

Item: 8.10

Report to: NHS Hull Clinical Commissioning Group Board

Date of Meeting: 25th September 2020

Title of Report: Learning Disability Mortality Reviews (LeDeR) Annual Report in 2019/20

Presented by: Deborah Lowe, Deputy Director of Quality and Clinical Governance / Lead Nurse

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STATUS OF THE REPORT:

To approve	<input checked="" type="checkbox"/>	To endorse	<input type="checkbox"/>
To ratify	<input type="checkbox"/>	To discuss	<input type="checkbox"/>
To consider	<input type="checkbox"/>	For information	<input type="checkbox"/>
To note	<input type="checkbox"/>		

PURPOSE OF REPORT:

- To provide an update to the NHS Hull Quality and Performance Committee in regard to the progress of the implementation and management of the LeDeR process in Hull.
- There is a national requirement that the LeDeR Annual Report will be published on the CCG website, this will be achieved by 30th September 2020 following presentation at the Hull Clinical Commission Group Governing Body on Friday 25th September 2020.

LEVEL OF CONFIDENCE:

NHS Hull Clinical Commissioning Group (CCG)

PROCESS	Rating
There is a HIGH level of confidence in NHS Hull CCG discharging it's duties in relation to the LeDeR programme.	High
PERFORMANCE	
There is a HIGH level of confidence in NHS Hull CCG discharging it's duties in relation to the LeDeR programme.	High

RECOMMENDATIONS:

The members of the NHS Hull CCG Board are requested to approve this report in relation to progress within the national LeDeR programme.

REPORT EXEMPT FROM PUBLIC DISCLOSURE

No Yes

CCG STRATEGIC OBJECTIVE:

1. Facilitate strategic Humber-wide planning and transformation, focusing on quality outcomes and patient experience as the catalysts for clinically-led change.

The safeguarding of adults, children and young people who are at risk of or being abused and neglected is embedded within all quality and safety processes of the organisation.

IMPLICATIONS:

Finance	Workload for the LeDeR programme is managed by the current workforce. There are no identified financial risks associated with this report currently, however there may be potential should the demand for resources and reviews increase.
HR	There are currently no identified HR implications so far in Hull; however some areas of the region are struggling to identify reviewers creating a back log of reviews awaiting allocation.
Quality	Quality issues not addressed within LeDeR and safeguarding processes may result in unacceptable levels of care and poor performance from contracted providers and partners.
Safety	Risks not addressed may result in safety and safeguarding concerns for adults, children and young people.

ENGAGEMENT:

- Challenge and scrutiny of provider compliance and performance for LeDeR takes place via the Clinical Quality Forums (CQF), Quality Delivery Groups (QDG) and the Quality and Performance Committee (Q&P).
- Quality assurance of all reports for Hull residents is completed at the NHS Hull CCG monthly LeDeR panel attended by partner agencies in health and social care.
- Inter-agency working primarily takes place with local health partner agencies via the Hull and East Riding LeDeR steering group.
- Wider health engagement takes place via the NHS England Yorkshire and Humber LeDeR regional meeting each quarter.
- Further engagement with the Local Learning Disability Partnership has been established.

LEGAL ISSUES:

All LeDeR and safeguarding activity described in this report is underpinned and supported by current national legislation and statutory guidance.

EQUALITY AND DIVERSITY ISSUES:

	<i>Tick relevant box</i>
An Equality Impact Analysis/Assessment is not required for this report.	X
An Equality Impact Analysis/Assessment has been completed and approved by the lead Director for Equality and Diversity. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.	
An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.	

THE NHS CONSTITUTION:

Safeguarding and safety is integral to the NHS Constitution and is framed by the values and principles which guide the NHS, with particular reference to the provision of high quality care that is safe, effective and focussed on patient experience.

Principle 1 – The NHS provides a comprehensive service, available to all.

Principle 2 – Access to NHS services is based on clinical need, not an individual's ability to pay.

Principle 3 – The NHS aspires to the highest standards of excellence and professionalism.

Principle 4 – NHS services must reflect the needs and preferences of patients, their families and carers.

Principle 5 – The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.

Principle 6 – The NHS is committed to providing best value for taxpayers money and the most effective, fair and sustainable use of finite resources.

Principle 7 – The NHS is accountable to the public, communities and patients that it serves.

**NHS HULL CLINICAL COMMISSIONING GROUP
LEDER ANNUAL REPORT 2019/20**

REPORTED TO NHS HULL CCG BOARD HELD ON 25TH SEPTEMBER 2020

1. Introduction

The purpose of this report is to:

- a) Provide assurance with regards to the process and functions NHS Hull CCG has in place to manage the LeDeR programme.
- b) Demonstrate how NHS Hull CCG is fulfilling its statutory safeguarding responsibilities in relation to the Care Act 2014 and Children's Act 1989/2004.
- c) Provide details of the key learning points identified following the completion of reviews and the actions being implemented to address these.

There is a national requirement that the LeDeR Annual Report will be published on the CCG website, this will be achieved by 30th September 2020 following presentation at the Hull Clinical Commission Group Governing Body on Friday 25th September 2020.

2. Background

The National Learning Disabilities Mortality Review (LeDeR) Programme has been established as a response to the recommendations from the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD 2013). CIPOLD reported that people with learning disabilities are three times more likely to die from causes of death that could have been avoided with good quality healthcare.

The LeDeR programme is funded by NHS England and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. The programme is being delivered by the Norah Fry Research Centre at the University of Bristol. Funding for the delivery programme will cease at the end of May 2020 and NHS England/Improvement will be taking over the management of the programme.

The main objectives of the programme are;

- Identify the potentially avoidable contributory factors related to deaths of people with learning disabilities.
- Identify variation and best practice in preventing premature mortality of people with learning disabilities.
- Develop action plans to make any necessary changes to health and social care service delivery for people with learning disabilities.

All deaths of people with a diagnosis of a learning disability will be reported to the LeDeR programme. The deaths of those aged four years and over will be reviewed.

Links with other Review Processes

The LeDeR review process links with other investigation/reviews where appropriate including:

- Serious Case Reviews (SCR's).
- Safeguarding Adult Reviews (SAR's).

- Safeguarding Adult Enquiries (Section 42 Care Act).
- Domestic Homicide Reviews (DHR's).
- Serious Incident Reviews.
- Coroners' investigations.
- Child Death Reviews.

To note – the death of an individual with a learning disability does not automatically trigger a safeguarding response. However, at any point through the LeDeR review process, if safeguarding concerns are identified, the local area safeguarding process would be followed.

3. Purpose

The purpose of this report is to provide NHS Hull CCG Governing Body with an annual update of the CCG's position in relation to the Learning Disabilities Mortality Review Programme.

4. Local arrangements and governance

The Deputy Director of Quality and Clinical Governance/Executive Nurse is the nominated Local Area Contact (LAC) for Hull and is supported by the deputy LAC's, which include the Professional Advisor Primary Care Nursing, the designated professional for safeguarding adults and the strategic lead for mental health and learning disabilities.

LeDeR is formally reported via the Quality and Performance Committee for strategic oversight. Learning or requirements for change or development from reviews which has implications for the commissioning of services will be reported to the Planning and Commissioning Committee.

NHS Hull CCG has developed a robust process for the management of LeDeR, with the establishment of monthly LeDeR panel meetings. The process also has a dedicated administrative support.

The LeDeR panel membership consists of representatives from across the local health and social care economy.

In addition, a local steering group has been established in partnership with East Riding of Yorkshire CCG, health partners and the two local authorities. The progress and learning from completed LeDeR investigations are presented to the group for discussion and inform future plans in respect of quality improvement and initiatives in improving the lives and health outcomes for people with a Learning Disability. The steering group also ensure that robust processes continue to be developed and are well embedded to support the ongoing management of LeDeR locally. This group reports directly to the regional steering group.

5. LeDeR Process

The Local Area Contact (LAC) is notified of a reported death requiring review via the Bristol system, the IT platform that manages LeDeR. Email notification is sent both directly to the LAC and also a dedicated mailbox. It is then the LAC's responsibility to identify a reviewer from the trained pool of staff and allocate the review. The review can be allocated either internally within the CCG or to a provider organisation and is usually dependent on the most suitably placed based on the details provided in relation to the death.

It is important that reviewers, regardless of experience are supported both emotionally and physically throughout the process. Therefore, each review is allocated a buddy (if required) to support them during the review. A reviewer support group has also been established of which the frequency is monthly and has been positively received. The reviewer's role includes making contact with the family and invites them, should they wish, to be involved in the review providing important detail and information into the person's life and care experiences which will then lead to build a detailed pen portrait of the individual.

The reviewer's role is to develop a chronology of the individuals care. This is achieved by gaining access to reviewing all relevant medical notes to collect information about the circumstances leading up to the person's death. Should the reviewer encounter any challenges with for example the accessing of records then the CCG support in achieving this.

There are currently ten members of staff who are trained within the CCG to undertake LeDeRR reviews. In addition, the CCG is also supported by four reviewers from the Local Authority that have also completed the training. Providers also have their own staff trained and support the overall process.

LeDeR reviews have taken place with the support of primary care, with practices continuing to be involved in the process and assisting reviewers to access deceased patient records. Furthermore, two new reviews from Primary Care Networks have been allocated to the CCG. A senior staff member from Modality has completed the reviewer training. This is a real positive step for primary care.

On receipt of a notification the LAC allocates a reviewer, the LeDeR dedicated administration report will then support by sending the notification to the allocated reviewer. This notification includes the expected submission date of the review which has been set at a sixty day timescale. It is however acknowledged that some reviews may require a full multi-agency approach, or require longer than the sixty days due to the complexity and requests from families, therefore the timescale for completion is discussed where necessary and agreed with the LAC. An internal CCG notification of a newly reported death requiring review is also circulated.

The CCG holds a detailed log which captures key information relating to each reported death, this also recording the progress of the reviews being undertaken. A progress update is requested every three weeks from the reviewer's. Each reviewer with an ongoing review is expected, where possible, to attend the LeDeR review panels in person to provide an update as to the progress of the review. In attending this also affords the reviewer the opportunity to raise any concerns and report against the progress and / or completion of the review. In ensuring a robust approach to all recommendations the reviewer is asked to ensure all actions are discuss and agree with the relevant organisation/s in ensuring both change and learning is implemented.

Where reviewers are unable to attend the panel in person, the LAC discusses the key points from the review and this is feedback into the panel meeting. In the event that the reviewer is no longer able to complete the review the LAC will reassigning the review, along with potentially a revised timescale for submission. This situation has occurred during 2019/20 following a reviewer leaving the organisation and the case was successfully reallocated.

Once a review is complete, the reviewer submits directly onto the Bristol system. The LAC then receives automatic notification of the submission. The reviewer, where possible, then attends the LeDeR review panel to present and discuss the report. This ensures an additional layer of scrutiny than that of just the LAC having the responsibility of reviewing and signing off the review. This also provides an opportunity for any gaps in the review to be identified and amended or enhanced prior to the final submission by the LAC to the

Bristol system. Once the panel are satisfied with the review, the LAC submits the review onto the Bristol system. The review is reviewed by Bristol, who will either sign off and close the report or may request additional information. Due to the robust process of the review panels, it is seldom that additional requests for information are received.

However, should any additional information be requested then this is resubmitted onto the Bristol system and reviewed by the LAC. Once Bristol is satisfied with the review, it is signed off and closed on the system.

To enhance the process, a local learning and action plan has been developed. This captures key themes and commonalities inclusive of good practice identified from reviews. This is then translated into a local LeDeR action plan which details which organisation/s and the individual/s that are accountable for the delivery of the agreed action, inclusive of timescales for implementation, monitoring and auditing arrangements for measuring the effectiveness post implementation. Where appropriate, actions may also be referred to specific forums for ongoing monitoring for example the provider quality forums. The overall monitoring remains the responsibility of the review panel.

The CCG has and continues to progress and evolve well with the management of the LeDeR process. In addition, NHS Hull CCG's performance remains excellent with regards to the allocating and undertaking of reviews timely and has to date not suffered any backlog in reviews which has been the case in many other areas of the country. The process will continue to be reviewed periodically and evolved to ensure it remains fit for purpose.

6. Patient and carer involvement

The CCG has membership on the local Profound and Multiple Learning Disability group, within the year feeding back on the process and learning from LeDeR reviews within Hull.

The local LeDeR steering group welcomed the involvement of one of our local carers within the year, with a nominated member from the carer community attending the meeting.

Within this year members of the CCG, Hull University Teaching Hospitals NHS Trust and CHCP presented at an event for both services users and carers facilitated by Inclusion North. The event was well attended and focussed upon sharing group practice and learning from the experience of others.

7. Current Local Position

For Hull CCG, there have been 34 deaths reported to the LeDeR system from 2016 through to March 2019, these being for Hull residents with learning disabilities.

During 2019/20 NHS Hull CCG was notified of 18 deaths requiring reviews. Of these;

- A total of 11 male and 7 female deaths were notified
- Ethnicity for all reported deaths were white British
- A total of 10 deaths were reporting as having occurred in hospital, 8 were within the home or residential care.
- Of these 3 patients had annual health checks in place at the time of their death with a further 10 remain yet to be confirmed following completion of their LeDeR review. However; 5 were confirmed as not having annual health checks in place.

- A total of 7 deaths were reported for people with a DNR in place. 1 did not and a further 10 are to be confirmed when the review has been completed.
- A total of 6 had end of life care plans in place. 2 did not and a further 10 are to be confirmed when the review has been completed.
- Within the year a total of 6 reviews have been successfully completed and have subsequently been both approved and archived by Bristol, with an additional 1 awaiting final review and approval by Bristol.
- A total of 2 reviews have been suspended as they are subject to the Child Death Overview Panel (CDOP) process.
- The age at death is varied with the youngest being 8 and the oldest 88 years old.

At the time of this report a total of 4 reviews are progressing well with allocated reviewers and buddies and the remaining 5 reviews have been suspended as a result of the Coronavirus pandemic and will be resumed when circumstances allow. Due to the suspension of the reviews and the inability to both identify and share any learning timely a risk was added to the CCGs risk register to reflect the current situation.

The most common cause of death recorded from the reviews where this has been confirmed during 2019/20 is that of pneumonia. In the majority of these cases the individuals had comorbidities however a commonality and further learning is acknowledged in recognition of pain management for learning disability people and the responding to and management of deteriorating health in people with learning disabilities.

There are a number of cases where the cause of death has not been confirmed at this point in time and therefore these categories will be updated when this information becomes available.

Cause of death

- 1 X Primary refractory large cell lymphoma.
- 2 X Aspirational Pneumonia
- 1 X Aspirational Pneumonia and urine infection
- 5 X Unknown at present yet to be confirmed
- 1 X Pneumonia
- 1 X 1a) S U D E P (Sudden Unexpected Death in Epilepsy), b)
- Generalised Epilepsy (Drug Refractory), c) II Learning Disability
- 2 X Dementia
- 1 X Diagnosed Pancreatic cancer
- 1 X Community acquired pneumonia
- 1 X Cardiac arrest / Pneumonia
- 1 X 1a. Sepsis secondary to Pyelonephritis, b. Chronic urinary retention, c. Cerebral Palsy, 2. Intracranial haemorrhage
- 1 X Stroke

The place of death varied between in the hospital setting and usual place of residence, which is either a residential / care home setting or the individuals own home. The detail of these can be found in appendix 1.

One commonality identified is that not all of the individuals had an annual health check completed within twelve months prior to their death, this being a key objective for future improvement.

The notification of deaths can be made by anyone to the Bristol system. There have been a number of times when one death notification has been made multiple times by different organisations which should be seen as positive as this indicates that the requirement to report all deaths of people with a diagnosed learning disability needs to be reported. Where there have been duplicate reporting these are then removed from the system and the original one reported progress through to the review process.

The majority of notifications received during 2019/20 were made by HUTH who reported five of the eighteen deaths. Other organisations reporting deaths include CHCP, care / residential homes, primary care and the Local Authority.

Two multi agency reviews have been completed and the action plans are due for reporting. The key themes:

1. Communication between services lacking at times highlighting the continued need for care co-ordination
2. The need to understand the role of the Advocacy Service and be clear how the Advocate supports the person.
3. The need to encourage patient's relatives to support their LD family member to attend the Primary Care Practices for their annual health check.

8. Learning from deaths good practice

There have been a number of good practice examples found within this reporting year, these include;

- Good Palliative Care Coordination including shared records and note keeping.
- GP Practices offering support to patients and family/carers following diagnosis.
- Patient Passport being present in the Hospital notes.
- GP Practices having appointed a Learning Disability Champions.
- GP practices who have a newly equipped room with visual aids at practice for people with a Learning Disability.
- Care providers being responsive to the needs of both the patient and family and their wishes were given consideration when working to make the patients stay more comfortable.
- Responsiveness of care from Dietetics at HRI, community nursing and the patients GP.
- Care home staff's commitment to include the client in decisions taken, to implement her wishes safely with attending Hull Fair, despite suffering a severe illness.
- Patient being cared for compassionately in his own surroundings with evidence of compliance to his own care standards and adaptation to the patient's wishes.

Community professionals continually supporting both patient and family in what were difficult circumstances.

9. Learning from deaths areas for improvement

The following details the findings of the review and thematic narrative which have been identified following the completion of reviews during 2019/20. These all being areas for further learning and development which have been highlighted from the completed reviews:

Allocation and reviews

- The allocating of reviews to organisations has at times been problematic, resulted unnecessary delays.
- Some families wish to be actively involved and engage in the review process however there are some families who choose not to engage which can result in a lack of detail for the pen portraits of the individuals and gaps within the chronologies.
- There is a need to ensure support is in place for all reviewers. Hull CCG has more recently implemented a `buddy` system to support reviewers in achieving a quality review and report.

Use of Hospital Health Passport

- There remains variability in the use of hospital passport at present. Where a hospital passport is not conveyed with the individual essential information, including that of required reasonable adjustments, in relation to the individual is lost to the receiving hospital.
- There is a need to ensure Advanced Care Planning and ReSPECT forms are integrated within the patient `passport`.

Placement of patients

- Some individuals with a diagnosis of a learning disability are being placed in environments which do not specifically meet their needs and with care staff not always being appropriately trained to care for individuals with a learning disability.
- In managing the equipment needs for a patient, a clearer process needs to be in place, to ensure transfer and receipt across all care homes and the management of this.

Assessment and diagnosis

- Some reviews found that individuals were being identified as having a diagnosis of a learning disability when they had never received a formal assessment diagnosis.
- The CCG continues to receive LeDeR notifications reported for patients reported to have learning difficulties but do not have a diagnosed learning disability.

Process Documentation

- The documentation of Best Interest meetings noted to be lacking in some reviews. Whilst these may be undertaken, the records do not adequately evidence this.
- Further training is required in and understanding and the implementation the Mental Capacity Act and Best Interest Assessments. Some delays also being noted in Delay in DoLS application and approval.

LD Annual Health Checks (AHCs) in Primary Care

- There remains variability with the completion of the GP annual health check, which is in-keeping with the national findings from the LeDeR programme.
- Medication reviews also continue to be a focus area as full compliance is not achieved across all Primary Care and Learning Disability registers within Primary care not up to date.

Certification of death

- Whilst there has been a noted reduction however a small number of death certificates are still including Learning Disability as a cause of death.

Advocacy / IMCAs

- The training delivered as part of the Advocacy Programme needs to be reviewed with particular regard to working with people with Learning Disability.
- There is a need to review the process for how and when IMCAs become involve, ensuring the timely engagement of an independent advocate.

Learning Disability Teams

- The Learning Disability Team need to continuously review systems and processes to ensure these are robust, effective and positively improve the experience of people using health services with learning disabilities.
- To ensure robust Care Coordination is in place at the point of care delivery. To ensure relatives and the patients next of kin are informed and involved at all times.

10. LeDeR performance

NHS Hull CCG has implemented a robust review process to not only support the reviewers and the families / carers involved throughout the process but to also ensure that the reviews are undertaken timely.

The reviews are allocated to the most appropriate reviewer who receives a submission date to complete the review, no longer than six months from allocation. In addition, reviewers are invited and encouraged to attend the monthly LeDeR review meetings to present the progress of the reviews and share any challenges. Where they are unable to attend in person a verbal update is required.

These mechanisms have ensured that a backlog has not developed and where necessary early intervention and support for reviewers is identified and swiftly actioned. As a result, no reviews from NHS Hull CCG were required to be passed onto the North of England Commissioning Support Unit who was tasked by NHS England to help clear backlogs on a national level.

11. LeDeR development and achievements for 2019/20

Specialist support

Practices have identified lead personnel for learning disability and actioned changes within the practice to ensure a person with a learning disability has a positive visit to the practice. This has included Identifying a named Practitioner to assist the person, family or carer.

Identifying a “quiet room” to see a person who may be distressed in areas where there maybe noise or groups of people. Furthermore, there have been advancements in Learning disability nurse roles within both CHCP and in HUTH

Two band 5 LD nurses have now joined the Wellbeing service, they were recruited in January 2020 but due to COVID-19 had their start dates delayed.

The Learning Disability Nurse continues to support this and attended the Practice Team Learning event which took place on the 11th February 2020 and presented to all of the Practice Nurses.

Annual health checks

Hull CCG has seen an increase in the delivery of annual health checks. Reasonable adjustments are being made in both Primary Care and hospital. Data from 1 April 2019 to 31 March 2020 shows that 38% of LD annual health checks have been completed.

Health passports

There is good recognition and a reported increased use of the person's personal health passport within this year, this is a key area for further growth in the coming year.

Sharing learning from deaths

NHS Hull CCG has continued to share learning through both the local and regional steering groups. Hull CCG was also invited and able to present at the Inclusion North event held in Grimsby in March 2020, showcasing its work with LeDeR.

LeDeR process

Hull CCG has a well-established LeDeR panel consisting of a variety of professionals Buddy support for reviewers in place. NHS Hull CCG has regular representation at the local and regional steering groups.

Education and training

Education is being delivered by the LD nurse inclusive of environment, health passports and the offering of flexible appointments to an individual with LD.

Carer and family involvement

Hull CCG has representation at the local Profound and Multiple Learning Disability group, within the year has fed back on the process and learning from LeDeR reviews within Hull.

The local steering group has welcomed the involvement of local carers within the year with a nominated member from the carer community attending the meeting.

Members of the CCG, Hull University Teaching Hospitals NHS Trust and CHCP recently presented at an event for both services users and carers facilitated by Inclusion North. The event was well attended and focussed upon sharing group practice and learning from the experience of others.

12. Priorities and Programme of Work 2020/21

NHS Hull CCG continues to analyse the findings of reviews, considering the experiences of families and carers, to identify the commonalities identified through LeDeR reviews that inform changes that will result in improvements and better experiences in the delivery of health and social care for people with learning disabilities. Our priorities for the coming year being to;

- To further improve upon the numbers of people with Learning Disabilities attending a dedicated annual health check. Engaging with families via communications to ensure all are able to distinguish between unplanned visits to the GP and the requirements under the guidance for completion of a full learning disability annual health check.
- To ensure recommendations and actions identified via reviews are captured and assigned to the relevant organisation/s with robust monitoring processes in place via the LeDeR review panel ensuring the actions are implemented timely with measurable outcomes and sustained improvements.
- Through education and training ensure there is a sound understanding of the differences between a learning disability and a learning disability to ensure patients are diagnosed appropriately.

- To increase the number of reviewers within PCN`s, providers and CCGs through the LeDeR review panels.
- To increase support for reviewers by building on the current `buddy` system of support via the reviewer support forum
- To further raise awareness of the LeDeR programme within Hull utilising protected time for learning events within primary care, care home boards and requesting providers processes for raising within organisations.
- To further develop training into Care home and domiciliary care providers to ensure that all deaths of individuals with a learning disability are notified to the LeDeR programme and in working with people with a Learning disability. The progress as to the effectiveness of this will be monitored by the number of deaths reported from these settings and where issues are identified the LeDeR panel to make recommendations for action to be taken to drive further improvements.
- To work collaboratively across Humber CCGs in developing a `Learning into Action Group` in identifying and implement recommendations made and, where appropriate, assist with the development of service improvement across Hull.
- To continue to engage with Learning Disability networks and continue the support and feedback on LeDeR into Inclusion North.
- To improve the utilisation of current reporting systems within Hull to share progress and lessons learnt on a regular basis such as through provider Quality Review meetings, Safeguarding Adult Boards etc.

13. **LeDeR Funding**

In 2019, NHS England announced that there were monies available that would be allocated to each CCG to support the LeDeR programme. Applications were made and the NHS Hull CCG in partnership with ERY CCG was successful in securing £50,000. Ongoing discussions are taking place with the Hull and East Riding Steering group as to how to utilise the funding.

14. **RECOMMENDATIONS**

It is recommended that the NHS Hull CCG Governing Body approve this report for information on the current process that is place to manage the LeDeR programme.

There is a national requirement that the LeDeR Annual Report will be published on the CCG website, this will be achieved by 30th September 2020.

Report completed by;

Deborah Lowe, Deputy Director of Quality, Clinical Governance / Lead Nurse
 Lynda Whincup, Professional Advisor Primary Care Nursing
 Liz Sugden, Quality and Patient Safety Lead
 Date: 12th September 202

