NHS Nottingham and Nottinghamshire Integrated Care Board

LeDeR Programme

Learning from the Lives & Deaths of people with Learning Disabilities and Autism

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Introduction

The LeDeR programme (learning from the lives and deaths of people with learning disabilities and autism) is a national initiative that aims to improve patient safety by learning from serious incidents and deaths. The programme was established in 2015 and is now overseen by NHS England.

Nottingham and Nottinghamshire Integrated Care Board (NNICB – formerly CCG) has been involved in the LeDeR Programme since 2017. The Nottingham and Nottinghamshire Integrated Care Board has a dedicated LeDeR team that is responsible for coordinating the programme and supporting local healthcare providers to learn from serious incidents and deaths.

This report provides an overview of the progress and impact of the LeDeR programme in Nottingham and Nottinghamshire from April 01 2022 to 31 March 2023. The report highlights the key achievements of the programme, as well as the areas where further improvement and development is needed.

Key Achievements

The LeDeR programme has made a significant contribution to improving patient safety in Nottingham and Nottinghamshire. The programme has helped to:

- Improve the quality of LeDeR reviews, the learning and SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) actions arising from the learning.
- Challenge & prompt serious incident investigations where they haven't been carried out.
- Share learning from serious incidents and deaths across the healthcare system.
- Enable the implementation of changes to practice, based on learning from serious incidents and deaths.
- Appoint a new Quality Manager/Local Area Contact in May 2023, commencing in August 2022. Between May and August 2022, there was no full time Quality Manager/Local Area Contact for the LeDeR Programme.
- Appoint two reviewers commencing September 2023 and October 2023 respectively.
- Enable systems access to General Practitioner (GP) notes for reviewers.
- Enable platform access to hospital notes from our largest system acute trust.
- Create a culture where it is incumbent on all stakeholders to report serious incidents and deaths, with commitment to learning from these events.

Areas for Improvement

The following recommendations are made to further improve the LeDeR programme in Nottingham and Nottinghamshire. Whilst the LeDeR programme has made significant progress, there are still areas where further improvement is needed. These areas include:

- Ensuring all reviews are completed within the NHS England stipulated 6-month timeframe.
- Supporting provider colleagues to complete Structured Judgement Care Reviews (SJR's/SJCR's) in a timely fashion that allows completion and Nottingham and Nottinghamshire Integrated Care Board (NNICB) Quality Assurance Panel approval prior to the NHS England deadline.
- Improving the quality of data collection and analysis at local and national level.
- Strengthening the learning from serious incidents and deaths to improve care practice.
- Further developing our follow up of SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) actions to measure for impact and assurance that all actions have been completed by the care provider.

Summary

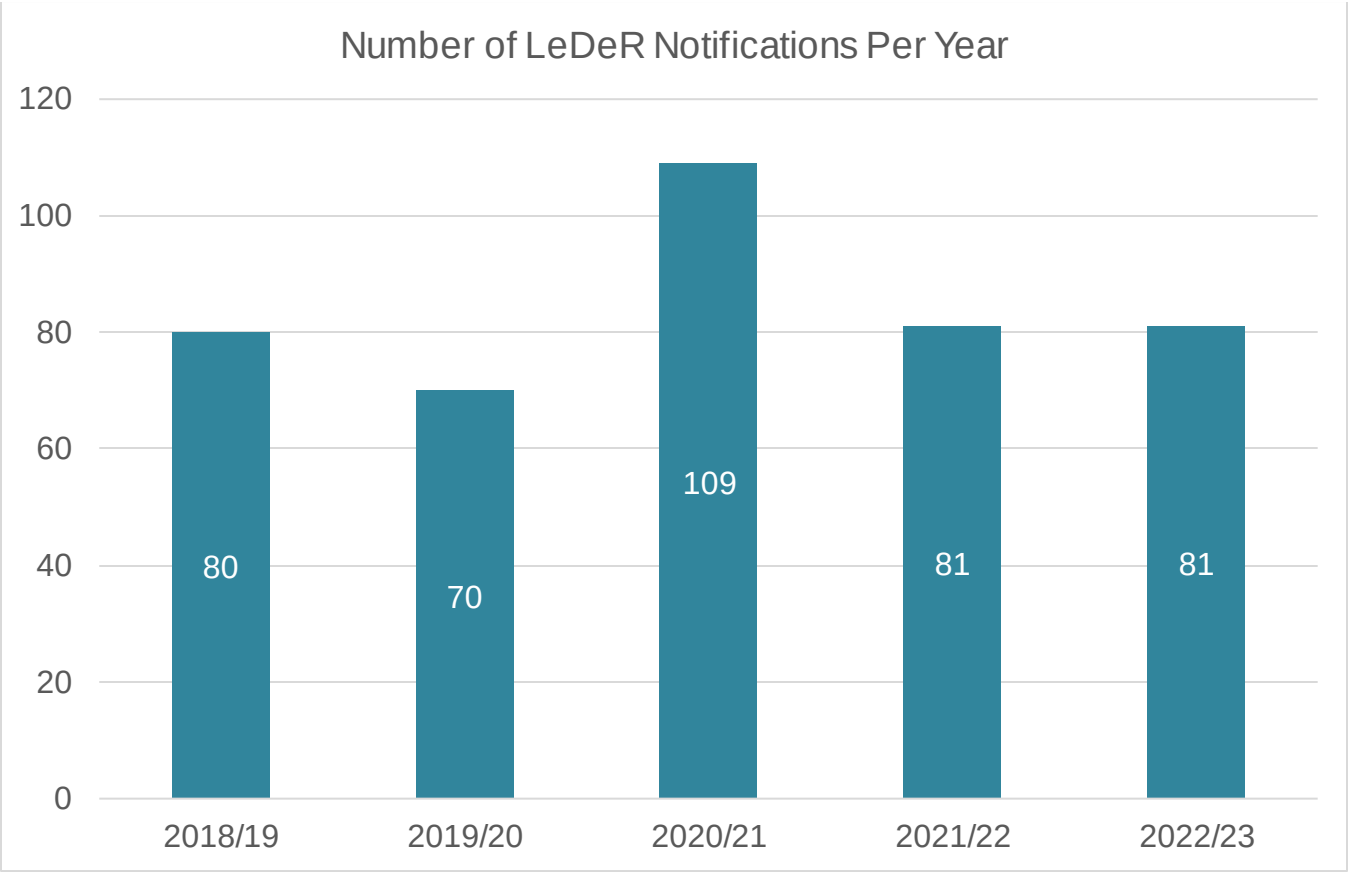
The LeDeR programme is a valuable tool for improving patient care and safety. The programme has made considerable progress in Nottingham and Nottinghamshire and has helped to create a culture of safety. However, there are still areas where further improvement can be achieved as a system. The Nottinghamshire Integrated Care Board (NNICB) is committed to continuing to improve the LeDeR programme and to making patient safety our foremost priority.

2022/23 Statistics & Data

LeDeR reports to date (March 2023)

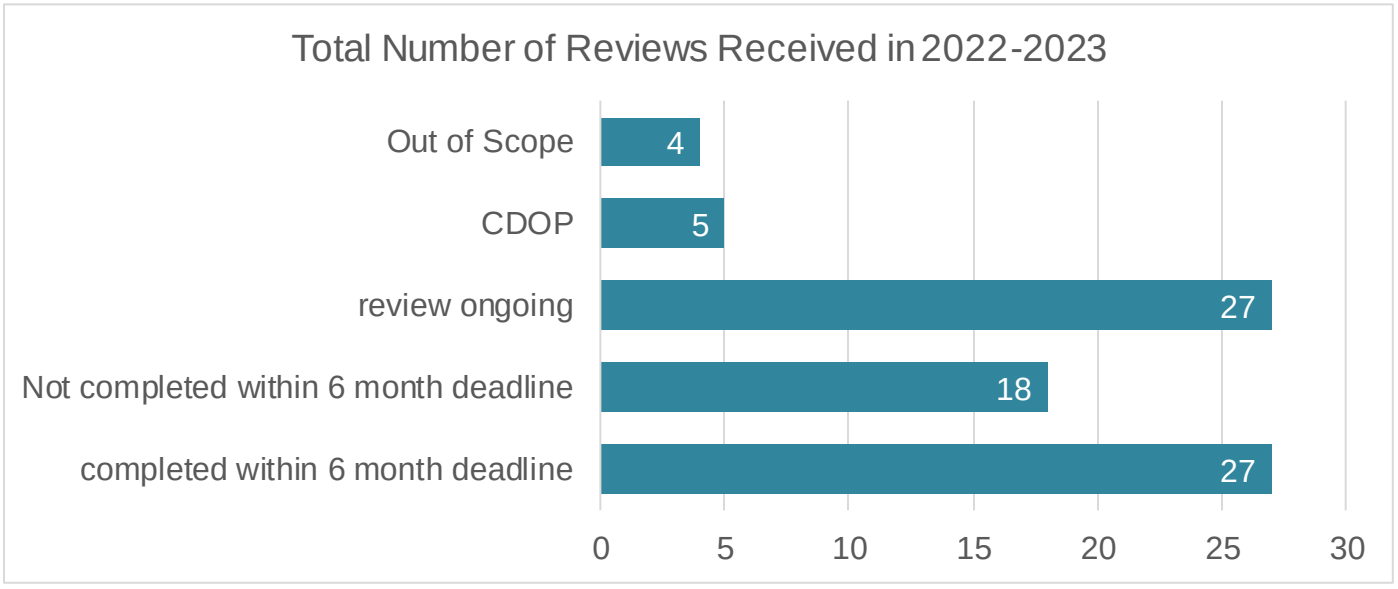
The breakdown of data below shows the number of notifications to date and 2022/23 performance.

81 notifications were made in 2022/23 and 72 of these were found to be in scope and went onto be reviewed. Four were found to be out of scope after investigations and five were Child Death Overview Panel (CDOP) reviews.

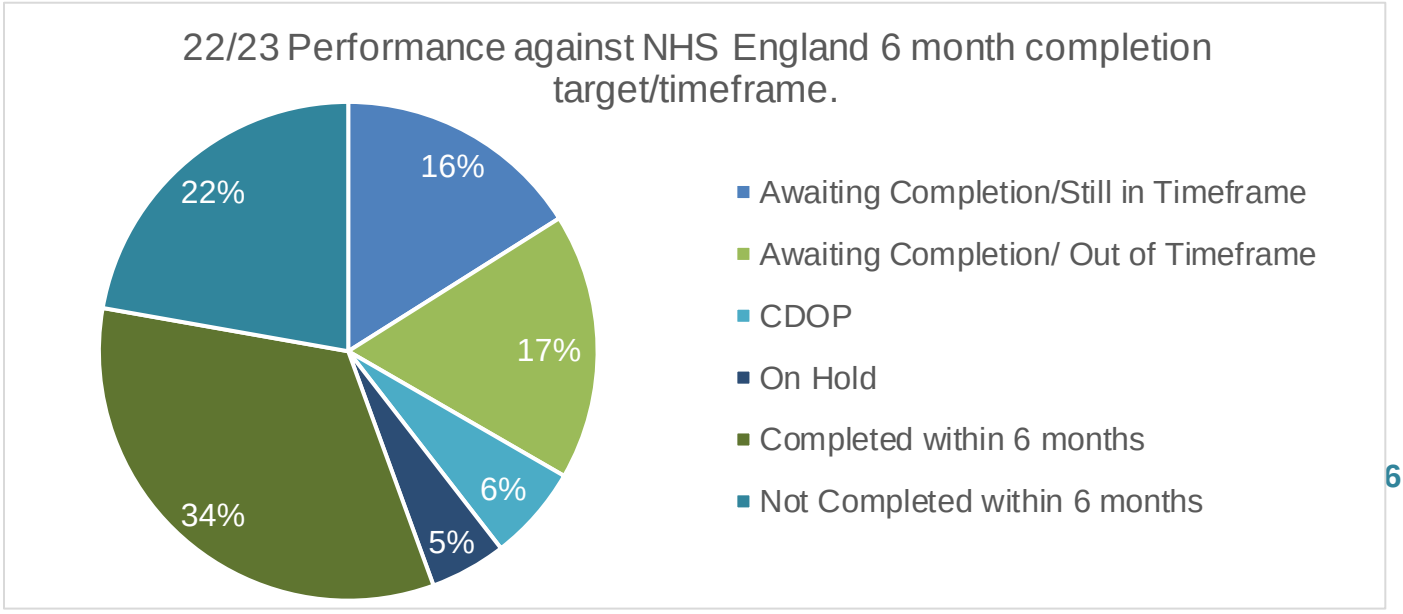


Annual report data 2022/23

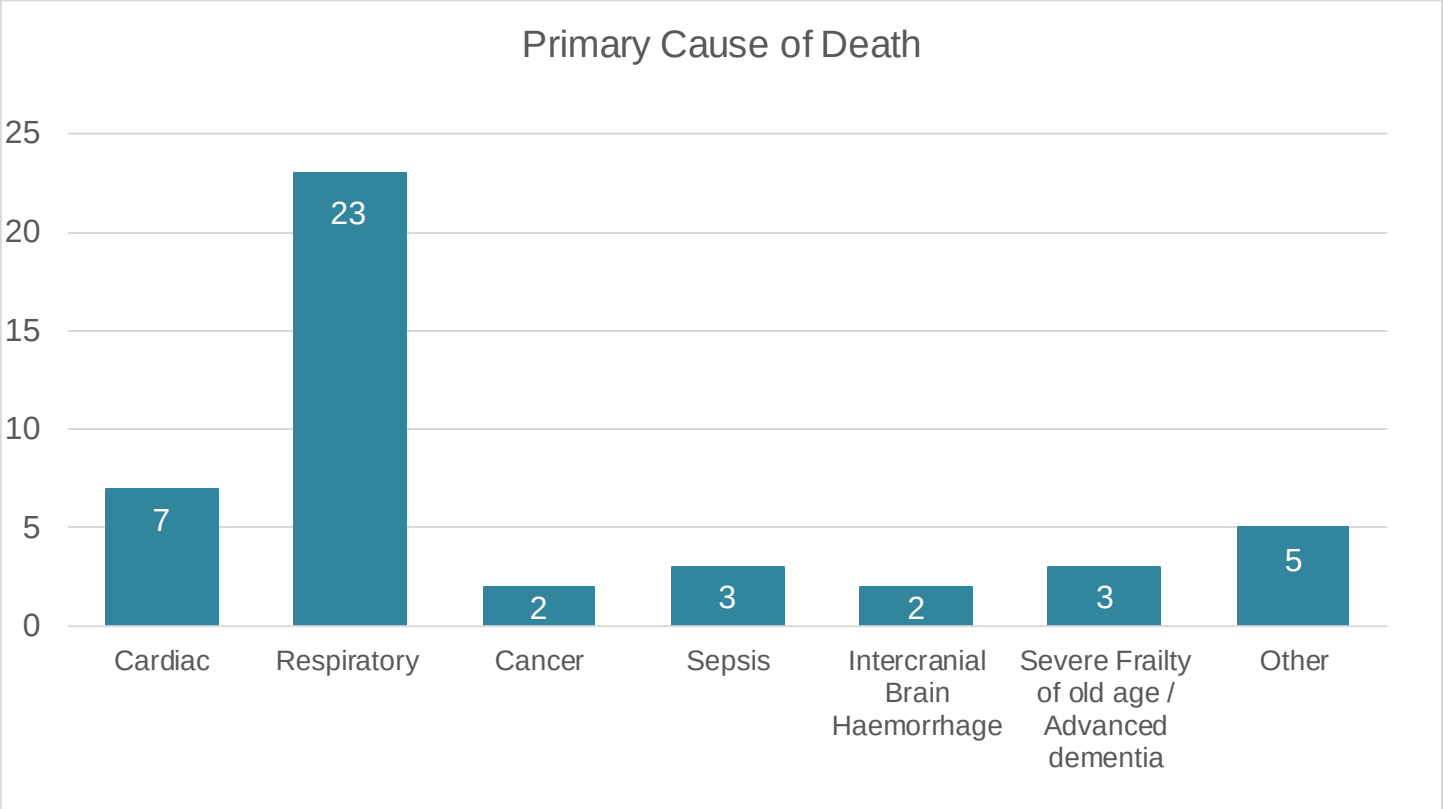
- 81 LeDeR Reviews have been received in 2022/23. This number has remained consist since the programme began apart from 2020/21 where we saw an increase due to COVID deaths.
- 5 Child Death Overview Panel (CDOP) – Reviews received and taken through the necessary process.
- 4 were found to be out of scope due to no diagnosis of Learning Disability (LD) or Autism Spectrum Disorder (ASD)
- 72 reviews were found to be in scope and allocated to LeDeR reviewers.
- 45 have been completed and signed off by the Local Area Contact (LAC) and Quality Assurance (QA) panel, 27 reviews were completed in the 6-month deadline.



18 reviews missed the 6-month deadline, 27 reviews remain live, of these 14 have missed the completion deadline, 13 reviews are still within the deadline. Delays are due to statutory processes, delays receiving notes, with 4 reviews currently on hold from the at coroner.

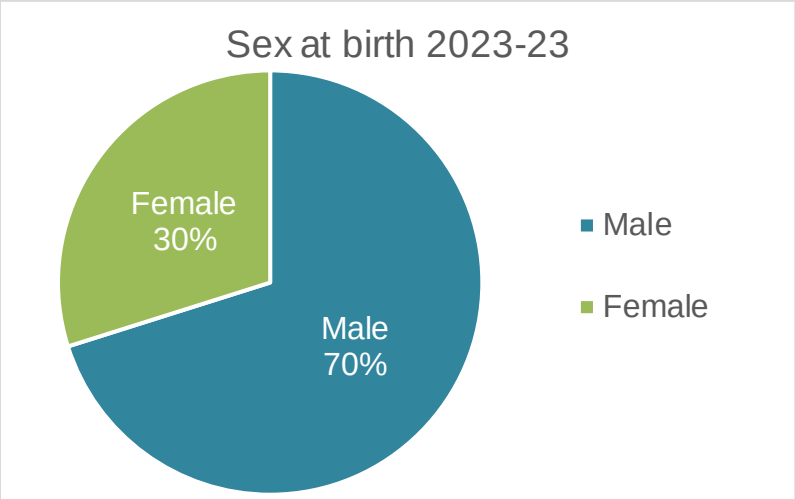


Cause of Death



This chart shows the cause of death taken from the 45 completed reviews so far during 2022/23. This data is constantly reviewed throughout the years to ensure that any themes and trends are identified. This data represents the primary cause of death, however some of these people had multiple contributing comorbidities. The forthcoming LeDeR Data tool will allow us to look at trends, using more granular data.

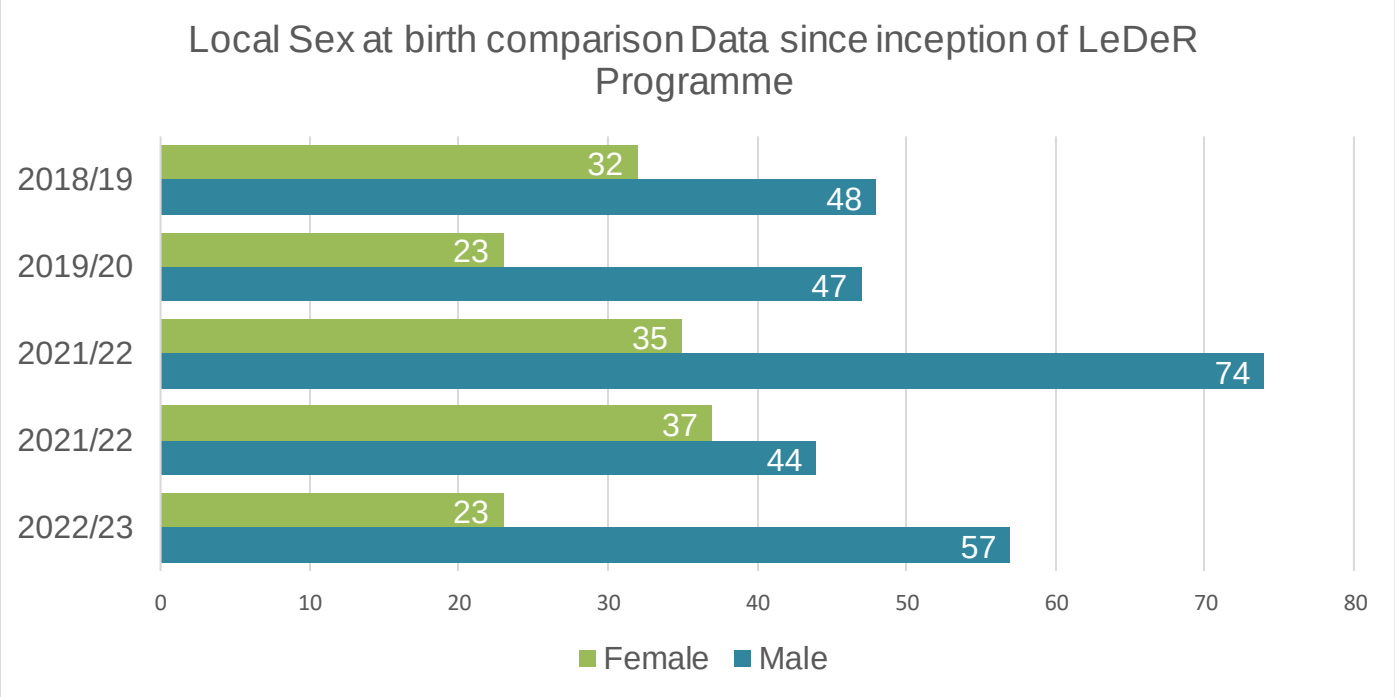
Gender and Age

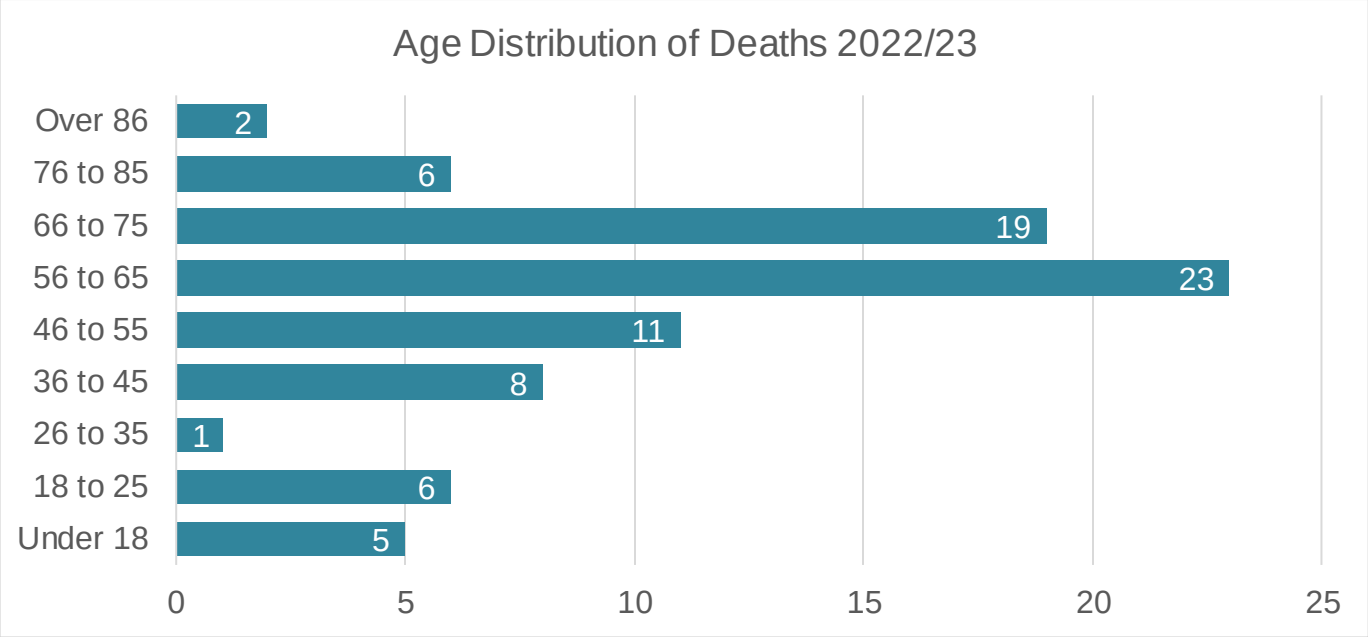


Out of the 77* LeDeR notifications received and taken to review, 70 percent were male, and 30 percent were female. The percentages are **exactly** the same in the data for completed reviews.

*In scope = 72 reviews, CDOP = 5

We have noted that percentages for male deaths are significantly higher than those for female deaths. A neighbouring system's percentages were balanced almost equally between the sexes.
We will be monitoring our data in 2023/24 to see if this trend continues and will use the Physical Health Steering Group to disseminate the information to providers, along with actions to try and explain what we are seeing and if there are service gaps that need to be addressed.

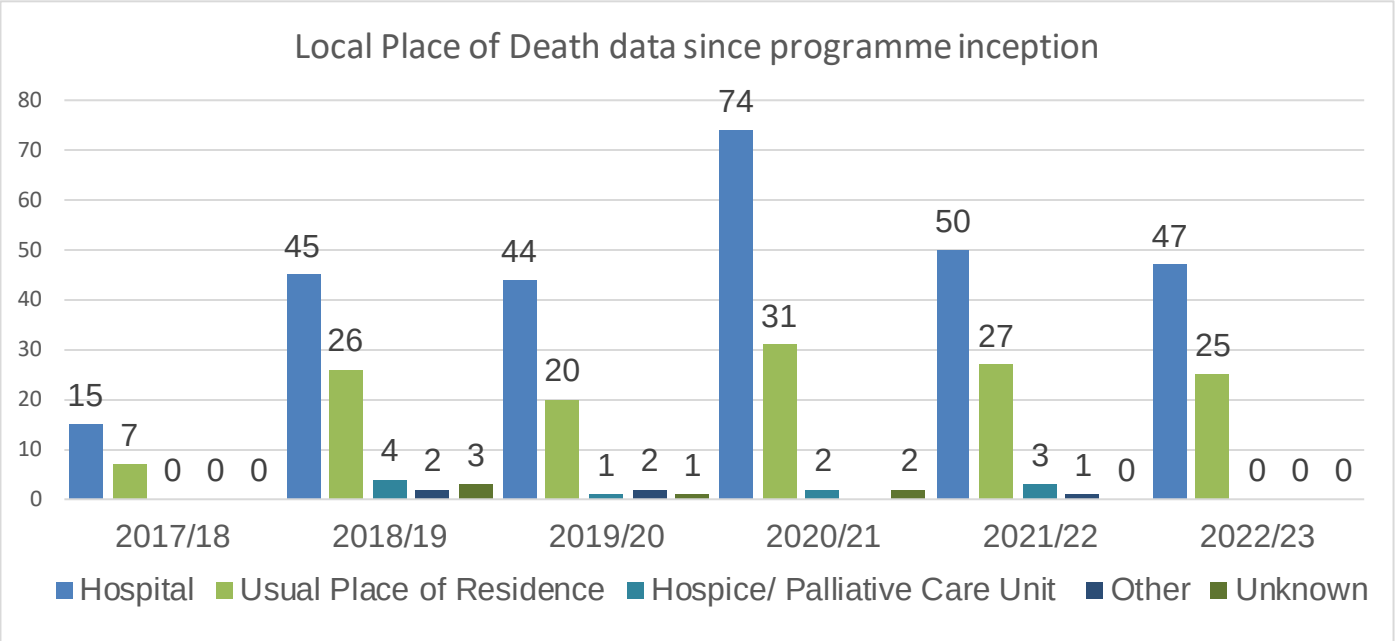




This chart shows the age of the individuals with Learning disabilities at the time of death, the majority of deaths taking place between ages of 56 to 65. The average age of death of people with Learning disabilities in 2022/23 was 55 – very little variation from the previous year as illustrated in the table below.

Reporting Period	Average age at death	These figures reflect the national picture during the same periods of time.
2022/23	55	
2021/22	54	

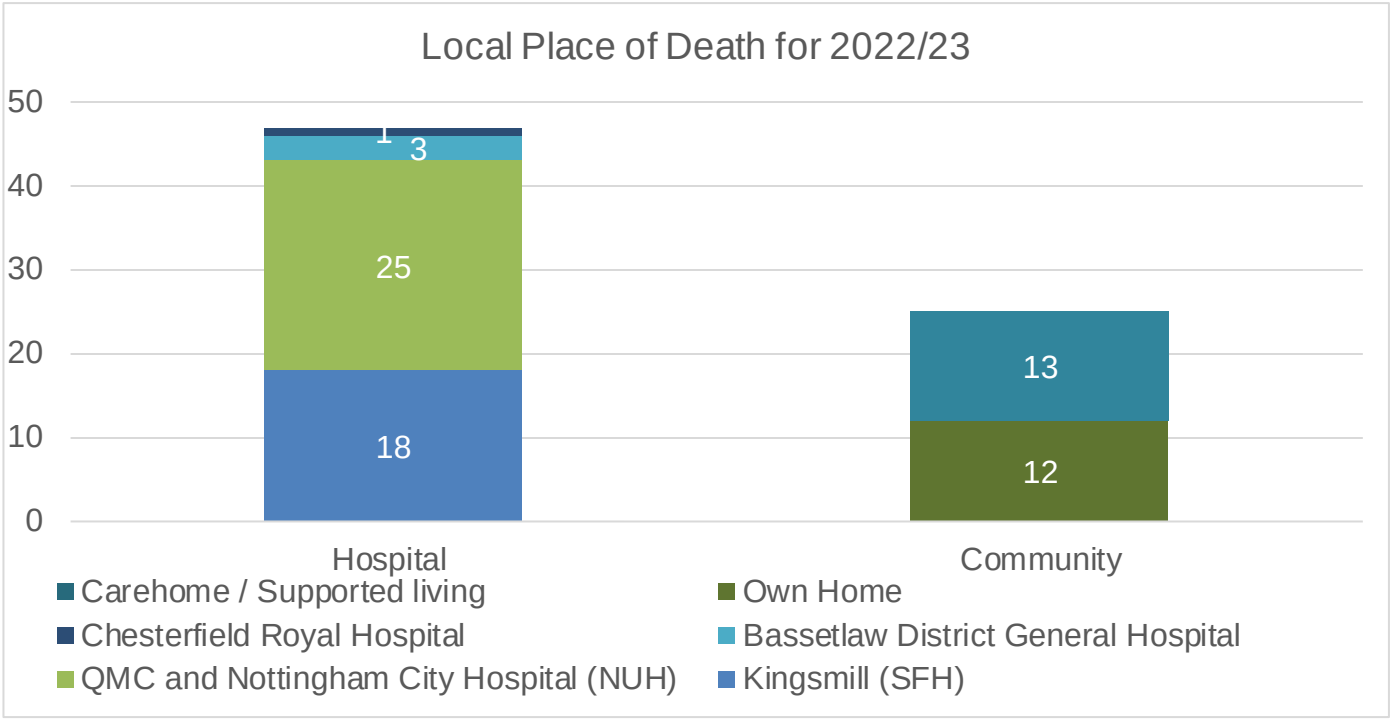
Place of Death



The above data was compiled from the 72 notifications taken to review and does not include Child Death Overview Panel (CDOP) reviews and out of scope reviews.

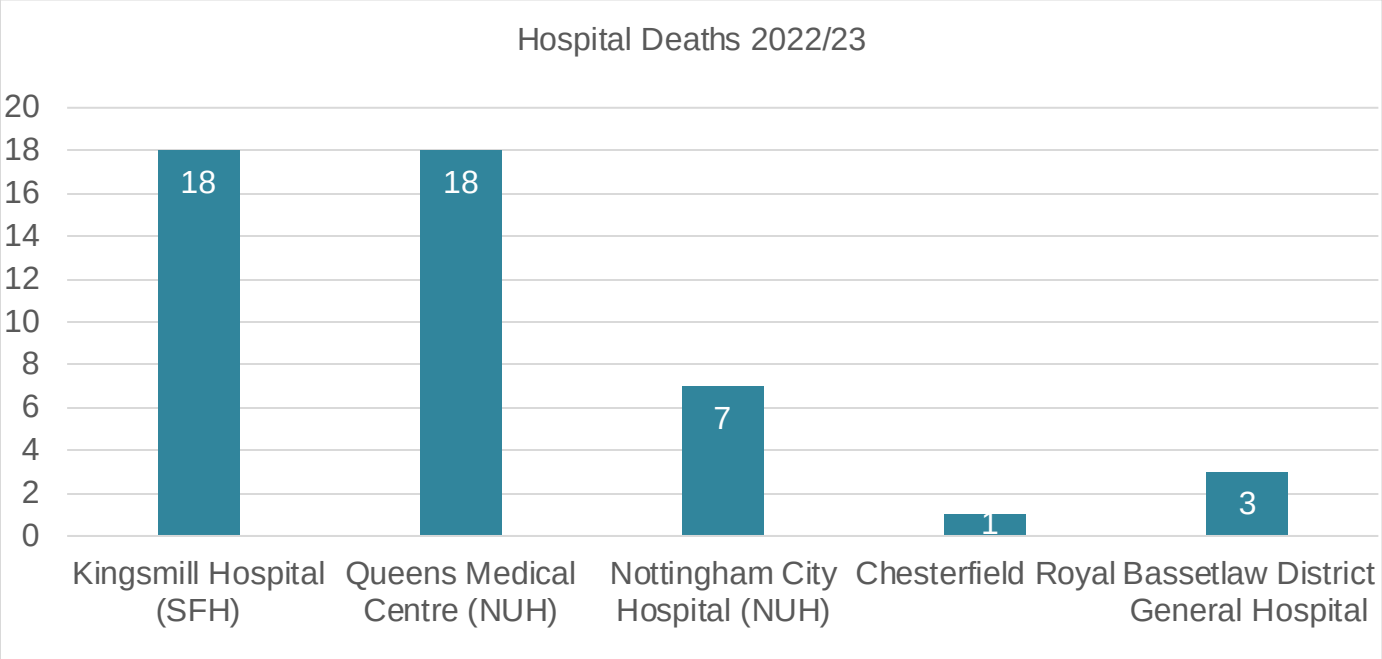
The chart above shows historical data.
Hospital deaths remain the most likely with 47 deaths across Nottingham and Nottinghamshire hospitals, 25 deaths took place in the community or usual place of residence, this would include deaths in supported living and care homes as well as those living independently in their own homes. We do not collect data on the preferred place of death and assume that ideally, people would rather die in their own home with familiar people, than in a hospital.

Because ReSPECT forms (Recommended Summary Plan for Emergency Care and Treatment) are only recorded in focused reviews and vary in detail, an accurate picture of desired place of death would be impossible. This is the position that a neighbouring system adopts too.

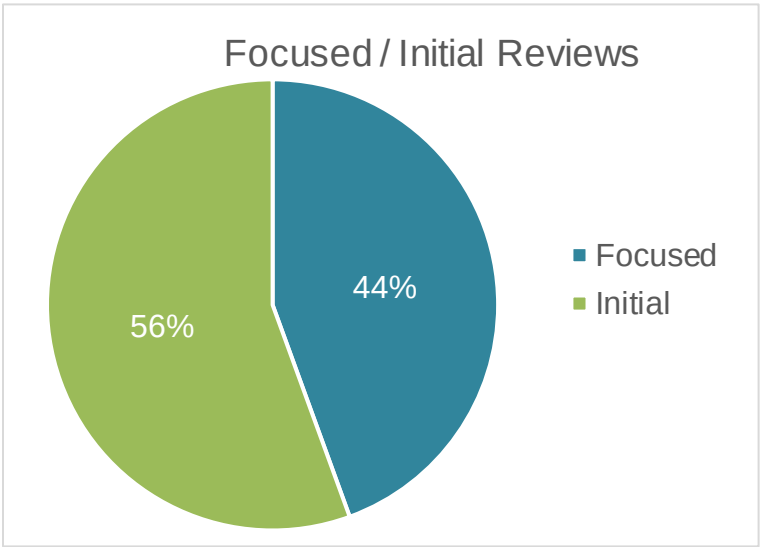


In 2022/23, the most likely place of death was hospital. This chart shows break down in deaths by hospital and community. Most deaths occurred in Nottingham University hospitals Trust (Queens Medical Centre and Nottingham City Hospital) this reflects the significantly larger population that Nottingham University Hospitals Trust covers.

Of the community deaths, 12 took place in the individuals own home, and 13 were found to have taken place in residential homes / supported living placements.
It is no surprise that more of the Learning Disability & Autism (LDA) population die in hospital, as people are admitted when they are physically most vulnerable.



Focused Reviews



(Please note our use of the USA spelling of 'focused', to match the LeDeR platform and convention at NHSE).

NHS England stipulate that a minimum of 35% of reviews must be focused.

In 2022/23 of the 72 reviews that have been allocated and are completed or ongoing, 44% are being completed as focused reviews.

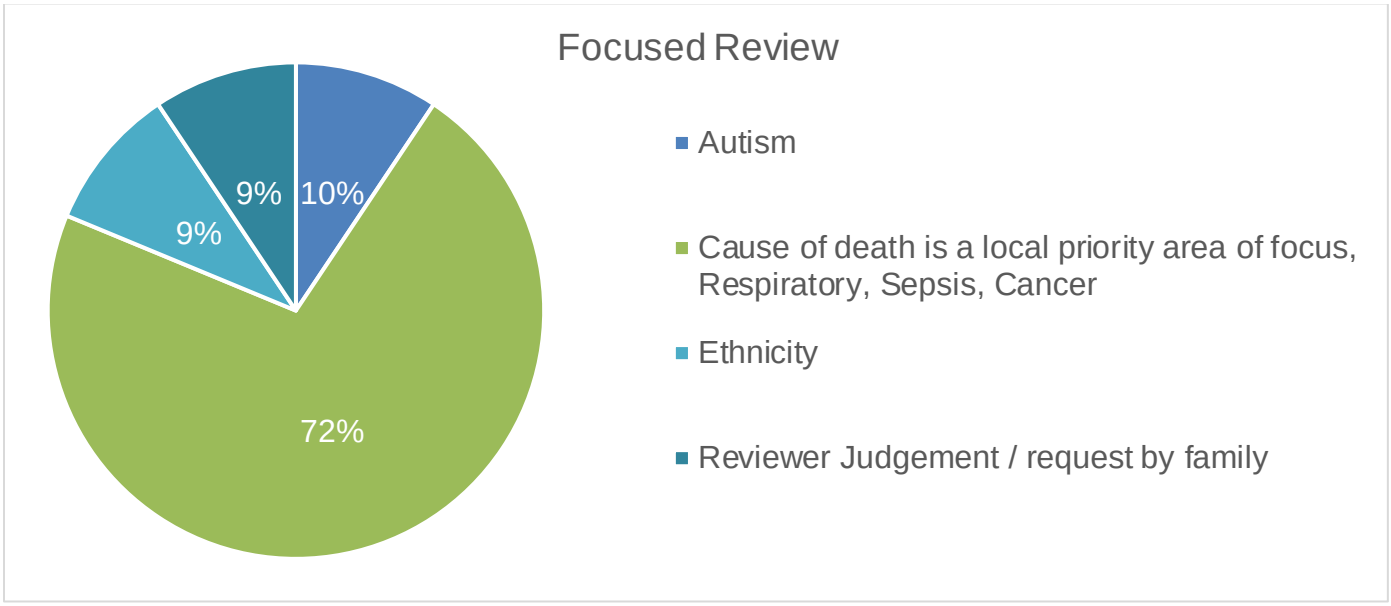
Focused reviews are completed if they are a "local priority area of focus", due to the cause of death, namely respiratory, Cancer, Sepsis. In 2022/23 72% of all focused reviews are being completed or have been completed for this reason.

Due to analysis of the data, deaths related to cardiovascular/cardiac in origin are now a priority area of local focus.

Three reviews have been converted to focused on the request of the reviewer or family. This is due to concern about potential gaps in services or learning that could be gained from a focused review.

Three reviews were autism only cases, these are automatically completed as focused.

Three reviews were focused due to the individual coming from an ethnic minority.



Ethnicity & Intersectionality

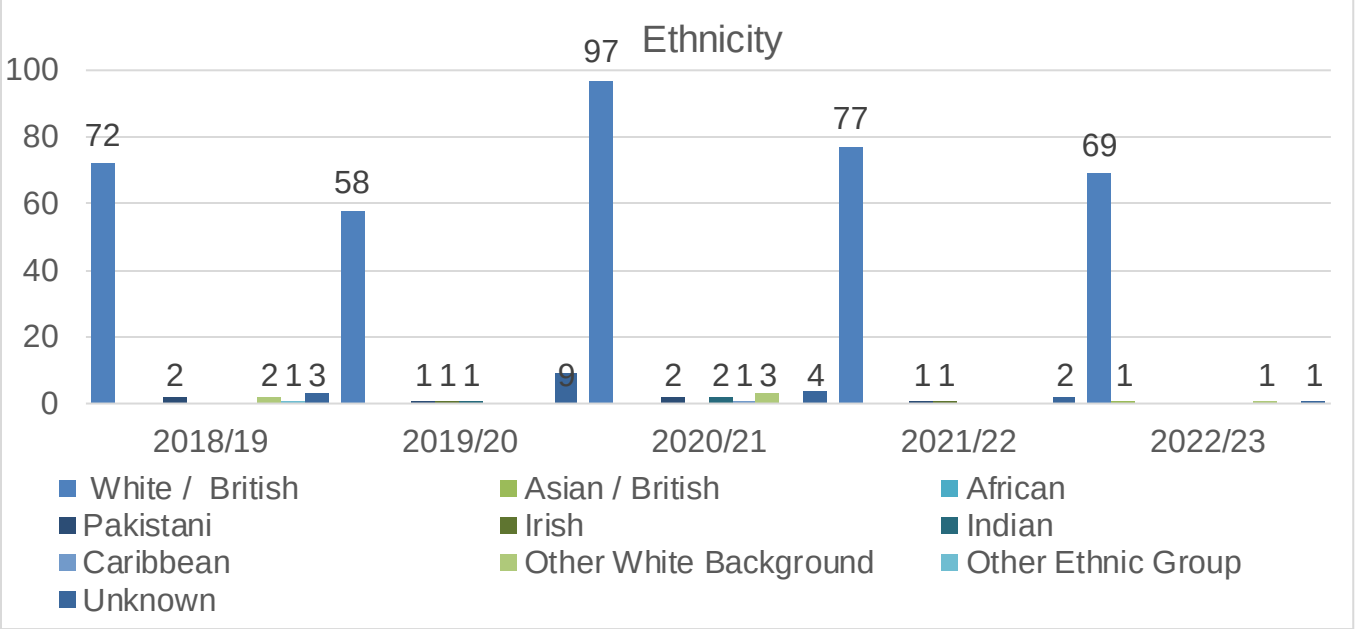
We live in a changing world, and the LeDeR programme when addressing health inequalities, has to ensure that the review process takes account of, and mitigates for the fact that all people with a learning disability or autism, regardless of race, culture, gender and sexuality receive health and social care that puts them on a parity with the whole population. This may mean that reasonable adjustments and mitigations are put in place to 'level up' the experience of individuals who may find that their characteristic puts them at a disadvantage in obtaining appropriate care.

In order to give assurance that appropriate reasonable adjustments and mitigations are being put in place, LeDeR reviewers are now required to undertake NHS England intersectionality training to ensure that the life and death of a person from a minority group is reviewed through the lens of being a member of that minority. The reviewer is then better placed to examine how this intersected with their Learning Disability/Autism and influenced access to social care and healthcare.

LeDeR will continue communication with the newly appointed head of Equality, Diversity and Inclusion (EDI) to explore and identify opportunities to work with people from Black & Minority Ethnic (BME) communities and form a better understanding of how LeDeR needs to interface with these groups and individuals.

ICB staff who undertook Intersectionality 'Train the Trainer' training in recent months will roll out a half-day Intersectionality Training session for LeDeR reviewers once the new additions to our team are 'onboarded'. We approached our LeDeR colleagues in Derby to collaborate with us and jointly host this online event. This has now been agreed.

Data shows that 95% of notifications received remain to be from a 'White British' background.



There is a clear a disparity between Nottingham and Nottinghamshire LeDeR statistics and statistics of the U.K. general population as collected in the 2021 Census which showed that the 'White British' portion of the population is only 74.4% whilst the overall white population is 82%. The overall percentage of non-white ethnic minorities is 18% and is broken down in more detail in the Office of National Statistics (O.N.S) chart above.

We are not at this moment certain as to the reason for this apparent under-reporting in the LeDeR cohort of people, but we are undertaking measures over the next year to investigate and mitigate for this.

In 2023/24, we will:

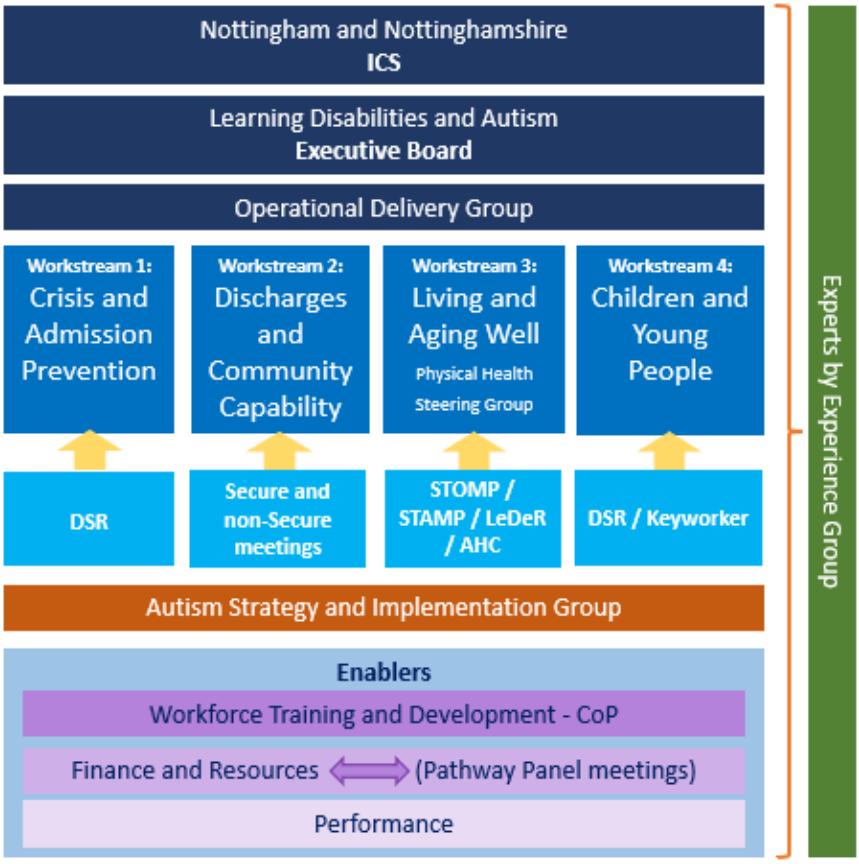
- Roll out intersectionality training to all reviewers in collaboration with Derby and Derbyshire LeDeR colleagues in conjunction with the NHS England supplied training. This will commence once we have appointed and onboarded new reviewers.
- Utilise new members of the LeDeR team to begin outreach into local ethnic communities.
- Explore the possibility of collaborating with Ethnic minority radio stations and key community leaders and groups in order to disseminate information about LeDeR to encourage LeDeR notifications in this cohort of people. This will have the benefit of giving LeDeR a better profile within ethnic minorities in Nottingham and Nottinghamshire.
- Collect postcode data on all LeDeR people from April 2023, to give us more granular data.

Governance Structure

The Physical Health Steering Group provides oversight and support to the local delivery of the programme.

The steering group meets bi-monthly and has representation from the ICB, NHS (primary care, community and acute) organisations, local authorities, General Practitoners, and experts by experience.

The steering group is facilitated and chaired by the ICB. The steering group has a wider remit than LeDeR, but is given updates to the learning and themes arising from completed LeDeR reviews across the system and is fundamental to cascading LeDeR findings to appropriate providers as well as signing off on.



LeDeR has also informed changes to organisational policies and practice when incidents have been reviewed and learning has been cascaded with a focus on quality improvement. Examples of this include increasing the of use communication tools between primary and secondary care systems such as health passports, or challenging thinking among acute care systems regarding capacity and consent to treatment. Further work is on-going to ensure changes in practice are embedded well across the system and workforce.

The LeDeR Quality Assurance Panel identifies themes, concerns, good practice and learning with actions then taken to the Physical Health Steering Group for wider dissemination. The group also ensures that outputs from the steering group are aligned to wider system partners and processes including safeguarding adult reviews, child death reviews (2022/23), inquests and police/prison/probation reporting. Updates, Situation reports and high-level reporting are also submitted to ICB Quality & Performance Committee to ensure system wide learning is embedded and risks are managed.

The LeDeR Team

During 2022/23, an external consultancy has been undertaking 87% of Nottingham and Nottinghamshire LeDeR reviews.

We are committed to aligning with NHS England guidelines that require us to use NHS Nottingham & Nottinghamshire Integrated Care System employed reviewers.

Our initial plan was to utilise our clinical staff within the ICB to complete reviews on behalf of the system. However, this was not sustainable as people moved roles, and found it challenging to complete reviews within the specified time frames due to competing demands from their substantive roles. This presented us with a significant challenge and limited capacity.

A proposal for ICB employed LeDeR reviewers has since been successful and will be recruited within the 2023/24 period. The ICB Reviewers will work with the LeDeR Local Area Contact and Head of Transforming Care for Learning Disabilities and/or Autism Spectrum Disorder, to undertake the timely completion of LeDeR reviews and will support the effective development and implementation of processes to ensure that robust reviews of good quality are undertaken. Working with the LeDeR Local Area Contact (LAC) and wider nursing/quality leads, they will identify areas of improvement for local practice by using the learning and intelligence from the reviews. This will allow us to support care providers in affecting change and influence the reduction of premature and avoidable deaths whilst improving the lives of people with a Learning Disability and people with Autism.

We also plan to enrol reviewers onto the local system nursing bank to undertake LeDeR reviews on an ad hoc basis. They would satisfy NHS England requirements and this proposal will be worked through in 2023/24

Annual Health Checks

As of 31 March 2023, there have been 5,220 health checks completed in 2022/23 across the ICS. This puts performance against this year's denominator, set by NHS England at the start of the year and based on the previous all age Quality and Outcomes Framework (QOF) General Practice Learning Disability register at 79% and 76% against the current General Practice Learning Disability register on E-Healthscope (14 years and over). Against the end of year target of 4649, the ICS has over performed by 571 health checks. This is an amazing achievement and means the ICS has not only met the 70% target for this year, but also met the Long Term Plan (LTP) ambition of 75% a year early.

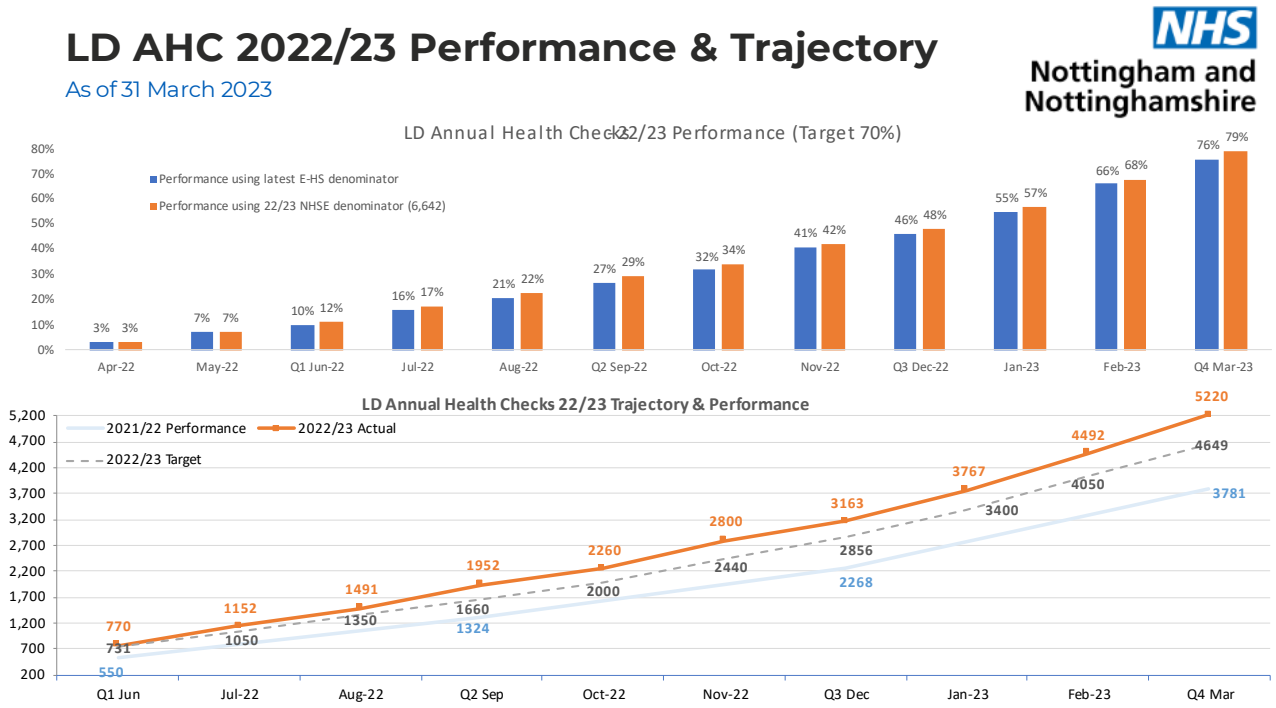
Of those health checks completed, 2% across the ICS are recorded not to have a Health Action Plan (HAP) with the largest gap in Nottingham City (8%), followed by Mid-Notts (2%) and South Notts (1%). Bassetlaw only had two health checks recorded as not having a Health Action Plan (HAP), which puts them at 91% against the adjusted Learning Disability register with Health Action Plans (HAPs) declines removed. Across the ICS, approximately 296 people are recorded to have declined a Health Action Plan (HAP) which equates to a decline rate of 4% against the total Learning Disability register on E-Healthscope.

Practices were incentivised this year, via the Impact and Investment Fund (IIF), to complete the Health Action Plans (HAP's). Locally the threshold for payment is 80% of Annual Health Checks with a Health Action Plan (HAP) completed, which has contributed to the improved performance by 20% (last year the gap was 22%). The Impact and Investment Fund (IIF) Health Action Plan (HAP) incentive remains in place for 2023/24 and has been revised to also include the recording of ethnicity.

NHS England also asked systems to prioritise and complete health checks for everyone who didn't receive one in 2021/22, known as the priority cohort in the table below. As of 31 March 2023, 1,461 health checks (66%) have been completed for the priority cohort across the ICS. This is a

fantastic achievement given the ongoing challenges in primary care whilst also continuing to deliver checks in line with their regular recall systems.

PBP	Performance %	AHC & HAP %	ICS Performance % using NHSE denominator	LD Register	LD AHCs Completed	LD Register with declines removed	With HAP Completed	Priority cohort AHCs completed	No. of priority cohort outstanding	Priority cohort denominator	% of priority cohort completed	No. of HAP declines	% of HAP declines	No. of AHC declines	% of AHC declines	No. of DNAs	% of DNAs
Bassetlaw	86%	91%		703	607	664	605	84	16	100	84%	39	6%	35	5.0%	1	0.1%
Mid Notts	77%	75%		2376	1825	2305	1725	593	262	855	69%	71	3%	54	2.3%	24	1.0%
Nottingham City	70%	62%		1983	1380	1888	1169	354	276	630	56%	95	5%	24	1.2%	23	1.2%
South Notts	80%	81%		1763	1408	1672	1356	430	191	621	69%	91	5%	68	3.9%	15	0.9%
ICS	76%	74%	79%	6825	5220	6529	4855	1461	745	2206	66%	296	4%	181	2.7%	63	0.9%



STOMP/STAMP

STOMP - **ST**opping **O**ver **M**edication of **P**eople with a learning disability, autism or both

STAMP - **S**upporting **T**reatment and **A**ppropriate **M**edication in **P**aediatrics

STOMP & STAMP are national programmes in the NHS to reduce the over-medication of children and young people with a learning disability, autism or both. The programmes are working to make sure that children, young people and adults with a learning disability, autism or both are only prescribed the right medication, at the right time and for the right reason. This will help to improve their health and well-being and give them a better quality of life.
The Nottingham and Nottinghamshire Integrated Care System STOMP & STAMP working group supports the aims of the national project at a local level.

The STOMP/STAMP programme aims to:

- Encourage people with a Learning Disabilities and/or Autism (LDA) to have regular check-ups about their medicines.
- Make sure doctors and other health professionals involve people, families and support staff in decisions about medicines.
- Review the use of psychotropic medicines in people with a learning disability, autism or both.

- Improve the quality of care for children and young people with a learning disability, autism or both who are prescribed medication.

- Ensure that children and young people are only prescribed the right medication, at the right time and for the right reason.

In Nottinghamshire, the STOMP working group is raising awareness of STOMP/STAMP in Children's services and considering it when developing and reviewing Education Health Care Plans (14 to 18 year-olds). They are also working to improve the quality of care for children and young people with a learning disability, autism or both who are prescribed medication.

A senior pharmacist post has been recruited to that will enable complete baseline searches on the General Practice (GP) patient records to identify children and young people with a Learning Disability, Autism or both, prescribed psychotropic medicines.

The Nottingham and Nottinghamshire ICB LeDeR programme is now fully aligned with STOMP and STAMP. The Quality and LeDeR Programme Manager is representing the ICB at system-wide and regional meetings and collaborating with system, regional and national NHS England STOMP/STAMP colleagues.

Significant findings are shared with system-wide and regional stakeholders, so that collaborative learning can be taken forward throughout the ICB to improve the lives of local people.

We are now in the process of onboarding pharmacist expertise as part of our LeDeR review quality assurance process. Details are to be finalised, but this could be achieved by attendance at panel, or by remote evaluation of redacted LeDeR reviews, reviewed by a pharmacist before final approval. We expect this to become business as usual by the end of 2023.

Non-LD Autism

Projections previously undertaken for people coming through LeDeR with Non – Learning Disability Autism haven't been recognised in the data yet. This is due to lack of 'flagging' on patient administration systems within Primary & Secondary Care, leading to notifications not being made for this cohort of people within LeDeR.

Flagging of people with autism cases is not fully developed. This is being piloted at Nottingham University Hospitals Trust (NUH) and nationally within the Annual Health Check architecture. Nottingham and Nottinghamshire LeDeR team has only received 3 Autism notifications between 01 April 2022 and 31 March 2023.

The national rollout is currently planned for 2024/25, subject to satisfactory evaluation and contracts.

Respiratory

Since November 2022, LeDeR has been involved in a focus with colleagues across the Nottingham/Nottinghamshire system as to how we might improve the outcome of people with an intellectual/learning disability and who have complex respiratory issues that lead to aspiration pneumonia.

We decided that it would be best to make initial contact with the key consultants and health professionals within our system so that we can understand what is already available across the system and the eligibility criteria.

This initial scoping exercise has now been undertaken and meetings are ongoing to decide upon a trajectory.

Negative health outcomes and increased mortality associated with Dysphagia (swallowing difficulties) are well recognised. The Speech and Language Therapy Service in the Community Intellectual Disability (ID) teams are developing an enhanced Dysphagia training plan for the year ahead (2023/24).

Their focus is on delivering training to community Intellectual Disability (ID) services where referral rates are high or support and is provided to those who are likely to have Dysphagia associated risks.

The training focus is on recognising signs and symptoms of Dysphagia, indicators for referral and practical strategies to reduce risk of aspiration.

Progress against objectives outlined in 2021/2022 LeDeR Report

Objectives for 2022/23	Actions undertaken
Nottingham and Nottinghamshire will develop an outcomes dashboard with a focus on exploring underlying causes of ill health and preventable deaths to facilitate a system-wide quality improvement approach to reduce the number of preventable deaths.	NHS England has developed a 'LeDeR Data Tool'. The 'LeDeR data tool shows deaths reported to the LeDeR programme for which a review has been completed. The aim of the tool is to give local areas access to data from LeDeR reviews to inform service improvement. The tool is not intended for performance reporting or tracking progress of reviews. This tool contains data derived from completed LeDeR reviews (as full information is then available). All charts in the tool are based on date of death i.e., the date the person died rather than the date the notification was received by LeDeR. A year is January to December, which means that additional steps will need to be taken when comparing with fiscal year data from other sources.
Review all recommendations within the LeDeR reviews at Quality Assurance Panel and Workstreams to embed the learning across the system in a quality improvement approach to reduce the number of preventable deaths. Ensure that a sample of reviews that highlighted good quality and a sample showing poorer quality care are looked at by the system physical health steering group and comparison made to understand where high quality care is happening and focus on areas/examples that require improvement.	All reviews are sent to care providers in redacted form and those where concerns have been highlighted are fed back in meetings with providers. This allows additional context and SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) actions to be provided to the care provider. Bespoke exemplar reviews produced by NHS England have been sent out to reviewers, but other versions have not, due to potential identification of reviewer, care

	providers and of course, the person for whom the review was written.
We will break down the average age of death by locality area as well as take an average across the whole area, in order to understand if average LeDeR deaths are linked to variations in general population age of deaths, which vary between differing areas.	Information is now being recorded by postcode, which will, when combined with Government and NHS England data, give us a more granular picture of LeDeR deaths in comparison to deaths in the wider population.
We will work towards achieving the national outcomes objectives in line with people with a learning disability and autistic people (LeDeR) policy (Version 1, 23 March 2021) during 2022/23 and review progress in 2023.	We are currently working towards national outcomes objectives in line with people with a learning disability and autistic people (LeDeR) policy (Version 1, 23 March 2021). Progress is reviewed each quarter and mitigations are in place to achieve alignment with the objectives.
Increase communication and education of LeDeR into the community and wider workforce with a focus on raising General Practitioner (GP) awareness	Planned additions to the LeDeR Team will deliver promotion of LeDeR amongst stakeholders including General Practitioner's (GP's) and community representatives, with particular focus on ethnic minorities and representatives of those with protected characteristics.
Work with NHS England regional team to ensure that we are supporting delivery of the Oliver McGowan training in conjunction with the Nottinghamshire Training Alliance Hub. Understand what the resource is and what the practical implications are for us as a system to ensure that the work is coordinated and is achievable within timescales. Greater use of reasonable adjustments in health and care services for people with a learning disability and autistic people.	Oliver McGowan training is being rolled out within the ICB and across the Nottingham and Nottinghamshire Integrated care system in 2023.
Better outcomes for people as a result of local service improvement project.	Potential improvements are still at scoping stage but will be developed throughout 2023/24.
To complete LEDER reviews within timescales using reviewers with knowledge and expertise from across the system.	Measures are being put in place to deliver LeDeR reviews of a robust quality within the NHS England timeframe of 06 months. The quality assurance panel is made up with professionals with different backgrounds and this will include a pharmacist by the end of 2023. We are working with system colleagues to ensure the prompt receipt of care records for our reviewers.

Objectives for 2023/24 and Beyond

- We will continue to feedback and consult with system colleagues on a regular basis and will communicate reviewer and LeDeR Quality Assurance panel concerns, questions, recommendations and actions. In the spirit of PDSA (Plan, Do, Study, Act) cycles, we aim to continually review and refine our feedback processes and are currently adding a "Focussed Review Multi-Disciplinary Team (MDT) Meeting". This will be a tool to take a detailed look at aspects of care highlighted in a LeDeR review where we feel that more information is needed when quality and safeguarding issues are indicated.

- People with learning disabilities and epilepsy are at greater risk of premature death and higher risk of sudden unexpected death in epilepsy (SUDEP). We will work with colleagues through LeDeR reviews to identify people who die and who suffered with epilepsy during their life.

- Cardiac issues are now the second highest cause of death for people with learning disabilities and autism in 2022/23. Other causes of death such as cancer have not emerged as being statistically unusual, so we gained approval from the Nottingham and Nottinghamshire Integrated Care System Physical Health Steering Group to swap our local areas of focus for the undertaking of focussed reviews. Cardiac issues have now replaced cancer as a local area of focus. We are now in early discussions with system colleagues on how to best address this issue.

- A representative from the LeDeR team is now included in the ICB Quality/Safeguarding panel discussions for all serious incident investigations involving Learning Disability & Autism cases. This will also give advance warning if a death has occurred as the result of a serious incident. It also allows our input to be given in cases where a living person is involved. This is now 'business as usual'.

- We are now routinely looking for any hint of safeguarding issues/referrals in the LeDeR notifications and where these are found, we're discussing it with the ICB Safeguarding Team and Quality Team to ensure that they are alerted and that if investigations are being undertaken, the LeDeR review can be put on hold until they are complete and all information is made available.

- The NHS England LeDeR platform has been completely overhauled and will be key to delivering improved the quality of reviews. There has been a significant improvement to the ease of use for reviewers and sections are more logically distributed, with expectations set

- out in the margins of each free-text box. This improvement has been followed up with a handbook and training session for all reviewers.

- NNICB reviewers will form part of our quality assurance panel. This will serve to accelerate learning between peers.

- Improve performance against our 6-month target by developing timely access to medical notes, Structured Judgment Reviews (SJR's) and General Practice (GP) records and improving quality of reviews so that less time is spent adding to and making corrections or amendments to reviews.

- Give robust feedback to care providers in the form of SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) actions that will improve the safety and care of all of those entrusted to our Nottingham and Nottinghamshire Integrated Care System.

- Respiratory, cardiac, sepsis and cancer deaths to be a focus in 2023/24 to align with system CORE20Plus5 target areas.

- Learn from the results of the Nottingham University Hospital Trust Autism Pilot

- Embed ICB Reviewers into the Nottingham and Nottinghamshire System

Appendix 1

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General population demographic by ethnic group

Ethnic Group - Source: Office for National Statistics – Census 2021	2021(percent)	2021(number)	Percentage as wider ethnic group
Asian, Asian British or Asian Welsh: Bangladeshi	1.1	644,881	9%
Asian, Asian British or Asian Welsh: Chinese	0.7	445,619	
Asian, Asian British or Asian Welsh: Indian	3.1	1,864,318	
Asian, Asian British or Asian Welsh: Pakistani	2.7	1,587,819	
Asian, Asian British or Asian Welsh: Other Asian	1.6	972,783	
Black, Black British, Black Welsh, Caribbean or African: African	2.5	1,488,381	4%
Black, Black British, Black Welsh, Caribbean or African: Caribbean	1.0	623,119	
Black, Black British, Black Welsh, Caribbean or African: Other Black	0.5	297,778	
Mixed or Multiple ethnic groups: White and Asian	0.8	488,225	3%
Mixed or Multiple ethnic groups: White and Black African	0.4	249,596	
Mixed or Multiple ethnic groups: White and Black Caribbean	0.9	513,042	
Mixed or Multiple ethnic groups: Other Mixed or Multiple ethnic groups	0.8	467,113	
White: English, Welsh, Scottish, Northern Irish or British	74.4	44,355,038	82%
White: Irish	0.9	507,465	
White: Gypsy or Irish Traveller	0.1	67,768	
White: Roma	0.2	100,981	
White: Other White	6.2	3,667,997	
Other ethnic group: Arab	0.6	331,844	2%
Other ethnic group: Any other ethnic group	1.6	923,775	

NHS Nottingham & Nottinghamshire Integrated Care Board

LeDeR Programme Annual Report April 2022 – March 2023

LeDeR Team:

Jonathan Sansome - Quality and LeDeR Programme Manager, Nottingham & Nottinghamshire ICB

Kirstie Charlesworth - LeDeR Programme Admin, Nottingham & Nottinghamshire ICB

Contributors:

Adele Smith - Senior Transformation and Commissioning Manager, Nottingham & Nottinghamshire ICB

Emma Mattick - Clinical Lead Speech and Language Therapist, Nottinghamshire Healthcare Trust

* An 'easy-read version of this report is available on the same web page as this report.