NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Meeting of BNSSG Governing Body

Date: Tuesday 5th January 2021
Time: 1.30pm
Location: Virtual meeting. Details within the calendar invite

Agenda Number :	
Title:	Update for System Multi Agency Review (MAR) action plan for Oliver McGowan
Purpose: Discussion	
Key Points for Discussion:	

The Independent Review into Oliver McGowan's LeDeR Process phase two was published in October 2020 and papers were presented to Governing Body in November 2020.

This report is to update the Governing Body on the MAR action plan attached at Appendix 1. The action plan has been presented and discussed at the December LeDeR Steering Group and December meeting of the Quality Committee.

It has been discussed with system leaders and the relevant executive champions, in the Local Authority and provider organisations, are leading actions.

The MAR action plan will be reported and monitored through the Healthier Learning Disability and Autism Programme Board, chaired by Hugh Evans, Director of Adult Social Care, Bristol City Council and reported into the Healthier Together Mental Health, Learning Disability and Autism Steering Group.

The second MAR re-emphasizes the importance of an effective service model that supports people with Learning Disabilities and Autism. Specific areas for inclusion into the system work programmes are:

- Transition to adulthood including how the whole family is supported as a young person transitions from children's to adult services
- Safeguarding process; recognition of where Best Interests decision making is needed and how practitioner staff are confident their safeguarding practice meets requirements
- Ensuring Annual Health Checks deliver supportive and holistic Health Action Plans which are integrated into multi-agency care and support plans
- Support needs and treatment choices that may be required in a crisis are discussed and agreed with the person and then clearly documented in their care and support plan. This will include the type of medication or restraint that may be needed.
- Model of care including the effectiveness and consistency of learning disability and autism services in our healthcare settings, particularly the use of care navigators.

Recommendations:	• To receive the MAR system action plan associated with the review • Receive quarterly update on progress against actions outlined in the MAR
Previously Considered By Feedback:	Discussed at BNSSG LeDeR Steering Group and Quality Committee. Key discussion points included reviewing the Independent LeDeR review action plan and proposing further improvements to the current governance arrangements.
Management of Declared Interest:	Consideration has been given to potential and actual conflict of interest and none have been declared
Risk and Assurance:	Without organisational/whole system sign up. There is a risk that the system action will not be delivered This will affect the ability of the wider system across BNSSG to take and embed learning from this MAR
Financial / Resource Implications:	The delivery of the LeDeR programme requires sustainable funding beyond March 2021 that will need to be identified by the BNSSG system.
Legal, Policy and Regulatory Requirements:	No legal implications associated with this paper
How does this reduce Health Inequalities:	Learning from themes is reported to the BNSSG LeDeR steering group and enables recommendations/ actions to reduce health inequalities for people with learning disability to be implemented across BNSSG.
How does this impact on Equality & diversity	LeDeR programme focus is on improving equality and diversity outcomes for people with learning disabilities
Patient and Public Involvement:	LeDeR Service User Forum is in place, stood down during Covid but service users voices are reported monthly to the LeDeR Steering Group
Communications and Engagement:	Engagement of system partners and service user voice through the BNSSG LeDeR Steering Group. To be presented to BNSSG system safeguarding boards. Discussion at provider LeDeR Steering Groups
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Sponsoring Director / Clinical Lead / Lay Member:	Rosi Shepherd, Director of Nursing and Quality

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LD System Action Plan from Multi Agency Review Meeting for Oliver McGowan published in October 2020

Learning Point 1. The Trust's did not appear to have a formal process in place for handover of care.			
Identified issue	**Recommended Actions**	**Lead**	**Progress update – Dec 20**
Transfer of care: The transition of care for Oliver did not occur in a co-ordinated and formal way between paediatric and adult services.	To ensure proper transition pathways are agreed and in place for people moving between children and adult services that are robust, multi-disciplinary and organisational. These pathways should be multi-organisational, to ensure the individual care and support is holistic. To monitor and review the implementation of the transitional pathway into practice, with focus on the oversight of agreed measures, including the quality of outcomes for young people, the rate of compliance with the pathway and number of people who have completed the transition process.	Hugh Evans - Director of Adult Social Care - Bristol	Supporting and improving transition for 16-24 year olds, is a priority for all organisations. The aim is to map transitions pathways and identify gaps or blocks. The local authorities and health providers are working together to develop a system wide approach with a single transition to adulthood policy across BNSSG
Learning Point 2: There was no single consultant with overall responsibility for care of Oliver. There was no agreed treatment plan in place.			
Identified issue	**Recommended Action**	**Lead**	**Progress update – Dec 20**
Care coordination: Multiple clinical teams were involved in Oliver's care, with no agreed management plan in place – particularly in the last 12 months of his life.	Where young people have complex health conditions, with several clinicians and professionals involved, there is an identified clinical lead with overall responsibility for the co-ordination of that individual's care, treatment and support, ensuring that family voices are at the centre of care planning.	Directors of Nursing – UHBW and NBT	NBT increased Learning Disability Liaison Service to x4 WTE with a 7/7 service who are able to fully support an MDT approach to care. Evaluation of the services is underway and will be presented to the Clinical Executive in February with a request for ongoing funding.Work in progress to develop parity of service at UHBW.
Learning Point 3: Information recorded on the drug charts did not indicate detail about the nature of reactions.			
Identified issue	**Recommended Action**	**Lead**	**Progress update – Dec 20**
Medication: Information recorded that related to known drug reactions was unclear, impacting on prescribing decisions.	Agree a clear standardised process within the trust for recording drug reactions, including the nature of the reaction and any likely impact on future prescribing decisions, to improve patient safety. Take into consideration existing key professional standards in developing the process.	Medical Directors – UHBW, NBT and AWP	Trust drug charts and adverse reactions documentation being reviewed to agree a standardised and consistent policy and approach.

	Audit compliance with recording drug reactions and implement action arising from the audit findings.		
Learning Point 4: Key support services may be changed due to business reasons without suitable review on the impact of the person receiving that service. **(Action for Commissioners)**			
Identified issue	**Recommended Action**	**Lead**	**Progress update – Dec 20**
Commissioning: A key support package was changed due to a business decision that adversely impact on Oliver's wellbeing.	Make sure support packages are commissioned with the individuals and families at the centre. For people with autism, changes should be limited unless absolutely necessary (or required by the individual).	Denise Moorhouse Associate Director - Continuing Healthcare	CHC team have revised operational procedure for support packages to ensure the individual and their family are at the centre of decision making
Learning Point 5: Staff within emergency services may not have the skills to respond appropriately to all the needs of people with autism and/or learning disabilities.			
Identified issue	**Recommended Action**	**Lead**	**Progress update – Dec 20**
Training: Ambulance and police personnel involved in Oliver's last admission when taking him to hospital and within the emergency department did not have the necessary skills to fully understand his condition and respond appropriately to his behaviour.	Make sure ambulance and police personnel have specialist training to support people with autism and/or learning disabilities.	Rosi Shepherd, Director of Nursing Project Manager for BNSSG Learning Academy	Skills for Care have been testing the Tier 2 Oliver McGowan training pilot. BNSSG have been invited to participate in the pilot scheme in Jan/Feb. The training will include ambulance & police in the next phase.
Learning Point 6: There was not an identified quiet area in the emergency department that was available for patients with autism and or learning disabilities to support their well-being.			
Identified issue	**Recommended Action**	**Lead**	**Progress update – Dec 20**
Autism: The environment in the emergency department was extremely busy and noisy. Oliver was not taken to a quiet area quickly enough.	Environmental audits should be carried out regarding meeting the needs of patients with autism in Hospitals, with a commitment to make recommended changes in designated areas. There are several people with autism who specialise in this area, and the panel suggests that the trust commissions such an individual or group to carry this out. There are also specific standards available at: www.nice.org.uk/guidance/cg142/resources/end orsed-resource-checklist-for-autismfriendly- environments-2016-2665557037	Liz Williams, Director of Transformation AWP Directors of Nursing - NBT & UHBW	NBT have undertaken initial environmental audits led by a service user with autism who made recommendations for improvements for people with autism. NBT, UHBW and AWP to agree commissioning of an environmental audit of key admission suites in all three Trusts.

	The role of the trust autism/learning disability liaison practitioner to advise staff teams on best practice is agreed and implemented. On behalf of the chief nurse, the hospital autism/learning disability team should undertake an ongoing and formal evaluation of the care experiences of people with autism, through coproduction with those individuals. The evaluation should be formally reported to the trust board. Nursing care plans should be developed with information about autism-specific strategies where an individual patient requires this.		
Learning Point 7: Medication regimes must follow STOMP recommendations.			
Identified issue	**Recommended Action**	**Lead**	**Progress update – Dec 20**
STOMP: Throughout his life, Oliver received an array of medications that were changed frequently without an understanding of their effects.	Evaluate organisational use of levels of psychotropic medication with autistic people, in line with STOMP recommendations. Work consistently with the STOMP online medication pathway, with particular focus on the actively involving patients and their families (see https://medication.challengingbehaviour.org.uk/ pathway)	Liz Williams, Director of Transformation AWP	New director to lead organisational audit of psychotropics prescribed for people with autism across the system. Develop audit tool and undertake audit during January 2021.
Learning Point 8: The safeguarding team did not proactively support decisions about care and best interest meetings within the intensive care unit.			
Identified issue	**Recommended Action**	**Lead**	**Progress update – Dec 20**
Safeguarding: The Trust safeguarding team was not proactively involved in decisions about Oliver's care.	Trusts must work consistently with safeguarding and best interest legislation, incorporating it into key policies agreed by the trust board. When a person with learning disabilities and/or autism is admitted and they do not have capacity at that time, the trust safeguarding team must become involved with that individual to ensure their rights are upheld and protected.	Michael Richardson, Deputy Director of Nursing BNSSG Director of Nursing - NBT & UHBW	Review to be undertaken of system safeguarding practice and training to ensure MCA and Best Interests meetings are held, make clear decisions and documented according to safeguarding legislation
Learning Point 9: There was no evidence of a best interest meeting being held regarding the management of Oliver's care to take him off the ventilator.			
Identified issue	**Recommended Action**	**Lead**	**Progress update – Dec 20**
Best interest meetings: Meetings were not held in relation to decisions about clinical care in the intensive care unit.	When potentially contentious decisions about care need to be made, best interest meetings must be held in line with the Mental Capacity Act. These should be documented and, if necessary, arbitrated.	Michael Richardson Deputy Director of Nursing BNSSG	Review to be undertaken of system safeguarding practice and training to ensure MCA and Best Interests meetings are held, make clear decisions and documented according to safeguarding

		Director of Nursing - NBT & UHBW	legislation
Learning Point 10: The pharmacy service in ICU was inconsistent.			
Identified issue	**Recommended Action**	**Lead**	**Progress update – Dec 20**
Pharmacy: There was inconsistency in the pharmacy service for ITU, a seven-day service was not available. The pharmacists working in ICU were not integrated into the MDT in ICU.	Trusts should consider electronic prescribing that is integrated with electronic records within the ICU. A seven-day pharmacy service should ideally be provided within the ICU, to provide specialist pharmacy support, with roles and responsibilities clearly defined. Pharmacists should be seamlessly integrated within ICU teams, with an ability to provide professional challenge and advice in relation to the prescribing and administration of medication and to undertake audit regarding practice. A range of patient-friendly information leaflets should be available to patients and relatives that describe the 'usual' therapeutic interventions given within ICU.	Director of Nursing - NBT & UHBW	Nurse Directors in discussion with Directors of Pharmacy to progress these recommendations.