Leeds CCG Learning Disabilities Mortality Review (LeDeR) Programme
Annual Report 2019 - 2020

Learning Disabilities Mortality Review (LeDeR) Programme

Executive Summary

The persistence of health inequalities between different population groups has been well documented, including the inequalities faced by people with learning disabilities. As a CCG we are committed to tackling health inequalities and improving the health of the poorest and most vulnerable in society the fastest. We are keen to use all the learning from the LeDeR programme to shape the care and support for people with learning disability in Leeds

The Learning Disabilities Mortality Review (LeDeR) programme, commissioned by NHSE in 2015, was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

Each LeDeR reviews describes a human story and we recognise the commitment and hard work of the Reviewers to not only complete the reviews, but to also tell those individual stories so that we can learn about those individuals' experiences and continue to drive any required improvement in the quality of health and care services.

This work forms part of the wider Transforming Care agenda for people and an overview of the key activity to transform care for people with a Learning Disability have been provided in the report.

Delivering the LeDeR programme has not been without challenge and this annual report for April 2019 – March 2020 aims to provide the committee with an overview of the current LeDeR program, the performance over the last 12 months and the learning coming from the reviews

Covid-19 has had a significant impact not only on the number of deaths reported but also the availability of reviewers and the LAC (Local Area Contact) to support the process. All Covid-19 deaths of people with Learning Disabilities in Leeds are currently under review or completed at time of writing this report.

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1.0 Introduction: What Is LeDeR

1.1 Following several national reports and investigations it is now known that people with learning disabilities die on average 23 to 27 years earlier than the wider population. In 2016 NHSE commissioned The Learning Disabilities Mortality Review (LeDeR) programme that is co-ordinated by Bristol University, a system designed to review the death of every person with a learning disability in England. From the most recent LeDeR programme national report the median (average) age at death was 61 for males and 59 for females, an increase of 1 year for males since 2018.

1.2 The LeDeR review process is inclusive of the families of those with Learning Disabilities and all families are contacted and offered the opportunity to be involved in the review of their relative's death from the outset.

1.2 Every death of a person with Learning Disabilities is reported to the programme and allocated to a local LeDeR reviewer who looks not just the cause of death but at factors such as:

- the health needs of the individual
- the care they received
- If they were receiving annual health checks
- If the person was accessing the right services
- If their medication was being reviewed
- if reasonable adjustments were being made to support the individual access health care
- if Mental Capacity Act was correctly applied, including DOL's and best interest decisions

1.3 Following the completion of a review the Local Area Contact (LAC) quality assures the correct process for the review has taken place, and then the report is submitted to the national programme (via standardised report template submitted to a secure online portal). The focus of the reviews is to identify:-

- Explore if any health inequalities occurred
- Identify good practice
- Any learning points to use in service improvement initiatives for people with Learning Disabilities.

2.0 Delivering the LeDeR Programme locally

2.1 The Appendix A to this report provides a flowchart of the process from initial notification to completion of the review, including the process of learning.

2.1.2 The average review takes between 2- 6 days of dedicated time from the start of the process to completion and submission of the review. In reality it can take much longer to complete as it is dependent on a number of factors including the complexity of the case, contacting key health professionals involved, meeting with the family and ease of access all the information. If a case is complex or is causing concern for the reviewer or the family a multi- agency review can be requested after completion of the review, often chaired by the LAC

2.1.4 Once a review has been completed and submitted to the LeDeR electronic platform (hosted on a secure Bristol University site) the CCG LAC is notified that a LeDeR review has been completed. The LAC completes a quality assurance process of the review before final submission to the LeDeR system.

2.2 LeDeR rapid review process

2.2.1 LeDeR reviews can be lengthy and if complex can take a long time for the reviewer to complete. This has led to a significant backlog of cases developing from around 2018. Whilst this backlog is being tackled it has been recognised that not all deaths need a full LeDeR review, particularly if no concerns are raised by family or the multi- disciplinary team supporting the person

2.2.2 Due to the growing backlog of cases that require review NHSE have developed a rapid review process for 2020 which means that some more expected deaths or deaths without concern can be subject to a rapid rather than full review.

2.3 Linking LeDeR cases to statutory processes

2.3.1 All statutory processes take precedence over the LeDeR review including:-

- CDOP(Child Death Overview Panel: All child Deaths aged 4-17: statutory requirement Children Act 2004
- Safeguarding Children Practice Review as indicated by the Local Safeguarding Children Partnership
- Safeguarding Adults Review (SAR) as defined within the Care Act
- Serious Incident Reviews: 'adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.'
- Police Investigations: if a crime is suspected
- Domestic Homicide Reviews: Section 9 of the Domestic Violence, Crime and Victims Act (2004)
- Deaths referred to the Coroner: to determine who the deceased person was and how, when and where they came by their death.
- An complaint against one of our provider organisations

2.3.2 In practical terms this means the LeDeR reviewer links into the statutory process, to identify any lessons for the LeDeR review, including recognising where families have agreed to be involved in the statutory process.

2.3.3 Where a case has been considered by CDOP processes, the reports from the CDOP process are shared to the LeDeR system after being reviewed by the Local Area Contact (see section 2.3) for any learning, and a LeDeR reviewer does not need to be allocated..

2.4 The role of the CCG LAC: Quality Assurance of a LeDeR Review

2.4.1 Each CCG is required to employ the LAC role to oversee the LeDeR programme delivery locally and this includes delivering Quality Assurance review of all LeDeR reviews.

2.4.2 The LAC role includes:

- Receiving notifications of deaths of people with learning disabilities in the area.

- Allocating cases to be reviewed to local Reviewers (this includes checking reviewer capacity to undertake reviews)
- Monitoring the progress and completion of reviews to try to deliver the NHSE required timeframe standard for reviews – so that reviews are completed in a consistent and timely way wherever possible
- The provision of ongoing advice, support and training for local Reviewers as necessary.
- Sign off reviews that have been completed and submit these to the LeDeR electronic platform
- Highlighting and escalating any systemic learning that needs to be addressed to the Transforming Care Partnership

2.5 The number of Local reviews 19-20

2.5.1 Table 1 below details deaths reported in the last year, the numbers of reviews completed, and the number with a reviewer and reviews awaiting allocation.

Table 1

	All Notifications	Unallocated	In progress	Complete	Over 3 months to allocate reviewer	Over 6 months since review started
March 2020 (year end19/20 position)	48	8	24	16	36% (4)	51% (18)
September 2020	19 (YTD)	14 (backlog pre Covid)	29	8 (mostly backlog 18/19)	No data available	No data available

2.5.2 It is of note that there are a number of cases have waited for LeDeR Reviewer to be allocated, and the challenge of delivering reviewer capacity is discussed in 2.4.3.

2.5.3 In 2019 NHSE introduced standards required for all LeDeR reviews notified to CCG's and asked

- All deaths notified to the CCG's a reviewer should be assigned within 3 months
- The Review must be complete within 6 months of notification received

2.6 Challenges to delivering the reviews

2.6.1 The most significant challenge to the delivery of the programme locally has been the delivery of the reviews in line with the NHSE requirements. This has been due to key factors:

- The LeDeR process is not nationally mandated, however CCG Chief Nurses are accountable for delivery of the programme but with limited additional resource to support the programme.
- Trained reviewers often with full time posts having sufficient time away from their other duties to be able to complete a LeDeR review.

- The number of deaths notified to the CCG's outweighing the recruited reviewer capacity.
- Review report documentation has become more detailed as the programme has developed, making the completion of reviews more complex and discouraging some reviewers

2.7 Recruiting Reviewers locally

2.7.1 The challenge to recruit Reviewers has continued over the course of the year. This resulted in a backlog of cases awaiting a review. Covid -19 has also added to the number of reviews required and many of the reviewers have been redeployed during Covid.

2.7.2 All key NHS providers in Leeds have committed to training more reviewers within their organisation. The number of local reviewers currently available in Leeds is 29 but all of these have full time positions in organisations including the CCG

2.7.3 The CCG has been given funding from the Learning Disability Commissioning team to appoint 2 dedicated part time reviewers to complete LeDeR reviews. These staff members are due to come into post shortly and will assist in clearing the backlog.

2.7 NHSE target and funding support

NHSE recognised the significant issue with the completion of LeDeR reviews and in 2019 commissioned the North East Commissioning Support Unit (NECS) to undertake reviews for some cases that had been waiting a significant amount in a backlog. NECS currently deal with the backlog of cases up to September 2019. Leeds CCG currently has 18 reviews sitting with NECS in this cohort

2.8.1 NHSE also identified national funds to be used within areas for both improving reviewer capacity and for supporting learning into practice. Bids were invited in 2019 from CCG's and the West Yorkshire bid was done collaboratively with all CCGS in a bid to appoint a Band 7 regional coordinator and 2 Band 6 reviewers, hosted by Bradford CCG. These posts were recruited to towards the end of 2019, however Covid- 19 has affected the progress made by this central team, as 2 of the coordinator were redeployed and now just returning to their roles

2.8.2 NHSE has recently agreed further funding to WY&H CCG's of 88K to support backlog clearance. Local area LACs agreed that this funding would be pooled to support the central team and support further recruitment of coordinators and administrative support to the LeDeR process

3. Completed LeDeR reviews 19/20

There have been 24 completed LeDeR reviews received in 2019/20, these were reviews completed in this timescale but a proportion of these will be in the backlog and include some deaths from 2017/18. Below are details and overview of initial learning points. All of these reviews have been quality assured by the LAC, and only one case required a multi-agency review which is currently on hold while a complaint against LTHT is being dealt with

The causes of death for each person are detailed below and are taken from the primary cause of death listed on the death certificate which is documented as part of the review

Table 2

Cause of Death	No.	Percent %
Pneumonia – including aspiration pneumonia	6	25%
Dementia	4	16%
Frailty – as a result of Dementia/ CP/neurological condition	3	12.5%
Myocardial Infarction/Cardiac Failure	3	12.5%
Cancer (Colon, Renal and Gastric)	3	12.5%
Pancreatitis	1	4 %
Bowel Perforation	1	4%
Failed Gastric Feeding	1	4%
Cerebral Vascular Accident	1	4%
Renal Failure	1	4%

The causes of death in Leeds do fit somewhat with the nation causes of deaths for people with learning disabilities, with pneumonia and aspiration pneumonia account for the biggest percentage of deaths.

Each LeDeR review receives a grade of care by the reviewer that is then checked by the LAC during the quality review process with 1 being excellent care to 6, Care fell far short of good practice. The table below shows the grading of care for all 24 reviews in Leeds in 18/19

At the time of writing this report it is believed that 12 people in Leeds with a learning disability have died as a result of Covid 19. The majority of these deaths occurred in April 2020, although 3 did occur in towards the end of March. All the deaths are currently under review and learning will be shared through the local LeDeR panel and through the organisational networks.

Table 3

Grading of Care	1.	2.	3.	4.	5.	6.
Description	Excellent Care (exceeded expected good practice)	Good Care (care met good practice)	Satisfactory Care (fell short in some areas but did not significantly impact on wellbeing)	Care fell short of good practice (did impact on wellbeing but not cause of death)	Care fell short of good practice (had an impact on wellbeing and potentially to cause of death	Care fell far short of good practice (and did contribute to cause of death)
Number of graded reviews	1	12	8	3	0	0

3.1.1 For the three reviews that were graded at a 4, the LAC discussed all cases with the reviewers. Care fell short of good practice in one case due to the person having a severe phobia of healthcare and this was not being addressed early enough in his care, meaning that dialysis and other treatments could not be given towards the end of his life.

3.1.2 The second case graded at a 4 the reviewer has concerns that the shared living accommodation staff where the person lived failed to show enough understanding and curiosity regarding the individuals nutrition and dental care that might have contributed to weight loss. The individual also had a lack of a disability action plan which could have helped in the management of his multiple complex long term condition. These issues we raised with the home in order to ensure learning

3.1.3 The third case that was graded as a 4 is current awaiting a Multi- agency review. Care concerns from the reviewer and family are again in respects to the patient having a severe phobia and being unable to attend hospital appointments for assessments of her epilepsy. She was experiencing an increase in her fits towards the end of her life but was unable to attend appointments at LTHT with the neurologists. No reasonable adjustments appear to have been made for her to attend appointments or be seen in her own home. The person died after a fit whilst in respite care

3.2 Key Themes for learning

Learning points	Taking the learning forward
Evidence of formal mental capacity assessment and 'best interest decisions that are made during key consultation that are clear and documented in medical records	This is not organisation specific, but more incidents of this tend to be seen in secondary care in more acute environments. LTHT explain that their learning disability team and safeguarding teams are working with clinical service units across the Trust to promote best practice. Support is given individual wards and departments to assist with complex cases, providing expert advice and support. The trust is working with the digital transformation team to ensure MCA and best interest documentation is available on PPMP/Leeds Care records and this work and remains high the agenda for the coming 12 months.
Reasonable adjustments made for the person's Learning Disability. This may include easy read documentation, extended appointment times, home visits, joint consultations and desensitisation for anxious/phobic people	Whilst extended appointment times appear to being used in primary care we could not see evidence of this in secondary care. Some patients were nervous and fearful of attending any appointment in a health setting and some patients had multiple DNA appointments sometimes over many years. We could not always see alternatives that had been offered or active attempts to deal with the anxiety by desensitisation. The community learning disability team in LYPFT offer psychological support to people with LD. They provide assessment to individuals, family or group therapy for service users and desensitisation could be one approach used for dealing with severe phobia's and anxiety
Communication between professionals and organisations	We did not always see joined up approaches to patient care, or clear wellbeing and recovery plans.

	Through the 'get me better' programme all providers are encouraged to have a health action plan. The health action plan is worked up as part of the annual health check with the patient and designed to be shared with all professionals involved in their care. The health facilitation team in LYPFT assist teams across Leeds to ensure health action plans are in place for all people with LD across Leeds

3.3 Good Practice

3.3.1 The main learning points that have been identified in the last year from LeDeR:

End of Life care
We saw some examples of good EoLC planning, in particular from GP's and community services who knew their patients well and where deaths were expected had made detailed plans. Many patients care had involved the palliative care team, and plans put in place around DNACRP (Respect), preferred place of death and anticipatory medication requirements. We also saw joined up care with the two hospices in Leeds and where people with LD as part of their EoLC plan had chosen to be cared for at the hospice.
Reasonable adjustments Whilst we saw some examples where reasonable adjustments could be improved, we saw many examples of where the needs of people with a learning disability were adjusted for and did meet best practice. We saw some excellent examples of GP's and working with multi professional involved in a peoples care. Longer appointment times, home visits with other professionals, annual health checks and detailed medication reviews. Timely and appropriate referral to secondary care services and good coordination of individuals care between multiple services
Communication and MDT working Again whilst we saw some examples of poor communication which impacted on peoples care on the whole we saw many more good examples of how communication and joined up care helped in the care of people with learning disabilities. In particular the some great examples of MDT working between community LD teams, speech and language, physiotherapy and primary care on the holistic needs of patient

3.4 National LeDeR annual report

The LeDeR programme published its fourth annual report in July 2020, which covered the period from the 1st July 2016 to 31 December 2019, with a particular focus on deaths reported in 2019.

http://www.bristol.ac.uk/sps/leder/resources/annual-reports/

A total of 12 key recommendations were identified:

Key recommendations	
1	Ensure continued focus on BAME deaths of all adults and children within, but not limited to, the LeDeR programme. (Audience: NHSE, DHSC).

2	For the DHSC to work with the Chief Coroner to identify the proportion of deaths of people with learning disabilities (and possibly other protected characteristics) referred to a coroner in England and Wales. (Audience: DHSC, Chief Coroner).
3	The standards against which the Care Quality Commission inspects should explicitly incorporate compliance with the Mental Capacity Act as a core requirement that must be met by all health and social care providers. (Audience: Care Quality Commission)
4	Consider the recommendations from the 'Best practice in care coordination for people with a learning disability and long term conditions'77 (March 2019) report and: • Establish and agree a programme of work to implement the recommendations. • Liaise with NIHR regarding the importance of commissioning a programme of work that develops, pilots and evaluates different models of care coordination for adults and children with learning disabilities. (Audience: DHSC and NIHR)
5	Adapt (and then adopt) the National Early Warning Score 2 regionally, such as the Restore2, to ensure it captures baseline and soft signs of acute deterioration in physical health for people with learning disabilities by Involving people with learning disabilities, their families and professional organisations. Disseminating for use across acute, primary and community settings. (Audience: NHSEI, professional organisations and people with learning disabilities)
6	Consider developing, piloting and introducing Specialist physicians for people with learning disabilities who would work within the specialist multidisciplinary teams. A Diploma in Learning Disabilities Medicine, and making 'learning disabilities' a physician speciality of the Royal College of Physicians. (Audience: DHSC and the Royal College of Physicians)
7	Consider the need for timely, NICE evidence-based guidance that is inclusive of prevention, diagnosis and management of aspiration pneumonia in adults and children. The outcome of such considerations should be shared with DHSC and NHSE. (Audience: NICE, DHSC, NHSE)
8	RightCare to provide a toolkit to support systems to improve outcomes for adults and children at risk of aspiration pneumonia. (Audience: NHSE)
9	For safety of people with epilepsy to be prioritised. The forthcoming revision of the NICE Guideline 'Epilepsies in children, young people and adults' to include guidance on the safety of people with epilepsy, and safety measures to be verified in Care Quality Commission inspections. Audience: DHSC, Care Quality Commission.
10	For a national clinical audit of adults and children admitted to hospital for a condition related to chronic constipation. The National Clinical Audit and Patient Outcomes Programme is one way this could happen. (Audience: National Clinical Audit and Patient Outcomes Programme Partners Sub-group, NHSE).

4.0 Work within the CCG

4.1 Quality and Learning disability commissioning team

In 2019 the quality team along with the learning disability team began the first LeDeR panel for Leeds. The panel brings together the CCG teams with the representatives from all of the provider organisations to look at current performance against reviews and clearance of the backlog, signed off reviews, and dissemination of key learning.

4.1.2 Primary Care

Primary Care providers are commissioned nationally by NHS England to complete learning disability health checks. The Leeds CCG commission on behalf of NHSE, and work with GP Practices on a local Quality Improvement scheme that delivers learning disability health checks to the registered Learning Disability population of all practices.

The CCG have set a target of 75% completion of health checks in line with the quality scheme requirements. All Practices participated in the local scheme which equates to 94 practices. The CCG has reviewed the end of year data for the city, each Primary Care Network and individual Practices, this showed an overall position of 2,056 health checks completed from a register of 2,927, this equates to 70.2%.

Sam Browning a GP in Leeds is also the Clinical Lead for Learning Disabilities in the city and has been working closely with colleagues in the Royal College of General Practice LD Special Interest Group and our Leeds Health Facilitation Team. They have published guidance for practices and service users around ensuring continued to deliver Annual Health Checks safely within the context of the Covid 19 pandemic, the lockdown and how to prioritise appointments during recovery phase.

They have also worked with the data quality team to provide more guidance to practices to ensure learning disability registers are robust and that our data is reflective of activity within primary care around Annual Health checks. Sam has recorded a video message realised through the CCG communications team to encourage service users to continue to ask for help from the health service despite the pandemic, to reassure them that we are still here for them.

The documents have been shared via our Primary Care Bulletin and are all available on our 'getcheckedoutleeds' website, alongside new Covid-19 easy read information to help explain the issues around the pandemic and health care.

4.2 Work in NHS Provider Organisations

4.2.1 Leeds Teaching Hospitals (LTHT)

The Learning Disability and Autism Team at LTHT is led by a Speech and Language Therapist and also includes two registered nurses for learning disabilities and a physiotherapist currently on secondment. This is the first example in the country of a multidisciplinary team that supports acute liaison for learning disability and autism in acute care areas.

The Learning Disability and Autism Team have supported person centred care throughout the COVID19 pandemic. Patients have experienced more significant challenges than the wider population, for example, needing to shield, understanding people when they are wearing PPE, changes to routine and having changes to the support packages in their everyday life. The team have also supported a number of patients who have died of Covid 19 in the hospital and ensured that end of life plans are discussed and agreed with patients and their families

The team have ensured that they have worked with patients, their families, and with local and national partners to create reasonable adjustments to care. For example

- On-going guidance about completion of ReSPECT forms, ensuring there is no opportunity for diagnostic overshadowing
- Use of Trust Bulletins to advise LTHT staff around the best practice for use of the clinical frailty scale
- Adjustments to standard hospital pathways, for example around allowing visitors
- Daily telephone or notes review for all COVID19 patients
- Increased use of the hospital passport, including a drive for people to send in versions for electronic upload to reduce reliance paper documentation. Approximately 400 passports and 160 flags were added to LTHT clinical systems earlier this year
- Encouragement for patients to use video calling to enhance recovery (for example, family members video calling to join in and encourage patients with therapy sessions)
- Enhanced support for our patients to access the 'Attend Anywhere' or Microsoft Teams calls
- Creation of accessible resources ('Easy Read' format) for Covid 19 informaiton which were developed for use both locally with in the nightingale hospital. The resources all use symbols, which were created by the' Easyonthel' team at LYPFT
- Cross city work with the CCG, GP Lead for Learning Disabilities and Health Facilitation Team to share key messages, for example the #stillhereforyou campaign
-

4.2.2 Leeds and York Partnership Foundation Trust (LYPFT)

The LeDeR initiative along with the NHS improvement standards have been key drivers for the work occurring across LYPFT which enable improving care for people with learning disabilities and Autism. A Learning disability steering group has been established with the trust, which has

the key aim to drive improvements across our Trust and in particular mainstream mental health services.

The steering group looks at local improvements on wards and in teams regarding how we meet the needs of people with learning disabilities. Also to encourage our specialist LD services and MH services to work more closely together, to improve the accessibility of services for people with LD and to improve their health needs. Work of the group includes looking at the accessibility of information, making reasonable adjustments, encouraging input into services from the LD health facilitation team, and dealing with the training needs of staff within the organisation.

The Health Facilitation Team at Leeds and York Partnership Foundation Trust have worked with service users, carers, professionals and organisations to co-produce resources that support compliance of the accessible information standard. The team produces documents that include the patient, carer and professional (triangle of care) to improve communication within the health care working relationship and all documentation is designed to support this. The annual health check booklet is one example of the team's commitment to ensuring health appointments are accessible and many other examples are available on their website

https://www.getcheckedoutleeds.nhs.uk/

LYPFT have also been using patient stories from structured judgement reviews and LeDeR reviews to share good practice and ensure learning in the organisation. One recent story shared highlighted excellent end of life care and a compassionate and caring approach from the care coordinator, who went over and above what would be expected. This enabled the service user to have a good death, with all needs addressed and with the support of someone who knew her well and advocated for her throughout. As a result of this the good practice was widely shared with the services involved and the Care coordinator was asked to present the patient story to the Trust Board

4.2.3 Leeds Community Health Care (LCH)

The Leeds Community Healthcare is committed to making improvements for all people with a learning disability or autism within their care. The trust actively supports the LeDeR programme, and as part of the trusts learning from deaths process any deaths of a patient with suspected LD are escalated to the LAC for consideration of a review. The trust is actively developing a team of LeDeR reviewers and have successfully recruited to its first LD liaison nurse.

5.0 Work of Transforming Care Programme (TCP)

The work of the TCP is to ensure the physical health of any person with Learning Disability or Autism in a specialist mental health or learning disability hospital, or of those in the community who is at risk of being admitted to a specialist hospital. Patients receive an independent Care (Education) and Treatment Review(C(E)TR) which is overseen by a specialist panel.

All aspects of the patient's physical health are reviewed, and any issues are addressed and also reflected in the C(E)TR recommendations. There is a time frame for these to be completed/considered and then the C(E)TR chair follows up in the agreed timeframe. A process for escalation is in place should there be concerns if the provider of that care is not meeting the person's physical health needs.

The health needs of people with learning disabilities and autism will also be a priority in the recently established Host Commissioner and Out of Area quality visits. Covid-19 has been included in these planned reviews and we have been encouraging all providers to use the NHSE Covid grab and go sheets alongside hospital passports should an admission to an acute hospital be required. Any patients that have been admitted to specialist hospital with Covid-19 have also been reviewed following their discharge.

5.0 Conclusion

During 2019/20 there have been some significant challenges in delivering the LeDeR programme such as lack of reviewers, available time to complete reviews, and the challenge of the Covid 19 pandemic. Despite this the reviews completed in 19/20 were of high quality and have given us evidence of the care that people with a learning disability receive which on the whole has been good.

We have seen good practice around end of life care, MDT working and examples of individualised care that were really encouraging to read. Areas for improvement include the correct use and documentation of mental capacity and best interest decisions, ensuring all reasonable adjustments are made for people with LD, and care and communication through professionals involved in care is joined up and done with the person

6.0 Recommendations

- Continue and build upon the LeDeR panel for Leeds, sharing learning and good practice and understanding where key actions sit
- Develop a bank of part time reviewers in the CCG in order to develop the pool of reviewers
- Develop a specific role to support the Quality and LD commissioning teams delivery LeDeR and the learning into practice
- Work with provider organisations to ensure the application of the MCA and best interest decisions are applied and documented correctly
- Continue to work towards all patients with a registered LD have an annual health check, target for 20/21 75%
- To ensure all patients having an annual health check then have a health action plan that has been developed with the patient and shared with professionals
- Ensure that all reasonable adjustments that can be offered in practice are available for all people with LD, such as easy read documentation, longer appointment times and hospital passports
- Ensure that all people with LD are offered psychological support if required, particularly with anxiety and phobias that may stop them accessing health care services

Appendix A

Flowchart from notification to learning