NHS
Sheffield
Clinical Commissioning Group

Sheffield's learning from deaths of people with a learning disability (LeDeR)

Annual Report 2020/21

Sheffield Clinical Commissioning Group

1. Introduction

People with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. On average men with learning disabilities die 23 years earlier than men without learning disabilities and for women it is 27 years earlier[1]– mostly from preventable illnesses and in part due to physical health needs being overlooked.

The learning from deaths of people with a learning disability (LeDeR) programme was set up in April 2015 as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and reduce health inequalities. It grew out of the Confidential Inquiry into Premature Deaths of People with a Learning Disability (CIPOLD).

The aim of the annual report is to bring local information and learning together from the reviews of deaths in Sheffield to understand and to reflect on themes that can inform and improve practice across the health and social care community in Sheffield. It covers the period April 2020-March 2021.

To note, further information about the period prior to March 2020 can be found in our 2016-2020 report. This report includes data for 2016-2020 and information about local accountability and governance of the LeDeR programme, as well as further examples of action from learning collated in 2020. This report covered an extended period to September 2020, so it should be noted that some of the learning, outcomes and recommendations within the 20/21 will overlap and be represented in this report.

An accessible version of this report will be provided.

The people whose deaths are reported in this report are people who were known and loved by many and whose loss will have had a profound impact on those around them.

The report focuses on:

- Local actions that have been delivered over the last year (April 2020-March 2021) to address the learning identified in previous LeDeR reviews and in relation to the impact of the pandemic on our learning disability population in Sheffield.
- Findings from Reviews during 2020/21, including data and learning.
- The strategic actions planned for the next 3 years (2021/24) through which we aim to improve the health of people with a learning disability and/or autism and reduce health inequalities.

The impact of the pandemic has been shocking over this last year and has made the need for the LeDeR even greater. Nationally, a Government publication on COVID-19 deaths of people identified as having learning disabilities (Published 12 November 2020), shows the devastating impact of the pandemic, indicating a death rate 4.1 times higher than the general population after adjusting for other factors such as age and sex (451 per 100,000 people). But as not all deaths in people with learning disabilities are registered on these databases, researchers estimated the real rate may have been as high as 6.3 times higher (692 per 100,000).
The national data also highlighted:

[1] https://www.nursingtimes.net/news/learning-disability/talk-to-people-with-learning-disabilities-about-death-professor-urges-06-08-2019/

- The death rate for people aged 18 to 34 with learning disabilities was 30 times higher than the rate in the same age group without disabilities
- The disproportionate impact on people with a learning disability from Black, Asian and Minority Ethnic backgrounds
- That COVID-19 accounted for 54% of deaths of adults with learning disabilities in residential care in the review period and 53% of deaths of adults with learning disabilities receiving community-based social care.

To note, in Sheffield there was an increase in reported deaths during 2020/21 compared to 2019/20, however some of the deaths reported during 2020/21 were from prior to the reporting period. In terms of actual deaths, numbers were comparable between the two years – 40 deaths during 2019/20 and 41 deaths during 2020/21.

Based on data from Sheffield reviews that were completed during April 2020-March 2021, 25% of deaths (9 deaths) reported through LeDeR were due to COVID-19. However as this is based on the completed reviews in the reporting period, this percentage does not include people who died in 20/21 reporting period but whose review was not completed. Sheffield health data shows that the COVID-19 share of deaths for all causes for the total population was 20.06% (April 2020-March 2021).

An evaluation of learning disability deaths is being undertaken between Sheffield Teaching Hospitals, Sheffield Health and Social Care Trust and the Sheffield Clinical Commissioning Group. The aim of the evaluation is to ascertain whether patients with a learning disability were treated equally in comparison to patients with no identified learning disability, pre-and post-Covid:

- To review Structured Judgement Review (SJR) outcomes of deceased patients with a learning disability who died whilst under the care of Sheffield Teaching Hospitals vs patients with no identified learning disability.
- To review the care of these patients in the community prior to final admission to hospital.
- To triangulate information for these patients to identify recurrent themes or areas for improvement.

Three cohorts of patient deaths will be reviewed in the evaluation, as follows:

- Cohort 1: 40 pre-COVID-19 deaths (including 20 learning disability cases)
- Cohort 2: 40 post-COVID-19 deaths, no diagnosis of Covid (including 20 learning disability cases)
- Cohort 3: 40 post-COVID-19 deaths, with a diagnosis of Covid (including 20 learning disability cases)

Pre-COVID-19 deaths will be randomly selected from the Structured Judgement Review (SJR) database for the period 01/01/2019-22/03/2020 and filtered to meet the criteria above. All post-COVID-19 learning disability deaths will be included from 23/03/2020, as this cohort of patients is much smaller. Non-learning disability deaths will be randomly selected from the SJR database for the same period.

All of the above cases will have been referred for a SJR by the Medical Examiner, LeDeR report or elective admissions report produced by Information Services. The Structured Judgement Review for the identified patients will be reviewed and the quantitative analysis undertaken for the demographics and phases of care scores. Thematic analysis will be undertaken for the qualitative data. This data will then be triangulated with LeDeR reviews and thematic analysis will be undertaken.

2. Changes to the LeDeR programme/policy

A commitment to continuing the LeDeR programme was made in the NHS Long Term Plan 2019: "3.31 We will continue to fund the LeDeR [Programme], the first national programme aiming to make improvements to the lives of people with a learning disability".

Sheffield Clinical Commissioning Group, in partnership with Sheffield Health and Social Care Trust and a range of local stakeholders and partner organisations, is committed to the on-going local delivery of the LeDeR programme. This commitment includes ensuring that local reviews are promptly allocated and completed within agreed timescales to a high standard; that systems are in place to collate and analyse the findings of local reviews; and that the learning from completed reviews is disseminated across sectors and is used to demonstrably improve local practice and deliver local system change. Sheffield is noted to identify a large number of cases through proactive working and population identification, but to have also delivered significant learning shared across the region.

Nationally, the NHS has worked with stakeholders including bereaved families, people with a learning disability and autistic people over the past 12 months to update and develop the new policy which will focus not only on completing reviews but on ensuring that local health and social care systems implement actions at a local level to improve and save lives.

The new policy, which looks at the life of a person as well as their death, will also now extend to include all people who are autistic – who do not have learning disability – as well.

As the new policy will only be phased in from June 2021, the data in this report focuses on people with a learning disability or learning disability **and** autism, and not those with autism alone. However, our strategic plan for 2021-25 has been updated to include the full scope of the new policy, including extension for all people who are autistic – who do not have learning disability – as well.

3. Learning into action 2020/21

This section provides an overview of some of the learning in action during the last year, through which we have continued to address the issues and concerns identified as key themes from previous LeDeR reviews.

To note, within Sheffield our LeDeR improvement plans are closely aligned with the cross-organisational Sheffield strategy for *Improving the physical health of people living with learning disabilities, autism, and severe mental illness (2019-2022)*.

We have been working with providers to share learning and focus on embedding change as individual providers and providers as a collective throughout 2020/21, as outlined by the updates below. However, in 2021/22 there will be an increased focus on this, particularly as reviews are now being carried out more quickly after notifications have been received which allows for more 'real time' feedback.

- **Recognising the Deteriorating Patient –** We have ensured that Providers (Day Care Services, Residential Care Homes, Nursing Care Homes, Supported Living Services etc.) in Sheffield have been trained in recognising patient deterioration as part of the Transforming Care Partnership roll out of the LeDeR ECHO[2] Project. This is an online training programme

[2]ECHO is an online tele-mentoring network that enables the delivery of training and education from a specialist hub centre to multiple sites

addressing the key findings identified from LeDeR regarding Constipation, Epilepsy and Seizure control, Dysphagia/Posture, and Sepsis. See section 7 for more information about the roll out of the training. To note, according to the national LeDeR report 2020/21:

- Constipation is one of the five most common long-term health conditions reported in completed LeDeR reviews (23%) and a third of these reviews mention the prescription of laxatives.
- While around one in 100 of the general population has epilepsy, nearly one in three people with a mild to moderate learning disability has epileptic seizures – and the more severe their learning disability, the more likely they are to have the condition. A recent study found that more than 33% of people with a learning disability did not have an epilepsy care plan and 100% were unaware of the risk of sudden death due to epilepsy.
- Respiratory conditions are a leading cause of avoidable deaths among people with a learning disability and the risk is increased in those with dysphagia (swallowing difficulties). Dysphagia has also been linked to avoidable hospital admissions for dehydration and constipation. See also section 3 of this report for our learning in action on dysphagia and Posture Management.
- Sepsis is a life-threatening reaction to an infection and a leading cause of death among people with a learning disability. Symptoms may not be obvious, and someone may not be able to communicate that they are unwell; their health can deteriorate very quick.

- **Health Passports –** We have increased the number of people with learning disabilities using a Health Passport. A Health Passport is a document used for people with learning disabilities about them and their health needs. It also contains other useful information, such as their interests, likes, dislikes and preferred method of communication. Health passports are used if someone has to go into hospital or for other health care appointments. In November 2020, a 'Health Passport Survey' was distributed to 3,130 adults with a learning disability in Sheffield:
  - A total of 762 have been returned, this is an overall response rate of 24%.
  - 273 people stated that they had a Health Passport.
  - However, 423 people stated that they did not, and 66 people were not sure. Those who did not have Health Passport were asked if they would like someone to get in touch with them to help them get one.
  - From this, 291 referrals have been made to the Community Learning Disability Team for a Community Nurse to make contact with them to offer support to complete a Health Passport.

- **Annual Health Checks –** We have worked hard to maintain and increase completion of annual health checks for people with learning disabilities with their GPs during the pandemic. Recent activity, which will be ongoing includes:
  - Guidance to practices about carrying out learning disability health checks (and risk stratification of checks) during the pandemic (summer 2020).
  - Following NHSE North Region guidance, a pre-health check questionnaire (the 'Get Checked Out Survey') was distributed using the Case Register to 3,130 adults with a learning disability. A total of 861 have been returned to the relevant GP practice. This has increased awareness and engagement of annual health checks.
  - Training and support for health and social care (particularly GP practices) to support reasonable adjustments for people with learning disabilities and/or autism and learning disabilities health checks – this has included 5 x well-attended training sessions (Feb/March 2021).
  - We have commissioned Sheffield Mencap to carry out engagement and outreach with older family carers and BAME communities to support access to health checks.

- **Blood Tests** – This is now an embedded piece of work. The Community Learning Disability Team continues to support referrals for individuals with a needle phobia who require blood tests which cannot be carried out via their GP practice. An easy read venepuncture desensitisation leaflet has been drafted, specific to referrals to the Community Learning Disability Team. The Bloods Pathway had been reviewed to reflect the referrals received for Flu vaccines including consideration of reasonable adjustments.

- **Oral Healthcare –** a collaborative project is underway between the specialist dental teams, Public Health, CCG, and the Community Learning Disability Service to improve the oral health resources and support available for people with learning disabilities, their families and care providers. This will include surveying local people about the challenges they face regarding oral health, producing an accessible video to address these challenges, raising awareness with GPs about specialist dental support, offering training to more care providers about oral health, and including the oral health of people with learning disabilities in the current refresh of the Citywide Oral Health Strategy. This project is in its early stages but will be implemented during 2021.

- **Dysphagia and Posture Management –** This is now an embedded piece of work. The Community Learning Disability Team continue to follow the Dysphagia pathway which includes postural management in relation to Dysphagia. The Dysphagia protocol has been updated this year and continues to include advice around linking posture management to Dysphagia need.

- **Antipsychotic Medication / STOMP -** In partnership with CCG Pharmacy, the Community Learning Disability Team and Community Intensive Support Service are working to ensure high quality antipsychotic prescribing protocols and STOMP medication optimisation pathways are in operation with clear documentation of long-term monitoring of:
    - Rationale
    - Long term monitoring of physical health
    - Side effect monitoring
    - Consideration of stopping/reducing
    - Patient/Carer views
    - Alternatives to medication
    - Ensuring clear communication of responsibilities between secondary and primary care

Other key areas of focus in 2020/21 have included:

- **We have ensured a coordinated and proactive approach across providers and services to support people during the pandemic** – this has included:
    - Writing to Sheffield Teaching Hospital to seek their assurance to all Covid Gold Command partners that DNACPRs (do not attempt cardiopulmonary resuscitation decisions) would not be applied in a blanket way to people with learning disabilities, and to ask for individualised risk assessments relating to the needs of people to have paid or family carers attend the hospital site with a person with learning disabilities to better support their care if attending or admitted to hospital.
    - Ensuring that information, advice, and support in relation to staying healthy in the context of the COVID-19 pandemic, is accessible for people with learning disabilities and their families.
    - An offer from the Community Learning Disability Team to Care Homes to provide advice and guidance regarding COVID-19 tests for people learning disabilities.
    - Joint work across primary and secondary care to improve physical health monitoring and care in in-patient settings.

- Work by Sheffield Psychology Board to develop easy read outreach materials which were distributed across the city.

- **We have championed and maintained a strong local focus on COVID-19 vaccinations for people with learning disabilities**: Even prior to the JCVI (Joint Committee on Vaccination and Immunisation) instruction to include all people with learning disabilities in priority group 6, we had already been using any permitted flexibility in vaccine deployment at a local level to vaccinate significant numbers of people living in care homes and supported living accommodation. Following the JCVI instruction, we have had a coordinated communications campaign to increase the number of people accessing their vaccine (for example, by supporting GPs to increase their learning disability registers to include more people with mild learning disabilities, by raising awareness across health and social care and with learning disabilities engagement groups, and through CCG Covid outreach grants to the VCS, including to Sheffield Mencap).

  As at 14 June 2021, Sheffield's COVID-19 vaccination rate for people with a learning disability aged 18 and above was 97.8%[3].

- **Flu vaccinations -** In Sheffield we had a coordinated approach this year to increasing uptake of flu vaccination for people with learning disabilities and/or autism who were at risk/eligible for a free flu vaccination. The approach included targeted resources/communications to GP surgeries and pharmacies, referencing flu vaccination in the GP learning disabilities annual health checks guidance, and inclusion of key messages in the flu social media campaign. SHSC Case Register and Community Learning Disability team wrote to everyone on the learning disabilities case register to remind them that they were eligible for a free flu vaccination. Local data showed:
  - That this proactive approach made a difference as people with learning disabilities were MORE likely to have had their flu vaccination last year than their comparator risk groups.
  - 57.5% of people with learning disabilities were vaccinated, compared to 53.3% of all patients at risk of flu aged 18-64 years.
  - 54.6% with a recorded autism diagnosis (with or without learning disabilities), and a flu risk category, had their vaccination.

- **Improving bowel cancer screening uptake** - Public Health England Screening and Immunisation Team, Sheffield CCG and Sheffield Health and Social Care Trust are working together to improve bowel cancer and screening uptake amongst people with learning disabilities. The Sheffield Annual Learning Disability Mortality Review (October 2020), reported only 11% of cases reviewed had received generic screening in the 12 months prior to their death.

  The aim of this initiative is to improve uptake of the bowel screening offer amongst learning disabled individuals in Sheffield, by supporting the setup of a bowel screening flagging pathway to improve the opportunity for people with a learning disability to make informed choices about bowel cancer screening by providing specialist help and support at the pre-invite stage.

  The Sheffield Case Register will provide an annual download to the North East, Yorkshire, and Humber Bowel Screening Hub via a data sharing agreement, under the categories public task,

[3] Sheffield CCG data - *(total =3549; done = 3472) For the patients with a valid risk stratification score and an LD flag, linked to vaccine data / MHMDS data with an LD flag.*

preventative medicine, for men and women aged 50 to 74 years (to accommodate age extension of the screening programme when implemented).

The bowel cancer screening hub will populate the Bowel Cancer Screening System (BCSS) with an additional care notes flag. This will allow the programme to intervene with an individual's screening episode before the invitation and test kit (Faecal Immunochemical Test/FIT) are posted out.

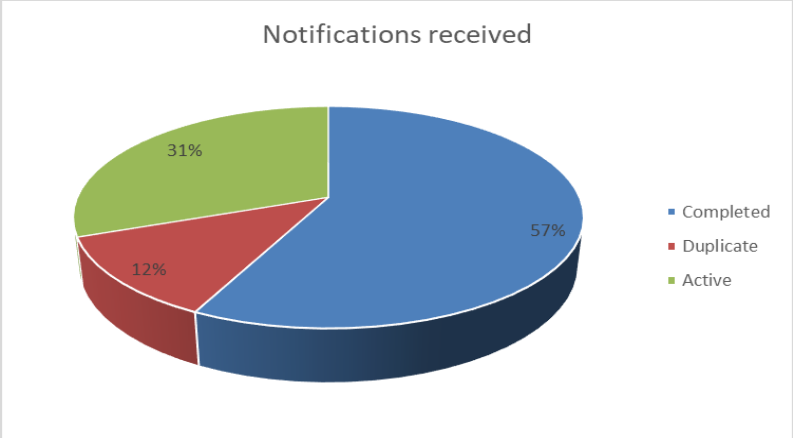
An individual to be invited with additional care notes report can be produced 4 to 6 weeks prior to invitation. This list will be sent to the Sheffield Case Register to allow a Home Visitor to contact the individual to discuss the imminent arrival of the test kit in the post, discuss screening and completion of the test, provide links to video/animations with translated subtitles or British Sign Language if required. Awareness training and supporting telephone conversation scripts will be provided to aid the support workers in this role. The bowel screening hub can adapt the individual's invitation letter to meet specified communication needs e.g., large print, easy read, language translation (where available).

4. Findings from Deaths in Sheffield

During the period April 2020 - March 2021 there were:

- 70 deaths notified to the LeDeR programme.
- This includes 38 completed reviews, 6 duplicate reviews and 26 active reviews.
- Of the active and completed cases, 3 were child deaths (aged 18 or below) aged 6 years, 9 years and 14 years.
- There were 41 actual deaths in the reporting period.

Graph 1 – Death Notifications Received



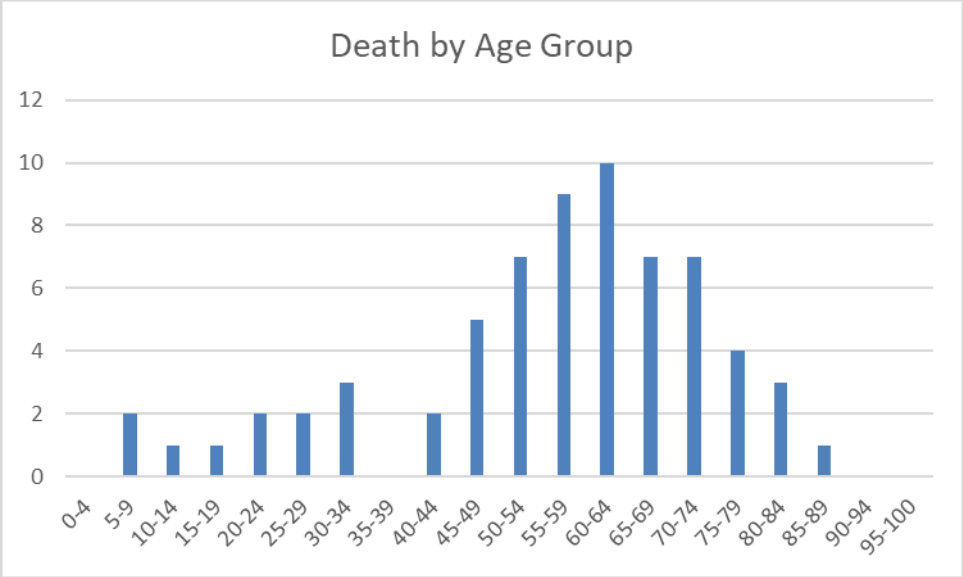
Compared to the reporting period April 2019 - March 2020 there were:

- 34 deaths notified to the LeDeR programme. Broken down this includes 27 completed reviews, 2 duplicate reviews, 3 active reviews and 2 were rejected as not having a Learning Disability.
- Of the active and completed reviews, 2 were child deaths (aged 18 or below) aged 4 years and 8 years.
- There were 40 actual deaths in the reporting period.

It is important to note that as the 2020/21 data is based on completed reviews and that due to late reporting and backlogs in reviews, the completed reviews were not all from deaths that occurred in the 2020/21 time period, it is problematic to make direct comparisons between the 2019/20 and 2020/21 periods. This will become less of an issue going forward as from 2021, ICS's will need a robust plan in place to ensure reviews are completed within 6 months of the notification of death.

Note: From this point, graph data relates to completed and active reviews only (64) for adult & child:

Graph 2 – Death by Age Group

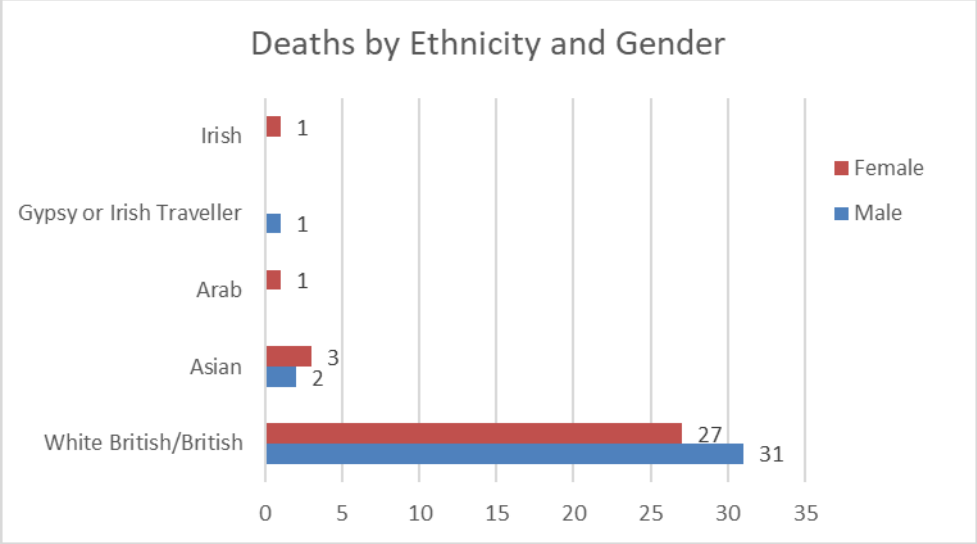


The age range of deaths reported was 6 years to 88 years.

Notifications of death were highest in the 55-59 (9 deaths) and 60-64 (10 deaths) accounting for 29% of total deaths.

The median age of death was 59 years (average was 56).

Graph 3 – Death by Ethnicity and Gender



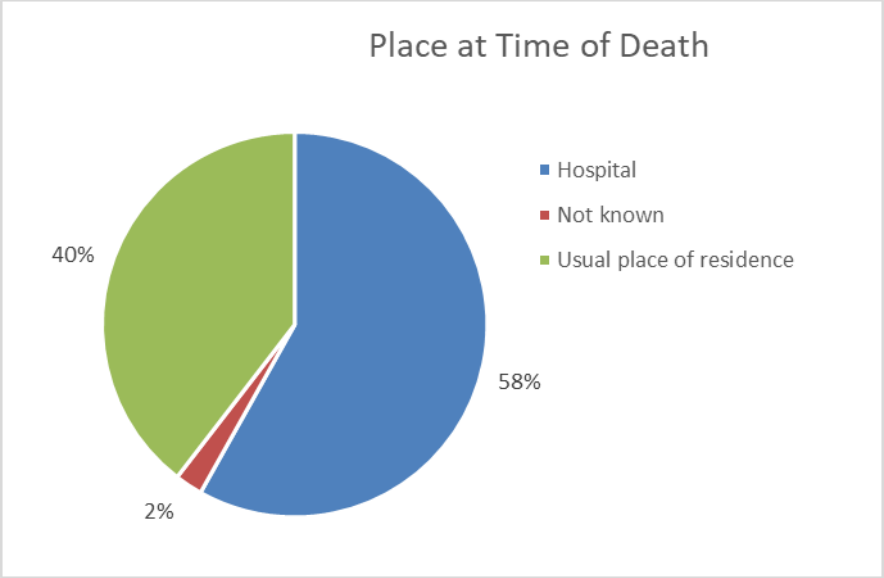
Of the completed reviews, the numbers of males and female deaths was relatively comparable (51.5% male, 48.5% female).

The median age of death for males was 58 (average was 54) and for females 59 (average was 58)).

Ethnicity is reported as White British for the majority of deaths at 88%, 7.5% Asian and 4.5% other ethnicities. To note, Sheffield is an ethnically diverse city, with around 19% of its population from black or minority ethnic groups. The largest of those groups is the Pakistani community, but Sheffield also has large Caribbean, Indian, Bangladeshi, Somali, Yemeni and Chinese communities.

Note: From this point graph data relates to completed cases only (38) for adult & child

Graph 4 – Place of Death



The majority of deaths (58%) occurred when people were in hospital.

Cause of Death
According to the National LeDeR report for 2020/21:

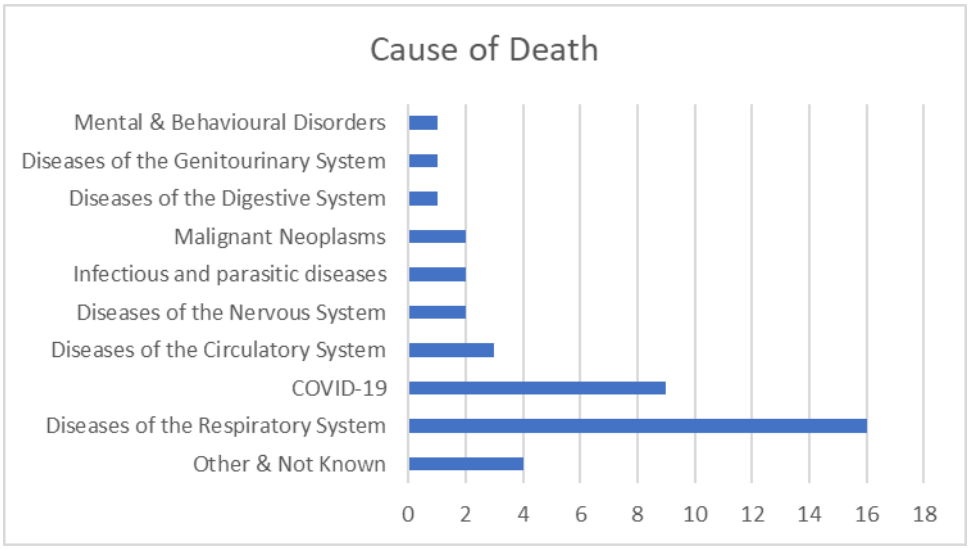
- The most frequently recorded **preventable** medical causes of deaths in adults with a learning disability were ischaemic heart disease (22%), aspiration pneumonia (12%) and stroke (8%). Ischaemic heart disease, also called coronary heart disease (CHD), is the narrowing of the arteries that supply blood to the heart muscle, depriving this of oxygen.
- Bacterial pneumonia – a lung infection – was the stated cause of death in 24% of adult and 20% of child deaths notified to LeDeR in 2019 and aspiration pneumonia – following inhalation of anything other than air – in 17% of adults and 3% of children. NHSE quoted the 2019 data here because of the impact of COVID-19 on respiratory deaths data in 2020.
- The report identified neoplasm (an abnormal or excessive growth of tissue) as the cause of death of 10% males and 12% females with a learning disability; this compares with 31% and 27% in the general population respectively. Neoplasms may be benign (not cancer) or malignant (cancer).

Locally, the most frequent cause of death from the reviews completed in 2020/21 were:

- Diseases of the respiratory system (44%)
- COVID-19 (25%);
- Others & Not Known (11%) and
- Diseases of the circulatory system (8%)

Also to note, Malignant Neoplasms accounted for 4%.

Graph 5 - Cause of Death



This compares to an analysis of deaths for the last Sheffield LeDeR report, covering November 2016 to September 2020, which showed that locally the most frequent cause of death were:

- Diseases of the respiratory system (51.28%);
- Diseases of the circulatory system (12.82%); and
- Malignant Neoplasms (8.97%).

However, it is important to note that as the 2020/21 data is based on completed reviews and the completed reviews were not all from the 2020/21 time period, it is problematic to make direct comparisons between the two periods.

Note: From this point graph data relates to completed cases only (41) for adults

The Use of Antipsychotic Medication

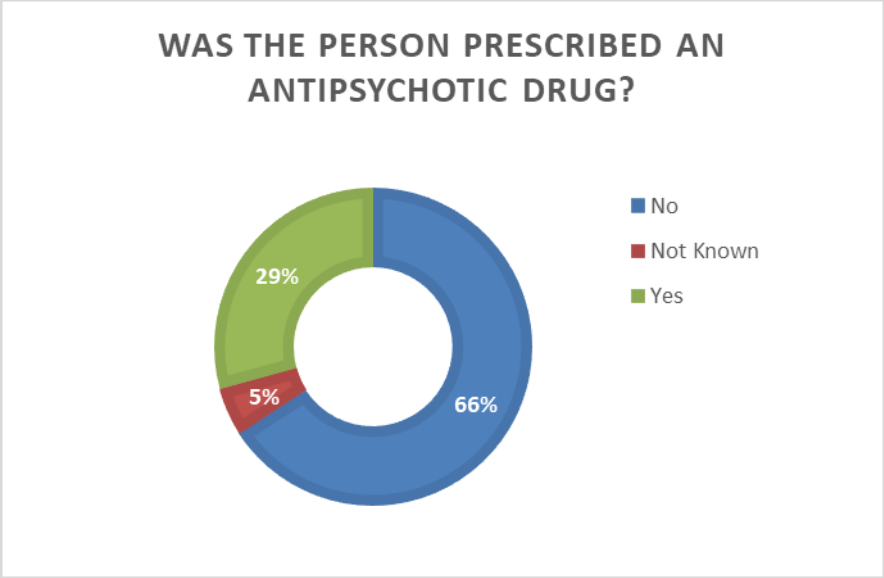
STOMP is a national project for stopping over medication of people with a learning disability, autism or both through psychotropic medicines. Sheffield CCG Pharmacy Lead and commissioning leads are involved in the STOMP programme, and again this work is overseen by the Physical Health Improvement Group.

Psychotropic medicines are used to treat psychosis, depression, anxiety, sleep problems and epilepsy. However, they can also be used in people whose behaviour is seen as challenging and presenting a risk to themselves or others. People with a learning disability, autism or both are more likely to be given these medicines than others.

Public Health England says that every day about 30,000 to 35,000 adults with a learning disability are taking psychotropic medicines, without a diagnosis of the above specific health conditions. Children and young people are also prescribed them.

Psychotropic medicines can cause a number of side effects and have a negative impact on long-term health.

Graph 6 – Was the Person Prescribed an Antipsychotic Drug?



The completed reviews include a review of the individual's medication, when they last had a medical review of medications, and specifically if they were prescribed an antipsychotic.

It is evident that the majority, 66% of individuals, were recorded as 'not' being prescribed antipsychotic medication.

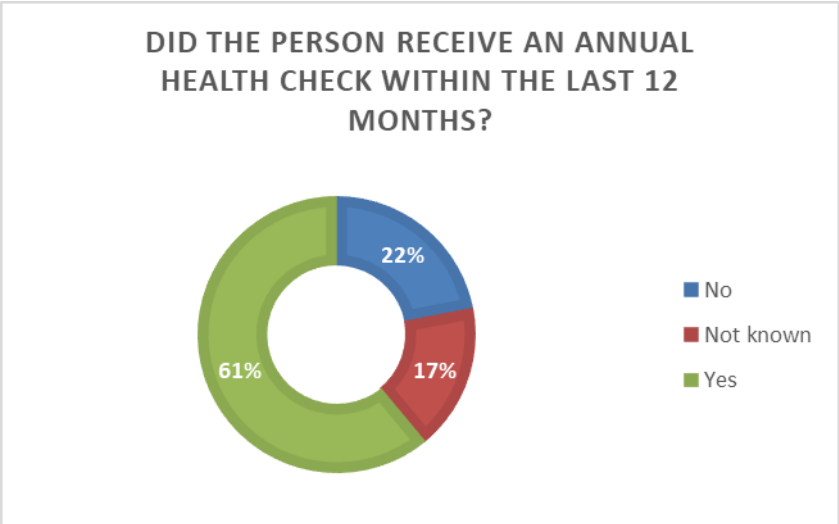
Annual Health Checks

Annual health checks were introduced nationally to try to minimise the health inequalities many people with a learning disability face. By identifying conditions such as diabetes or heart disease early or reducing people's risk of developing them in the first place, annual health checks can also help to reduce premature mortality and are therefore a vital part of the LeDeR response.

Annual health checks offer appropriate lifestyle advice and support interventions, identify and manage treatable long-term conditions. An annual health check helps people with learning disabilities to stay well by talking about their health and finding any problems early, so they can get the right care.

Work to improve the quality and completion of annual health checks is overseen by the Physical Health Improvement Group.

Graph 7 – Did the Person Receive an Annual Health Check within the Last 12 Months?



Of people known to be on GP learning disability registers, 61% had received an annual health check in the year before death, 22% had not received an annual health check and 17% were noted as not known.

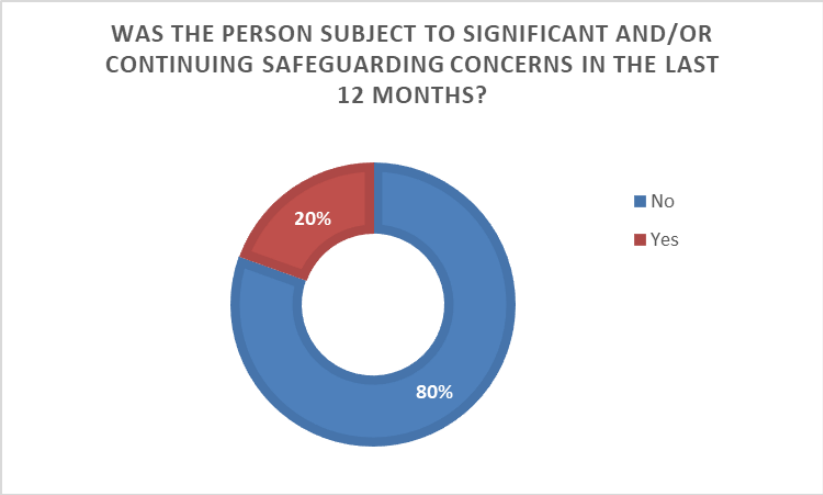
This compares well to the 2016-2020 data which showed that of people known to be on GP learning disability registers, 27% had received an annual health check in the year before death, 45% had not received an annual health check and 28% were noted as not known.

The national target for completion is 75% and the overall comparison for Sheffield for 2020/21 is that 57% of people aged 14+ (based on the Learning Disabilities Quality Outcomes Framework GP LD Registers) received their annual health check. The completion rate was 51% in 2019/20.

Safeguarding Concerns

For 20% of the people with learning disabilities, safeguarding concerns had previously been raised. No safeguarding concerns were raised in respect of 80% of cases.

Graph 8 – Was the Person Subject to Significant and/or Continuing Safeguarding Concerns in the Last 12 Months?

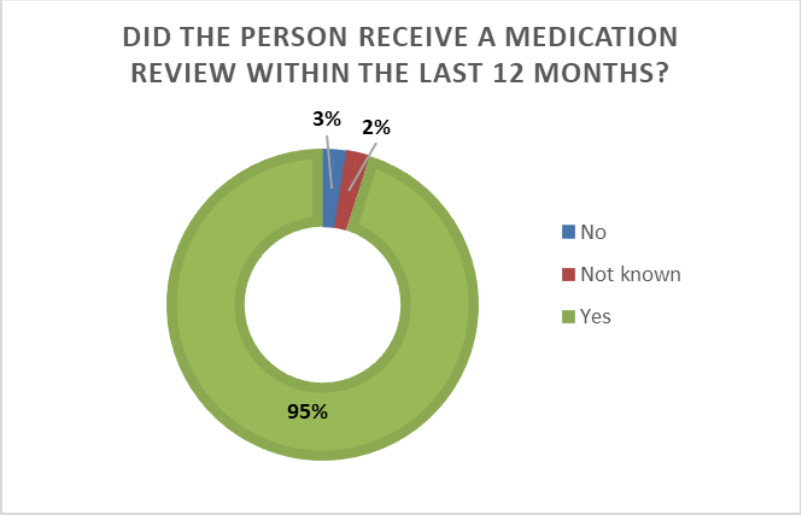


Safeguarding referrals have included serious injuries, allegations of financial abuse and gaps in provision of care.

In the case of the latter, the safeguarding route has been used by providers to escalate issues relating to commissioned packages.

Medication Reviews

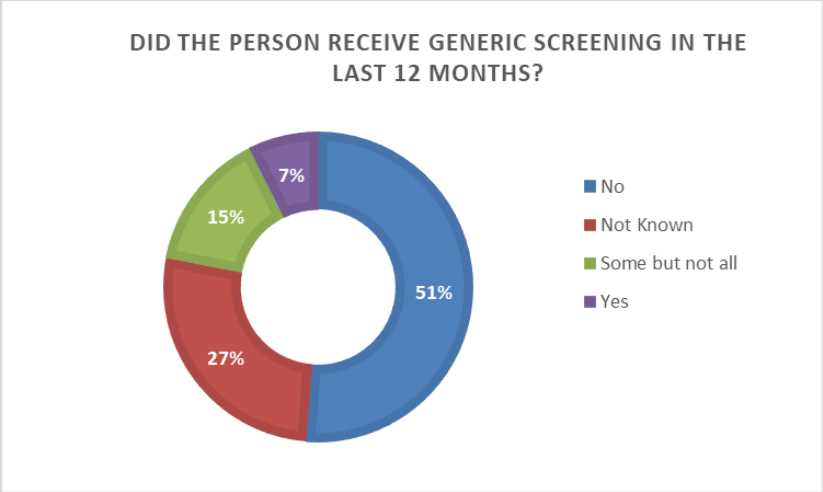
Graph 9 – Did the Person Receive a Medication Review within the Last 12 Months?



95% of people had received a medication review within the last 12 months prior to their death. 3% had not and 2% were not know.

Generic Screening

Graph 10 – Did the person Receive Generic Screening in the Last 12 Months?



7% of people had received generic screening in the 12 months prior to their death. 15% had received some but not all. 51% had not, 27% were not known.

These figures are affected by limited access to GP information for reviewers. Other influencing factors relate to lack of reasonable adjustments on the use of standard invitation letters; recording of non-attendances (eg did not attend) without consideration of the need for people to be supported to attend appointments (eg was not brought).

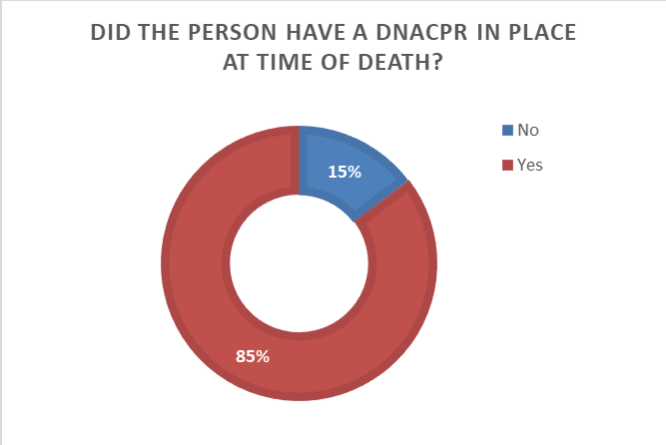
For example, unless significant reasonable adjustments are made, successful mammogram screening for women is limited due to their physical disabilities.

The national 2020 LeDeR report points the fact that although people with learning disabilities are less likely to die of cancer than people without learning disabilities, LeDeR reviews tell us that people with a learning disability who have cancer can be diagnosed late; diagnostic overshadowing is sometimes an issue; access to investigations can be poor due to lack of reasonable adjustments and assumptions about ability or willingness to tolerate tests. Improving access to screening for people with a learning disability is a vital learning from local LeDeR reviews.

End of Life Pathway

Within the review there is a requirement to understand if end of life care planning was in place for those where death was expected. The following graph shows that this was the case for 86% of the reviews.

Graph 11 – Did the Person have a DNACPR (do not attempt cardiopulmonary resuscitation) Decision in Place at the Time of Death?



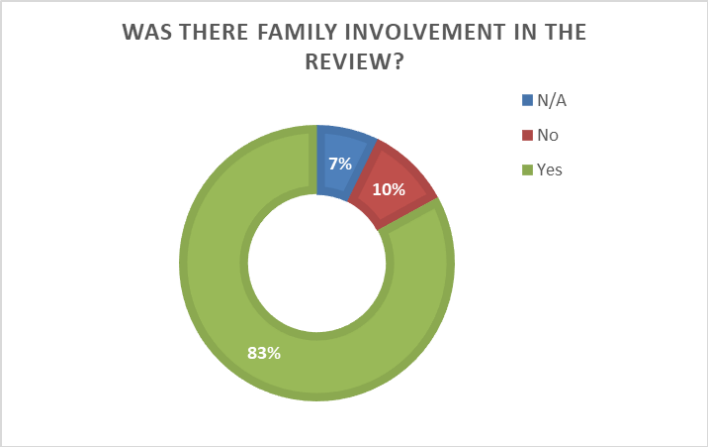
The reviews look to see if a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was in place or not. 86% yes, 14% no.

Whereas there are many clinically appropriate reasons for DNACPRs to be in place, nationally concerns have been raised about inappropriate use of DNACPRs for people with learning disabilities.

Family Involvement in the Review

Involving families in the review process is an important part of the work of the local reviewer. Families are encouraged and supported to be involved throughout the entire review process or as much as they feel able or want to be involved. Contacting and involving families is undertaken in a timely, sensitive, and respectful way, however, being sensitive to their needs may result in reviews commencing at a later date when they feel better able to engage in the process.

Graph 12 – Family Involvement in Reviews



Was there family involvement in the review 83% yes, 10% No, 7% not applicable.

Grading/Quality of Care (Completed Reviews)

Not all reviews generate learning, with a significant number of reviews demonstrating good care throughout the life, and end of life, of the individual.

It is reassuring that 58% were rated satisfactory and above, with the majority being satisfactory. However, it is important to note that 42% fell short of satisfactory practice. Where the care fell short of satisfactory practice 20% were deemed to have an adverse effect on the individual. The lessons learned from this feedback have formed part of the action plan for 2020/21.

Table 1 – Grading/Quality of Care (Completed Reviews)

Grading/Quality of Care (completed Reviews)			
Grading of Care in Adult Cases		Number of Reviews	%
1 =	This was excellent care (it exceeded expected good practice)	0	0
2 =	This was good care (it met expected good practice)	8	22
3 =	This was satisfactory care (it fell short of expected good practice in some areas, but this did not significantly impact on the persons wellbeing)	13	36
4 =	Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to cause of death	8	22
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	7	20
6 =	Care fell short of expected good practice and this contributed to the cause of death	0	0
Total		36	

As highlighted above, for reviews completed in 2020/21 care was unsatisfactory (rated 4, 5, or 6) in 42% of cases. In comparison from 2016-2020 data, care was unsatisfactory (rated 4, 5, or 6) in 32% of cases.

However, for reviews completed in 2020/21 there were no cases rated 6 (Care fell short of expected good practice and this contributed to the cause of death), whereas 2016-2020 included 14% of cases were rated 6.

The LeDeR Quality Review Panel noted areas of good practice including:

- GP visited on several occasions to prepare for bloods being taken. Negotiating with the person, listening to music, and undertaking the task.
- District Nurses going above and beyond to ensure appropriate care and treatment of an individual and maintain the individual's safety. For example, in one case the district nurses dropped everything to return to the home of the couple when an ambulance was called (on more than one occasion), they were raising concerns about the husband's ability to cope, were

picking up on issues about carers not fulfilling their role and, in another case, the same district nursing team did additional training to be able to meet the needs of an individual at home.

- Agencies collaborating effectively together for example:
    - GP involving IMCA, family, care home, for Mental Capacity Act and Best Interests decisions
    - Acute hospital SALT and CLDT SALT positive communication following hospital stay
    - Advanced care planning undertaken with GP, IMCA, family and care home involvement
    - GP working with providers, video calls, visits, calling families, chasing up when people had not attended annual health check and challenging consultants when people discharged from hospital when their care had been changed with no communication
    - Letter from Endocrinology Consultant to all departments in hospital to ensure the treatment that an individual would need would be administered immediately when admitted to hospital
    - Care provider, GP, family, and St Luke's working together to provide excellent end of life care
    - Agencies and individuals achieving person centred and positive care in a sensitive and dignified way e.g.
    - Providers respecting persons wishes, ensuring a priest was called at end of life to offer last rites
    - Provider ensuring a 90-year-old person who was requesting daily activities ensured his wishes were respected and happened
    - Care staff keeping daily contact with nursing home when person had to move, to ensure continuity of care in end-of-life care.
- Care provider having DNACPR revoked when put on in hospital without consultation – on more than one occasion
- Care provider supporting individual to make a will and having a lasting power of attorney
- Good use of Mental Capacity Act by care provider to ensure individuals needs are met in a sensitive and dignified way.

5. Key themes for 2020/21

Undertaking a review of a death, in itself, is helpful, but it is the lessons learned from a review that are vital in sharing best practice and making recommendations as to how services could avoid the re-occurrence of similar, potentially avoidable, contributory factors to deaths.

Key themes in Sheffield in 2020/21 were:

1. Care Co-ordination across health and social care providers

A consistent theme throughout the majority of reviews has been the need for Care Co-ordination. Individual care has been impacted by lack of oversight and silo working by organisations, particularly in complex cases and where individual needs change. Examples have included failure to recognise and respond to co-dependency within a household; lack of collaboration between inpatient and community services; inadequate responses to changes in need. Extended gaps between reviews (Social Care and CHC), which may delay the identification of unmet needs, and the requirement for collaborative responses. Transition planning for those moving from children to adult services was described as poor and caused families' unnecessary distress. Transition nurse involvement needs to be visible for advice and support to all agencies.

2. Safeguarding

Reviews have identified inconsistencies in the recognition of safeguarding issues, the application of the safeguarding process and the follow-up of referrals across agencies. Specific examples found are of allegations of injuries caused by poor moving and handling not followed up; lack of recognition of neglect by a carer who was also a vulnerable adult themselves; lack of reporting by providers where the mental capacity of the individual is in question leaving the person vulnerable to harm and self-neglect. Reviewers have also often been unable to access information on internal investigations carried out by providers.

Reviews have also identified that the use of VARMM processes needs improvement where people with a mild learning disability are at risk and there have been issues with a lack of coordination, and failure to follow the process.

3. Recognising the Deteriorating Patient

A number of reviews have found problems with timely and appropriate responses related to changes in presentation and need. There is evidence of missed opportunities for escalation leading to poor outcomes for people with learning disabilities in all settings including hospital; nursing and residential homes; and people's own homes. Contributory factors include the person being unable to communicate their discomfort due to communication impairment or opportunities to communicate; lack of consideration of mental capacity and best interests when the person has 'declined' interventions; and diagnostic overshadowing.

4. Access to Health Specialists and Follow-up

A number of reviews have found gaps in access to specific specialisms including Community Dietetics and Dentistry. This relates to the need for reasonable adjustments, awareness of the appropriate referral pathways and commissioning (in the case of the former).

Responsibility for the monitoring of recall to outpatient appointments is inconsistent and has included an example of an 8-year gap for someone requiring annual cardiology reviews. Notably, this was not identified during their Annual Health Check.

Reviews have found examples of good end of life care. However, in some instances access to palliative care and the use of reasonable adjustments eg, "DISDAT" tool for pain management could have been more person-centred.

5. Funding Decisions

Individuals have been impacted by delays in funding panel decisions. This has led to delayed discharges from hospital and inadequate staff capacity and skill within care packages, and in one case left an individual without any formal support for a number of months even though the individual had been assessed and their needs had changed. Lack of agreements for funding for additional support from familiar carers while in hospital may lead to poor standards of care. Reviews have identified that people have been more likely to engage in care and treatment when supported by someone familiar.

6. Blood Tests

One of the areas in which inequalities is evident is in the taking of blood tests. Barriers noted by local general practitioners, parents and carers of individuals include concerns around consent for

the blood test, mental capacity to give consent for a blood test, and distress that may be caused to individuals who have a needle phobia, and concern about using restrictive practices. This has meant that there are a small number of individuals who have been unable to have a blood test carried out at their GP practice which has impacted on diagnosis and treatment.

7. Health Passports

It was clear from reviews that health passports are used when provided to wards most of the time. However, these were not always provided on admission and/or were not updated. In some cases the provider had to give numerous copies to the hospital as they kept getting 'lost' or 'mislaid'.

Individuals in Sheffield have access to a number of different versions of hospital passports that have been developed over the years by a variety of organisations over time. The SCCG and partners developed a standard version of a 'Health Passport' to help guide and support individuals, family carers and providers over the recent three years. Sheffield is currently undertaking a city-wide survey of the use of /health passports to understand who has one, who needs one and who needs help completing these.

8. Dysphagia and Posture Management

It is generally accepted that people with learning disabilities are more likely to have dysphagia (swallowing disorders) than other people and to experience oro-facial, cranial and postural abnormalities. In the cases reviewed, the needs of people with eating and swallowing disorders were not always addressed appropriately. Providers were not always certain of their responsibilities and in some cases boundaries between clinicians from the Community Learning Disability Team and private/voluntary day service provider clinicians were blurred. Documentation was not explicit with regards to feeding and positioning methods particularly for those individuals with complex physical disabilities with posture management needs. In addition, there were also issues with family carers not always following eating and drinking guidelines which was not addressed through safeguarding processes.

9. Oral Healthcare

People with learning disability may have poor oral health due to sugar-containing diets (including food, drinks and medication) plus difficulties maintaining oral hygiene. Access to dental services for people with learning disability can be challenging, this may be due to some individual's being unable to tolerate specific procedures and requiring specialist services.

10. Annual Health Checks – see further information under section 3 and 4.

11. Antipsychotic Medication/STOMP - see further information under section 3 and 4.

12. Access to generic screening – see further information under section 3 and 4.

13. Application and documentation of the Mental Capacity Act (MCA)

A common theme across all mainstream services is the need for increasing the confidence and competency in working with people and their families in relation to the application of the Mental Capacity Act (MCA). The MCA is not consistently being applied in a way that supports and protects the rights of individuals. There is not always evidence of how capacity is being assessed and how a "best interests" decision is being made. The phrase 'best interests' sometimes appears to be used as a clinical shorthand, possibly for an arbitrary decision, rather than indicating a

specific process undertaken within the framework of the MCA with associated record of this in the care notes. In other instances, expressed wishes and feelings appear to be being equated with mental capacity.

There is room to make much better use of Independent Mental Capacity Advocates (IMCA) as an independent voice for people with learning disabilities, particularly when in hospital.

A number of Multi-Agency Reviews found instances where no evidence of Mental Capacity Assessments took place, particularly where there was poor concordance with health interventions.

For one married couple, it was evident that they would have benefited from a joint review with multi-agency input as their needs deteriorated. There was little documentation around the couple's mental capacity, his influence on her access to care and related risks. There were missed opportunities to make use of VARMM (Vulnerable Adults Risk Management Meeting) to bring agencies together to share concerns and actions. Any of the agencies involved could have made referrals.

Families still do not always understand that their role and responsibility changes when their child becomes an adult and that they are not the decision makers anymore, but part of the decision making. This needs ongoing work doing at an early stage to prepare families for this.

6. Governance Arrangements

6.1 National context

Nationally, a revised LeDeR review process will be put in place from 1 June 2021 and will be supported by the new web-based platform and new training for LeDeR workforce.

Sheffield is engaging with the ICS (Integrated Care System) and NHS England and Improvement to develop new approaches and implement the revised processes.

Locally, there have been effective governance arrangements in place during 2020/21, which are outlined below. These will be maintained whilst the new governance arrangements that underpin the implementation of the revised are developed and established.

6.2 Current local arrangements

The LeDeR programme is a service improvement programme and as such requires a governance process to ensure that any learning and recommendations from the deaths of people with Learning Disabilities is shared an acted upon.

Sheffield CCG has developed a robust quality assurance process. The Quality Assurance Panel convenes bi-weekly to review LeDeR deaths. Recommendations and actions form the Quality Assurance Panel is overseen at the monthly Steering Group where actions and recommendations are monitored for progress.

Membership of each group includes representation from Sheffield CCG including commissioners and various quality managers, representation from provider services and local authority as well as a service user by experience and patient representative. The governance has been further strengthened by Sheffield CCG Chief Nurse, Director of Quality, who is responsible for the oversight and assurance of the LeDeR programme within the CCG.

Further improvements to governance have included reporting on LeDeR at monthly Quality Review Group meetings and 6 weekly reporting to Quality Assurance Committee where updates on the progress of the program are provided, which informs Governing Body.

7. Improving Health Inequalities for People with Learning Disabilities and Autism across South Yorkshire and Bassetlaw Integrated Care System (SYB ICS)

Addressing health inequalities faced by people with learning disabilities and autism is a key priority for the SY&B ICS. We have an established Health Inequalities Steering Group which currently meets 6-weekly that specifically looks at a collaborative approach, sharing best practice to improve our pathways, provision and more importantly raise awareness.

There are several projects across the ICS where we are working to address the health inequalities that our learning disability and autism population are still facing:

- **The LeDeR ECHO Project**

Utilising the ECHO platform, we are rolling out a series of ECHO modules to Learning Disability and Autism care homes, supported living settings and domiciliary care which will increase the knowledge, competency, and confidence of staff. Focussing on the key findings and recommendations from the LeDeR reports including the following which will be phase 1 of the project:

- Constipation
- Epilepsy and Seizure Control
- Dysphagia/Posture
- Sepsis Awareness

These sessions will also be available to GP practices, other Clinicians, and family carers later in 21/22.

- **ECHO training –** Self Advocates from Speakup have attended ECHO training and are now supporting the rollout of the above modules presenting the case studies.

- **SAMI/RESTORE 2 Mini Tool Project**

To compliment the above project, we are also rolling out SAMI Restore2 Mini Tool (a physical deterioration and escalation tool for care/nursing homes) training which is an accredited training programme. The programme offers education and training for care support staff within care settings, supported living, care homes and domiciliary care. Carers are taught to recognise measure and report changes to an individual's health status at an early stage, thus preventing deterioration in that person's health and wellbeing and avoiding preventable deaths in line with the LeDeR Programme. The aim of the programme is to identify early signs of illness, prevent unnecessary hospital admissions/attendances at A&E, reduce stress for the cared for person, increase confidence of carers, improve communications with primary care and urgent care services. We will also be providing calibrated equipment including Oximeters, Blood Pressure Machines, Thermometers and Clinical Watches. This work will also link in with the national Oximeter Pilot.

SAMI - Final FLYER FOR LD V5.pdf

- **Big Health Days**

Speakup facilitated two big health days prior to the lockdown. Over 200 people with learning disabilities, autism or both attended (the first day was for children and young people and the second day was for adults). As well as working closely with our health action teams, we partnered with SENSE and South Yorkshire Sport so that people had the opportunity to take part in sport and physical activity. Everyone had the opportunity to take part in 5 workshops on, Cancer Screening, Sexual Health and Dysphagia along with two workshops on physical activity. Everyone really enjoyed the days and when lockdown has ended, we would like to run more of these events.

- **Other Projects**

- Speakup Self Advocates have co-produced an online accessible newsletter, "Spreading the News". This gives easy read information about COVID-19, lockdown and keeping safe. There have been 19 editions of the newsletter; it has been distributed through the Speakup website and shared through all communication and engagement leads across health and social care as well as VCR's and parent carer forums. There are 3 further co-produced easy reads, "Kick Out Those Lockdown Blues", offering some ideas on coping with lockdown.

- Speakup and their advocates have carried out Zoom sessions in January 2021 to spread awareness on the "early signs and symptoms of cancer" and the "Covid-19 Grab and Go sheet" these sessions will be for people with learning disabilities, family carers and supporters along with any provider services who would like to know more. A special edition of the 'Spreading the News' re cancer awareness covering 5 key areas has also been co-produced.

- The newsletter has been well received and other Integrated Care Systems are asking to use this.

- Linking in with local and ICS flu groups to try and increase the uptake of flu vaccinations. Speakup put together a flu 'Spreading the News' edition in easy read which will include all PHE guidance and links to those services to provide support regarding desensitisation. https://www.speakup.org.uk/flu

- Health Check work - Prior to Christmas Speakup contacted 27 homes in Rotherham (responses from 21) to find out if people had, a health passport, COVID-19 grab and go sheet, had attended their annual health check and had been offered a flu jab. Speakup were then asked to do the same for Doncaster and Sheffield and to include information about the ECHO training; an online form to capture the information was created. Since the 31 March 2021 Speakup have contacted 311 homes. Speakup also contacted care homes in Barnsley & Bassetlaw to share information about the ECHO training. Findings from the online form will be shared at the SY&B Transforming Care Health Inequalities Steering Group Meeting.

- GP Training – Speakup have delivered one training session in Doncaster, four in Sheffield, one for Rotherham. Speakup have also been training medical students in Sheffield and have run two training sessions this year to 80 students. Speakup advocates also ran a session with Sheffield University to health and social care workers to talk about the Transforming Care Partnership (TCP) work and have since been contacted by a dentist who is wanting to create a quality-of-life scale around oral health.

- NHSE masterclass - Experts by experience at Speakup helped to run a masterclass for Coping with Covid: Supporting People with Learning Disabilities, Autism, or both.

Sheffield Learning from lives and deaths – People with a learning disability and autistic people: Strategic Action Plan 2021 – 2024

(Identifying where the NHS Long Term Plan can help us to address and mitigate the morbidity and mortality identified through LeDeR)

LPT Commitment	Objective(s)	How and What will be delivered	Timelines & Lead
Year: 2021 - 2022			
What is the area of focus	*What are the key objectives and outcomes of the work?* *What are the key milestones for delivery*	*How & what will be delivered to meet the objectives and outcomes – this should be linked to the key milestones for delivery*	*Identification of lead organisation and timescale (Month or Qtr.)*
Sessions with providers on sharing learning/developing new infrastructure	In 2021/22 there will be an increased focus on working with providers to share learning and focus on embedding change as individual providers and providers as a collective throughout 2020/21, as outlined by the updates below.	• This will include several focused sessions with providers on wider areas of learning, as well as continuing to contact providers on specific issues.	Sheffield CCG
Annual Health Checks and Quality of Care	Sheffield will meet the national target for completion of Learning Disability Annual Health Checks (75%) Practices will achieve the Learning Disability QOF Quality Improvement domain 2021/22.	• Sheffield CCG will improve the identification of people with a learning disability in GP practices and improve uptake of annual health checks by taking a systematic citywide approach to support practices to achieve the Learning Disability QOF Quality Improvement domain 2021/22. • During May 2021, we will launch our local co-designed learning disability and autism health check/health living pages (which includes a health professionals' section).	Sheffield CCG / SHSC community learning disability team *Quarterly milestones identified throughout 2021/22*

LPT Commitment	Objective(s)	How and What will be delivered	Timelines & Lead
		• We are in the process of producing videos for training and awareness raising, as part of our Learning Disability exemplar/"Champion" project. • We are progressing work to commission a citywide health action team (for people with Learning Disability, Severe Mental Illness and Autism) which will incl. workforce education/training, modelling, and supporting delivery of health checks and health action plans). This work was delayed due to the pandemic. • We will work with providers across the city to ensure good uptake of the Oliver McGowan training (when this is rolled out) and other Learning Disability & Autism training.	
Support for Providers in Recognising the Deteriorating Patient #1	Sheffield care providers will continue to participate in the TCP roll out of the LeDeR ECHO Project online training programme addressing the key findings identified from LeDeR. Topics: Constipation; Epilepsy and Seizure control; Dysphagia/Posture; Sepsis awareness.	• Currently approx. Sheffield 86 providers have attended/are booked to attend sessions, with 122 attendees having attended sessions to date or being booked for upcoming Constipation sessions; 141 for Epilepsy and Seizure control; 134 for Dysphagia/Posture sessions; and 129 for Sepsis awareness. • Providers and commissioners will continue to work closely together to ensure uptake of the sessions.	TCP / Sheffield CCG *Training started in January 2021 and runs until November 2021*.
Support for Providers in Recognising the Deteriorating Patient #2	Sheffield care providers will participate in the TCP roll out of SAMI (including RESTORE2) training.	Dates for 2021/22 to be confirmed.	TCP / Sheffield CCG

LPT Commitment	Objective(s)	How and What will be delivered	Timelines & Lead
Health passports	Increased use of Health passports for people with Learning Disability and/or autism	We will increase: • The number of people with Learning Disability and/or autism using a Health Passport • The number of Health Providers who are actively using these to ensure personalised care and reasonable adjustments	SHSC/STH/ SCC
Access to Health Specialists and Follow-up	Improve reasonable adjustments, awareness of the appropriate referral pathways and inclusion of the needs of people with Learning Disability in commissioning	• Ensure gaps/issues are followed up through the provider sessions • Link to the wider work in Sheffield on recall/'declined' appointments for vulnerable patients • Link to Physical Health Strategy workstreams (planned for 2022) on reasonable adjustments flags/awareness	SHSC/CCG/ STH
Oral Health project	Improved oral health for people with Learning Disability through co-ordinated approaches across providers and integration within the citywide Public Health Oral Health Strategy	• Improve the oral health resources and support available for people with learning disabilities, their families and care providers. • Surveying local people with Learning Disability/carers about the challenges they face in maintaining good oral health • Producing an accessible video to address these challenges • Raising awareness with GPs about specialist dental support • Offering training to more care providers about oral health • Including the oral health of people with Learning Disability in the current refresh of the Citywide Oral Health Strategy.	STH/SHSC/ CCG
Healthy Weight Project	Improved access to community dietetic support/ weight	• Close working between wider partners and the Local Authority on the non-recurrent funding for	SCC/CCG/ SHSC

LPT Commitment	Objective(s)	How and What will be delivered	Timelines & Lead
	management advice tailored to people with Learning Disability and their family and paid carers	2021/22 (national funding stream) on extending community obesity provision (this include an Learning Disability focus)	
Uptake of Covid vaccinations	Ensure a high uptake of Covid vaccinations for people with Learning Disability and Autism, including people from BAME communities	• Close work with GPs, the VCS and care providers • Monitoring of vaccine uptake • Targeted and accessible communications with people with Learning Disability and/or autism	CCG
Antipsychotic Medication / STOMP	Ensure high quality antipsychotic prescribing protocols and STOMP medication optimisation pathways are in operation with clear documentation of: Documentation of long-term monitoring • Rationale • Long term monitoring of physical health • Side effect monitoring • Consideration of stopping/reducing • Patient/Carer views • Alternatives to medication • Ensuring clear communication of responsibilities between secondary and primary care	• Collaborative Care Plans (CCPs) to be introduced across CISS and CLDT and Physician Associate template designed to capture all key metrics and caseload antipsychotic monitoring summary table in development. • SHSC & CCG Pharmacy to work together to develop and improve communication via the 'shared care policy'. • Learning Disability GASS has been agreed as the Learning Disability side-effect monitoring tool at Medicines Optimisation Committee (M.O.C). • CCPS to support a 'Every Contact Counts' supporting conversations between every Learning Disability professional contact with service users and carers about STOMP/medication & side effects. • Development of a 'one stop shop' PA/Nursing support at outpatient clinics with a focus on	CCG/SHSC

LPT Commitment	Objective(s)	How and What will be delivered	Timelines & Lead
		difficult to engage service users and overcome barriers to accessing mainstream services e.g., phlebotomy, cardiology service. • Signposting a referral to PBS training and consultancy sessions to ensure every person prescribed anti-psychotics for behavioural distress has a PBS plan and 'system around the person' support.	
Access to generic screening	Improve the opportunity for people with a learning disability to make informed choices about bowel cancer screening	• Setup of a bowel screening flagging pathway by providing specialist help and support at the pre-invite stage	SCCG/SHSC
LeDeR Programme will contribute towards improving health and social care wide issues that have impacted on the quality of care of people with learning disabilities	Improve the following locally identified wider health and social care issues: - Care Co-ordination across health and social care providers - Safeguarding - MCA and DOLS application in practice across different settings and professional groups - Funding Decisions - Clear information to families about if Day Services are CQC registered	Through ensuring that LeDeR findings influence wider citywide work on these key issues that have been identified through the Reviews but are also wider, systemic concerns. E.g. via Adult Safeguarding and through links with the Vulnerable Adults Panel etc.	NHS/SCC
Roll out of new LeDeR Policy	Sheffield will engage with the ICS and NHSEI to develop new	• Complete mandatory training on the new process and web-based platform	ICS/ Sheffield CCG

LPT Commitment	Objective(s)	How and What will be delivered	Timelines & Lead
	approaches and implement the revised processes and to develop, implement and transition from existing LeDeR framework to an integrated ICS model	• Follow new processes • Contribute towards ICS workforce plans and data reporting • Contribute towards the ICS plan in place to ensure reviews are completed within 6 months of the notification of death	
Year: 2022 - 2023			
Annual Health Checks and Quality of Care	Sheffield will meet the national target for completion of Learning Disability Annual Health Checks (75%) Practices will continue to drive improvement based on the Learning Disability QOF Quality Improvement Domain 2021/22.	• Systematic citywide approach to support practices • Citywide Health Team Commissioned service	
GP autism registers	Introduction of GP autism registers	• Systematic citywide approach to support practices • Citywide Health Team Commissioned service	
Annual health checks for people with autism (and no Learning Disability)	Introduction of a local incentive scheme for annual health checks for people with autism (and no Learning Disability)	• Systematic citywide approach to support practices • Citywide Health Team Commissioned service • Co-design approach utilising local networks and experience of people with autism/family carers	
To address any ongoing or newly identified issues from the previous year – to be confirmed following			

LPT Commitment	Objective(s)	How and What will be delivered	Timelines & Lead
review of learning points.			
Year: 2023 - 2024			
Annual Health Checks and Quality of Care	Sheffield will meet the national target for completion of Learning Disability Annual Health Checks (75%) Practices will continue to drive improvement based on the Learning Disability QOF Quality Improvement Domain 2021/22.	*As above*	
GP autism registers	Increased uptake of GP autism registers	*As above*	
Annual health checks for people with autism (and no Learning Disability)	Increased uptake of local incentive scheme for annual health checks for people with autism (and no Learning Disability)	*As above*	
To address any ongoing or newly identified issues from the previous year/s. – to be confirmed following review of learning points.			