

Learning Disability Mortality Review LeDeR Annual Report

2019 -2020

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Sheffield Annual Learning Disability Mortality Review (LeDeR)

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Sheffield Annual Learning Disability Mortality Review (LeDeR)

SECTION 1 – National Context

1.1 Introduction

The Learning Disabilities Mortality Review (LeDeR) Programme is a world-first programme of its kind aimed at making improvements to the lives of people with learning disabilities through a national review into their deaths, carried out in England to improve the standard and quality of care for this group of people.

The programme is delivered by the University of Bristol, and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Nationally, work on the LeDeR programme commenced in June 2015 for an initial three-year period. In Sheffield, implementation commenced in November 2016, and by the end of 2017, the LeDeR programme was fully rolled out across England.

People with learning disabilities, their families and carers have been central to developing and delivering the programme nationally.

Under the LeDeR programme all Clinical Commissioning Group (CCG) areas have to deliver a local procedure for reviewing deaths of people with a Learning Disability as part of this national review.

The (LeDeR) Programme was established as a result of one of the key recommendations of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD). CIPOLD reported that many people with learning disabilities were dying earlier of preventable health conditions younger than they should, and up to 30 years earlier than the rest of the population. Some of the reasons related to the standard of health and social care that they received, but also related to other wider social determinants of ill health, such as poverty and social exclusion.

The overall aim of the LeDeR programme is to help reduce premature mortality and health inequalities in this population, through driving improvement in their lives and in the care that they receive.

The LeDeR programme collates and shares anonymised information about the deaths of people with learning disabilities nationally, so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

Values and Principles

The core principles and values of the programme are:

- valuing the contribution of people with learning disabilities and their families to all aspects of our work
- taking a holistic perspective, looking at the circumstances leading to deaths of people with learning disabilities, and not prioritising one source of information over another
- aiming to ensure that reviews of deaths lead to reflective learning, which will result in improved health and social care service delivery
- to embed reviews of deaths of people with learning disabilities into local structures to ensure the continuation of the learning taken from the reviews.

The issues and causes of death identified within the national LeDeR annual report (published 16 July 2020), alongside the findings from locally completed reviews reflect the many challenges that people with a learning disability face in living their lives.

Whilst there is much work already underway nationally and locally to improve access to healthcare to address inequality, there is more work to be done. Through the development of new tools to support practitioners and providers, and new resources to develop skills and awareness, we aim to improve access to the right care and

support, through developing a culture of improved information, knowledge; vigilance and interventions for people with a learning disability.

More information about the LeDeR programme can be found on the website for LeDeR hosted by the University of Bristol <http://www.bristol.ac.uk/sps/leder/about/>

Easy read information about the programme and its publications can be found at:

<http://www.bristol.ac.uk/sps/leder/easy-read-information/>

1.2 Background

1.2.1 National Context

People with a learning disability experience significant health inequality when compared to the rest of the general population. To put this into context the life expectancy for people with learning disabilities in 2020 can be equated to what the rest of the general population could have expected in the 1940's. Today, nationally it is evidenced that men with learning disabilities die on average, 23 years earlier and women 27 years earlier than other people within the general population of preventable health conditions.

However, these health inequalities should not be inevitable and can be mitigated by improved education, prevention, early intervention, and timely access to healthcare throughout their lives.

1.2.2 Definition of Learning Disabilities

The LeDeR programme follows the definition outlined in 2001 by the white paper 'Valuing People'.

Learning disability includes the presence of:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- a reduced ability to cope independently (impaired social functioning)
- which started before adulthood, with a lasting effect on development.

1.2.3 Scope of the LeDeR Programme

Initial reviews are undertaken of **all** deaths notified to the LeDeR programme of people with learning disabilities aged 4 years and older in England.

The following reviews will take precedence over local reviews:

- Serious Case Reviews (SCRs), Safeguarding Adult Reviews (SARs), Safeguarding Adults Enquiries (Section 42 Care Act) Domestic Homicide Reviews (DHRs), Serious Incident Reviews, Coroners' investigations, Child Death Overview Panel (CDOP) and Mothers and Babies: Reducing Risk through Adults and Confidential Enquiries (MBRRACE).

1.2.4 Notification of a Death

Reporting a death of a person with learning disabilities can be done in a number of ways and by anyone:

- via **0300 7774 774** directly to a member of the central LeDeR programme team, or
- via the Programme's secure web-based portal, which can be accessed through the LeDeR website or via the following link: <http://www.bristol.ac.uk/sps/leder/notify-a-death/>

The person reporting the death is asked to provide as much of the core information required to notify a death as possible. The information provided is checked by the National LeDeR team to ensure that the death meets the inclusion criteria for the LeDeR programme. Once confirmed, the death is transferred to the LeDeR Local Area Contact (LAC) who in turn will carry out their own local eligibility checks prior to allocation to a reviewer.

1.2.5 Confidentiality and Data Sharing

The National LeDeR programme applied to the national Confidential Advisory Group (CAG) for Section 251 (of the NHS Act 2006) approval for the use of patient identifiable information, in order that reviews can be undertaken of the deaths of people with learning disabilities.

The programme has been given full approval to process patient identifiable information without consent. Specifically, this provides assurance for health and social care staff that the work of the LeDeR programme has been scrutinised by the national CAG. The CAG is appointed by the Health Research Authority to provide expert advice on uses of data as set out in the legislation and advises the Secretary of State for Health whether applications to process confidential patient information without consent should or should not be approved.

The key purpose of the CAG is to protect and promote the interests of patients and the public whilst at the same time facilitating appropriate use of confidential patient information for purposes beyond direct patient care. More information about Section 251 approval is available at:

www.hra.nhs.uk/about-the-hra/our-committees/section-251/what-is-section-251/

1.3 Local Context

This report is the published report on the learning from deaths of those people with learning disabilities within Sheffield. The report covers the period of **November 2016 up until 30 September 2020**.

The aim of this report is to bring information together to understand and to reflect on themes that can inform and improve practice across the health and social care community in Sheffield.

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.

1.3.1 The Sheffield Case Register

Established in 1974 and managed by Sheffield Health & Social Care NHS Trust, the Sheffield Case Register captures data on all people (from birth to death) with a learning disability in Sheffield. This data is used to inform local and national research studies; as a basic data set for all local work on commissioning; to develop business cases; manage priority activity/care pathways and improving access to care and signposting.

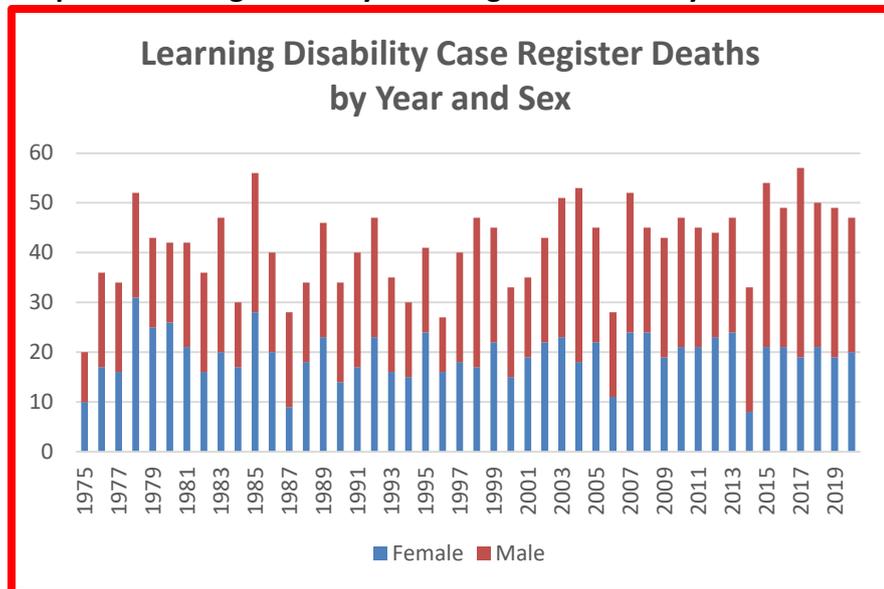
In Sheffield the Case Register:

- provides an annual download to Sheffield Teaching Hospitals (STH). Patient Admission System then flags patients for every inpatient and outpatient contact at STH sites. This enables STH to track hospital admission rates and patterns of service usage across each hospital specialty and tracks morbidity and mortality rates
- provides an annual download to GPs to enable them to identify people with a learning disability on their QOF register and DES Annual Health Check register (increases eligibility)
- signposts people into services
- is used to communicate information to families e.g. flu jabs
- enables service audits such as access to neurology services for people with epilepsy/ breast screening/cervical screening/QOF disease register comparisons, update of annual health checks and hospital passports

Sheffield is unique in having a register that has existed for so long, and this enables us to take a longitudinal view of deaths over time, and prior to the LeDeR process.

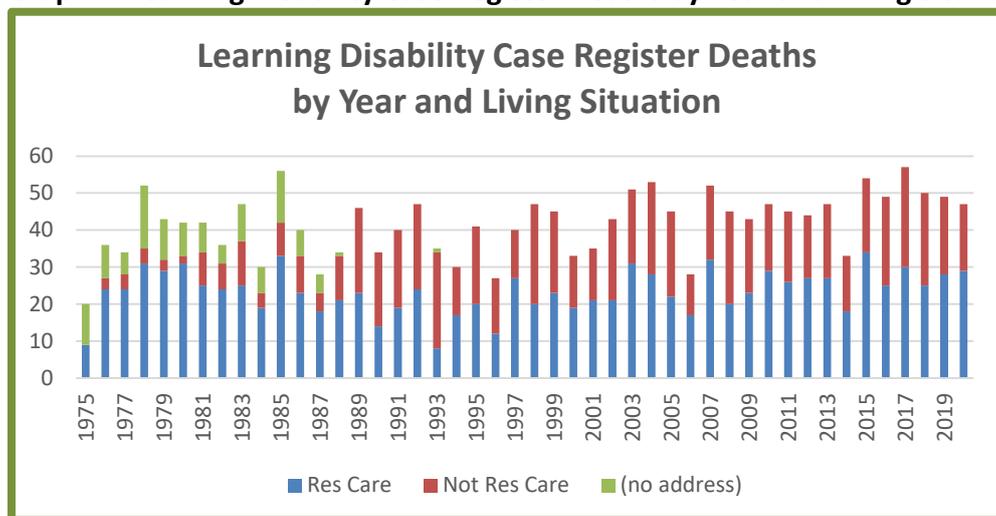
Over the last 46 years there have been 1922 deaths in Sheffield of people with a learning disability known to the Sheffield Case Register, an average of 42 per year. Graph 1, 2 and 3 provide anonymous summary details of the demographic of the individuals who died over this period.

Graph 1: Learning Disability Case Register Deaths by Year and Sex (1975 to September 2020)



Patterns in the deaths show an upward trend, but it should be noted that over the last 20 years, there has been an increase in the number of premature babies who have survived birth at earlier gestation periods, but who are living with more profound and multiple impairments to their health and therefore overall reduced life expectancy.

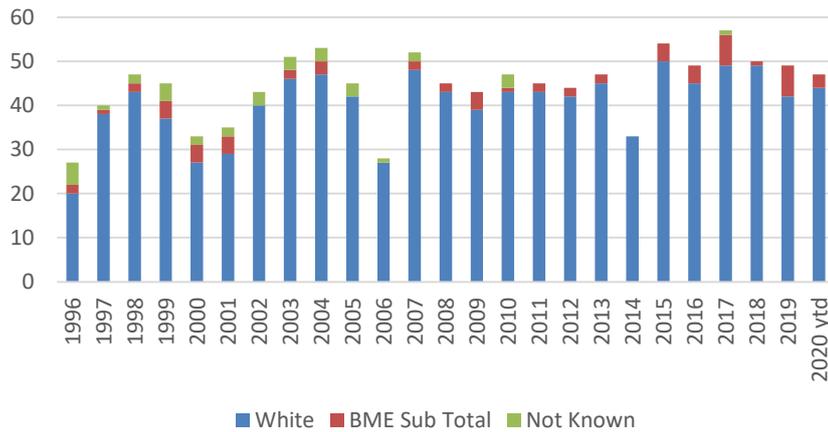
Graph 2: Learning Disability Case Register Deaths by Year and Living Situation (1975 to September 2020)



This graph demonstrates that over the past 45 years, there has been an increase in the proportion of people living in a wider range of accommodation which is less restrictive than residential and hospital care, and which includes supported living and people in their own tenancies. However, many people living independently may only have support packages which target specific support such as finance support, help with shopping as an assessed need, and may fail to respond to GP letters, screening invitations and vaccinations.

Graph 3: Learning Disability Case Register Deaths by Year and Ethnic Group (1975 to September 2020)

Learning Disability Case Register Deaths by Year and Ethnic Group



The ethnic minority profile of Sheffield has changed over recent years. However, within some communities, it is recognised that there are groups who have a higher incidence of profound and multiple impairment and therefore complex health conditions.

1.3.2 Medical Examiners Project

From April 2017 to November 2019 the Medical Examiners at the Sheffield

Teaching Hospitals worked with National LeDeR as a pilot project that notifies deaths of people with learning disabilities in that area. The aim was to assess whether the Medical Examiner system of reporting deaths provides LeDeR with more complete and comprehensive information than notifications of deaths from other sources.

The work of the Case Register and ability to track people through GP practices and Sheffield Teaching Hospitals and the Medical Examiners project may account for or contribute to the higher number of notifications received by Sheffield.

SECTION 2 - LeDeR Process in Sheffield

2.1 Purpose of the LeDeR Review

The purpose of the LeDeR review is to:

- identify any potentially avoidable factors that may have contributed to the person's death
- develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities
- identify good practice

For more information please refer to the following Appendices:

- Appendix 1 - LeDeR Process Flowchart
- Appendix 2 - LeDeR Notification of Death Diagram

2.2 Initial Review

Drawing on the wider learning from work on reviewing deaths in NHS Trusts, the LeDeR methodology places the person with learning disabilities at the centre of the review. The 'pen portrait', is a strengths based focused recording of the person's likes, abilities character and communication and is at the heart of the review.

Sadly, for some individuals it is not possible to complete more than a basic pen portrait due to a lack of family involvement and with so little of their life having been documented. Some care settings are better at being able to describe who the person was, their likes and dislikes, whilst others are not.

A chronology is completed detailing at least the last year of the person's life. From the information collated reviewers are required to analyse information and formulate recommendations based on issues and learning identified. These SMART recommendations identify where quality can be improved and good practice shared, through the identification of recurrent themes

2.3 Multi-agency Review as part of the LeDeR Process

The purpose of the multi-agency review is to include the views of a broader range of people and agencies who have been involved in supporting the person who has died, where it is felt that further learning could be obtained from a more in-depth analysis of the circumstances leading up to the person's death.

There are a number of circumstances that would indicate that a multi-agency review is required. These may be identified very early on in the initial review process or may emerge as the review progresses. A multi-agency review is always required:

- Where the assessment of the care received by the person is graded high at a score of 5 or 6 within the 1-6 rating scale
- When any red flag alerts are indicated in the initial review
- If there have been any concerns raised about the care of the person who has died

The table below details the number of multi-agency reviews held in Sheffield.

No of Multi-Agency Review Meetings	Relating to No of Deaths
16*	14

*Three multi-agency reviews related to one person

2.4 Priority Theme Reviews

For the first two years of the Programme (2016 – 2018) Priority Themed Reviews were held. The Priority Theme Review aspect of the LeDeR programme examined the deaths of a subset of people with learning disabilities in more detail:

- Deaths of people aged 18 to 24 years
- Deaths of adults and children from a Black or Minority Ethnic group.

The priority themed reviews carried out for these groupings are noted as follows:

No of Multi-Agency Review Meetings	Relating to No of Deaths
3	3

In December 2018, it was agreed that there was no longer an automatic requirement to carry out a multi-agency review for both of these priority groups.

SECTION 3 - Accountability & Governance

3.1 Accountability

Whilst the programme is managed by Bristol University on behalf of NHS England, NHSE has aligned LeDeR to the national Transforming Care Programme (TCP). The on-going development and progress of LeDeR locally is therefore monitored through the Sheffield, Rotherham, Doncaster and Bassetlaw TCP Board.

3.2 Delegated Delivery Arrangements

At the instigation of the LeDeR programme, SCCG leadership for the programme came from within the nursing and quality directorate.

However, through discussions across partners, Sheffield Health and Social Care Trust (SHSC) were recognised as being the best placed partner to manage the review programme, as they already had a Mortality Review function and process within their organisation.

The majority of staff who came forward to be trained as assessors were learning disability clinicians from the SHSC Learning Disability Service or Social Workers from the Local Authority who work closely with the above service, with a smaller number of CHC nurses also trained. Therefore, allocating reviews to these clinical staff in terms of overall workload prioritisation was best managed from within the SHSC Learning Disability Service itself.

As the national Transforming Care Programme was launching at around the same time as LeDeR, CCG capacity was required to focus on this programme, and it was recognised that additional capacity had to be sought from system partners.

The Operational Head of the SHSC Learning Disabilities Service at the time was therefore identified by SCCG as the Local Area Contact for the programme and has maintained this role when she moved into the Associate Director of Patient Safety role within SHSC.

The multi-agency LeDeR Steering Group however, remains the responsibility of the SCCG to convene and chair. Responsibility for the oversight of LeDeR moved to the Mental Health Commissioning Team from the Deputy Chief Nurse/ Head of CHC in late 2018/2019.

3.3 LeDeR Steering Group

As stated, the governance of the LeDeR programme is overseen by the Sheffield LeDeR Steering Group, which meets every 6 weeks. The Head of Commissioning within the Mental Health Commissioning Portfolio chairs the group, and governance reporting goes through the Physical Health Improvement Group and also now reports through the Quality Assurance Group.

The group members include:

- Senior Quality Manager, CCG
- Associate Director Patient Safety/Local Area Contact
- Speakup representing Experts by Experience
- Nurse Director Head & Neck, Sheffield Teaching Hospital
- Chief Executive, Sheffield Carers Centre
- Transforming Care Project Officer, ICS
- Head of Services Future Options, Sheffield City Council
- Named Professional Safeguarding, Sheffield Clinical Commissioning Group
- Senior Operational Manager, Community Learning Disability Team

Terms of reference are agreed and a local information sharing agreement is also in place. (Appendix 3).

An update on the local delivery of the LeDeR programme is included in the monthly quality report submitted to the SCCG's Quality Assurance Committee. Periodic updates on LeDeR are also provided to the Learning Disability ICS Transforming Care Partnership Group and Board and the local Safeguarding Boards.

The SCCG is also accountable to NHSE for delivery of the programme and reports to NHSE go through the ICS Transforming Care Programme and ICS Lead for the programme, and into regional and National LeDeR reporting mechanisms (Refer Appendix 7 Governance Structure).

The Sheffield Annual LeDeR Report (this document) will be shared with key local stakeholders and can also be referenced in the SCCG's own overarching Annual Report as required.

3.4 Quality Assurance (QA) Panel

The SCCG chairs a bi-weekly LeDeR Quality Assurance Panel with key partners and professionals to discuss the reviews that have been completed to quality assure and sign them off so that the reviewer can submit to the Local Area Contact (LAC) for final sign off and submission to LeDeR. This process enables the panel to give constructive feedback to reviewers to enrich their future reviews, provide invaluable insight into training needs and identify themes and lessons learned (Refer Appendix 8 Quality Assurance Process).

The LeDeR Steering Group will discuss the recommendations and learning to submit to the Physical Health Improvement Group (PHIG) for local oversight and implementation, and will work with partners to identify local actions. The Integrated Care System (ICS) regional Transforming Care Partnership Board (TCP) also oversees learning and ensures that improvement actions are implemented through regional work of the TCP partners/ICS.

Examples of local learning have included actions led by SHSC learning disability clinical staff around the management of swallowing disorders; constipation and pressure care. Additionally, further work on Annual Health Checks led by the PHIG aims to address mortality rates. Learning from Sheffield work has been shared across the ICS region.

ICS dissemination of learning has included the current development of the ECHO (Extension of Community Healthcare Outcomes) platform to deliver training on a range of topics that would contribute to improved health and mortality for this group. Sheffield LeDeR LAC, CCG Clinical Director, and commissioners have been heavily involved in this work with St Luke's Hospice as a partner.

3.5 Sheffield Local Statement of Purpose

SCCG, in partnership with 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, but to have also delivered significant learning shared across the region.

3.6 Partnership Working, Patient and Public Voice and the Local Learning Disability Community

The local learning disability community has been involved in delivery of the LeDeR programme via input from Speakup Rotherham, a group of Experts by Experience which is represented at the ICS Transforming Care Programme Board. This contribution provides the basis for what we hope will be an expanding role for patient and public voice in local delivery of the programme going forward, building on training that they have delivered to Primary Care in Sheffield.

Other key local stakeholders have supported delivery of the programme through supporting reviewers with their expert knowledge and attending review panel meetings, or attending the steering group.

3.7 Engaging Reviewers

As the programme has evolved over the last three years, funding opportunities have arisen through LeDeR/NHSE and the Transforming Care Programme, and Sheffield have repeatedly been successful in securing funds to employ assessors, in 2018/19/20.

However, it was anticipated that the programme would only run until 2019/20, but it has continued to be nationally extended. It is now anticipated that the programme will continue for the foreseeable future, as the COVID pandemic is demonstrating that there is a disproportionate impact on people with learning disabilities.

There are therefore, challenges to the delivery of the LeDeR programme, beyond December 2020, as it is now recognised that dedicated resources will be required, long term, rather than reliance on temporary funding allocations through the ICS Transforming Care Programmes.

A SCCG paper is in development by the Deputy Director of Finance in collaboration with the Learning Disability Lead commissioner, to identify permanent funding to secure LeDeR assessor time.

From the onset of the LeDeR Programme in Sheffield, NHS and social care partner organisations cited pressures on clinical and social worker staff time arising out of the rising demands as the key reason for reviewers being unable to fulfil their reviewer role. Nevertheless, the expectation from LeDeR is that NHS Trust level participation is expected.

As at September 2020 the total number of trained and active LeDeR reviewers and their professional background for Sheffield is detailed in the table:

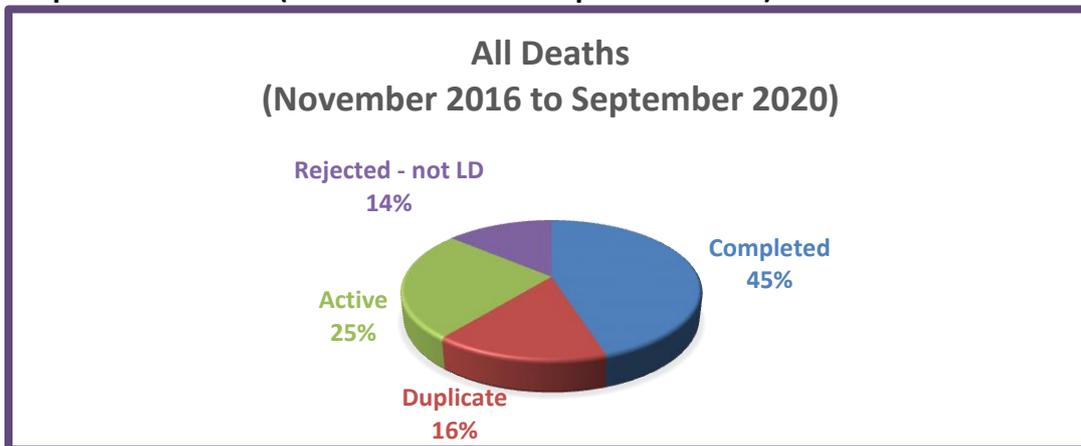
Organisation	Number of Reviewers Trained	Active Reviewers	Profession
Sheffield Health & Social Care NHS Foundation Trust	8	4	<ul style="list-style-type: none">• 1 Occupational Therapist• 2 Nurses• 1 Speech & Language Therapist
Sheffield Clinical Commissioning Group	5	1	<ul style="list-style-type: none">• 1 Nurse
Sheffield City Council	3	0	<ul style="list-style-type: none">• 0 Social Workers
Voluntary & Private Sector	1	0	<ul style="list-style-type: none">• 0 VCS worker

SECTION 4 – Findings from Deaths in Sheffield

4.1 Deaths Notified to the LeDeR Programme

Graph 4 provides a summary of all Sheffield deaths from the start of the Sheffield LeDeR programme (November 2016 to September 2020). In total 201 death notifications were received, a number of these were rejected due to the deceased not having a learning disability or because more than one notification had been received for the same person.

Graph 4: All Deaths (November 2016 to September 2020)



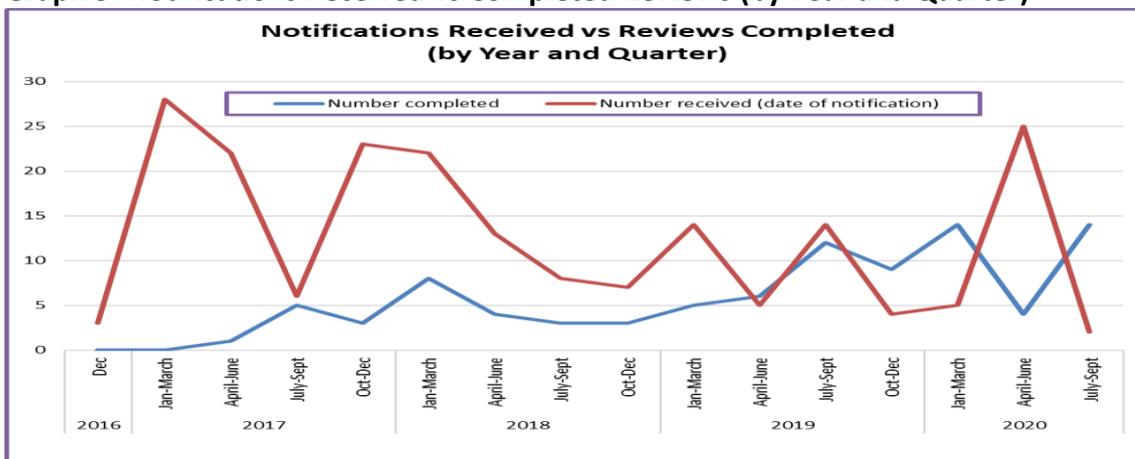
Of the current active and completed cases, 17 were child deaths (aged 18 or below).

4.2 Deaths Notified by Completion Rate

Graph 5 details the number of notifications received vs the number of completed reviews. The average number of notifications received (all) per month during the review period is 4.3.

The average number of reviews completed per month is 2, although recent assessor capacity and changed processes is increasing throughput. Trained reviewers not having sufficient time away from their other duties in learning disability services to be able to complete a review at the onset of the programme and a number of assessors who were trained but not able to fulfil this role played a key part in Sheffield's growing backlog, before dedicated resources were identified.

Graph 5: Notifications Received vs Completed Reviews (by Year and Quarter)



As can be seen, there has been an upward trend in the number of reviews completed over the programme, but there was a dip in reviews completed during the COVID-19 pandemic lock down as medical and nursing home records could not be accessed by the reviewers.

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

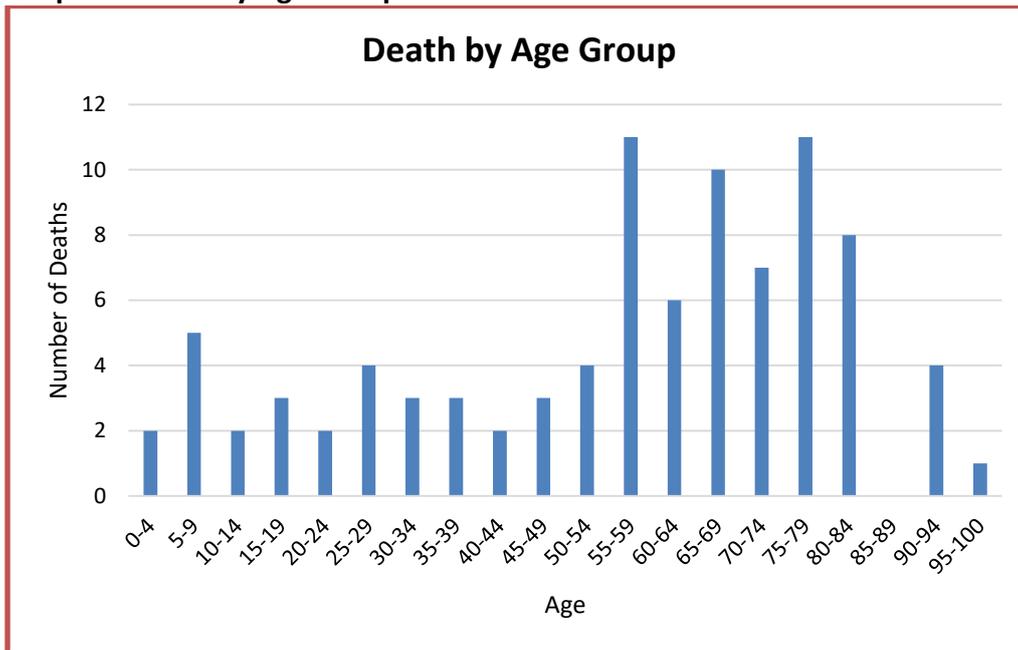
4.3 Death by Age Group

Information regarding the age of death is of significance to the LeDeR Programme, given that this is a key marker of health inequality. The age range of deaths reported was 4 years – 98 years.

Notifications of death were highest in the 55-59 (11 deaths) and 75-79 (11 deaths) age groups both each accounting for 12.1% of total deaths.

The median age of death was 60 years (average was 51.25).

Graph 6: Death by Age Group

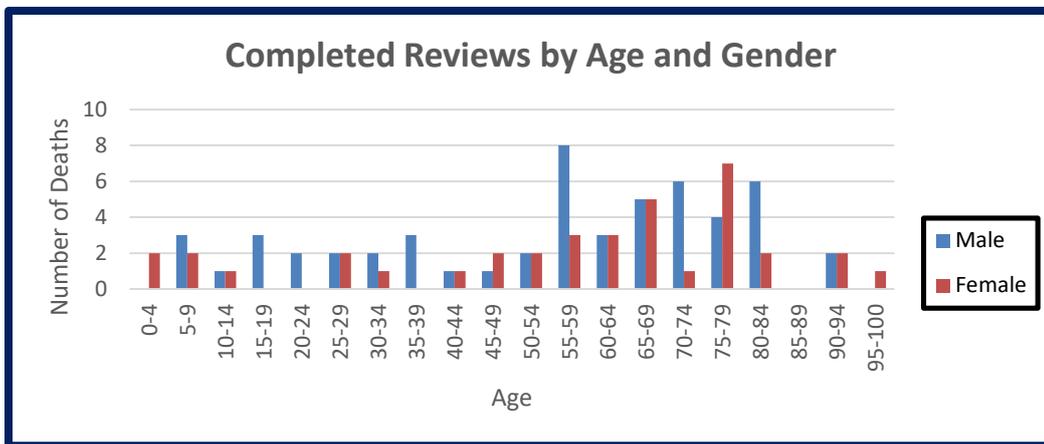


4.4 Death by Age and Gender

Of the completed reviews, the numbers of males and female deaths was relatively comparable (40.7% female, 59.3% male).

The median age of death for males was 63 (average was 57) and for females 59 (average was 54).

Graph 7: Completed Reviews by Age and Gender

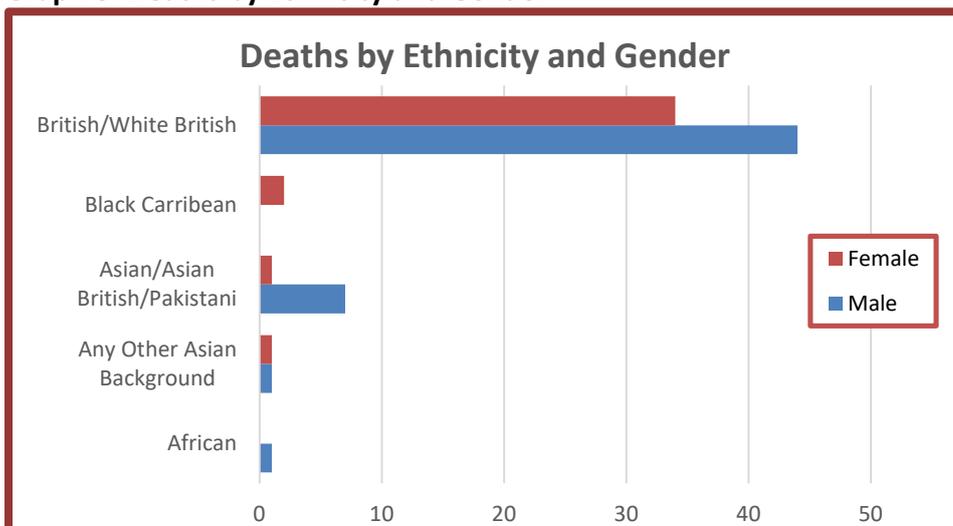


4.5 Deaths by Ethnicity and Gender

The 2019 National Annual LeDeR Report (July 2020) reported that the majority of deaths 90% were of white British ethnicity; 4% were Asian; 2% from other white ethnic groups; 2% mixed and 2% were from other ethnicities. The proportion whose ethnic group was described as ‘white British’ was higher at 90% than the 86% recorded for England and Wales in 2018.

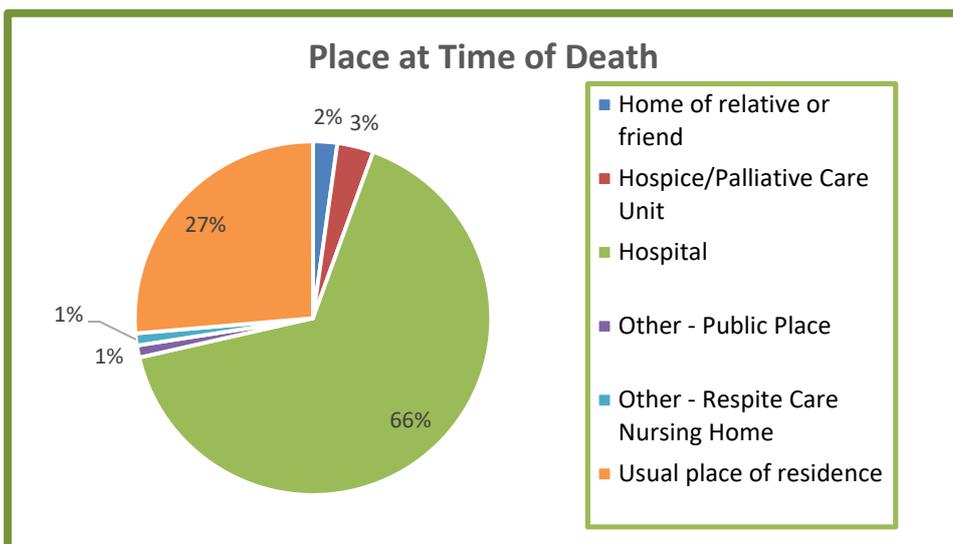
Locally the person’s ethnicity reported the majority of deaths 85% were of white British ethnicity, 11% Asian and 3% other ethnicities.

Graph 8: Deaths by Ethnicity and Gender



4.6 Place at Time of Death

The majority of deaths (66%) occurred when people were in hospital. This is higher than the national LeDeR figure of 60%. This is partially thought to be due to local ability to identify people with learning disabilities when admitted to Sheffield Teaching Hospitals and through the Medical Examiner Pilot.



Graph 9: Place at time of Death

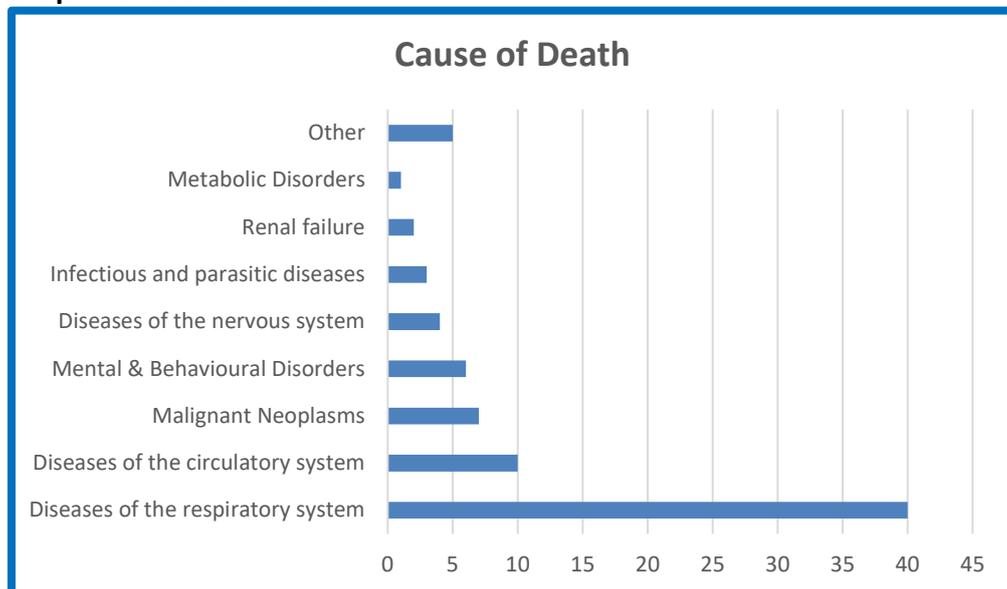
Note: From this point onwards graphs data relates to completed cases only (adult only)

4.7 Cause of Death

The cause of death is reported using a completed Medical Certificate of Cause of Death (MCCD). Nationally, in people with learning disabilities, the most frequent causes of death by ICD-10 chapter were diseases of the respiratory system (20%), diseases of the circulatory system (15%) and congenital and chromosomal abnormalities (14%). Other causes of death mentioned in Part I of the MCCD for people whose underlying cause of death was attributed to Down’s syndrome, dementia or Alzheimer’s disease (46%), bacterial pneumonia (33%) and aspiration pneumonia (27%). (Bristol University 2019)

Locally, the most frequent cause of death by ICD-10 chapter were diseases of the respiratory system (51.28%); Diseases of the circulatory system (12.82%); and Malignant Neoplasms (8.97%).

Graph 10: Cause of Death



4.8 The use of Antipsychotic Medication

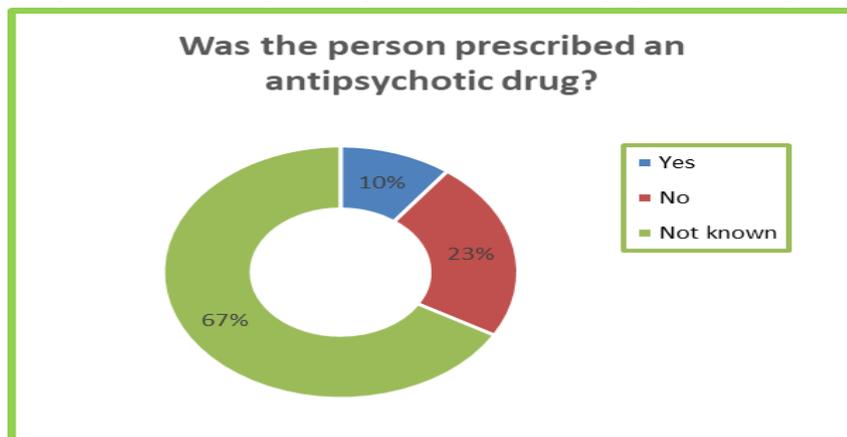
STOMP is a national project for stopping over medication of people with a learning disability, autism or both through psychotropic medicines. Sheffield CCG Pharmacy Lead and commissioning leads are involved in the STOMP programme, and again this work is overseen by the Physical Health Improvement Group.

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 11: 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.

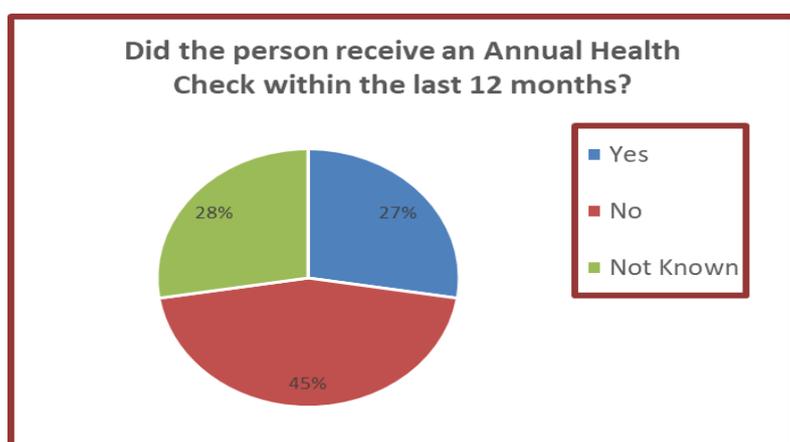
From graph 11 it is evident that the majority, 67% of individuals, were recorded as ‘not known’ for being prescribed

antipsychotic medication.

4.9 Annual Health Checks

In 2019/20 in Sheffield 1,674 people aged 14+ with a learning disability had an annual health check (AHC) (i.e. 39% against QOF all-age learning disability population of 4,288 as measured via NHSE, or 53% of people against the local learning disability 14+ register). The NHSE target is to reach 75%. In Q1 2020/21 approximately 200 health checks were completed.

Graph 12: Did the person receive an Annual Health Check within the last 12 months?

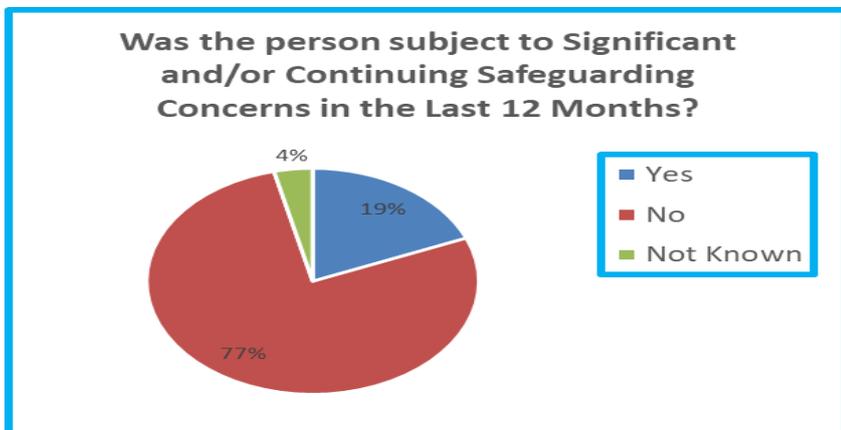


Of people known to be on GP learning disability registers, 27% had received an annual health check in the year before death, 45% had not received an annual health check and 28% were noted as not known.

4.10 Safeguarding Concerns

For 19% of the people with learning disabilities, safeguarding concerns had previously been raised. No safeguarding concerns were raised in respect of 77% of cases.

Graph 13: 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 in an attempt to escalate issues relating to commissioned packages.

It must be acknowledged that people with a Learning Disability are more vulnerable and far less likely to self-report abuse or neglect. The 12-month scope of this data

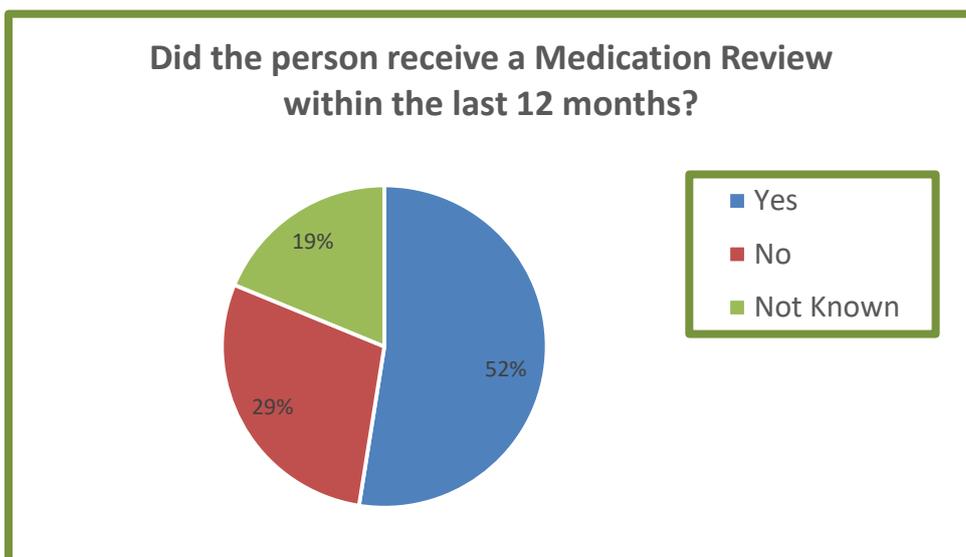
should not detract from historic abuse which anecdotally is more prevalent.

4.11 Medication Reviews

52% of people had received a medication review within the last 12 months prior to their death. 29% had not and 19% were not known.

This data is interesting in comparison to the completion of Annual Health Checks (27%). It is reasonable to think that these may be completed at the same appointment. However, Medication Reviews may not have been carried out face-to-face with the patient.

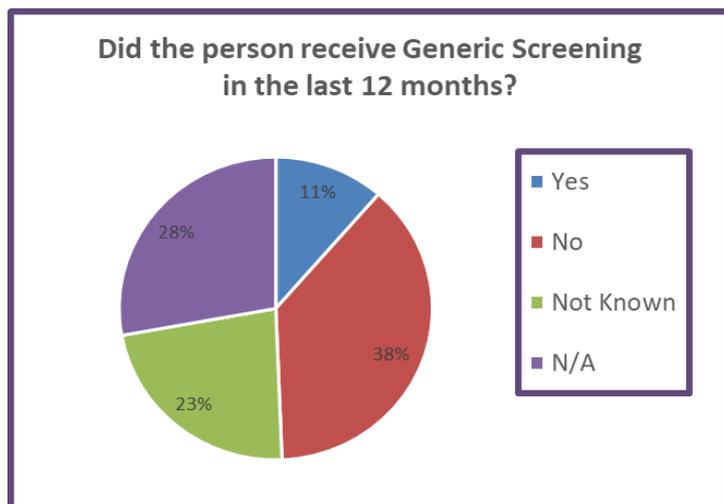
Graph 14: Did the person receive a Medication Review within the last 12 Months?



4.12 Generic Screening

11% of people had received generic screening in the 12 months prior to their death. 38% had not, 23% not known, and 28% not applicable.

Graph 14: Did the person receive generic screening in the last 12 months?



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 (e.g. did not attend) without consideration of the need for people to be supported to attend appointments.

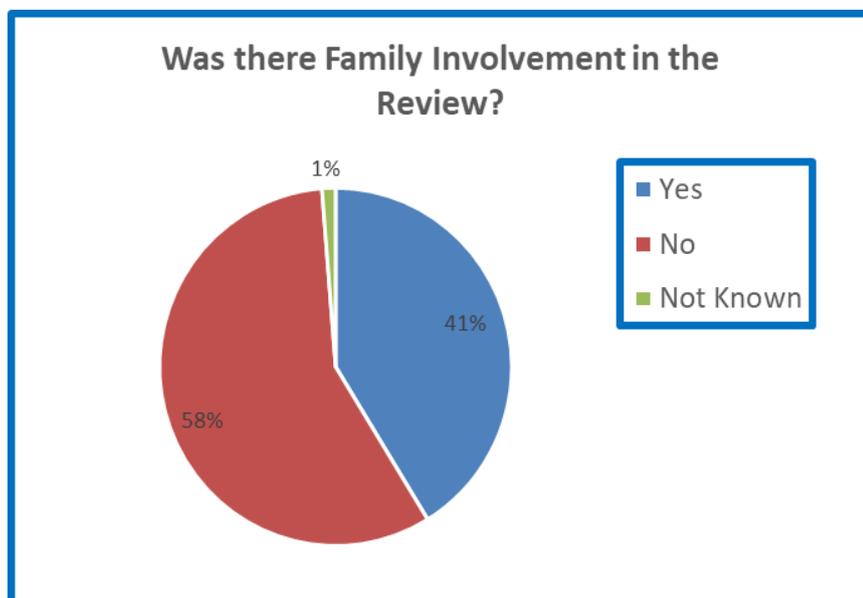
For example, unless significant reasonable adjustments are made, successful mammogram screening for women is limited due to their physical

disabilities.

4.13 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 15: Was there Family Involvement in the Review?



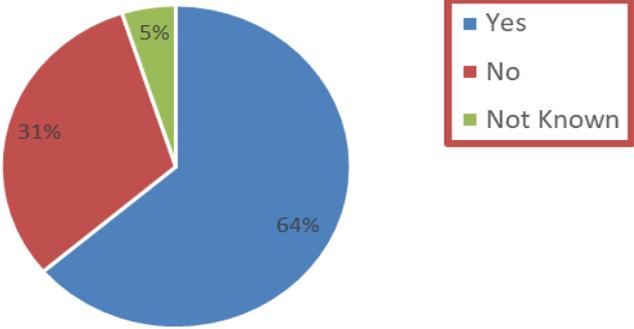
Was there family involvement in the review 41% yes, 58% No, 1% not known.

4.14 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 64% of the reviews.

Graph 16: Did the person have a DNACPR in place at time of death?

Did the person have a DNACPR in place at time of death?



The reviews look to see if a Do Not Attempt Cardiopulmonary Resuscitation order was in place or not. 64% yes, 31% no, 5% not known.

5. SECTION – QUALITY OF CARE PROVIDED

5.1 Indicators of the Quality of Care Provided

As stated previously, the aim of undertaking LeDeR reviews is to share learning from when care has gone well to support people with Learning Disabilities to live full and enriching lives.

The aim is also to identify learning from when things haven't gone as well for an individual and to use this information to support improvements in the health and social care for others. It is important that the assurance for the consistency of the grading and the quality of each review is discussed at the LeDeR Quality Review Panel.

5.2 Grading/Quality of Care (Completed Cases)

At the end of a review, having considered all the information available to them, reviewers are asked to provide an overall assessment of the care provided to the individual and provide a grade. The table below shows the grading of care and the LeDeR Reviewers' overall assessment of the care received:

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 68% were rated satisfactory and above, with the majority being satisfactory. However, it is important to note that 32% fell short of satisfactory practice. Where the care fell short of satisfactory practice 14% 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 2: Grading/Quality of Care (completed cases)

Grading/Quality of Care (completed cases)			
Grading of Care in Adult Cases		Number of Reviews	%
1 =	This was excellent care (it exceeded expected good practice)	7	9%
2 =	This was good care (it met expected good practice)	20	25%
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)	27	34%
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	9	11%
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	7%
6 =	Care fell short of expected good practice and this contributed to the cause of death	11	14%
Total		80	

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

- 6 monthly diabetes reviews at home from the District Nurses. This was exceptional as reviews would normally be annual and as the individual was not housebound, they would not normally have

been visited at home

- Day service provider included photographs of the person's equipment within their care plan to avoid confusion
- One provider's care plan records were found to be very robust with clear guidelines for staff to follow. The plans were very inclusive of family members and other health professionals, including: Management of Diabetes, Health Assessment and Palliative Care Plan

- The Sharing Lives environment provided a loving stable environment over a 16-year period. The person was welcomed into the family as well as the extended family. Their needs were met with Psychology support with his Dementia. They accessed Community Learning Disabilities Team, had a proactive GP. They had a varied social life and was enabled to enjoy meaningful activities.

6. SECTION – DEATHS OF CHILDREN

6.1 Child Deaths Overview Panel

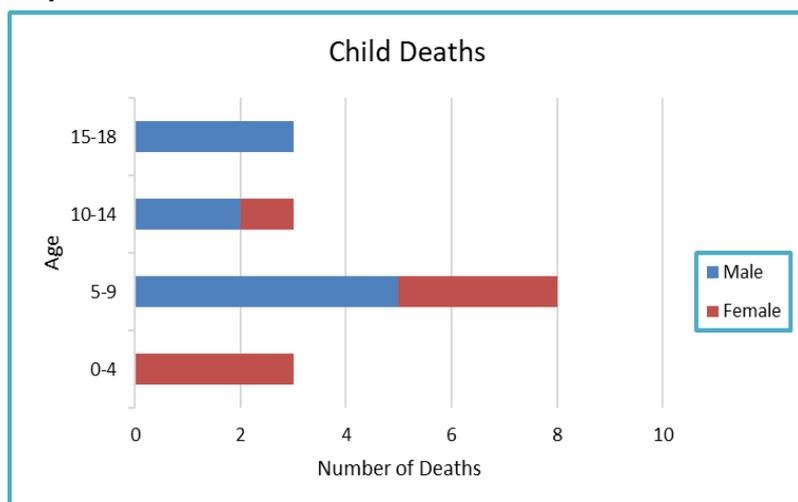
Local Safeguarding Children Partnerships are required to review the deaths of all children who normally reside in their area. The regulations are outlined in Working Together to Safeguard Children and the CDOP statutory and operational guidance.

The purpose of the child death review process is to collect and analyse information about the death of each child who normally resides in Sheffield with a view to identifying any matters of concern or risk factors affecting the health, safety or welfare of children, or any wider public health concerns. There are a number of national programmes which centre on the review of deaths or particular types of child death including the LeDeR process. As such, CDOPs are advised to complete the child death review process rather than the LeDeR review.

Where the child had a learning disability and comes under the remit of the LeDeR programme the completed child death report is then uploaded to the LeDeR system and effectively forms the LeDeR review. The SCCG's lead nurse for child reviews sits on the child death panel and will be asked to sit on the LeDeR Steering Group to ensure links between the two are maintained.

During the review period 17 cases were notified to the LeDeR platform, which related to the death of a child with learning disabilities. Due to the small number of cases, specific demographic data has been withheld to prevent inadvertent identification of the individuals. Graph 17 details the number of child deaths by age and gender.

Graph 17: Child Deaths



47% of deaths were within the 5-9 year age group.

7. SECTION – LEARNING

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.

A summary of common themes is detailed below:

- **Care Co-ordination**

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.

- **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.

- **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 e.g. "DISDAT" tool for pain management could have been more person-centred.

- **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. 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.

- **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 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 capacity and best interests when the person has 'declined' interventions; and diagnostic overshadowing.

- **Hospital/Health Passports**

It was clear from reviews that hospital passports are used when provided to wards. However, these were not always provided on admission and/or were not updated.

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 Hospital/ Health Passports to understand who has one, who needs one and who needs help completing these.

- **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, capacity to give consent for a blood test, and distress that may be caused to individuals who have a needle phobia, and concern about 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.

- **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 for 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 regard to feeding and positioning methods particularly for those individuals with complex physical disabilities with posture management needs.

- **Oral Healthcare**

Access to dental services for people with learning disability is found to be reduced, this can be due to phobia, and inability to tolerate interventions and poor oral health care can occur over many years, including poor dietary control.

- **Registration of Day Services**

A number of reviews highlighted that families were unaware that the day service provision their son or daughter accessed was not regulated by the Care Quality Commission and felt that this should be made clear prior to the point of access to the service.

- **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 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 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.

8. LEARNING INTO ACTION – Our Strategic Action Plan

The Strategic Action Plan based on the learning from the LeDeR is outlined below:

LeDeR Strategic Action Plan

Initiative
A Strategy for Sheffield: Improving Physical Health for People with Learning Disabilities
Summary
<ul style="list-style-type: none">• Key stakeholders in Sheffield are working together through the Physical Health Implementation Group (PHIG) to look creatively at how we improve the physical health of people living with severe mental illness (SMI), learning disabilities (LD), autistic spectrum condition (ASC) and dementia.• The Strategy for Sheffield for 2019-2022 is included within the projects/priorities in the Sheffield Mental Health Transformation Plan (with governance through the PHIG and reporting to the Mental Health, Learning Disabilities, Autism and Dementia and Delivery Board, which is a Board under the ACP governance structures). <p>The Strategy includes five key commitments which focus on:</p> <ul style="list-style-type: none">• physical health care and interventions/reasonable adjustments• holistic physical and mental/learning disability health care• equal access to healthy living and wellbeing activities and support in their community• engagement of people with lived experience/carers• and organisations/Boards embedding the strategy within key decisions, activities, strategies, and policies. <ul style="list-style-type: none">• Collaborative working is a key element of all aspects of the strategy and planned improvement work. Sheffield Clinical Commissioning Group (SCCG), working with Sheffield City Council (SCC), is taking the lead for the strategy. Sheffield Health and Social Care Foundation Trust (SHSC) and Sheffield Teaching Hospitals Foundation Trust (STH), and Sheffield Children’s Hospital (SCH) are also lead partners in this work, with VCF partners. There is close working across a range of transformation activity between PHIG, Sheffield Teaching Hospital Mental Health Committee and the Primary Care Mental Health transformation programme physical health pathway.• The update below focuses on the work on annual physical health checks, but as outlined above the work of the Strategy is much wider than this.

Learning Themes this will address

Overall governance and ownership of LeDeR Learning

Initiative

Annual Physical Health Checks (AHC)

Summary

- Annual Physical Health Checks (including the resulting interventions and follow up activity) are a key way to manage comorbidities, reduce unnecessary hospitalisations, promote health positively and reduce premature mortality. The NHS Long Term Plan includes priorities to increase the number of people receiving physical health checks for people living with severe mental illness and learning disability, and for across the NHS, to do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives, and that physical health checks will also be introduced for autistic people.
- GP Surgeries have been advised by NHSE that there is a national expectation that Learning Disability (LD) and Severe Mental Illness (SMI) annual physical health checks (AHC) should still be completed during this time of COVID. However, completing AHCs in primary care is undoubtedly a challenging ask due to current pressures. To support this, the Sheffield SMI/LD/Autism Physical Health Group has co-produced some new [LD](#) and [SMI](#) resources to support primary care to deliver AHCs during COVID. For LD, these complement the [NHSE Resource](#) that is published nationally. These have been promoted to GP practices, secondary care, and social care providers.
- The commissioned service that is aimed to improve uptake and delivery of the severe mental illness and learning disability GP annual health checks has recently been given approval to progress to deliver a Locally Commissioned Service (LCS), and it is anticipated that this will be operational in the new year 2021. The LCS will mirror the national incentive scheme already in place for LD annual health checks, but with a stronger emphasis on incentivising collaborative and innovative work on health checks between primary and secondary care and the Voluntary Sector, and the offer of a blended approach across partners.
- The commissioned service will ensure delivery of an increased completion of severe mental illness and learning disabilities annual physical health checks and national screening, leading to follow up intervention, lifestyle guidance/coaching (reactive and preventative), care planning, and long-term care management where needed. The service will also support activity to improve access for people living with autistic spectrum condition to physical health checks and screening, including working with the PHIG to develop a local approach to delivering GP-led annual health checks for people living with autistic spectrum condition.
- Preventative and person centred focused approaches to enabling good physical health are key factors in achieving the service's aims. It will also deliver increased capacity within community based physical activity/healthy living projects/services to better meet the needs of people living with SMI, LD,

ASC.

Learning Themes this will address

- Early identification and management of comorbidities, reduce unnecessary hospitalisations, promote health positively and reduce premature mortality
- Improve care coordination
- Access to Health Specialists and Follow-up

Initiative

SAMI/RESTORE 2 Project

Summary

We will be rolling out SAMI (including RESTORE2) 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, improved communication 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.

Learning Themes this will address

- Early identification and management of comorbidities, reduce unnecessary hospitalisations, promote health positively and reduce premature mortality
- Improve care coordination
- Access to Health Specialists and Follow-up

Initiative

Blood Desensitisation Pathway

Summary

In response to the identified need four Community Nurses received phlebotomy training and a Blood Test Desensitisation Pathway has been developed in conjunction with the Clinical Psychology and Community Learning Disability Nursing Team for individuals where there is a definite need for a blood test which cannot be carried out via their GP practice because the service user has a needle phobia. (Refer Appendix 4).

Learning Themes this will address

- Addressing inequalities in accessing support (blood tests)

- Improve care coordination
- Access to Health Specialists and Follow-up

Initiative

Safe Seating for a Safer Swallow

Summary

The Community Learning Disability Team have reviewed their Dysphagia policy and carried out extensive work around Safer Seating for a Safer Swallow across the city. An information poster was developed which has been communicated to all Learning Disability Provider services (Refer Appendix 5 & 6). The Dysphagia pathway has been reviewed and updated so that posture is a key element within the management plan and screening process. All PMLD client management sheets now include photographs of positioning and explicit wording including all and any types of seating the person can be fed in. All dysphagia needs of all other service users across the city were reviewed in the context of posture and eating and drinking.

As people with learning disabilities have poorer oral health and greater difficulty accessing dental services than people in the general population, the work around dysphagia will now link closely to the developing work around oral health care as this has an impact on increased bacterial infection risk.

Learning Themes this will address

- Addressing inequalities in accessing support (Oral health, Dysphagia and Posture Management)
- Improve care coordination
- Access to Health Specialists and Follow-up

Initiative

Oral Health Care

Summary

Oral health can be put at risk because of poor communication, reduced ability to perform mouth care, anxiety accessing the dentist or a general lack of understanding about specialist needs. An individual with a learning disability may not understand or appreciate the importance of oral hygiene and the risks it could pose to health should it be ignored long-term. It can be difficult for parents or carers trying to get the individual to co-operate with a healthy day-to-day routine especially if they have sensory, behavioural or oro-facial issues which could restrict oral care. Individuals may also become anxious at the thought of going to the dentist or may need extra reassurance and reasonable adjustments.

It is important for individuals, parents and carers to learn more about how to develop good oral health routines for those with learning disabilities so future problems can be avoided. We need to ensure support for good oral and dental care is seen as an essential part of promoting good health and quality of life

for people with learning disabilities. Accessible information and training must be provided to ensure everyone is informed about the increased risk factors of poor oral hygiene and what issues can increase damage to our teeth, gums and oral cavity.

The Community Learning Disability Team (CLDT) have established pro-active pathways with dental providers and specialist LD dentists within Sheffield to guarantee people with learning disabilities have equal access to oral care and information. The CLDT are developing an easy read information package and poster campaign in collaboration with specialist dentists. It will include how not completing oral care can impact on your health in less obvious ways such as heart disease and aspiration risk. This work will be supported by an easy read checklist for daily use as a prompt for individuals completing oral care (so twice daily brushing, flossing, mouthwash etc) with reminders to book appointments. A more detailed guide for carers on the completion of oral care particularly for those who are Nil by mouth is in development. One element of this work will be on working with general dental practices to focus on reasonable adjustments.

Learning Themes this will address

- Addressing inequalities in accessing support (Oral health)
- Improve care coordination
- Access to Health Specialists and Follow-up

Initiative

STOMP

Summary

All GP practices have now undertaken the STOMP audit, 40 practices completed and submitted the audit prior to the original submission date back in 2018, here is a [link](#) to the report. We do not intend to analyse the remaining audit returns as we feel practices undertaking the audit have succeeded in raising awareness. The Sheffield Learning Disability Cardiff template is being updated to incorporate questions and to raise awareness of STOMP to ensure sustainability.

We have delivered an educational session on STOMP to GP registrars, this was received well and will now be a regular topic on the registrar programme.

SHSC have undertaken an internal audit, although it was only a small sample size, highlights are:

- The majority of patients on psychotropic have had medication reviews
- A number had clear medication reduction plan in place demonstrating the evidence of the principles of the STOMP values
- It was noted 50% of the individuals sampled were not on any psychotropic medication

- There were gaps in the monitoring of physical health checks, some of this could be due to lack of recording/sharing as oppose to not being done - more work needed
- SHSC are working with SHU to undertake a STOMP service evaluation, focusing on the relationship between psychotropic prescribing and psychosocial factors following discharge from an inpatient Assessment & Treatment Service (ATS)
- To support the appropriate use of antidepressants in children and the ongoing support and care, a shared care protocol has been agreed which can be found [here](#).

Learning Themes this will address

- Improve care coordination
- Access to Health Specialists and Follow-up

Initiative

Green Light Toolkit Work: SHSC Clinical Director Leadership

Summary

The government published a Green Light Toolkit. This is a way of checking what mental health services do to help people with a learning disability and/or autism to use services. The Green Light Toolkit has 27 standards. SHSC completed this audit in 2017 and 2019 and developed a project plan to make quality improvements. The plan outlines keys actions required to support inclusivity and quality improvement and enable people with a learning disability and/or autism to access the same services as everyone else. This will be made possible via reasonable adjustments, service user engagement and workforce development.

SHSC has established a Greenlight Steering Group which focusses on improving reasonable adjustments and reducing barriers to access across trust services. This has focussed on the following workstreams:

- Development of a Green Light for Mental Health Policy for people with learning disabilities and/or autism
- Increase visibility of greenlight strategy aligned to Learning Disability strategic development/business case including board development sessions
- Delivery of Green Light Awareness sessions to services across the trust
- The setting up of a Champions Network – supporting practice development
- Agreement to commission Easy Read Online to produce an accessible version of every service leaflet within the trust
- Review of training the trust offers with a view to supporting the national strategy to roll out mandatory training regarding learning disability and ASD training

Learning Themes this will address

- Addressing inequalities in accessing support
- Improve care coordination
- Access to Health Specialists and Follow-up

Initiative

Sheffield Tobacco Strategy refresh specifically targets people with learning disabilities

Summary

Smoking is still the biggest killer in the UK and is the biggest cause of health inequalities between rich and poor. Addiction to tobacco begins in childhood and takes hold into adulthood. The Sheffield strategy aims to support everyone to live longer and healthier smoke-free lives.

The comprehensive local Sheffield Tobacco Control Programme includes services, policy, smoke screening and accessible communications. Services will focus on screening, prevention, cessation and harm reduction and will be targeted to those most vulnerable (including people with learning disabilities and/or autism) to the health harms of tobacco and groups who smoke the most.

Learning Themes this will address

- Early identification and management of comorbidities, reduce unnecessary hospitalisations, promote health positively and reduce premature mortality
- Improve care coordination
- Access to Health Specialists and Follow-up

Initiative

Other projects under the Sheffield Physical Health Implementation Group (PHIG) programme

Summary

PHIG is a multi-agency group involving experts by experience and has a focus on reducing barriers to health and closing the mortality gap for people with learning disabilities, autism and/or severe mental illness. The group has continued to meet during COVID, and has focused on responding to the commitments in relation to the pandemic. Examples of key pieces of work during COVID include:

- Supporting a local response to national steer regarding Annual Health Checks during COVID
- The city has been successful in being selected as an Exemplar Site with increased investment to develop new ways of supporting the uptake of Annual Health Checks

- The case register has sent out accessible information about staying safe and well during COVID via post to over 4000 people with learning disabilities
- CLDT offer to learning disability care homes and supported living providers to support COVID swabbing, which is integrated with wider community swabbing activity
- Remote support using digital opportunities and the creation of a YouTube channel with a range of videos supporting information about staying well during COVID across nursing, psychology, occupational therapy and speech and language therapy
<https://www.youtube.com/channel/UCuttySvALsm7INI8RMvLO9w>
- Co-ordinated plans to increase flu vaccination uptake for people with LD, and people with SMI/ASC and 'at risk' long term health conditions
- The CLDT has continued a programme of training delivery through COVID and have created an online package to be used while face-to-face training has stopped
- SHSC has accelerated its internal physical health strategy work, including a cross-organisational response to supporting physical health of people within SHSC inpatients wards during COVID-19. This has been integrated with work towards SHSC's CQC response.

Learning Themes this will address

- Early identification and management of comorbidities, reduce unnecessary hospitalisations, promote health positively and reduce premature mortality
- Improve care coordination
- Access to Health Specialists and Follow-up
- Addressing inequalities in accessing support

Initiative

Sheffield Strategy for People with Learning Disabilities

Summary

Following the success of the city in implementing transforming care and reducing inpatient bed use we are now in the early stages of developing a multi-agency, service user led engagement process to develop a new strategy for the city focussing on further closing health inequalities and building the right support to ensure a 'good life' is the right of every person. It is envisaged the strategy will draw on the CQC paper, **Right support, right care, right culture - How CQC regulates providers supporting autistic people and people with a learning disability (October, 2020)**.

Learning Themes this will address

- Early identification and management of comorbidities, reduce unnecessary hospitalisations, promote health positively and reduce premature mortality
- Improve care coordination
- Access to Health Specialists and Follow-up
- Addressing inequalities in accessing support

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Initiative
The LeDeR ECHO Project
Summary
<p>Utilising the ECHO platform, we will be delivering a series of ECHO modules to Learning Disability and Autism care settings including residential and supported living which will increase the knowledge, competency, and confidence of families/carers/services across the ICS. Focussing on the key findings and recommendations from the LeDeR reports including the following which will be phase 1 of the project:</p> <ul style="list-style-type: none"> • Dysphasia/Posture • Sepsis awareness • Epilepsy and Seizure control • Constipation <p>These sessions will also be available to GP practices, other Clinicians and family carers. Sheffield are active participants in this regional work.</p>
Learning Themes this will address
<ul style="list-style-type: none"> • Early identification and management of comorbidities, reduce unnecessary hospitalisations, promote health positively and reduce premature mortality • Improve care coordination • Access to Health Specialists and Follow-up • Addressing inequalities in accessing support