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LeDeR Annual Report

Hampshire, Southampton, Isle of Wight and Portsmouth Clinical Commissioning Groups

For the period 1st April 2020 – 31st March 2021

NHS England and NHS Improvement

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Executive Summary

This is the second annual report of the Learning Disabilities Mortality Review (LeDeR) programme published by the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) CCG's aimed at making improvements to the lives of people with learning disabilities . This system-wide work will continue to develop further as we formally merge the six CCGs across Hampshire, Southampton and the Isle of Wight to form NHS Hampshire, Southampton and Isle of Wight Clinical Commissioning Group from 1 April 2021 and as we move towards the formation of the Hampshire and Isle of Wight Integrated Care System (ICS) during 2021/22.

This report presents information about the review of deaths of people with learning disabilities who were notified to the LeDeR programme within the south east region and specifically to CCGs within SHIP from 1st April 2020 to 31st March 2021. Detailed within the pages of this annual report for 2020/21 are an evaluation and summary of the key themes and trends from these LeDeR reviews that focus on factors including:

- Age of death
- Gender
- Ethnicity
- Place of death
- Causes of death
- Overall assessment of the quality of care
- Themes and trends linked to best practice, learning and recommendations for improvement actions that reviewers have made. Some of the themes from the local data have been compared to the national 2019 LeDeR annual report data for comparison.

A small number of real pen portraits have been included within the report to provide an insight into the lives of people who have been reviewed, the person themselves and their health and their care needs, and the extent to which those needs have been met by health or other services. The names of these people have been changed to protect identities. In the coming year we will have a more dedicated focus on learning from families and/or experts by experience with an improvement focus'.

This report is available to read at https://hampshiresouthamptonandisleofwightccg.nhs.uk/aboutus/latest-reports

Executive Summary

Deaths reviewed by the programme

- From 1st April 2020 – 31st March 2021, 145 deaths were reviewed by the programme in comparison to 50 deaths reviewed in 2019/20 period..
- Of the reviews completed in 2020/21 1.4% required a full multi-agency review and 1.4% were referred to the Child Death Overview Panel for review.

The people whose deaths were reviewed

- Of the 145 deaths that were reviewed: 63% were males this is higher than nationally which is 58%* and 37% were females; 86.2% were white British and the proportion of deaths notified from people from Black, Asian and Minority Ethnic (BAME) groups was 2.1%; 27.5% were known to have had mild learning disabilities, 31.2% had moderate learning disabilities, 31.8% severe learning disabilities and 9.5% profound and multiple learning disabilities.

Age at death

- Provisional estimates show that life expectancy in England in 2020 was 78.7 years for males and 82.7 years for females. For deaths notified in 2020/21, the learning disability median age at death was 61 for males and 61 for females. Our data suggest that the disparity between the age at death for people with learning disabilities and the general population (all ages) in 2020 was 17.7 years for males and 21.7 years for females.

Place of death

- The proportion of people with learning disabilities dying in hospital was 52.4%, (in comparison to 2019/21 of 72%) usual place of residence 29.7%; care /residential home 11%; at home 2.8% and unspecified 4.1% in 2020/21*.Nationally for people with learning disabilities 60% died in hospital compared to 46% of general population

Causes of death

- Of the 145 deaths that were reviewed the 5 frequent causes of death on part 1 of the death certificate were, in descending order Pneumonia, Aspiration Pneumonia, Covid-19,Cardiac Arrest and Cancers.

* National comparison based on 2019 LeDeR annual report

Key Findings

Of the 145 deaths reviewed:

- 63% were males which a higher than the 58% reported nationally*
- 86.2% of adults with learning disabilities whose deaths were reviewed were white British, (11% were not stated) this is lower than nationally at 90%*. Our LeDeR Black Asian and Minority Ethnic Groups reported deaths of 2.1% is lower than the national figure of 10%.
- 52.4% (76) of adults with learning disabilities died in hospital, this is lower than nationally reported data for people with learning disabilities at 60%* but higher than that of the general population at 46%.
- The most common cause of death noted on the death certificate was pneumonia 23% (32). Nationally the 2019 LeDeR reporting of most frequent cause of death for people with learning disabilities was Bacterial Pneumonia 24%.*
- 63% of completed reviews concluded that individuals received care that met or exceeded good practice (Grade 1 or 2) compared to 56% nationally
- 93% (136 cases) reported one or more examples of best practice across the health and care system including primary care, care homes and acute providers.
- Reviewers recommendations include areas such as annual health checks, and reasonable adjustments during GP and Outpatient Appointment times .

*National comparison based on 2019 LeDeR annual report

Introduction

Background

- The national Learning Disabilities Mortality Review (LeDeR) programme was established in 2016 following the Confidential Enquiry into the premature Deaths of People with Learning Disabilities (CIPOLD). It was commissioned by the Healthcare Quality Improvement Partnership (HQIP), on behalf of NHS England, from the University of Bristol. It involves reviewing the deaths of all people with a learning disability to identify potentially avoidable contributory factors. LeDeR focuses on the learning that can be gained from reviewing the circumstances in which a person with learning disabilities dies, and their care and treatment through their life. In October 2017 SHIP CCGs assumed responsibility for delivery of the LeDeR programme from NHS England.
- This is the second annual report of the SHIP system English Learning Disabilities Mortality Review (LeDeR) programme. It presents information about the reviews completed of deaths of people with learning disabilities aged 17 years and over notified to the programme from 1st April 2019 – 31st March 2020. The definition of 'learning disabilities' as used by LeDeR is the presence of:
    - *'A significantly reduced ability to understand new or complex information and to learn new skills, with a reduced ability to cope independently, which started before adulthood, with a lasting effect on development'* In this years report we share a brief insight of some of the people whose deaths have been reviewed by the LeDeR programme during 2020 in the pen portraits section of this report.

Acknowledgements

We would like to acknowledge the contribution of the many people with learning disabilities, family members, reviewers, local area contacts who have led or contributed to the reviews of deaths of people with learning disabilities and worked to put service improvements in place.

Our thanks also to the SHIP Learning Disabilities Autism Programme Board who have provided oversight and support to the LeDeR programme during 2020/21.

*Bristol University LeDeR programme

Governance arrangements

LeDeR Process

- Responsibility for managing the LeDeR process of reporting, reviewing and quality assurance was passed to the CCG's in October 2017.
- Deaths of people with learning disabilities can be reported to the SHIP LeDeR programme by anyone via the Bristol University LeDeR programme web page.
- All CCGs have a Local Area Contact (LAC) and trained LeDeR reviewers. Each CCG LAC receives details of the death of the person who has died and it tis their responsibility to identify and allocate a reviewer to undertake the initial review.
- The initial review is uploaded to the LeDeR on-line portal by the reviewer and is then reviewed by the LAC to quality assure the completed review for consideration of closure prior to submission to the national programme. If it is felt that a fuller review could lead to improved practice, a more in-depth or multi-agency review takes place. This involves the range of agencies that have been supporting the person who has died.
- If initially the review is not approved by the LAC it is returned to the reviewer for further information and resubmitted for quality assurance to the LAC for closure. When approved by the LAC the completed review is forwarded to Bristol for redaction and archiving.
- Currently Bristol University LeDeR programme, collates all learning from across the country and produces quarterly reports to the LACs and NHS E. The Bristol University LeDeR programme also produces an Annual Public report based on the national submitted LeDeR reviews outcomes.

SHIP LeDeR Oversight & Support

- During 2020 the LACs established a two weekly LeDeR LAC Forum which provides peer support and networking facilitating discussion of the challenges of undertaking reviews, identifying common themes and trends. This group is supported by a Deputy Director of Quality and Nursing who reports into the system SRO for learning disabilities and autism.
- The SHIP LeDeR programme reports progress, quality concerns and risks into the Hampshire & Isle of Wight Learning Disability & Autism Programme.
- The Hampshire & Isle of Wight (H&IOW) Learning Disability and Autism Programme Board monitor progress and provide assurance of the delivery of the area's LeDeR Programme. This includes governance and leadership for all aspects of the Learning Disability & Autism.

Ethnicity

Ethnicity
Nationally the 2019 LeDeR programme reported 10% of deaths from Black Asian and Ethnic Minority Groups of which 4% were Asian; 2% from other white ethnic groups; 2% mixed and 2% were from other ethnicities). Our population in the SHIP area does not reflect the national deaths reported from Black Asian and Ethnic Minority Groups , the table below provides further detail on the ethnicity breakdown of the people whose lives and deaths we reviewed this year.

Ethnicity	White				Mixed/Multiple ethnicity groups				Asian or Asian British				Black or Black British			Other Ethnic Groups		
	British	Irish	Traveller or Gypsy	Any other White background	White & Black Caribbean	White & Black African	White & Asian	Any other mixed background	Indian	Pakistani	Bangladeshi	Any other Asian background	Caribbean	African	Any other Black background	Chinese	Any other ethnic group	Not stated
No. of reported deaths	125	0	0	1	0	0	0	0	0	1	0	0	0	1		1	0	16
% of all reported deaths	86.2%	0	0	0.7%	0	0	0	0	0	0.7%	0	0	0	0.7%	0	0.7%	0	11.0%
***Ethnicity% of local populace**	83.4%	0.6%	0.1%	3.2%	0.04%	0.2%	0.6%	2.0%	1.1%	0.3%	0.4%	3.3%	0.2%	0.6%	0.1%	0.6%	2.0%	3.3%

Deaths of People in our ICS: Pen Portraits

The purpose of the pen portrait is to present a clear picture of the person as they were, their health and their needs, and the extent to which those needs have been met by health or other services.

Bob's story:

Bob was a 68 year old gentleman who grew up in the family home. He attended a normal school and was allowed extra time in exams at secondary school and he achieved 4 O levels and more at night school.

Bob used to like to read train timetables and flight details rather than a book and that is what led him to his career in later life with the MoD in London. This was a clerical job that organised flights for personnel and visiting dignitaries across the world. This role played to his strengths and he worked hard. After 30 years of service he was given voluntary redundancy and he returned to the New Forest to be closer to his family.

In later life Bob lived alone in a flat and preferred to lead a reclusive lifestyle, smoked and drank heavily and regularly refused help when it was offered. This did not help Bob access the care that he may have needed, however he could fully communicate, knew his own mind and if he did not want to do something Bob would say so in no uncertain terms.

When his physical health started to deteriorate Bob was supported by his family and primary care as best as possible. His family were with him towards the end and when he passed away.

Jim's Story:

Jim was a 60 Year old gentleman who had lived with his parents in Hythe in their family home for many years. In later life, until 2018, he had a job cleaning the cells at a local police station. He drove and was quite independent, something that was very important to him.

When his parents died social services were able to support Jim in selling the family home and Jim chose to move to a mobile home on a local site. That is where he formed a friendship with his neighbour, who eventually became his main carer as he had no close relatives.

Jim was described as a kind and thoughtful person who was able to fully communicate and he enjoyed films, watching TV and playing puzzles. There was no real local community on the site where Jim lived and his social interactions mainly revolved around and included the carer who used to take him on day trips and on holidays.

Jim enjoyed being independent and was deemed to have capacity to make his own life decisions. Through a strong relationship built over many years a social worker and care support worker had regular contact. Through supportive collaboration and good communication they were able to ensure he was safe and worked with him to maintain his independence.

Pen Portraits continued:

Peter's Story:

Peter was a 52 years old gentleman who had spent the majority of his life living with his parents on the Isle of Wight until the last 12 years of his life. His mother had died and his father had dementia and needed specialist care. He moved into residential care that specialised in supporting individuals with a learning disability. Peter would love to go and visit his father regularly in a local nursing home until his death.

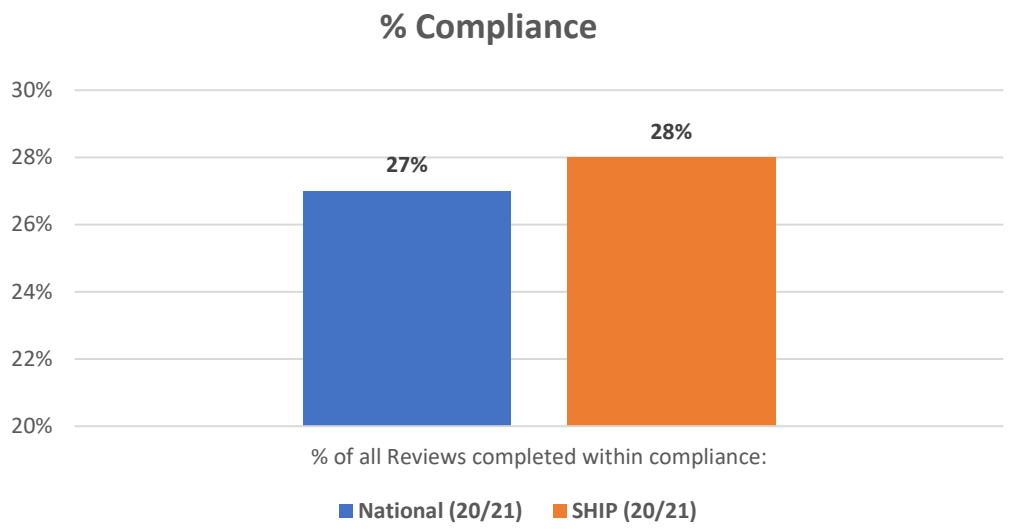
Peter interacted well with staff and visitors using a mixture of Makaton and some words, he attended day service twice a week and made three really good friends within the home. When Peter was well, he would love to take a drive out in the house car and he also really enjoyed travelling by train. He loved music, and would often be seen singing and dancing around the home to the radio. Peter particularly enjoyed watching older TV channels, and would watch these in his bedroom, preferring the space to be quiet. Peter loved to go to the shops, and was at his happiest when he went to the local shop to buy himself shiny pink balloon - particularly liking a heart or star shape. All the local shop owners knew him well.

Peter's health began to deteriorate over the last 9 months of his life, but following hospital care and excellent end of life care and support, he was able to return back to his care home to be with people who understood him. He was able to say good bye to his three good friends and he died peacefully with carers by his side.

The care home put pink balloons on the gates when he was collected by the funeral directors. His funeral was also organised by the care home staff. There were Pink and Purple Star balloons on the gates, and his coffin was decorated with Christmas Trees and Christmas Stockings, as this was his favourite time of year. The staff and friends who attended the funeral all wore Christmas jumpers, and the hearse and following cars were decorated with tinsel. Christmas music was played during the funeral and the staff and friends at the home were able to celebrate Peter's life with a Christmas get together afterwards.

Data Set: Performance

	All Notifications (2017-2021)	Completions		% of all Reviews completed within compliance:
	No.	No. & %		
*National (20/21)	12368	10873	88%	27%
SHIP (20/21)	442	411	93%	28%



- NHS England commissioned North East Commissioning Support (NECS) to complete all LeDeR backlog cases reported prior to 31 March 2019. NECS were commissioned to commence this work in September 2019 and 47 backlog cases from the total number of SHIP backlog cases were forwarded for review.
- During 2019/20 a national target was established requiring all deaths notified to the LeDeR programme from June 2020 to be reviewed and closed by 31st December 2020.
- The SHIP CCGs reviewed and closed all relevant cases within the deadline of the 31st December 2020.

Local Reviewer Arrangements

- Reviewers are responsible for undertaking robust and high-quality reviews of the deaths of people with learning disabilities.
- Our reviewers come from a professional health or social care background with experience at a senior level and support the LeDeR review system in addition to their substantive posts.
- All reviews are undertaken using the secure web based LeDeR review system, with all review documents completed on-line and any additional case notes and supporting paperwork stored within the LeDeR review system
- Utilising a NHS England funding bid 1.0 whole time equivalent (WTE) SHIP regional reviewer(s) were appointed to undertake reviews across SHIP. The funding for this post ended on 31st March 2021.The LDAP board extended funding for a 0.8 wte position until 30th June 2021.

*Source LeDeR reviews NHSE notified to 30th April 2021

Data Set: Demographics

Gender

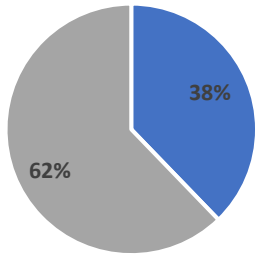
Of the 145 deaths that were reviewed:

- 63% were males and 37% were females.
- Our data from 2019/20 showed a similar picture of gender breakdown.
- The national 2019 LeDeR report showed 58% were male and 42 % were female.

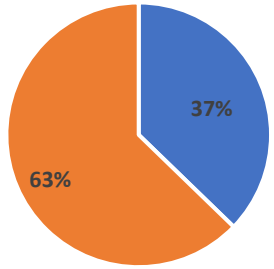
	2019/2020	
	Male	Female
No.	28	17
%	62%	38%

2020/2021	
Male	Female
91	54
63%	37%

Gender CCG 19/20



Gender CCG 20/21



Level of Learning Disability

- For every review carried out the level of learning disability for that person is confirmed and recorded as either mild, moderate, severe or profound/multiple.
- The information below shows the breakdown of this information for all of the reviews of people with a learning disability completed in the 2020/21

Level of Learning Disability	No.	%	National %
Mild	**38**	**27.5%**	**30%**
Moderate	**43**	**31.2%**	**33%**
Severe	**44**	**31.8%**	**27%**
Profound/Multiple	**13**	**9.5%**	**10%**
Unknown	**7**	**4.8%**	**0**

*National comparison based on 2019 LeDeR annual report

Data Set: Demographics, Age

All Adults with learning disabilities who died in 2020-2021:

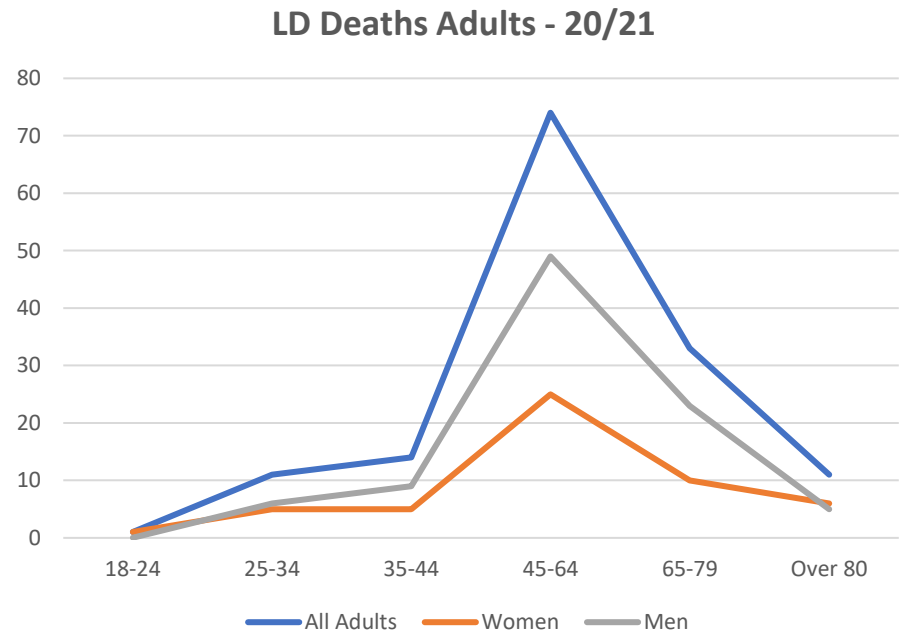
- There was a total of 145 deaths
- The range of age at death was 18 – 93
- The mean average age of death was 59
- The median average age was 61

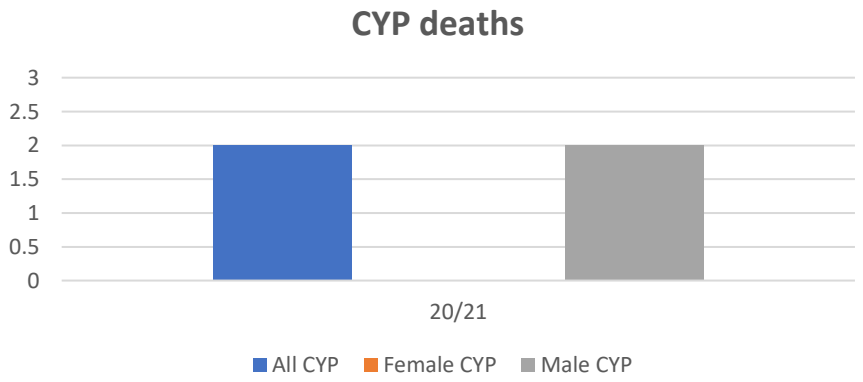
Women with learning disabilities who died in 2020-2021:

- There was a total of 52 deaths
- The range of age at death was 18– 93
- The mean average age of death was 60
- The median average age was 61
- Female life expectancy in the general population of England is 82.7.

Men with learning disabilities who died in 2020-2021:

- There was a total of 93 deaths
- The range of age at death was 27 – 85
- The mean average age of death was 59
- The median average age was 61
- Male life expectancy in the general population of England is 78.7.





All Adults with learning disabilities who died from confirmed or suspected COVID-19 in 2020-2021:

- There was a total of 9 deaths
- The range of age at death was 48-87
- The mean average age of death was 59
- The median average age was 54
- Number of women who died was 5
- Number of men who died was 4

Children with learning disabilities who died in 2020-2021:

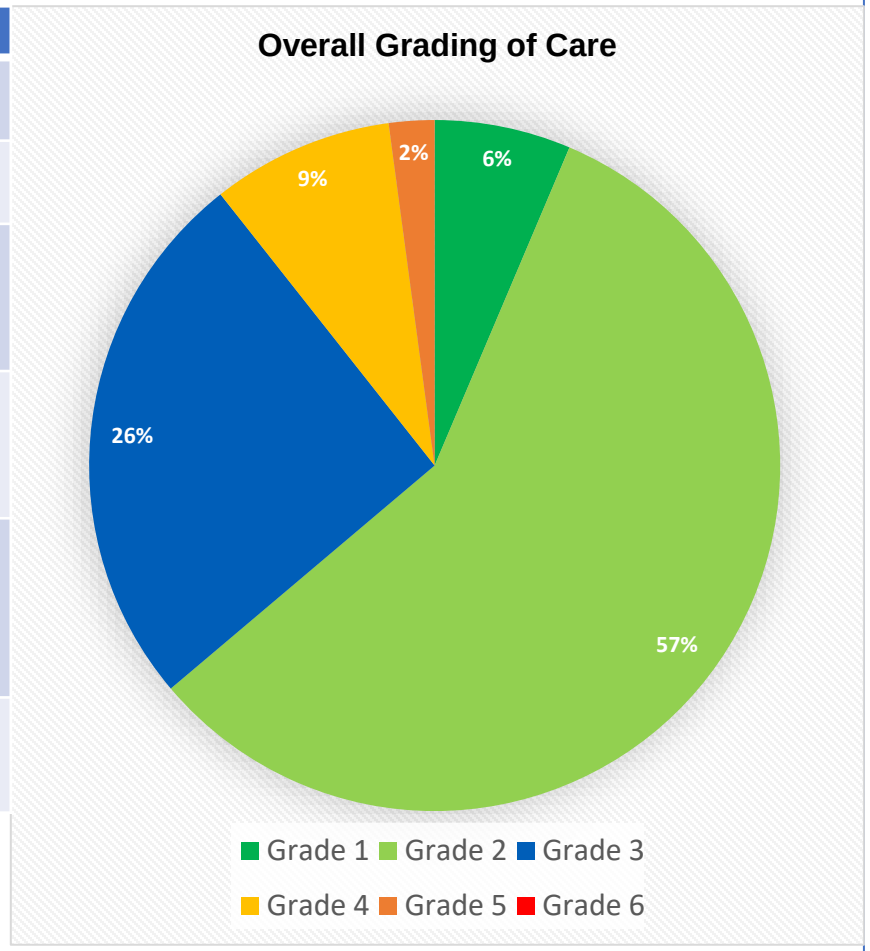
- There was a total of 2 deaths
- The range of age at death was 10 – 11
- The mean average age of death was 10.5
- The median average age was 10.5

Data Set: Cause of Death and Quality of Care

Quality of Care

The table below shows the number and percentage of completed reviews graded at each level of the overall quality of care received by the person.

Grade	Grading of Care
1	This was excellent care (it exceeded expected good practice).
2	This was good care (it met expected good practice).
3	This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the person's well-being).
4	Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death.
5	Care fell short of expected good practice and this significantly impacted on the person's 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.



- .63.% of completed SHIP reviews concluded that individuals received care that met or exceeded good practice (Grade 1 or 2) compared to 56% nationally .
- Examples of good practice include:
  - Good communication between care providers, health service and family
  - Liaison nurses in hospital displaying good networking skills
  - Keyworker and GP responsive to request to undertake home visits
  - The residential home enabled the gentleman to remain in the care home with the people he loved. The residential care team co-ordinated with the community palliative and learning disability teams, and the family remained involved throughout.
- Recommendations include:
  - General Practice and other health and social care professionals to consider ways to encourage people with a learning disability to attend all screening programmes
  - All staff should ensure the patient's next of kin are involved at all stages of treatment plan, so that views are taken into consideration and that they can advocate for their loved one when most needed.

Data Set: Cause of Death and Quality of Care

Cause of Death

The most common cause of death this year was pneumonia. A total of 32 deaths were attributed to this cause which is 22% of all deaths in 2020/21. The table below provides information on the top five primary and secondary cause of death.

No	Primary Cause of Death	No	Secondary Cause of Death
1	Pneumonia (n32)	1	Vascular Disease (n9)
2	Aspiration Pneumonia (n18)	2	Dementia (n7)
3	Covid-19 (n12)	3	Covid-19 (n6)
4	Cardiac Arrest (n10)	4	Downs Syndrome (n6)
5	Cancers (n8)	5	Nil

- Challenges in undertaking thematic reviews into the cause of death continues due to the accuracy of the description recorded as the cause of death on Medical Certificates of Cause of Death (MCCD) for people with learning disabilities.
- This is due to the fact that there tends to be a descriptive explanation of the cause of death written rather than any formal coding.
- We also continue to see a listing of a learning disabilities or an associated condition as an underlying secondary cause of death.

DNACPR – Do not attempt cardio-pulmonary resuscitation

A DNACPR decision is designed to protect people from unnecessary suffering by receiving cardiopulmonary resuscitation (CPR) that they don't want, that won't work or where the harm to them outweighs the benefits.
The DNACPR decision-making process should always take account of the benefits, risks and burdens of CPR and consider the individual person's wishes and preferences, the views of the healthcare team and, when appropriate, those close to the person. Hospital trusts and other providers are legally obliged to have a clear DNACPR policy for staff to follow. It must be accessible so that patients and/or their families are able to understand the decision-making process.

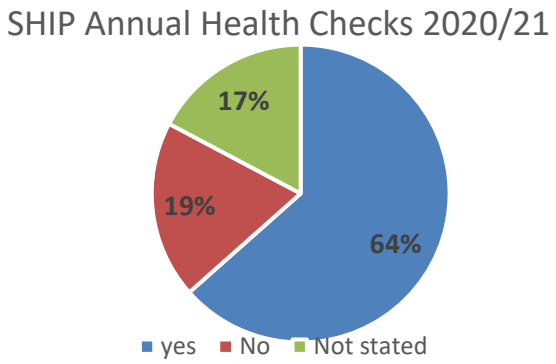
During the first wave of the Covid-19 pandemic, concerns were raised about the potential for "blanket" decisions being made around resuscitation, particularly for more vulnerable populations. As a result, the Care Quality Commission undertook a review of practice across a number of systems, taking into account the understanding and application of the Mental Capacity Act both when it comes to clinical decision making and taking into account the views of individuals.
Of the 76 cases where hospital was stated as place of death, 61.8% (47 cases) had a DNACPR in place. LeDeR reviewer's highlighted the following learning points in relation to DNACPR:

- DNACPR order reviewed on each admission, and care delivered in the best interests of the patient. Documented within notes, and discharge summary.
- Hospital consultant completed the DNACPR form with additional details.
- Reason for the DNACPR form being in place on the hospital form was stated as primarily "learning disability". Staff completing the DNACPR form should not use "learning disability" as a reason for it being in place.
- DNACPR forms are not always completed correctly. Down's syndrome should not be listed as a reason for CPR not to be undertaken. It is paramount that professionals are trained correctly in completing DNACPR forms.

Data Set: Cause of Death and Quality of Care

Annual Health Checks

The Annual Health Check (AHC) is a holistic view of patients and a recognised, evidenced method of improving the health of individuals with learning disability. They are intended for adults and young people aged 14 or over with a learning disability.
People with learning disabilities have poorer physical and mental health than other people and die younger. Many of these deaths are avoidable and not inevitable. Annual Health Checks can identify undetected health conditions early, ensure the appropriateness of ongoing treatments and establish trust and continuity care.
In 2016-17 only 53% of people on a learning disability register received an annual health check nationally. NHS England were aiming for 75% uptake of patients on general practice registers by 2020.
In SHIP 70% of all learning disability registered persons received an annual health check in 2020/21
Of the145 deaths reviewed in 2020/21 64% of our cases had an Annual Health Check documented within the last 12 months.



Role of cancer screening

Overall patients with learning disabilities are less likely to receive screening for the three types of cancers compared to patients without a learning disability. This difference is smallest for colorectal cancer screening and greatest for cervical cancer screening.
Unfortunately due to the data design of the LeDeR system we are unable to collect and analyse the offer and uptake of cancer screening across SHIP.

Learning from older Reviews completed in 2020-2021

In Quarter 4 of 2020/21 the SHIP system completed 12 LeDeR reviews. The learning from these reviews included:

- Hospital staff must ensure that the information included within the persons learning disability passport is shared with all staff caring for the patient.
- Hospital staff should identify and document the communication and reasonable adjustment needs of patients with learning disabilities and share with appropriate staff at the point of admission.
- GP processes need to ensure that people are invited for an annual learning disability health check.
- GPs should make adjustments to appointments including undertaking home visits.
- Accessible information/education should be sought and delivered over as long a period of time as required in screening programmes.
- Raise awareness of the need to promote self-examination for patients with learning disabilities.

Action from Learning:
What best practise and positive outcomes have been learned from the reviews?

During COVID-19 staff adapted Personal Protective Equipment to reduce the negative impact of wearing masks and the distress caused to patients. Staff would wear full, clear face visors during personal care.

- Large number of timetabled activities for the client
- Communication tools such as hospital passport and health action plan used.
- Postural assessment by Learning Disability Nurse (following training).

GP devised a personalised plan to enable more effective use of inhalers.

Family members kept informed throughout the admission, and included in plans of care. Enabled to be with their loved on the last day of her life. COVID-19 protocols restricting their visits prior to this.

Mother listened to with regard to knowledge of her daughter, and description of symptoms.

Each home has a Professional Link Worker from the Learning Disability Service to support with any housing, staffing, service user issues.

Action from Learning:
What areas for improvement were identified in recommendations from reviews?

GP to ensure that person is invited for an annual learning disability health check and this is clearly evidenced in the person's medical record
Annual health checks should be shared with health and social care learning disability teams in order that any additional support or care commissioning can be agreed.

Care homes to consider DNACPR orders and clearly indicate the wishes of the individual in hospital transfer letters, and hospital passport/"This is Me" documentation

End of life teams do not always have the experience to assess learning disability patients and should gain feedback from carers.
Palliative care teams might benefit from some learning disability training to prevent this occurring again.

GP to review policy for checking anyone with a learning disability diagnosis is placed on the register, and to signpost to services that could assist in decisions for the future

It is a strong recommendation that anyone with a DNACPR in place should have an 'Advanced Care Plan' sitting alongside it so that there is absolute clarity at the point the DNACPR comes into effect.

GP/primary care must be responsible for following up on people who do not routinely attend for health screens /necessary tests and consider reasonable adjustments, differentiation of how checks are carried out and referral to specialist learning disability services for desensitisation if needed.

Action from Learning:
What best practise and positive outcomes have been learned from the reviews of Covid-19 deaths?

All providers should have access to an oximeter. - A total of 106 O_2 pulse oximeter were distributed to all learning disability homes across SHIP system in 2020.

Develop a specific deterioration tool for use in the care home settings when COVID-19 is suspected (carers /family will often know the person best).
Across SHIP there has been an offer to learning disability care homes from the Telemedicine Service who provide additional clinical support and assessment and support to service users when they are unwell using teleconferencing. Also training was delivered in the use of RESTORE2 mini .

In the event of a potential second wave of COVID-19 hospitals should make reasonable adjustments for visitors to be with a relative.
SHIP acute providers reviewed guidelines for visitors and this allows patients with learning disabilities to have carers / visitors present where not having them would cause distress.

Put in place appropriate explanations of Personal Protective Equipment for patients with learning disabilities in acute trust settings.
SHIP acute providers put in place appropriate explanations of Personal Protective Equipment for patients with learning disabilities in acute trust settings.

Action from Learning:
What areas for improvement were identified in recommendations from reviews of Covid-19 deaths?

Learning disability services support to residential setting during pandemic for any issues such as client education, personal Protective Equipment and staffing..

It was reported there was an initial delay in being able to access Covid testing for all service users within the home.

An increase in the availability of suitable placements should be encouraged to enable clients with learning disability needs to be cared for in the most suitable environment.
All learning disability patients being cared for in nursing and residential homes should have a named GP who they see on a regular basis as required.

It doesn't appear that any reasonable adjustments had been made for the patient. The hospital learning disability team were not aware of the admission.
The learning disability team in the hospital should always be made aware when a patient with learning disability is admitted.

The trust did not follow the process for completing a DNAR for someone who does not have capacity due to a learning disability. The Provider is going to safeguard the events that occurred

Action from Learning:
What has been done to address the learning/themes in the national LeDeR reports?

Plan in place to ensure reviews are undertaken within six months of notification.
Plan in place includes identifying reviewers, streamlining processes, buddying arrangements, sharing resources and utilisation of NHSE funding across SHIP.

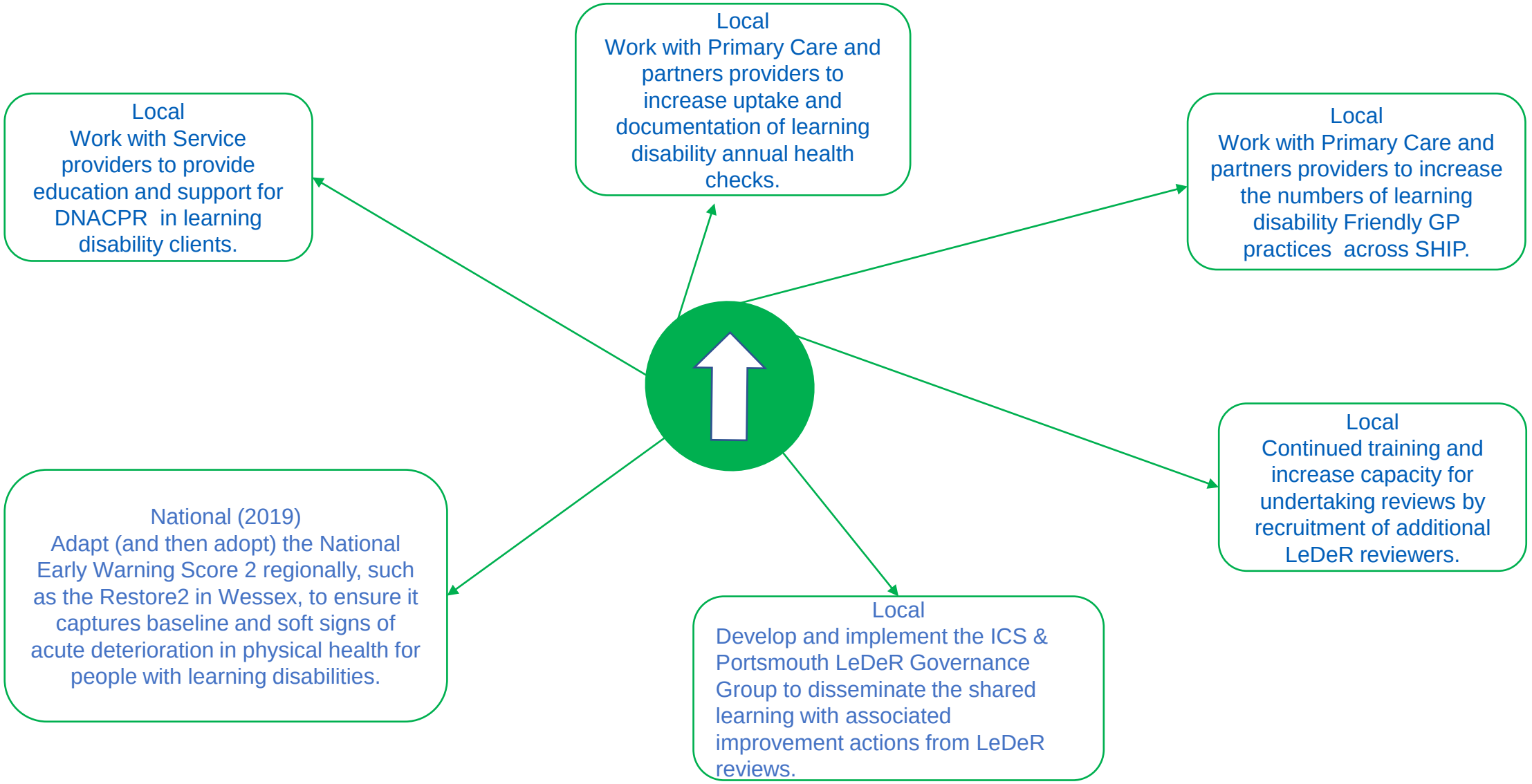
Systems and processes in place to analyse and address themes and recommendations from completed reviews.
Systems and processes in place to identify themes and learning established with Hampshire Safeguarding Adult Board.

Produce an annual report for appropriate committees for all statutory partners, demonstrating outcomes from reviews and action taken – Completed.

Have a named person with lead responsibility for LeDeR - SHIP has a named executive lead as part of the Learning Disability Autism Programme Board.

Become a member of the LeDeR Steering Group
– SHIP LeDeR Local Area Contacts are members of the SE Regional LeDeR Steering Group.

Action from Learning:
Local Priorities for delivery in 2021/2022 based on the learning from reviews locally and nationally



Action from Learning:
The evidence base for local priorities in 2021/2022

1. NHS England Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy (2021)
2. CQC Protect, respect, connect – decisions about living and dying well during COVID-19 (2021)
3. 3 year delivery plan (2021/22-2023/24) Learning Disability & Autism Programme
4. https://www.wessexlmcs.com/learningdisabilitiestheannualhealthcheck
5. https://www.england.nhs.uk/learning-disabilities/improving-health/annual-health-checks/
6. https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/health-check-toolkit.aspx
7. https://wessexahsn.org.uk/projects/329/restore2

Action from Learning: Evaluating the Impact

What is in place to monitor and review action plans /service improvements to ensure that they are implemented and effective in improving care, reducing inequalities & saving lives:

- Learning Disabilities Autism Programme Board
  - The Hampshire & Isle of Wight (H&IOW) Learning Disability and Autism Programme Board function is to monitor progress and provide assurance of the delivery of the area's *Learning Disability & Autism* Programme. This includes governance and leadership for all aspects of the Learning Disability & Autism to ensure programme targets are achieved.
- NHS South East LAC meetings
  - Provide leadership and oversight of the LeDeR Programme and ensure alignment with the overall ambitions of the learning disability and autism programme in meeting LTP ambitions. Support the implementation of Quality Improvement based on the learning from Reviews and as laid out in the National reports and local systems annual LeDeR reports. Hold an action log so that all issues, risks, best practise and information are captured and assigned to individuals for accountability.
- SHIP local LAC meetings
  - This meeting is to support the LAC's and, discuss challenges of undertaking reviews, and identify common themes and trends. The SHIP lead for this group is the Deputy Nurse for Quality and Nursing place based at the North & Mid. Any quality concerns and/or risks are escalated to the LDAP by the Deputy Nurse for Quality and Nursing .
- Hampshire Safeguarding Adults Board (HSAB)
  - A SHIP Local Area Coordinator attends the HSAB Learning and Review subgroup quarterly meetings to shared the best practice and learning from LeDeR reviews.

Action from Learning: Evaluating the Impact

How we will evidence that service improvements are making a difference to people with a learning disability and their families:

SHIP service improvements will be evaluated by using process and outcomes measures for our Local Priorities for delivery in 2021/2022 including:

- A series of random audits against CQC recommendations of learning disability DNACPR cases in our acute providers
- Percentage of completed learning disability annual health checks data in GP quality outcomes framework (QOF)
- An increase in the current number of GP learning disability friendly practices
- The number of training sessions delivered and staff attendance in the use of RESTORE2 mini
- The number of SHIP reviewers that have completed their mandatory LeDeR training.