger to own.

Item 5 Emerging concerns from the Safeguarding Boards

- Edge of care / unknown need remains the big concern. Actively asking boards to consider this.
- Children will be more vulnerable to criminal exploitation. Police involvement remains a mixed picture. Thurrock young people being in other borough gangs makes it difficult. Cllr Halden to lobby the PCC to make sure we keep a close focus on the vulnerable.

Item 6 What Consideration can we give to the adults in care / edge of care etc who are not economically active

- ESA remains too high compared to other forms of benefits. Invite DWP to this forum. Roger to get a contact to Cllr Halden to issue an invite.

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8 October	ITEM: 8
Thurrock Health and Wellbeing Board	
SET LeDeR End of Year Report	
Wards and communities affected: all	**Key Decision:** Acknowledgement of Report
Report of: Rebekah Bailie, Integrated Learning Disability Health Commissioner (acting on behalf of Collaborative Forum of CCGs and LAs across SET)	
Accountable Head of Service: Not applicable report produced by Council Partner	
Accountable Director: Roger Harris, Corporate Director Adult's Housing and Health	
This report is public	

Executive Summary

The LeDeR End of Year Report and accompanying documents highlight the issues impacting on people with Learning Disability and their premature deaths. People with learning disability across Southend Essex and Thurrock die on average 20 years younger than other people in the population and experience health inequalities which impact on their quality of life.

A joined-up approach between all aspects of health and social care must be taken to address the issues raised. The LeDeR Action Plan 2020-2021 outlines the priorities for the year and has been agreed by the LeDeR Steering Group and the Health Equalities Board, both of which have representation from Thurrock.

1. Recommendation(s)

1.1 To acknowledge and agree the LeDeR report and action plan

2. Introduction and Background

2.1 LeDeR is a national programme which was implemented across SET from September 2017. All deaths of people with learning disability from 4 years upwards are reviewed. Deaths of children and young people 4 – 18 years are reviewed by the Child Death Review Team and the recommendations incorporated into the overall LeDeR information. Deaths of adults 18 years and above are reviewed by a dedicated team of reviewers managed by the Integrated LD Health Commissioning Team.

2.2 Between the beginning of the programme in SET and the end of the 19-20 year there were 272 deaths of people with Learning Disability. At the end of March 137 reviews had been completed with 318 recommendations identified. (These are summarised by organisation and cross-system issues in the LeDeR Themes document)

2.3 Pneumonia is the leading direct cause of death (on part 1a of a death certificate) often as part of a pattern of early frailty and deterioration (45 years onwards). Aspiration pneumonia (caused by swallowing difficulty) was the second cause and cancer the third. Underlying cardiac issues were prevalent and need further investigation.

2.4 More people with learning disability die in hospital than in the rest of the population and there needs to be earlier and better end of life planning.

2.5 We have a small number of people from BAME backgrounds and need to have better understanding and representation of issues which impact. All but one of the BAME deaths were of children.

2.6 Most care was good or satisfactory. There are some examples of excellent care, but a similar level of very poor care which impacted on the death. We need more established processes to alert quality and safeguarding issues to councils and CCGs.

2.7 The details of the LeDeR findings can be found in the End of Year Report and the data for Thurrock can be found in the supporting data.

3. Issues, Options and Analysis of Options

3.1 Having analysed the recommendations and identified themes, the key areas for priority were identified as:

3.1.1 Annual Health Checks – all people with learning disability over the age of 14 years should receive an LD Annual Health Check.

3.1.2 Frailty – all parts of the health and social care system need to work together to identify, prevent and manage early frailty in people with LD

3.1.3 Dynamic Support Register – Essex Learning Disability Partnership – provider of specialist LD health services have been commissioned to develop this DSR for their caseload and to broaden this to include information from all other agencies.

3.1.4 Care coordination – it is vital for someone to have an overview of the person's health and wellbeing, liaising across health and social care to ensure there is a joined up assessment of need and plan for delivery. ELDP will start a pilot this year and expand.

3.2 The details of the deliverables and outcomes for the priorities can be found in the LeDeR Action Plan.

4. Reasons for Recommendation

4.1 It is recommended that the Board acknowledge and agree the LeDeR Report and Action Plan in order to make meaningful change for the people with Learning Disability in Thurrock.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The Report has been presented to the SET Experts by Experience Forum and a representative from Thurrock attended this and the Health Equalities Board.

5.2 Representatives from Thurrock CCG and Adult Social Care are invested in the LeDeR programme and attend the Steering Group, Quality Panel and working groups.

6. Background papers used in preparing the report

This report is the presentation of:

a) SET LeDeR End of Year Report 2019-20
b) SET LeDeR Action Plan

Also see accompanying documents for further detail and information

c) SET LeDeR Themes 2019-20
d) Supporting data

7. Appendices to the report

LeDeR%20End%20of%20Year%20Report	LeDeR%20Action%20Plan%2020-21v6.xls	LeDeR%20Themes%202020-21.docx	LeDeR%2019-20%20Appendix%201%20-

Report Author:

Rebekah Bailie

Integrated LD Health Commissioner and LeDeR Local Area Coordinator

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Southend Essex and Thurrock LeDeR Mortality Review End of Year Report 19-20

Executive summary

The LeDeR programme is now well established across Southend Essex and Thurrock (SET) and a local backlog of cases has been completed. The 2018 backlog of 98 cases is being managed by a CSU commissioned by NHSE.

Across SET, people with Learning Disability are still dying 20 years younger than the rest of the population and experience health inequalities because of their learning disability.

Pneumonia and respiratory issues are the leading direct cause of death, often as part of a pattern of frailty and deterioration.

There have been examples of excellent practise which show that it is possible to deliver outstanding care, but also instances where people did not get the care their required. In a few cases the poor care impacted directly on the cause of death of the individuals.

Some progress has been made against the 19-20 action plan including a review of DNACPR policy in acute hospitals, the establishment of Learning Disability Strategic Forums in CCGs, Easy Read resource pack for Annual Health Checks. However, in terms of delivering the whole action plan, complex engagement across a number of different footprints and organisations has been a challenge.

In 20-21 we are in a good position to achieve KPI compliance and will focus on 4 priority areas:

- Annual Health Checks
- Frailty
- Dynamic Support Register
- Case Management

Introduction to the LeDeR programme

The LeDeR programme aims to review all deaths of people with Learning Disability aged 4 years and upwards in order to identify health inequalities and issues which contributed to early or preventable deaths. The learning is to be used to change the system and raise the age at which people with Learning Disability are dying.

The LeDeR programme started in Southend Essex and Thurrock (SET) in September 2017 and since Jan 2019 has been managed through the Learning Disability Health Equalities Team, which works on behalf of the SET Collaborative Forum made up of 7 CCGs and 3 Local Authorities.

SET has almost a third (271/900) of the LD deaths in Eastern Region and LeDeR is therefore a resource intensive programme. SET has a relatively high population of people with LD (7134) because of
a) a history of long stay institutions such as Turner Village and South Ockenden. When these closed, people moved into the local community and supported living/residential provision clustered in those areas.
b) proximity to London and the relative low cost of housing and social care provision has meant that people with Learning Disability have moved into Essex.

More work is needed to fully understand the demographics of our Learning Disability community.

In addition to their funding of the whole LD Health Equalities Team, in the last year the Collaborative Forum funded 2.0 wte permanent reviewers, the Local Area Coordinator function and a Team Coordinator and this has made it possible for reviews to be completed and lessons learned. This made a significant impact on the year's performance and enabled us to achieve our local target. Processes are now embedded for operational running of the programme; quality assurance; governance and reporting; and liaison with other functions such as the Coroner's Office and Essex Safeguarding Board.

NHSE funding to SET for LeDeR 2019-20 was used to employ contractor reviewers to address backlog cases and to employ fixed term administrative support to request notes.

NHSE also commissioned NEC (a Clinical Support Unit in the North East of England) to clear 98 backlog cases from 2018.

Local Purpose
While much focus this year has been on establishing processes and capacity to complete reviews and bring the programme up to date, the learning from reviews has been considerable and gives a picture of both the common themes and the range of issues impacting on people's lives. The drive for the coming year has to be implementation of learning both at an organisational and CCG level and also in a more integrated system-wide approach to broader issues.

Involvement of the Local Learning Disability Community
All reviews are discussed at the Steering Group, which has representation from an Adult with Learning Disability, who is also a Health Access Champion, the Chair of Essex Family Carers Network and the Co-Chair of the HE Experts by Experience Forum.

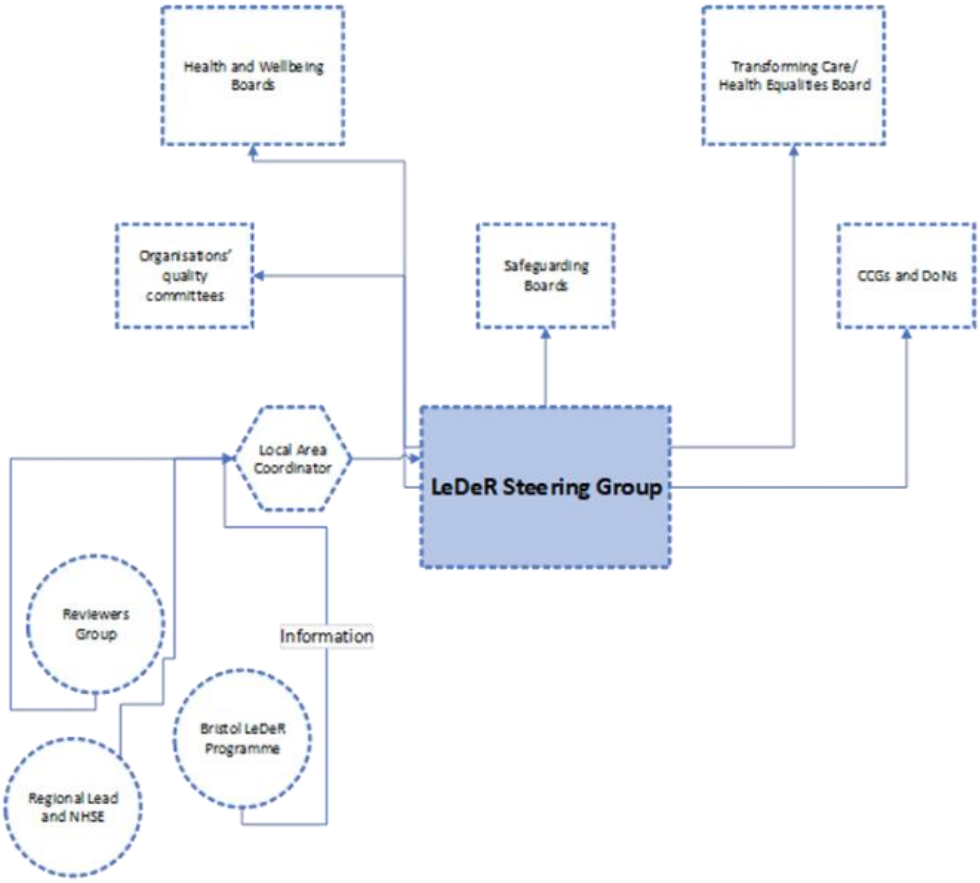
Working groups on AHC and STOMP have had intermittent representation from adults with learning disability, but recognising that this was insufficient, the LD Health Equalities Team had planned a structured approach to co-development, recruitment to a central EbyE group and involvement in key projects flowing from this. Unfortunately Corona virus halted this piece of work, but it will be re-started in 20-21.

A contract for EbyE representation in the coming year will enable representation of adults with Learning Disability and families at the Quality Panels.

Because of COVID and the inability to meet face to face, full engagement on the End of Year Report will not be possible before publication.

Governance arrangements

The LeDeR Steering Group provides oversight of the whole programme and reports to the Learning Disability Health Equalities Board and the Health and Wellbeing Boards.



Deaths in our local area[1]

Between 1st September 2017 and 31st March 2020, 272 people with Learning Disability died in the SET area. There are just under 100 deaths per year with around 10% of those children or young people. A comparison of year on year figures is available in Appendix 1.

[1] Please note local data is based on cumulative figures from September 2017. NHSE data is based on cases notified between Jan and Dec 2019.

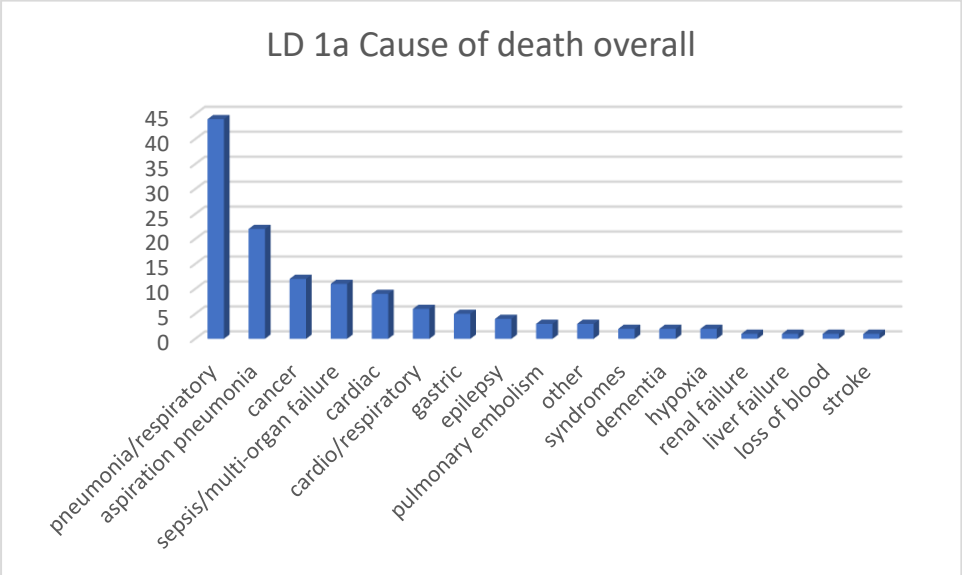
CCG	Total LD Reg	% of SET LD pop	No. deaths	% of deaths
NEE	1920	27%	85	31%
Mid	1374	19%	46	17%
Southend	1057	15%	38	14%
BBW	899	13%	25	9%
West	852	12%	35	13%
Thurrock	527	7%	21	8%
CPR	505	7%	22	8%
	7134		**272**	

North East Essex CCG continues to be the area with the highest population of people with learning disabilities, but an even higher proportion of deaths. A deep dive in mid 2019 showed no direct cause or correlation associated with this. Potentially the long stay institutions in the history of the area and the age of the local population had an impact.

i) Causes of death

With the larger number of completed reviews we can see that pneumonia (34% of all COD 1a)and aspiration pneumonia (17%) are the major clinical cause of death showing on 1a of death certificates and outweigh sepsis (9%), whereas last year, using a smaller data set, sepsis seemed a more significant issue (19%).

We still see a very common pattern of early frailty ending in increased infections and death from pneumonia or sepsis. Aspiration pneumonia sometimes fits into this pattern (for instance where swallow deteriorates toward the final presentation of dementia and is not appropriate for PEG feeding) but is also sometimes a result of textured diet guidance not being adequately followed in the community. Lack of dental treatment also impacts here.



Cancer continues to be the third largest cause of death. People with Learning Disability are sometimes dying before they are eligible for screening.

If we look at the secondary causes of death, cardiac issues are the leading underlying cause with chronic heart disease, cardiomegaly or hypertension are represented in 1b, 1c and Part 2 of the death certificates also (see appendix 1 for definitions and detail).

Worryingly terms such as “learning Disability”, “Cerebral Palsy”, “Downs Syndrome” also appear throughout all sections of the death certificates and training is needed in this regard.

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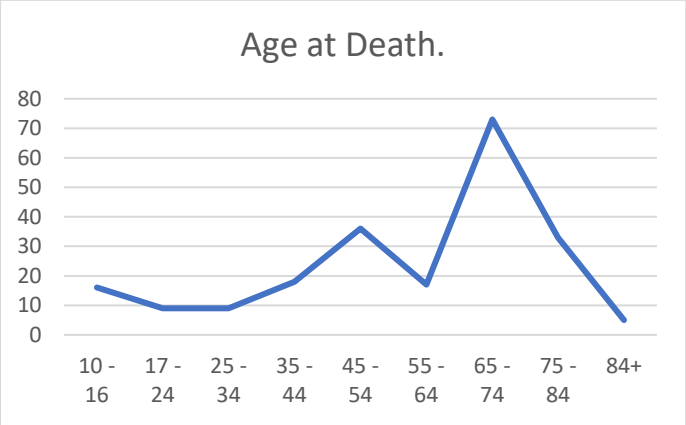
ii) Gender

Men with LD die at a higher rate than can be explained by gender split in the local LD population: 64% of deaths were of males whereas 58% of the LD population are male (as shown by GP Registers) and 58% of the national deaths are of males. Some CCGs show a more significant impact than others (details in Appendix 1). We need to explore further the underlying causes of our local gender difference.

iii) Age

In the UK general population, the average age of death for males is 79.3 years and for females 82.9 years (average 81.1). The average age of death for people with LD in SET is 60.4 years overall with a spike in deaths at 65 – 74 years. This continues to be well under the life expectancy in the general population but in line with the national average for people with LD (60 years). The LeDeR themes document highlights the systemic problems underlying this.



Children’s deaths are reviewed by the Child Death Review Team (CDRT) as part of their established process and more detail is available in Appendix 1.

iv) Ethnicity

People with Learning Disability across SET identify predominantly as British (87%) and this is broadly in line with the population of Essex (90% white British). Nationally

90% of people with LD identify as white British. All but one of the people who died and were registered as from a Black or Minority Ethnic background were children.

We do not currently understand the ethnic mix of people registered with LD on GP registers and have much work to do to understand the issues of race and ethnicity, particularly for children. We are seeking BAME representation on our SteeringGroup.

v) Place of Death

More people with Learning Disability in SET died in hospital (55%) than in the general population (46%). The figure is higher at the national average for people with LD (60%). LeDeR themes indicate a need for earlier and better End of Life planning so that people can be supported to die in the place of their choosing.

vi) Grading of Care

Grade of Care	No.
This was good care (it met expected good practice)	69
This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the persons wellbeing)	35
Care fell short of expected good practice but did not constribute to cause of death	17
This was excellent care (it exceeded expected good practice)	8
Care fell short of expected good practice and this significantly impacted on the persons 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
Grand Total	**138**

Care could refer to any organisation or combination of organisations which were involved in the person's life. 75% of cases reviewed showed good or satisfactory care. 6% gave examples of excellent care. 6.5% found care so poor that it either impacted directly on the death or had the potential to do so Cases where care fell short and contributed to the cause of death or had the potential to do so. This level of grading results in a Multi-Agency review and a referral to Essex Safeguarding Board for further scrutiny. We expect to see the full impact of this in the coming year.

Supporting data for i) to vi) can be found in Appendix 1.

Performance against national targets

1. Compliance with Key Performance Indicators

Of the 271 deaths at the end of March 2020 we have reviewed 51% with a further 33% in progress. This splits into two cohorts:

	Total	Unallocated	In progress	Completed
Local	173	18	23	132
NEC	98	2	91	5
	271	20	114	137

Because of the focus on backlog work to the end March 2020, we were not showing compliance with KPIs of

a) Allocation of reviews within 3 months of notification
b) Completion of reviews within 6 months of notification

However, we are now in a good position to achieve regular compliance in 20-21 now that our local backlog is complete.[2] We have more completed reviews than any other area in the Eastern Region and have sufficient capacity to manage our cases.

Allocations are made centrally by date of notification (not based on CCG area) and the availability of records. Access to GP records continues to be the major block to timely completion but as the programme has become familiar to primary care we have been able to build relationships with surgeries and use an agreed escalation route for significant problems.

	DEATHS OF PEOPLE AGED 18 AND OVER - excluding those on hold					DEATHS OF PEOPLE AGED 18 AND OVER: REVIEWS CURRENTLY 'ON HOLD'			CHILD DEATHS			
	Reviews assigned within 3 months of notification (notifications			Reviews completed within 6 months of notification		Waiting for coroner's inquest	Waiting for other investigation	Delays with family involvement	Total notifications to date:	progress	Completed	Completed
Region, steering group & CCG	No.	%	No. notified >6m	No.	%	No.	No.	No.	No.	No.	No.	%
England total	**2449**	**38%**	**5843**	**728**	**12%**	**38**	**69**	**19**	**588**	**274**	**314**	**53%**
EAST OF ENGLAND	**107**	**15%**	**675**	**28**	**4%**	**4**	**22**	**1**	**61**	**26**	**35**	**57%**
NHS BASILDON AND BRENTWOOD	6	30%	15	0	0%	0	0	0	1	1	0	0%
NHS CASTLE POINT AND ROCHFORD	5	25%	17	2	12%	0	0	0	0	0	0	0%
NHS MID ESSEX CCG	9	23%	37	1	3%	0	0	0	6	4	2	33%
NHS NORTH EAST ESSEX CCG	12	18%	67	0	0%	1	3	0	5	0	5	100%
NHS SOUTHEND CCG	9	28%	30	4	13%	0	0	0	3	1	2	67%
NHS THURROCK CCG	4	31%	12	2	17%	0	1	0	5	1	4	80%
NHS WEST ESSEX CCG	5	18%	26	0	0%	0	1	0	4	0	4	100%
	50		**204**	**9**		**1**	**5**	**0**	**24**	**7**	**17**	

A review may be put on hold if a safeguarding, coroner or police investigation is still in progress.

2&3 Representation of CCGs in LeDeR programme

All CCGs have membership of the LeDeR Steering Group and have a lead representative from Southend/CP&R. Thanks goes out all the organisations across Southend Essex and Thurrock who have consistently attended, contributed and engaged strategically to ensure improvements in the lives of people with Learning Disability.

4. Production of Annual Report

[2] After the end of year, the temporary suspension of LeDeR Reviewing during COVID pandemic caused a further local backlog, but a fresh NHSE target of KPI compliance by Dec 31st is achievable and a trajectory is under regular monitoring.

This report will be made public through presentation to Health and Wellbeing Boards in September and subsequent inclusion of minutes and supporting papers on their public facing webpages.

Recommendations made by reviewers for local actions.

The 19-20 Action Plan identified priorities as described below, but it was not possible at the time for Lead CCGs in the plan to take responsibility for wider strategic decisions outside their own areas.

Other items from the wider action plan were implemented locally and at single organisational level for instance, in Mid and South STP the acute hospital trusts reviewed their Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy and paperwork to ensure that learning disability or assumptions about the physical health or quality of life of a person with learning disability could not be used to inform DNACPR decisions. A paper on this went to NHSE as an example of good local work.

Where cross-organisational working groups were facilitated this was effective, but capacity for this was limited. For instance two working groups were held with representation across all 10 partners, resulting in:

a) an integrated pathway for STOMP “Stop Over Medication of People with LD/Autism”. The aim of this is to ensure a joined-up approach to removing or optimising medication used to control behaviour.

b) a pack of Easy Read Resources was formed to empower people with Learning Disability and their families to understand what they should expect from Annual Health Checks, get on their local GP register and prepare well for a check. A paper was submitted to NHSE as an example of good local work.

LeDeR Areas of Priority and Action 2019-2020					
Outcome	**Deliverable**	**Actions**	**Who**	**Existing Resources/Good Practise**	**Timescale**
Carers/family understand how to support and maintain the health of someone with LD	Widely available Information on healthy lifestyles, common health issues for people with LD, available services	Identify (develop if necessary) and agree resources - information leaflets, videos,	Thurrock CCG Lead	\\chesfs50\euchomedirs\rebekah.bailie\My	End Sept 19
		identify and agree key routes for sharing information (networks, organistaions, venues etc)	Thurrock CCG Lead		Oct-19
		ensure families and carers understand and request an annual health check and support adults to be well prepared for it	Mid and West CCG leading AHC oversight group	AHC working group has action plan	Dec-19
		agree as part of comms plan, budget if required	LAC and CP&R Comms Lead		Jan-19
Adults understand their own health and how to maintain it, when to ask for help.	Widely available Easy read information on healthy lifestyles, common health problems for people with LD and how to get help.	Identify (develop if necessary) and agree Easy Read resources - information leaflets, videos, local services etc	B&B CCG lead		End Sept 1
		identify and agree key routes for sharing information (networks, organistaions, venues etc)	B&B CCG lead		Oct-19
		develop and pilot adult held record including Health Action Plan	Southend to pilot	\\chesfs50\euchomedirs\rebekah.bailie\My	Mar-20
		ensure adults understand and request their annual health check and are well prepared for it.	Mid and West CCG leading AHC oversight group	AHC working group has action plan	Dec-19
		agree as part of comms plan, budget if required	LAC and CP&R Comms Lead		Jan-19
Adults/ arers/family can identify changes in health and know what to do to get the relevant help and prevent	Information on sepsis, pneumonia and their place in frailty/deterioriation.	identify and agree existing resources and develop local information as part of overarching health plan and comms plan using routes as above	NEE CCG lead	\\chesfs50\euchomedirs\rebekah.bailie\My	Sep-19
The health and social care system understands individuals health needs, identifies, intervenes early and manages risks to health collaboratively	Training for Primary Care on Sepsis, Pneumonia and their place in deterioration/frailty, how to support people with LD to access healthcare	Scoping of existing training and resources Identify where adaptations need to be made to make relevant for LD and support implementation Identify gaps and routes to commissioning/delivery of needed training and information Health and Wellbeing Strategy for LD to be established covering social prescribing, care navigation, and accessible information	LD Integrated Health Commissioning with Public Health and CP&R	ELDP offer training to GPs and capacity is detailed in LD Place Plans for each CCG Some Primary Care Engagement leads in CCGs are rolling out training on sepsis to Primary Care (West)	Oct-19
	Training on Sepsis, Pneumonia and their place in deterioration/frailty, how to keep healthy and get the right help - for social care providers	training on LD awareness to be devised/national resources used	ECC Lead	PROSPER offers training on sepsis to social care providers in ECC footprint	Jan-20
	Early intervention, extended Dynamic Risk Register to include those at risk of escalation to acute admission	ELDP to form cross-organisational working group	Inder Sawnhey Clinical Lead	ELDP contracted to deliver this in 2020.	Jan-20
	Training on LD Awareness	to be rolled out and made mandatory nationally	Integrated Commissioning	in development nationally	as advised

Local priorities and the evidence base that supports them

At the end of March 2020 we had 318 recommendations from completed reviews. These were grouped into themes and identified as:

a) Relevant to specific organisation
b) Cross-system issues

Organisations will report back to the Steering Group the progress towards their specific recommendations.

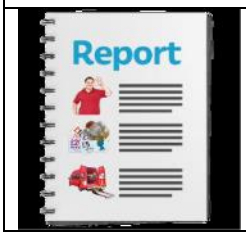
Of the cross-system issues, the following four priorities will be taken forward through commissioning of the LD specialist healthcare function and engagement with relevant STP or CCG level forums:

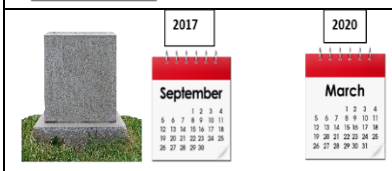
1. Delivery of effective Annual Health Checks
2. A clear understanding of early frailty in people with LD and an integrated offer to address it
3. A dynamic health support register to identify and support those at risk of acute admission
4. Case Management

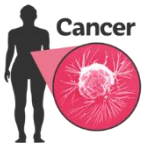
The action plan and a more detailed document outlining themes accompanies this report.

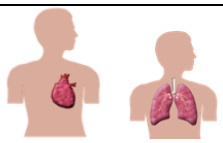
Rebekah Bailie
LeDeR Local Area Coordinator
25/06/20

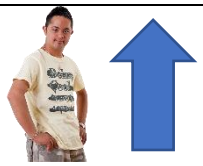
LeDeR End of Year Report – Easy Read

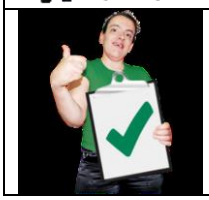
 	“LeDeR” means that when a person with Learning Disability dies, we check out:
	Why they died.
	If everything was done to give the person good health and stop them dying early.
	We say what should happen to make things better for people who are still alive.

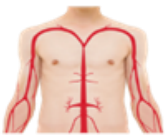
 7134	In Southend, Essex and Thurrock there are 7134 people with Learning Disability (aged 14 years up) on their GP LD Register.
	At the end of March we looked at all the reviews which were finished.
 272	272 people with LD died since LeDeR began in our area (September 17)
 137	137 reviews were finished.
	This is what we found.
	People with learning disabilities die 20 years younger than other people.

Cause of Death	**Southend Essex Thurrock** 	**National LeDeR** 
 Pneumonia (Lung infection)	**34** out of 100 people	**24** out of 100 people
 Swallowing and pneumonia	**17** out of 100 people	**16** out of 100 people
 Cancer	**9** out of 100 people	

Cause of Death	Southend Essex Thurrock 	National LeDeR 
 Sepsis	**9** out of 100 people	**7** out of 100 people
 Heart	**7** out of 100 people	
 Heart and lungs	**6** out of 100 people	
 Gastric and intestinal	**4** out of 100 people	
 Epilepsy	**3** out of 100 people	**6** out of 100 people
 Dementia	**2** out of 100 people	**9** out of 100 people
Other	**5** out of 100 people	

	Southend Essex and Thurrock	National LeDeR	All people in UK
 More men died than women	**64** out of 100 people were men	**58** out of 100 people were men	
 Average Age	**60** years	**60** years	**81** years
 Died in hospital	**55** out of 100 people		**46** out of 100 people
 White British	**87** out of 100 people	**90** out of 100 people	Everyone else in SET 90 out of 100 people

	The people who died and were Black, Asian or other Ethnic Groups were mostly children
	We need to plan better how people want to age and experience the end of their life
	Some care is very good

2019	This is what we did last year
	We now have a set of Easy Read documents to support Annual Health Checks and Healthy Living.
	We agreed how we are going to work together to make sure people are not given medicine to control their behaviour (STOMP).
	We understand more about GP LD Registers and know what we have to do to make them better.
	Sometimes doctors decide that someone should not be resuscitated. Our hospitals have made sure this is only when they can't get better and not because they have learning disability.
	We raised the awareness of sepsis in some areas
	We did all the old reviews (87) North East CSU (another health organisation) still has a lot of reviews from 2018 to do.

2020	This year we will focus on 4 important things
	Everyone should have a health check every year
	Frailty – some people have complicated health problems which can get worse. They may find it difficult to move and can get infections. This can happen earlier in life for people with learning disabilities and we need to help prevent it.
	Dynamic Support Register. We will understand the health risks for each person and work together to help them stay healthy.
	Care Coordination – one person should understand all of the needs and make sure everyone works together.
	The LeDeR Steering Group will check that these things are happening

Report by Rebekah Bailie
LeDeR LAC
Integrated LD Health Commissioner

LeDeR Themes 20 – 21

Contents

Introduction

Of the 137 reviews completed to date, 318 recommendations were made. Themes have been grouped in order to enable organisations to identify actions, but colour coding has also been used to show systemic and organisation specific issues. Items which are specific only to individuals will be communicated through a copy of the review to the relevant organisations involved.

1. Holistic approach to needs

This theme covers not only **joined up working** across the health and social care sector and the need for a "**case management**" function, but a **broader approach** to the needs of people with LD, who typically struggle to access information and services which take into account their needs in the wider context.

"the link between XX managing his finances and becoming malnourished should have been identified, and something simple like instating Meals on Wheels considered"

"in reviewing XX's death, I am aware I have access to different accounts of his health, but during his life, no one person had the oversight available to me from hospital notes, GP records, social care and provider notes read in conjunction. A more joined up approach to care-co-ordination would greatly assist this"

"professionals involved with people with LD, should not only consider the areas in which they are particularly involved (finance, mental health, community support etc) but also be prepared to notice and act on changes to physical health."

Action Points:

- Information sharing across all health and social care services
- A single functional and holistic plan agreed by the person with LD and their family across all health, social care and voluntary services
- A flexible case management function across health, social care and voluntary services
- Shared risk and escalation system
- Physical health pathways across all agencies, families and carers

2. MCA and Health Insight (42 recommendations)

In a number of cases, healthcare was refused and the person was deemed to have mental capacity to make this decision – in some cases leading directly to death. It was not clear that the person really understood the likely consequences of their decision and no work was evident to support that understanding.

The views and knowledge of families should always be taken into account, particularly in best interest decisions, but in some instances families made decisions to refuse healthcare outside their legal responsibility and when the mental capacity of the person was not clear.

An MCA Easy Read Toolkit and Specialist support is available to work through decision making, but early referrals are needed to allow time for this work to be done.

MCA should be considered for all major decisions – there is a need for broader training on this.

More information available to families, medical staff and care agencies about Lasting Powers of Attorney and deputyship to enable conversations about what is in a person's best interest and who can make decisions

Issues of self neglect should be raised as safeguarding alerts

All MCA and best interest processes and decisions should be clearly recorded in notes.

Actions

All organisation to review their training and process around MCA and people with Learning Disability

3. **Family**

Families need better information on what services and community resources are available to them.

A consistent contact to explain and help navigate health and social care, benefit and community services may be of benefit to help families with adult children with LD.

An assessment of a person's need should include the context of the family, especially if they live at home. The family hold vital information and insight into the person and are often their main carers.

A carers assessment should be carried out in this instance.

Some families are very reluctant to allow health or social care services into their lives and this means the person first comes into contact with services in crisis when very little can be done. Better engagement at transition into adulthood should keep contact with such families.

A number of adults with Learning Disabilities live with elderly parents, whose own health needs are significant. Earlier planning should be put in place to enable them to prepare for a time when they cannot be the main carers.

Families should be involved in decision making

Actions

All organisations to engage with family representatives and family focused organisations to review practises.

4. **Reasonable Adjustments (13)**

It is important that adjustments are made to the usual way services are offered so that people with Learning Disability can make use of them. Reasonable adjustments will be specific to each individual but common themes are:

- Availability of Easy Read Information
- Communication – use of sign, symbol, simple language, repetition and checking back.
- Availability of hearing aids, batteries and glasses
- Phobias and anxieties around transport or health venues

- Time – longer appointment times, early preparation and time for re-visiting information.

The ELDP Specialist LD Health service is available to advise and support the implementation of reasonable adjustments in the community and LD Hospital Liaison Nurses advise in acute settings.

Inclusive Communication Essex (ICE) produces and holds a list of Easy Read resources for Essex.

There are a range of resources on the internet to support reasonable adjustments and give Easy Read versions of common documents

Action:

Communication is needed to promote the services and resources available

Organisation Specific Recommendations

Having noted the need for the above and the fact that almost all recommendations involve more than one organisation working together, it may be helpful for action to identify the main organisation specified in the recommendation:

5. Social Care (103 recommendations)

This was the area with the highest number of recommendations and can be split into further areas:

Planning and getting the right support/place to live: When looking at both housing and social care support (either as a first placement or a move between providers) a better solution can be found if a range of information is taken into account. Families, current providers and Specialist Health (particularly for syndromes or long term conditions) often had information which was not included. In one case ignoring direct advice from a specialist Consultant lead to the death of the individual.
Issues of compatibility between tenants, more robust assessment of quality and location close to family and circles of support were also raised.

Action Points

- Integrated holistic assessment

Training: Social care providers are often the ones making a decision about calling the GP or ambulance, checking on a person's wellbeing, helping them plan food or access daily activities. These kind of contacts are key to wider wellbeing but despite demonstrating great care towards adults with Learning Disability, providers generally did not have the relevant training to recognise health issues, help the person understand relevant information, maintain their health or access health services. Key areas where this impacted on quality of life and life expectancy were:

- Healthy living – nutrition, hydration weight, smoking, exercise, bowel health, health screenings and annual health checks. How to access and explain information, how daily activities can support health, how to access relevant services in the community.
- Long term conditions – (respiratory, cardiac, diabetes, epilepsy, continence) helping the person with management of diet and exercise plans, identifying triggers to worsening

condition, recognising side effects and exacerbations and how to access support from specialist services
- Frailty – falls prevention, mobility, posture, skin integrity, recurrent infections, nutrition and hydration. How to access advice and relevant services to prevent deterioration.
- End of Life – see section below.

Social care providers cannot carry out these functions in isolation, but must be part of the wider team who collectively take responsibility for the overall care plan.

Action Points:

- Training for Social care providers (E.g. LD Significant Seven)
- Joined up health and social care commissioning
- Focused LD Public health programme supporting social care providers
- Clear LD frailty offer
- Directory of services

Also see section on MCA and Health Insight below

Processes and Systems

Without agreed and well understood processes, practise is inconsistent and dependent on local context and the knowledge of individuals. The areas highlighted as needing action are as follows:

- Handover of information between providers should be systematised as key issues have often been lost on move of home.
- Community Mapping should be used by providers to understand and manage how daily activities contribute to wellbeing
- Falls risk assessment should be in place and re-assessed on move of home
- Awareness and use of specialist LD health services should be improved
- Flagging of people with phobias and anxieties, particularly around health, transport, needle-stick etc should be in place with a clear pathway to de-sensitisation services.
- Clear routes for communication between providers and ASC/Health should be in place for significant changes/escalations in health.

Working with Hospitals

Hospital passports should be up to date and with the person on conveyance to acute setting and should include information on relevant phobias/anxieties

A familiar person should be with the person when they are admitted to hospital

Good channels of communication between hospital, the social care provider, social care should be in place to

a) Ensure appropriate and timely admissions
b) Ensure safe and appropriate discharge

Clear information on the type and availability of social care support should be clear in the discharge planning

Clear information on the person's needs and relevant actions for social care providers should be clear in the discharge plan

Families – see section above.

There were also 11 recommendations specific to individual cases, which will be shared with social care.

6. Primary Care (69 recommendations)

Annual Health Checks (32):

GPs have an opportunity in the Annual Health Check to gain an overview of the person's wellbeing, but in many of the reviews the check was not offered, did not highlight relevant issues or did not result in a Health Action Plan.

"GP's should be reminded that even where a person with Learning Disabilities is under an acute specialist service for management of a serious medical condition an AHC is still required and healthy lifestyle messages that may impact on their medical condition, should be reinforced at the AHC. These appointments should be regarded as an opportunity to explore the wider health issues for the person with LD and their carers."

GPs often seemed unaware that there are specialist services who can support a person with preparation for health check, anxieties around health appointments and can be referred to for direct treatment.

Easy Read materials are available on CCG websites to promote and support AHCs

Action Points:

- System for flagging those who do not attend AHCs
- Use of social prescribing allied to AHCs
- Use of Easy Read materials to invite people to AHCs and help them prepare
- Inclusion of key issues in AHC: healthy living, medication, oral hygiene, falls and frailty risks, dementia scores
- The person's ability to not only understand at the time, but to retain and implement advice should be taken into account when agreeing an action plan and the need for support should be reflected in it and communicated to the relevant people.
- Health Action Plans to be agreed and shared with the person, family and all relevant people across health and social care.

Pathways (12)

There is a need for training for Primary Care staff to adjust their communication other ways of working to enable a clear understanding of the person with LD and their health. People with LD often cannot articulate their symptoms and assumptions are made. Behaviour (which may indicate pain), weight loss or gain, a change in mood or habits can all indicate an underlying health need. Physical causes should be ruled out and family or carer information should be carefully considered.

There are a range of services to support people with LD and to work alongside primary care, but awareness and use of them is inconsistent. Pathways need to be agreed and widely understood:

There should be clear and agreed pathways in place when symptoms or conditions present to primary care, which ensure the correct services are involved and coordinated. (Dysphagia, Epilepsy, Dementia, Pierre Robin Syndrome, phobias and anxiety around health

issues, significant weight loss or gain, frailty, side effects of specific drugs for epilepsy and gastric conditions, End of Life).

Families and social care providers need to be included in these pathways to ensure they understand symptoms to look out for and when to call in the appropriate help.

Best interest meetings could be part of these pathways (see also section on MCA below)

Medication reviews should be held regularly, but also triggered when symptoms are reported that could be side effects of medication. (see also integrated STOMP Pathway)

There should be clear criteria for home visits

Action Points:

- Pathway development
- Training on reasonable adjustments

Other Issues for Primary Care (25):

preparation for an uptake of health screenings is low for people with Learning Disability and there needs to be a drive to provide accessible information and help a person make informed decisions and prepare for a screen.

Reasonable adjustments are key to supporting good health

Other items relevant to specific cases to be shared with PCNs.

7. **Specialist Health (ELDP) 11**

Most recommendations indicated the need for specialist LD services to be involved in a person's care and to be referred to in a more systematic way.

Services should be involved in specific condition and inter-agency processes such as discharge.

GPs and social care workers and providers are often unaware of what is available or how to access.

See also section on dysphagia

Action Points:

- Description and wide communication of services available and how to access them
- Involvement in multi-agency pathways

8. **Acute hospitals**

Admissions – information should be available on the communication needs, underlying health condition, reasonable adjustments necessary, This should be captured in an up to date hospital passport and a "blue bag" should come with the person, but family and carers should be in attendance to explain and handover.

A familiar person – family or carer should be available to the person while in hospital

Advocacy should be routinely available to people with LD, but especially where they have no family or carer.

The role of the **LD Hospital Liaison nurse** was very positive and should be available 24/7 with increased staffing.

DNACPR – the process was generally well followed but sometimes assumptions were made about the person's "Quality of Life" where there was little information on the person's quality of life prior to admission. Family members, while consulted sometimes reported feeling directed by medical staff and not having sufficient time or information on which to make a decision.

Communication with community - clear pathways to community services should be agreed to

a) prevent the need for admission,

b) optimise hospital stays (by de-sensitisation programmes, sharing of information and preparation work) and

c) enable a successful return to health at home after discharge

Discharge –checks should be made to ensure that prescriptions can be accessed, equipment is in place and that the home environment is suitable for discharge, particularly where elderly parents are the carers.

An integrated plan with community services is needed on discharge

Clear plans outlining the role of community services and the family/carers responsibility should be made available to families and carers on discharge – this should include what symptoms to look out for and when to ask for further intervention.

There should be a system to identify people who return to hospital, especially with the same condition. Their care and support in the community should be reviewed and addressed to manage their health and wellbeing.

Better communication is needed between specialist centres and local acute settings to ensure coordination of care.

End of Life – see below

Action Points:

- **Review of hospital passports and blue bag**
- **Integrated pathways with community services**
- **Integrated and accessible Discharge plan**
- **Accessible information for people with LD and their families/carers**

Condition specific Recommendations

9. **Frailty**– despite the highest cause of death being pneumonia, most of the recommendations relate to social care providers not recognising or acting to prevent deterioration, which ends in pneumonia or sepsis. This fits into a wider picture of early frailty, as described in last year's report. This is typically not recognised in people with LD who do not fit the age criteria and do not have anyone to coordinate their care.

There is a need to work collaboratively across health and social care to ensure the following for people with LD

a) Prevent falls
b) Maintain mobility and posture
c) Maintain good nutrition and hydration
d) Manage long term conditions
e) Identify signs of frailty and mitigate deterioration
f) Identify signs of crisis and act quickly to get help

Constipation – people have died from gastric and bowel related conditions involving long term constipation. Obstruction of the bowel and side effects of long term laxative use are not uncommon. Exercise and diet are almost never recorded to manage bowel health. Dieticians are rarely referred to for management of bowel health.

Action Points:

- Communication plan to raise awareness of bowel health and how to manage it

10. Heart

As well as being a direct cause of death, cardiac issues came up frequently in 1b, 1c of death certificates. Reviews did not find corresponding concern around heart health or understanding of the role of healthy living in maintaining heart health in families or social care providers and there is a large public health piece of work to improve this.

Recommendations largely relate to management of known or queried cardiac conditions:

- The Specialist Cardiac Nurses need to ensure when a patient has a Learning Disability that both patient, family and Care Home staff are informed about the national charity 'Cardiomyopathy UK' which have a website and helpline to support patients and their carers to help them have a fuller understanding of the heart condition.
- Easy Read materials relating to Cardiomyopathy/Heart Failure need to be developed and provided to patients with Learning Disabilities and their carers when they attend their Outpatient Appointment with the Consultant Cardiologist or Specialist Cardiac Nurses. The hospital LD Liaison Nurse should support this development.
- All Cardiac Specialist medical staff (medics and nurses) need to be made aware of the role of the LD hospital based nurse and how they may support those patients and their carers attending their clinics. Referrals should be always be made.
- Adults with Learning Disability who have a history of congenital heart disease such as Fallot's Tetralogy & repair should be routinely referred into the local Cardiology Clinic for regular monitoring to ensure any heart failure symptoms are identified early so treatment options can be explored and implemented in a timely way, whether this be active treatment or palliative care. This should be included as part of the Annual Health Care Plan developed following the GP Annual Health Check.
- Health Care Plans for those who have an increased risk for potential heart disease need to include the management of wider health determinants such as diet, fluid intake and exercise. Health Care Plans should be regularly reviewed at the Annual Health Check and desired outcomes monitored to ensure the interventions are effective.
- DNAs (E.g. for cardiac appt) should be escalated

Action:

CCGs to follow up recommendations with primary care and specialist cardiac services.

11. Cancer

- People with LD are suffering from bowel cancer at an earlier age when they have a learning disability. May be the NHS bowel screening programme age could be lowered.
- Oncology Department should ensure those with Learning Difficulties and their carers are made aware of easy read materials which explain what happens at review Out Patient Appointments including examinations and investigations.
  The Macmillan website has a range of appropriate materials that can be downloaded. https://www.macmillan.org.uk/information-and-support/resources-and-publications/other-formats/easy-read.html and https://be.macmillan.org.uk/be/p-23308-scans-and-x-rays.asp. Patients could be sent details of the website link in their OPA appointment letter.
- The transfer of records between out of area Oncology services in acute providers needs to reviewed to ensure timely sharing of information about treatments follows the client. Where the patient has identified Learning Difficulties the LD liaison nurse in the receiving area should be notified.
- Long term treatment for DVT should follow the most up to date NICE Guidance on management of DVT - this includes assessment for undiagnosed cancer and checking compliance with medication.
- Training for Primary Care Staff could include early recognition of blood cancers.
- GP Practices should ensure that those who have Learning Disabilities have Easy Read versions of the Bowel Cancer Screening test instructions that they can utilise and ensure where those with LD decline to take part in the screening programme (GPs receive notification of outcomes) that this is followed up and addressed at the next Annual Health Check.
- Where there are concerns about Capacity to consent for cancer screening programmes an MCA should be undertaken the result recorded and where appropriate a Best Interest Decision made as to whether to exclude the individual from the programme.

Action:

CCGs to follow up recommendations with Primary Care and oncology services

12. Dysphagia

Aspiration pneumonia is a common cause of death locally, often despite recommendations for textured diets being in place. Food and eating is very emotive and people with LD and their carers don't always fully understand the risks – in one case with a well meaning carer feeding a person cake when they could not safely swallow.

Advice on textured diets does not always transfer between care providers, day centres and there can sometimes be confusion when advice changes after a stay in acute.

PEG feeds often got blocked and management was not well understood.

Action Points

- Training for families and social care providers on textured diets and PEG feeding
- Clear agreed plans with risks of non compliance clearly set out and communicated to all involved.
- System for monitoring textured diet status between acute and community – hospital passports can support this.

13. Dental

Poor oral health was a contributory factor in a number of reviews, but issues prevented access to dentistry, typically phobias, uncontrolled diabetes or difficulty with General Anaesthetic **.**

Poor oral hygiene was also common

Specialist dental services and de-sensitisation programmes are available but not widely accessed

Action Points:

- De-sensitisation programmes to be advertised more widely
- Training and key messages around oral hygiene to be provided widely and for all ages
- Joined up planning to be in place where multiple factors prevent oral health

Other

- **NICE Guidance on reasonable adjustment in Diabetes care for people with LD should be followed consistently**
- **Epilepsy registers should be reviewed and validated**

14. End of Life (49)

End of Life planning occurs too late and is therefore rarely inclusive of the person's wishes. No one identifies the deterioration in health which will eventually lead to death (even where this is feasible) and so time is lost to maximise the person's quality of life and help them explore their health and end of life options. This is usually too early for hospice involvement, but no one agency identifies this as their role. **An integrated approach is necessary**

Some social care providers have delivered excellent end of life care in conjunction with health services, but others have not the skills or confidence. An audit, with targeted training and peer support could improve consistency.

It may be necessary to involve the palliative care team earlier than usual to enable time for planning and exploration of wishes

Advocacy can be very helpful in this work

Action Points:

- A clear agreed inter-agency "dying well" approach and pathways, based on co-development with people with LD.
- Training and accreditation for social care providers in End of Life care
- Materials for End of Life planning with person and family
- Early involvement of palliative services

Learning into Action

All themes will be followed up through presentations to the Steering Group and review of the action plan.
Organisations will take responsibility for implementation of recommendations relevant to their own organisations and for making links with other agencies within their own footprint.
LeDeR LAC is available to support and facilitate integrated pieces of work where this is necessary.

It is suggested that four priorities are taken forward for an integrated approach to end March 2021:

- Annual Health Checks
- Frailty
- Dynamic Support Register
- Case Management

Rebekah Bailie
LeDeR Local Area Coordinator
June 2020

Priority Area	Aim/Final Position	12 month outcome (to end Mar 2021)	deliverables	Who - organisations/Forums/ CCG	Measures
Annual Health Checks	Every person over 14 years with a Learning Disability will have a comprehensive and Annual Health Check, which identifies their needs and produces a Health Action Plan which outlines how these needs will be met. Both the Health Check and the Action Plan will be in a format which is understandable to them and shared with all involved in their care.	Everyone on ELDP case load/RAG rated as priority has a pre course questionnaire (or known to be done by someone else) and has had an AHC.	the LD primary care registers are validated and expanded	LD HE Team & EQUIP	50% take up of AHC
	All young people aged 14yrs who meet the criteria for a learning disability healthcheck are idenitifed and are offered the choice to be added to the GP LD register. Parents carers and young people are informed and understand the AHC process and are actively involved in the decision making process.	Increase in Practice LD register sizes and increase in AHC uptake within the 14yr + cohort.Increased understanding by parents, carers and young people and schools of the AHC offer . Increased understanding of local servcies available to Young people with a learning Disabilty.	The LD primary care registers are validated and expanded Learning Disability awareness campaign is promoted amoungst local populations and within the LD community support	Thurrock, Basildon and Brentwood CCG local area SEND systems	
			Profile of AHCs to be raised in special schools and at transition planning	Southend & CPR, Thurrock CCGs BBCCG, ECC	

			ELDP RAG rating of caseload used to identify those a) at risk and in need of priority Health Check and b) those who can be seen remotely/need face to face appointment.	ELDP	Improved experience of AHCs for people with LD and their families
			ELDP support primary care in booking AHCs for priority patients	ELDP	
			ECC media channel to promote benefits of AHCs	Michelle Brown	
			Social care providers support to people to prepare for/attend/set up remote appointment	LA Commissioners/Contracts. ECC MLM Aging Well project	

			training is delivered to help people (adults, carers, families) to understand and prepare for the AHC	ELDP	
	LD HE Team & EQUIP, Raise profile in specialist schools and day centres, Birthday Card/health check reminder. Regular comms in the GP/Primary Care bulletin and education forums. Early planning through the transission to adult services.raise profile through weekly comms on LD themes and with social care. LD Community engagement model		ELDP work with social care providers to help prepare the pre-course questionnaire and attend/set up remote appointments	ELDP/ Family Organisations/SC provider link?	
			promotion of flu vaccine	CCGs Public Health ELDP	50% uptake of flu vaccine
			Training/support for primary care to understand the Easy Read questionnaire, expectations of check and how to complete an Easy Read Health Action Plan – videos.	ELDP	
			LAs ensure social care providers support target number of checks	ECC Michelle Brown/MLM	

			CCGs promote AHCs, the use of Easy Read resources and new model of joint working with ELDP and ASC with primary care (bulletin, education forums, comms)	CCG Primary Care Leads and Clinical Leads	
			Community and user groups (such as Project 49 in Southend & Summit in Essex) will promote AHCs and support people not open to ELDP or social care to prepare and access remote appointments	Comms Leads (Amanda Shears Southend &CPR)	
			Primary Care (PCN Directors) agree delivery model and support new ways of working including GP LD Champions	PCN Directors/CCG Primary Care Leads Southend & CPR Imelda Callowhill	
			Engagement with people with LD & Families around experience of AHCs - baseline and re-measure	Healthwatch	

			GPs produce Easy Read Health Action Plans for each AHC		
			HAPS are shared with family, ELDP and Social Care where appropriate	GPs (Southend&CPR Taz Syed through the GP and AHP forums) CCG Primary Care Leads to support	

Priority Area	Aim/Final Position	12 month outcome (to end Mar 2021)	deliverables	Who	Measures
Frailty	Early frailty in people with Learning Disability will be understood, prevented where possible and mitigated to ensure optimum health and quality of life where it cannot be prevented.	Frailty in people with Learning Disability will be understood as part of the dynamic risk register function	Assessment of current understanding of frailty in ELDP and social care staff	ELDP Leads Gemma Robertson & Mary Seaman	Reduction in conveyance to hospital for frailty related conditions
			Tool/ process of assessing frailty in LD population	ELDP with CCG Frailty Leads and DoNs	
			Application to people open to ELDP as part of dynamic risk register	ELDP - GR & MS	
			whole system approach identified including mainstream frailty model, training for care homes, primary care, National directives such as care home DES)	CCG Frailty Leads Care Home Hubs Mid South Task and Finish Group	
			Aging Well Approach to include frailty approach in social care provision	ECC MLM programme	
			A shared understanding of inpatient lists, reasons and frequency of admission.	Frailty Leads West Frailty Oversight Group	

			training delivered to residential and supported living provision on identification and management of frailty	PROSPER, Mid&South Task & Finish	
Priority Area	**Aim/Final Position**	**12 month outcome (to end Mar 2021)**	**deliverables**	**Who**	**Measures**
Dynamic Support Register	There is a single, multi-agency owned, dynamic support register and process in place across the whole of SET. Anyone with a learning disability (initially aged 18 +) within the area is eligible for inclusion. Services are aligned and primed to respond to the needs presented. The tools/materials used to support the process are well known and understood; services look for them when someone presents to them.	The register is in place for those people open to ELDP	• An identified lead responsible of overseeing and co-ordinating all aspects of delivery; and for holding people/the service to account for the agreed actions.	ELDP Leads Jenna Braddick & Owen Fry	A reduction in premature deaths.
			• A clear protocol and process for identifying those considered at risk from a variety of acute and/or chronic health conditions.	ELDP/Acute Liaison Nurses/PCNs	A reduction in ambulatory care hospital admissions.
			• The register - a dynamic/live list of those at risk – held electronically with the ability to analyse the data both at individual and at a system level. [potentially linked to/one and the same as the TC DSR]	ELDP - JB & OF	A reduction in HEF Risk scores(!)

Priority Area	Aim/Final Position	12 month outcome (to end Mar 2021)	deliverables	Who	Measures
Case management	There is multi-agency agreement for and resourcing of the required capacity to ensure that all people with learning disabilities (initially 18+), in SET, with significant risks resulting from physical health issues are case managed. Case management, as a role/function, is understood and supported across the whole health and cares system. There are sufficient case managers with the required skills to undertake the role as needed. Individuals and their families report better co-ordinated health responses.	A pilot to be run in an agreed CCG or PCN area with an agreed cohort: • Those at RED • Those at AMBER • Those at GREEN	• An agreed risk stratification process, that includes: o Clear definitions re the different levels of risk and how this applies to the variety of conditions and situations that may apply o Clear expectations about the actions to be taken at each level of risk o Mechanisms for recording and monitoring agreed actions, and for escalating when necessary	ELDP Leads Joanne Ayris & Katy Heery	
			• An agreed list of items/actions considered good/best practice and where/how they will be implemented as part of the dynamic risk levels.	?	• A reduction in ambulatory care hospital admissions.
			A shared understanding of inpatient lists, reasons and frequency of admission.	LD hospital Liasion Nurses	

			• Data that demonstrates the type and volume of health issues known to (this part of) the system	PCNs/EQUIP/Hospital Liaison Nurses/ELDP	
			• The identification of issues within the system that need addressing/escalation outside the remit of managing the register itself.	?	
Additional	**Aim/Final Position**	**12 month outcome (to end Mar 2021)**	**deliverables**	**Who**	**Measures**
Condition Specific LeDeR Recommendations	Specialisms such as Cardiac, cancer, respiratory and Dental will understand the issues relevant to people with LD, will identify their LD caseload, work in collaboration with specialist LD nurses make reasonable adjustments to ensure access and good outcomes	A lead will be identified for cardiac services to develop an action plan	CCG clinical leads will circulate condition specific recommendations to the relevant department leads for action	CCG clinical leads	

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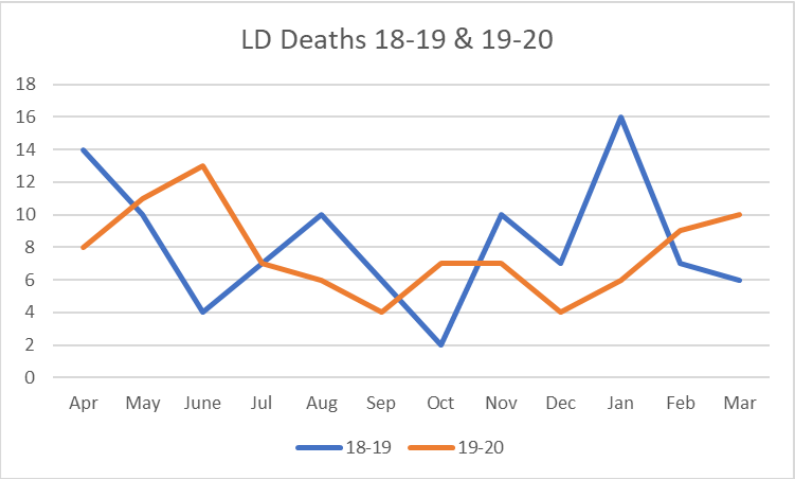
Appendix 1. LeDeR Supporting Data 2019-2020

LeDeR Notifications – comparison 2018 and 2019



	18-19	19-20
Apr	14	8
May	10	11
June	4	13
Jul	7	7
Aug	10	6
Sep	6	4
Oct	2	7
Nov	10	7
Dec	7	4
Jan	16	6
Feb	7	9
Mar	6	10
	99	92

With only two financial years to compare it is not possible to see any trends in notification.

Cause of Death

An official death certificate has the following sections:

I (a) Disease or condition leading directly to death
I (b) Other disease or condition, if any, leading to I(a)
I (c) Other disease or condition, if any, leading to I(b)

II Other significant conditions contributing to death but not related to the disease or condition causing it

1a must be filled in, but other sections are optional. A death certificate is not always available even on completion of report, particularly where GP records are not made available and not all sections are relevant for all certificates, so totals do not always relate to total number of deaths for the CCG.

Every death certificate is completed in the practitioner's own words (rather than a selected option) so that some grouping of causes of death has been done to make sense of the overall data. For instance "bronchopneumonia", "pneumonia" and "lower respiratory tract infection" would all be captured under "pneumonia/respiratory" but aspiration pneumonia is separate because it has a different cause.

This is not the case at the CCG level breakdown because the numbers are lower and so more easily read without significant categorisation. Codes might therefore not easily read across from the overall to the CCG data.

Cause of Death 1a, 1b, 1c and Pt II summarised for all ages Southend, Essex and Thurrock

COD1a

pneumonia/respiratory	44
aspiration pneumonia	22
cancer	12
sepsis/multi-organ failure	11
cardiac	9
cardio/respiratory	6
gastric	5
epilepsy	4
pulmonary embolism	3
other	3
syndromes	2
dementia	2
hypoxia	2
renal failure	1
liver failure	1
loss of blood	1
stroke	1

COD 1b

Heart	10
CP/LD/Downs	7
Bowel	6
pneumonia/embolism	5
COPD/respiratory LTC	4
Epilepsy	4
aspiration pneumonia	3
Frailty	3
Syndromes	3
Sepsis	2
Dementia	2
Cellulitis	2
DVT	2
Cancer	2
Stroke	2
chronic kidney	1
diabetic ketoacidosis	1
Cirrhosis	1
Immobility	1
infection in prosthesis	1
viral infection	1

COD P2	
Downs Syndrome/LD	11
cardiac	9
epilepsy	6
Cerebral palsy	5
multiple	4
syndromes	3
kidney	2
liver	2
cancer	2
diabetes	2
Autism	1
spastic paraplegia	1
gastric/bowel	1
anaemia	1
dysphagia	1
CD	1
hypotension	1
sepsis	1
UTI	1

COD 1c

Heart	4
Downs/LD/CP	3
Syndromes	3
Respiratory	3
Dementia	2
Diabetes	2
complications of surgery	2
Gastric	1
Epilepsy	1
Frailty	1
Dementia	1
Kidney	1
infected leg ulcer	1

Cause of Death – CCG Breakdown

BBW COD 1a	
Aspiration Pneumonia	1
Chest infection.	1
Pneumonia	3
Pulmonary Embolism	1
Respiratory and Cardiac Arrest	1
Septicaemia	1
	8

MID COD1a	
Bronchopneumonia	7
Cardio-respiratory failure	2
Aspiration pneumonia	2
Cancer of bowel	1
Chest Infection	1
Hypoxic Brain Injury & status epilepticus	1
Left ventricular failure	1
Congestive Cardiac Failure & COPD	1
Organ frailty	1
Right sided basal ganglia bleed. Bilateral basal ganglia lunar infarcts.	1
sepsis	1
Small Bowel Obstruction	1
	20

SOUTHEND COD1a	
Aspiration Pneumonia	3
BronchoPneumonia	3
Community acquired pneumonia	2
Cancer endometrial	1
Astrocytoma	1
Cardiomegaly	1
Dementia	1
Heart attack	1
Hospital acquired pneumonia	1
Juvenile Sandhoff Disease	1
Metastatic Hepatocellular Carcinoma	1
Peritonitis and Sepsis	1
Respiratory failure	1
	18

WEST COD 1a	
Aspiration pneumonia	6
Sepsis	2
Left lobe pneumonia with left lung collapse	1
Pneumonia	1
Respiratory Failure	1
Coalescing bronchopneumonia	1
Cerebral Palsey	1
Biventricular failure	1
Cause of death Liver disease from Alcohol ab	1
Hypothalamic Hamartoma	1
Protein Losing Enteropathy	1
Intestinal obstruction with peritonitis	1
seizure	1
	19

CPR COD 1a	
Aspiration Pneumonia	4
Bilateral Broncho Pneumonia	1
Myocardial Infarct	1
Multiple Organ Failure	1
Spontaneous retroperitoneal haemorrha	1
Vascular Dementia	1
	9

NORTH EAST COD 1a	
Bronchopneumonia	6
Cardiac Arrest	4
sepsis	3
Bronchopneumonia Pulmonary thrombo	2
Aspiration pneumonia with respiratory fa	2
Respiratory Failure	2
Community acquired pneumonia	2
Lung collapse	1
COPD	1
lower chest infection (LRTI)	1
Infective exacerbation of asthma.	1
malignant neoplasm of rectum	1
Liver cancer	1
Malignant Neoplasm of Female Breast	1
Perforated Duodenal Ulcer	1
Acute Renal Failure	1
Chronic Epilepsy	1
blood clot to the lung, causing cardiac arr	1
chest sepsis	1
Staphylococcus aureus Septicaemic. Complex Congenital Heart Disease with Eisenmenger Syndrome.	1
post operative blood loss	1
Natural causes	1
Old age	1

THURROCK COD 1a	
Multi -organ failure	1
Anaplastic astrocytoma of the brain	1
metastatic adenocarcinoma unknown pri	1
Aspiration Pneumonia	1
Bowel Cancer	1
Bronchopneumonia	1
Cardio Respiratory Arrest	1
Gastro Intestinal Bleed	1
Hypoxic Brain Injury	1
Laryngeal cancer	1
	10

Age and Gender

Average age is taken from GP registers and average age at death from LeDeR notifications.

CCG	Average Age	Av Age Death
NEE	44	58
Mid	36	65
Southend	47	62
BBW	41	64
West	40	57
Thurrock	41	65
CPR	35	52
	41	**60**

Southend and North East CCGs have significantly older populations whereas Mid and CPR are younger. The median age in the UK general population is 40 years.

In the UK general population, the average age of death is males 79.3 years and females 82.9 years (average 81.1). The average for people with LD is 60 years overall, 58 for females and 61 for males.

We know that a higher proportion of males die than females and that this is not explained by the gender split in the LD population.

There are different patterns across CCGs with Mid and West showing a more significant impact on males. In CPR the discrepancy is not so great.

CCG	Total LD Reg	Male	Male%	%male deaths	Fem	Fem%	%Fem deaths	No deaths
NEE	1920	1102	57%	64%	818	43%	36%	85
Mid	1374	820	60%	70%	554	40%	30%	46
Southend	1057	623	59%	61%	434	41%	39%	38
BBW	899	530	59%	64%	369	41%	36%	25
West	852	476	56%	66%	376	44%	34%	35
Thurrock	527	297	56%	67%	226	43%	33%	21
CPR	505	309	61%	55%	196	39%	45%	22
	7134	**4157**	**58%**	**64%**	**2973**	**42%**	**36%**	**272**

Children

24 children have died since the start of the programme across SET with age range from 5 – 16 years. The average age of death was 11 years and the median 7 years. 12 were male and 12 female. The breakdown by CCG is below:

CCG - Child Deaths	No.
MID ESSEX CCG	6
NORTH EAST ESSEX CCG	5
THURROCK CCG	5
WEST ESSEX CCG	4
SOUTHEND CCG	3
BASILDON AND BRENTWOOD CCG	1
	24

Grade of Care

The majority of care for children was good or satisfactory (83%) and 9% excellent. In 2 cases the care fell short of good practise and in one case this was contributory to the death. The CRDT board take forward all recommendations and actions.

Care Grade - Children	No.	%
This was good care (it met expected good practice)	15	65%
This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the persons wellbeing)	4	17%
This was excellent care (it exceeded expected good practice)	2	9%
Care fell far short of expected good practice and this contributed to the cause of death	1	4%
Care fell short of expected good practice but did not constribute to cause of death	1	4%
Grand Total	23	

Cause of Death

While not all children were on end of life pathways at the time of death, they tended to have more syndromes or complex health needs (than adults) which were contributory to or underlying the cause of death. All but one died in hospital or palliative care unit.

Not all reviews are complete, so cause of death is available for 18 children at time of writing.

N_COD_1a	N_COD_1b	N_COD_1c	N_COD_P2
Respiratory and Cardiac Arrest			
Pneumonia	POLG mutation mitochondrial cystopathy		
Cardio Respiratory Failure	Viral Illness	Edwards Syndrome	
Hypoxic Brain Injury	Epileptic Seizure	Gaucher Disease	
Pneumonia			
seizure	Lennox-Gastaut Syndrome	Trisomy 5p	
Cardiac Arrest	Catecholamine Polymorphic Ventricular Tachycardia		
Hypothalamic Hamartoma			
	Long QT Syndrome		Acute Colitis
Multi -organ failure	1b. Systemic inflammatory response syndrome (SIRS) septic shock		
Anaplastic astrocytoma of the brain			
Ia. Protein Losing Enteropathy	Ib. Failing Fontan with circulation failure.	Ic. Unbalanced Atrioventricular Septal defect (operated with total cava-pulmonary connection 2009).	Autism
Bronchopneumonia			Myopathy and learning difficulties
Pneumonia	Cerebral Palsy	Epilepsy	
Juvenile Sandhoff Disease			
Acute Renal Failure			Severe Global Delay, Cerebral Palsy, Epileptic Encephalophy.
I (a) Cardio-respiratory failure	I (b) Atrial and ventricular septal defects, pulmonary hypoplasia and lung abscess		II Multiple congenital abnormalities
Peritonitis and Sepsis	Gastric Fundus Necrosis and Perforation	Superior Mesenteric Artery Syndrome following corrective spinal surgery for progressive neuromuscular	

Ethnicity

The following table shows the ethnicity of all people with LD who have died in SET since Sept 17

Ethnicity	No.	%
British	237	87.13%
Any other ethic group	3	1.10%
Any other White background	3	1.10%
Irish	3	1.10%
African	2	0.74%
Pakistani	2	0.74%
Any other Black/African/Caribbean background	1	0.37%
Bangladeshi	1	0.37%
Chinese	1	0.37%
(blank)	19	6.99%
Grand Total	272	

We do not currently have data on ethnicity of our local LD population or whether it is representative of the general population in SET, but the data from deaths looks to be in line:

Ethnicity of Essex

White British	90.80%
Other white	3.60%
Asian	2.50%
Black	1.30%
Mixed	1.50%
Other	0.30%

Children and Ethnicity

Ethnicity Children	No.	%
British	16	67%
African	2	8%
Any other White background	2	8%
Bangladeshi	1	4%
Chinese	1	4%
Pakistani	1	4%
unknown	1	4%
	24	

When the figures for child deaths are split out it becomes clear that the deaths of Black and Minority Ethnic people are almost entirely those of children.

Place of Death – all age

Place of Death	No.
Hospice/palliative care unit	10
Hospital	149
Not known	9
Residential / nursing home that was not usual address	12
Usual place of residence	88
(blank)	4
Grand Total	**272**

55% of people with LD who died since Sept 17 died in hospital. This is lower than the national average for people with LD but higher than the average for the rest of the population.

Rebekah Bailie
LeDeR LAC

Meeting Planner

Health and Wellbeing Board

Health and Wellbeing Board Executive Committee

HWB Membership

Leader of the Council* (Cllr Robert Gledhill) Portfolio Holder for Children's and Adult Social Care **(Chair)** (Cllr James Halden), Portfolio Holder for Health (and Air Quality) (Cllr Mayes), Cllr Tony Fish, Corporate Director of Adults, Housing and Health* (Roger Harris) Corporate Director Children's Services*, (Sheila Murphy), Director of Public Health* (Ian Wake), Interim Deputy Accountable Officer: Thurrock NHS Clinical Commissioning Group* (Mark Tebbs), Chief Operating Officer HealthWatch Thurrock * (Kim James), Clinical Representative: Thurrock NHS Clinical Commissioning Group (tbc) Chair: Thurrock NHS Clinical Commissioning Group or a clinical representative from the Board (Dr Kalil), Executive Nurse: Thurrock NHS Clinical Commissioning Group (Jane Foster-Taylor), Lay Member Patient Participation: Thurrock NHS Clinical Commissioning Group (To be confirmed), Director – Place (Andy Millard), Director level Executive, NHS England Midlands and East of England Region (Waiting for confirmation) Chair Thurrock Community Safety Partnership Board / Director – Environment and Highways (Julie Rogers), Chair of the Adult Safeguarding Board or their senior representative (Jane Foster-Taylor, Thurrock CCG), Representative Thurrock Local Safeguarding Children's Partnership (Jane Foster-Taylor), Integrated Care Director Thurrock, North East London Foundation Trust (NELFT) (Tania Sitch), Executive member, Basildon and Thurrock Hospitals University Foundation Trust (Andrew Pike/Preeti Sud), Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) (Nigel Leonard), Chief Executive Thurrock CVS (Kristina Jackson), Senior officer, HM Prison and Probation Service (Karen Grinney), Interim AO for Mid and South Essex joint CCG (Anthony McKeever)

Operation matters regarding Health and Wellbeing Board

- Meetings are organised quarterly on a Friday morning
- One quarter of the whole number of Board Members, provided that in no case shall the quorum of a Committee be less than three
- Meetings must be held in Committee Room 1, unless virtual or Hybrid
- Meetings must be recorded as the Board is a formal committee of the council
- Meetings are public – members of the public can attend and sit in the public area. Any questions from the public must be requested prior to the meeting and will be considered on the discretion of the Chair.

HWB Executive Committee membership

Roger Harris (Chair), Mark Tebbs (Chair), Sheila Murphy, Les Billingham, Jane Foster-Taylor, Kim James, Michele Lucas, Ian Wake, Carol Hinvest, Julie Rogers/Michelle Cunningham, Teresa Salami-Oru

Operation matters regarding Health and Wellbeing Board

- Meetings are arranged by exception
- The Executive Committee helps to determine agenda items for the Health and Wellbeing Board

Meeting	Meeting date and time	Agenda Items	Deadlines
HWB	**8 October 10-12 noon.** **Papers published Wed 30 Sept.** **Papers sent for Imps Monday 21 September.** **Invitations sent to members**	1. Welcome and introductions 2. Minutes 3. Urgent items 4. Declaration of Interests 5. **BTUH CQC outcome for maternity services** – requested by Cllr Halden on 19 August 2020 6. **Update report from SEND Improvement Board to include SEND stretch targets** – requested by Cllr Halden (Sheila Murphy/Michele Lucas) 7. **Economically vulnerable Taskforce updates.** 8. **Greater Essex LeDeR Annual Report** – requested by	

Meeting	Meeting date and time	Agenda Items	Deadlines
HWB (Additional Meeting)	**Thursday 26 November 2.00 -4.00pm** **Invitations sent to members**	1. Welcome and introductions 2. Minutes 3. Urgent items 4. Declaration of Interests 5. **Thurrock Health and Wellbeing Strategy refresh** (Darren Kristiansen) 6. **Worklessness and Health JSNA** 7. **Active Place Strategy** (Julie Rogers) – 8. **CLA JSNA** (Elozona) (Deferred from October meeting on advice of Elozona) 9. **Initial Health Assessments for Looked After Children Update** (Sheila Murphy/Jane Foster-Taylor) 10. **Essex sexual abuse strategy** (Priscilla Tsang/Michelle Cunningham / Julie Rogers) **–** 9. **Children's wider mental health** requested by Cllr Halden	Publishing deadline: Wed 18 November Papers for Imps and to me/Cllr Halden Monday 9 November Agenda item 9 initial health assessments proposed at July Board. Excerpt from minutes: It was agreed a collaborative progress update will be provided at the next Board meeting. ACTION: Secretariat to include Initial Health Assessments to the Board work plan for the next meeting.
HWB	**Thursday 28 January 10:30-12:30** Cllr Halden to confirm date Invitations to be sent to members	1. Welcome and introductions 2. Minutes 3. Urgent items 4. Declaration of Interests 5. Health and Wellbeing Strategy refresh 6. 0-5 Wellbeing Programme (Teresa Salami-Oru) – Deferred from October meeting on advice of Teresa Salami-Oru 7. **Breastfeeding JSNA** (Beth Capps)	to publish papers for implications Waiting for Cllr Little to come back regarding dates

HWB	March 2021	1. Welcome and introductions 2. Minutes 3. Urgent items 4. Declaration of Interests **Break** 5. Initial Health Assessments for Looked After Children Update (Sheila Murphy/Jane Foster-Taylor)	Agenda item 5 prosed at July 2020 meeting. <u>Excerpt from minutes:</u> Members agreed that the proposed target of 90% of initial health assessments completed on time will be further reviewed at a Board meeting in 2021 to ensure it is both a realistic and stretching target. ACTION: Secretariat to include Initial Health Assessments performance to the Board work plan for a meeting in 2021.