NHS
North Central London
Clinical Commissioning Group

North Central London CCG Learning from lives and deaths- People with a learning disability and autistic people (LeDeR) annual report 2021-2022

Contents

1.0 Introduction to LeDeR and what it means across North Central London

This is the third combined North Central London (NCL) Clinical Commissioning Group (CCG) Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) annual report.

LeDeR has been established since 2016 to support local areas in reviewing the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement. As LeDeR is a service improvement programme, reviews are not investigations or part of a complaints process. Any serious concerns about the quality of care provided should be raised with the provider of that service directly or with the Care Quality Commission (CQC).

Reducing health inequalities and delivering good quality care to people with learning disabilities and autism remains a central focus across NCL. We are committed to driving improvements and reducing premature deaths.

2.0 Governance arrangements

The LeDeR programme underwent changes in 21/22 with the launch of a new programme policy, reporting system and training package. The Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021 went live on 1st June 2021.
These changes were timed with the ending of the five year partnership with the University of Bristol and a switch to South, Central and West Commissioning Support Unit (SCW).

King's College London, working with NHS England, will lead a collaboration of several academic, Trust and voluntary sector partners including University of Central Lancashire, Kingston and St George's University, South London and the Maudsley NHS Foundation Trust and King's Health Partners to undertake deep dives and data analysis to make service recommendations to the NHS to affect change, address health inequalities, and improve care and health outcomes.

Key changes to the policy included:

- Introduction of a 2 stage LeDeR review system where most cases receive a basic review, with only a proportion of cases moving to a full review where required or where families request this
- A new IT platform which went live in June 2021
- LeDeR reviews are the responsibility of health and social care services/ICSs
- LeDeR reviewer capacity is commissioned across ICS areas or on a regional footprint
- LeDeR review recommendations will be agreed by a local governance panel not the reviewer
- Introduction of reviews of people with a diagnosis of autism without a learning disability in January 2022

In North Central London (NCL), the LeDeR programme sits within the Learning Disabilities and Autism Programme (LDA) with a reporting line into the Quality and Safeguarding Directorate.

Reducing mortality and preventable deaths is a long term plan priority. The LDA programme for 22/23 will focus upon:

- Improving uptake of Annual Health Checks for people with a learning disability
- Introducing a specific health check for autistic people
- Expanding on STOMP/STAMP programme and linking it to Annual Health checks

The programme continues to be well embedded within NCL's local boroughs. During 2021/22 the Senior Reporting Officer (SRO) for the programme was the Executive Director of Quality. LeDeR reports to the CCG Quality and Safety Committee on learning from reviews. Local learning is also fedback into Safeguarding Adults and Children Boards/Partnerships.

NCL's local learning disability community has been involved in the LeDeR programme through representation on borough based health and wellbeing boards. Enfield have a member of the Learning Disability and Autism Council represented on their local steering group and a family carer member. A draft copy of this report has been shared for feedback through these forums before being finalised.

As the NHS head towards an Integrated Care System (ICS) from July 2022; the governance of the programme and engagement across the sector will change to further strengthen actions in response to learning from LeDeR. Preparations are underway for this change with providers and local authority partnerships. NHS England will hold ICSs to account for the delivery of the actions identified in reviews as part of their assurance processes so that ICSs improve the ways that local health and care services meet the needs of people with a learning disability and autistic people.

As LeDeR is a 'service improvement' programme therefore, where appropriate, the LeDeR review may arrive at differing learning and recommendations to other reviews or investigatory processes. It is pertinent to note that the governance of LeDeR must sit within the quality mainstream assurance and surveillance of the ICS and not be isolated from it. Local governance arrangements are expected to ensure that LeDeR is embedded as part of qualityassurance/mortality/safeguarding work, primary care development/ownership, commissioning intentions, and contract delivery to ensure that service change is written into contracts.

4.0 Deaths notified to North Central London CCG 2021/2022

4.1 Number of deaths

Year	Number of deaths notified	Completed
2016/2017*	6	6 (100%)
2017/2018	43	36 (84%)
2018/2019	51	34 (67%)
2019/2020	71	23 (32%)
2020/2021	74	58 (78%)
2021/2022	40	33 (83%)**

Table 1 – notifications to NCL

***Camden were the only borough receiving notifications in 2016/2017 **this includes historical reviews notified prior to 21/22**

In 2021/22 40 notifications of death were received for people with learning disabilities who were registered with GP's across North Central London. This was a noticeable decrease in comparison to 20/21 however, in keeping with previous years. Enfield, one of NCL's largest boroughs with a significant number of learning disability care homes and supported living providers, note that the proportion of people who died that were placed in Enfield by other boroughs increased. In 2021-22, 28% of the people who died that had a funded package of care were placed in Enfield by other boroughs. It is known that the numbers of out of borough placements have been increasing over recent years however, it is difficult to obtain this data as community learning disability teams are not always informed of such placements.

33 reviews were completed over the course of 21/22 with a large number completed before the switch to SCW. NCL have successfully completed 93% of reviews since the programme started in 2016 against a target of 100%.

NCL has good local intelligence mechanisms in place to share information on deaths and this was vital during a challenging period of change to SCW. Progression of reviews slowed with the introduction of the new LeDeR system. Access to training, technical issues, migration of outstanding reviews and lack of system data have all proved challenging. A recovery plan is in place to complete outstanding reviews and NCL are confident that a high proportion will be completed by Q2 22/23 with an aim to complete 100% of reviews.

5.0 Learning from LeDeR reviews

5.1 Age

Within NCL the over 60 age group accounted for 34% of the deaths which is a slight decrease of 2% in comparison to 20/21 data. Notably there has been increase in the 40-49 age group with a 9% increase.

Age	Number	Percentage
0-9	0	0%
10 - 19	1	3%
20 - 29	1	3%
30 - 39	3	9%
40 – 49	5	15%
50 – 59	4	12%
60 - 69	11	34%
70 - 79	5	15%
80 - 91+	3	9%

Table 2- age of death 21/22

5.2 Ethnicity

NCL has diverse communities across all its boroughs. Ethnicity for 2021/2022 is consistent with 2019/2020 and 2020/2021 reporting.

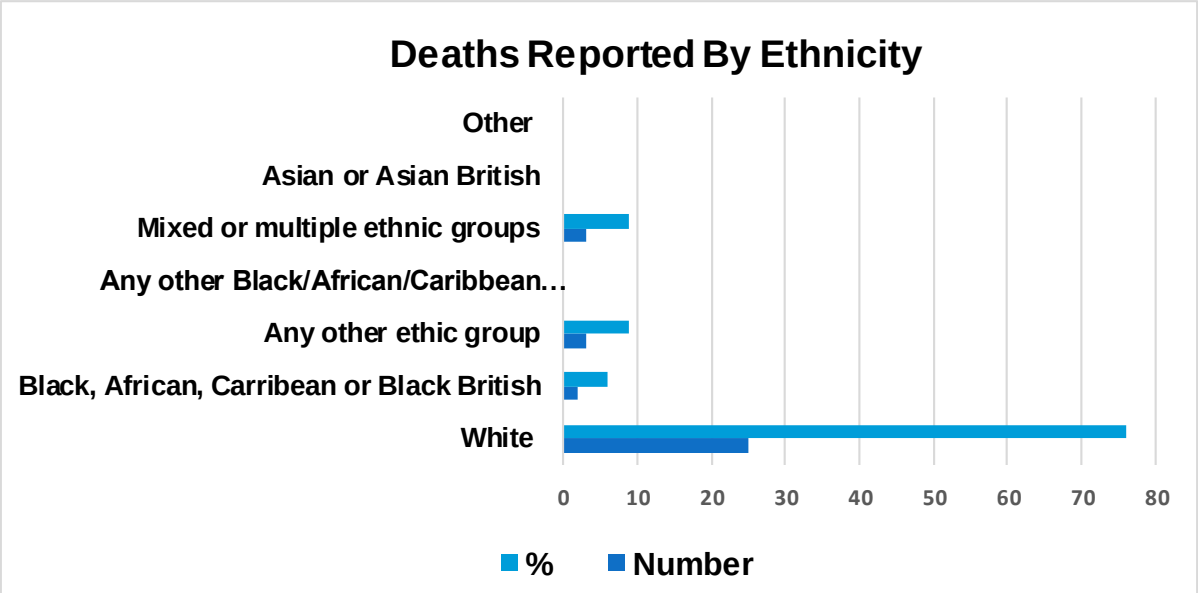

Figure 1- deaths reported by ethnicity

5.3 Gender

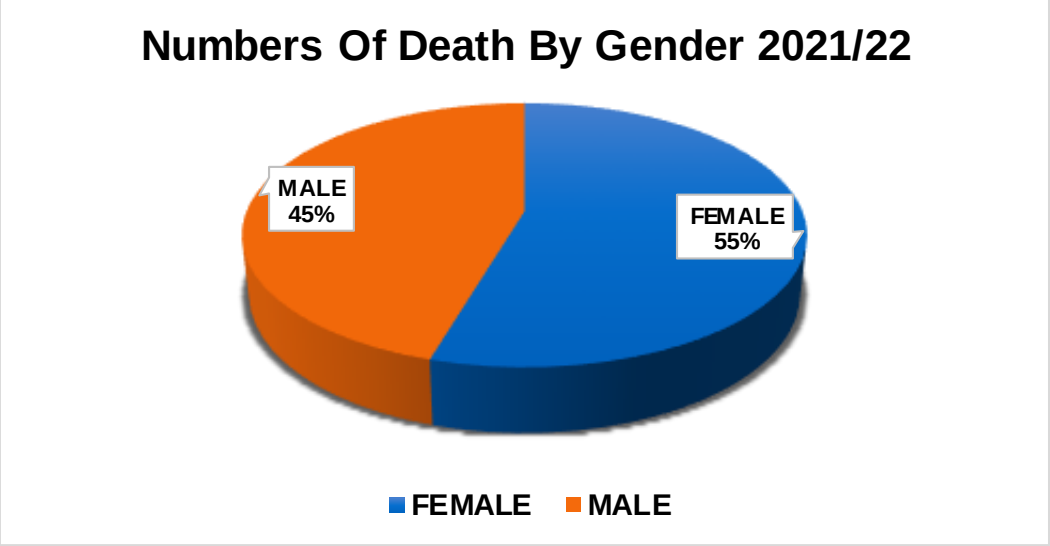

Figure 2- number of death by gender

Figure 2 indicates that male and female deaths reported to NCL in 2021/22 were largely equal, with females being reported slightly higher than in previous years where males accounted for a higher proportion of deaths. We currently do not have any national findings for 21/22 to draw a comparison.

5.4 Causes of death

Cause Of Death	%
Respiratory related- including aspiration pneumonia	55%
Covid 19	18%
Cardiovascular related	9%
Cancer	6%
Sepsis	6%
Hepatic failure	3%
Diabetic Ketoacidosis	3%

Table 3-Causes of death

Respiratory related illnesses and COVID 19 were the most frequently listed cause of death across NCL as was reported in 2020/21. Cancer, cardiovascular related causes of death and sepsis have all increased in 2021/22. No reviews highlighted a late diagnosis of cancer however, one particular review did highlight a delay in a scan referral which was pursued by a GP leading to a 2 week wait referral where the diagnosis was promptly made. The review concluded this delay would not have changed the outcome or progression of disease.

6.0 Service Improvements

6.1 Annual Health Checks (AHCs)

The Learning disability Annual Health Checks (AHCs) National target is to deliver annual health checks to 75% people aged 14+ with learning disabilities on the GP register. However, the denominator used by NHS Digital includes people with a disability of all ages.

Across NCL there has been a 26% uptake in patients undertaking checks in Q4 21/22, which is a fantastic achievement. At the end of 2021/22 NCL achieved 69.8% of checks, falling short by nearly 5%.

Further work is needed to ensure that the learning disability register is up to date and accurate. One particular LeDeR review highlighted that an individual had not been offered any annual health checks as they were not coded correctly on the GP practice register therefore were not known to be eligible.

Actions taken to improve uptake and quality of AHCs across NCL have included:

- Carrying out borough audits to explore areas of development for local systems to improve the uptake
- Scoping exercise to inform training for structured AHCs using the Barnet model
- Quarterly reporting from Q2
- Exploration of introducing E-Learning to reduce variation of AHCs

The consistent use of Health Action plans is being rolled out across NCL to support with reasonable adjustments and effective information sharing about health related investigations and concerns. Enfield undertook a project specifically looking at increase the quality of health action plans during 21/22 and this work is ongoing.

6.2 STOMP/STAMP

The STOMP/STAMP[1] project across NCL has taken a number of steps to improve awareness and quality in the prescribe use of Psychotropic medicines in those with a learning disability and autism

- Improving confidence in structured medical reviews for Pharmacists, GPs and medication reviews
- Enhancing surveillance of STOMP/STAMP agenda through Dynamic Support Registers (DSR) monitoring, hospital passport and health action plans
- Side effect monitoring through physical health reviews
- STOMP/STAMP training has been scheduled to commence in May 2022 delivered by a specialist Pharmacist
- An agreement to roll out the STOMP/STAMP Training using a place based model
- E- Learning Module and recorded Webinar being considered to support with confidence building and induction of new prescribing staff in NCL

6.3 Vaccine guidance –NCL approach

During the Covid vaccine roll out, specific guidance on supporting people was created by the NCL learning disability services, this was shared across the system and included:

- Guidance on supporting capacity and consent for people with a learning disability
- Learning disability specific forms to support capacity
- Easy read guide for people with a learning disability
- Covid and vaccines Social story
- Guidance on gathering information on best interests
- Access to support for people with a learning disability
- A guide for supporting vaccine consent for care homes/supported living

In addition to the above specific vaccine support was provided by all the community learning disability teams, this included a number of specialist clinics, home visits and support with best interests meetings.

Work has continued with GPs identifying those individuals with a learning disability who have not received a vaccine and who do not have the capacity to consent. NCL safeguarding leads have been providing support in those cases where escalation may be required.

During Q4 2021/22 the CCG took a case to the Court of Protection where an incapacitated learning disability patient's relative was objecting to them receiving the Covid vaccine. Following the court decision the patient was supported to have the vaccine, the learning and process from this case was shared across NCL, London and Nationally.

6.4 Whzan project

NCL CCG received significant funding in 2021- March 2022 to run a project looking to significantly scale the use of remote monitoring within 150 NCL Care settings, including learning disability

[1] https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/

settings, embedding the use of NEWS2[2] as a consistent tool, to detect signs of early deterioration in residents. The vision was to use nurse educators to provide training and support, to enable the Adult Social Care (ASC) workforce to embed the technology into their settings, to give ongoing support for the digital technology and any other training needs they may have.

With Bluetooth enabled instruments that enables ASC staff when trained and competent to take observations, that then provide a National Early Warning Score (NEWS2). The NEWS2 is used by London Ambulance service, NHS and GPs. This enables care home staff to use the same language as the NHS and ensure their concerns are listened to and acted on. Helping residents to get the right care, by the right person at the right time.

Once care homes have given permission, their GPs and other health professionals are then able to log onto the Whzan portal and view all the readings. Care homes continue to use their agreed protocol with GPs to escalate concerns, but are now able to tell their GPs they can view recordings on the portal, virtually.

NCL clinical lead with clinicians across the care home landscape, developed an escalation tool for care staff using NEWS2 to understand when to escalate a resident. This document is shared with homes when onboarding the technology into their setting.

The Whzan portal has a many other tools to support mutable conditions. Once a home has embedded Whzan, they are supported to look at the tools on the portal that maybe helpful for them such as falls, hydration, pain etc. and provide training to use these effectively.

Feedback on Whzan has been overwhelmingly positive and that we prevent people from getting worse and prevent hospitalisation.

The project has been given more funding in 22-23 to continue the work and support the technology to link with other systems and professionals to improve service user's health journeys. A video explaining the benefits to residents can be viewed here

Alongside Whzan, NCL won the Health Service Journal Healthtech Partnership of the Year award 2022 and is hoping to be shortlisted for the Nursing Times award for learning disability nursing.

6.5 Camden

In September 2021 Camden Safeguarding Adults Partnership Board hosted a learning workshop to consider the themes from 3 Camden Safeguarding Adult Reviews concerning people with learning disabilities. LeDeR steering group members participated in the event. Key learning points included:

- Better communication and local inter-agency information sharing
- Building on the work of Significant 7 and evaluating the impact of significant 7.
- Improved MCA implementation and completion of MCA audits

[2] https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2

6.6 Camden Learning Disability Service (CLDS)

- Adapted Significant 7 for use with learning disability supported living, supporting the delivery of training and the use of the tool.
- Allocated named workers for most individuals placed out of area, with a dedicated lead practitioner taking a lead role in out of borough reviews.
- The nursing team supported delivering booster covid-19 vaccinations to people with the most complex needs
- CLDS clinicians worked with GP practices to facilitate covid-19 vaccination with clinically vulnerable patients who lack capacity regarding this decision
- CLDS produced resources to facilitate discussions on covid-19 vaccinations

6.7 University College Hospital NHS Trust

- University College Hospital NHS Trust has a flagging system in the patient electronic record (EPIC) whereby patients are flagged with guidance for identifying reasonable adjustments, hospital passports and communication tools
- There are plans to film 3 new videos in addition to the 13 YouTube videos on the trust website to help de-sensitise people when using trust services – should be in a UCLH section
- UCLH has a **myuclh** website which provides EASY Read guidance for patients – should be in UCLH section
- The Learning Disability Clinical Nurse Specialist has delivered specialist learning disability training to 600 trust staff in the last 12 months

6.8 Royal Free NHS Foundation Trust London:

- Produced an easy read Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) leaflet to help people better understand DNACPR decisions
- Is developing a Learning Disability and Autism Register
- Has been involved with the national Getting It Right First Time Programme (GIRFT)

6.9 Islington

6.10 Islington Learning Disability Partnership (ILDP)

- Working with the HealtheIntent Learning Disability Registry team on the STOMP/STAMP measure design outcome with ILDP's community pharmacist
- Has facilitated specialist Learning disability Covid vaccination clinics
- Restarted the successful GP/ ILDP liaison meetings as an interface between primary care and ILDP to improve health outcomes
- Worked with the NCL Integrating Pharmacy and Medicines Optimisation team to improve awareness of STOMP particularly in primary care- this involves starting a project to identify

people with learning disabilities in primary care prescribed psychotropic medicines for them to have a structured medication review

- Creating a Patient Group Directive, a document that allows nurses and pharmacists to administer flu nasal sprays without a prescription from a GP- this has enabled ILDP to run the flu nasal spray outreach service alongside a flu vaccination service
- ILDP have developed a vaccination support pathway including needle desensitisation plan to assist in identifying people with Down's Syndrome who have not yet had a COVID vaccine
- In collaboration with Camden & Islington NHS Foundation Mental Health Trust a policy on prescribing for people who display behaviours that challenge has been reviewed ad updated
- Development of pathways for both mental health and physical health to help keep people out of hospital through fortnightly multidisciplinary meetings
- Rolling out the Whzan tool with the CCG in care homes and used by the community teams

6.11 Haringey

6.12 Haringey Learning Disability Service (HDLP)

- HLDP has been involved in a quality improvement project (QI) with the North Middlesex Hospital to improve the discharge pathway-**Appendix 2**
- Has further developed it's 'ComPHy' pathway which is multidisciplinary team lead aiming to provide a person-centred preventative approach to maintaining people's complex physical health needs at home, avoiding unplanned hospital admissions – it has recently been nominated for a Nursing Times awards
- Is exploring introducing Whzan to support the ComPHy pathway to be used in nursing led clinics
- Introduced an Epilepsy pathway through a nurse led quality improvement project for effective and sustainable epilepsy care and management in the community- it has been nominated for a HSJ award in patient safety
- Ran virtual training sessions for providers, carers and relatives on COVID vaccine desensitisation which aimed to upskill carers
- Provided individual case by case support to those who required capacity assessments and best interest decision making, giving due consideration to reasonable adjustments
- Is working with the Haringey GP Federation on an AHC project within the borough and is planning to deliver a masterclass on learning disabilities for nurses and health care assistants. The project aims to:
    - Improve communication with GP practices
    - Improve the uptake of AHCs and coding
    - Improve the quality of the AHCs, Health Action Plans and Hospital passport.
    - Look to monitor if the action described above has a direct impact in uptake of AHCs – if not reach out to practice managers and possibly clinical medical lead
- Has submitted a proposal to implement a nurse led duty system to support with discharge planning and coordination and also serve as a central point of contact for GP surgeries when facing difficulties with engaging with learning disability clients

6.13 Enfield

- Enfield Joint Autism Steering Group includes system partners within Enfield; the Council, BEHMHT, Voluntary Community Sector (VCS), Expert by Experience (EbE) and NCL CCG/ICS. The Group has been established to take forward pathway improvement and support addressing health and care inequalities for autistic people, to build the right support in the community and support people in inpatient care. To shape future services, maximise and maintain independence and inclusion
- Community Nursing team are restarting the Health check drop ins at 7-day services- clinics will support the baseline measurements of all those attending the day services and provide an opportunity for the nurses to raise awareness of self-checking for cancer using the testicles and breast dummies
    - All nurses have had WHZAN training and consent forms are currently being developed-for those who lack capacity to consent a discussion will be had with those supporting the person to establish why it would not be in the best interests of the person not to have their observations taken and shared with their GP
- Two families have agreed to be part of a pilot to trial WAZAN equipment in the family home. A nurse from the community team will be allocated to the families to support them with the pilot- this is in response to evidence that carers experience health inequalities as a direct result of their caring role
- Improved the uptake of Annual Health Checks and link to health action plans
    - The GP Liaison Nurse delivered a series of awareness raising session with Enfield GP's promoting the use of 'Action Plans' at annual health checks. This reached 5 Primary Care Networks, representing 16 practices.
    - This was followed up by a series of webinars for providers and support staff on how to integrate these action plans into individual Health Action Plans.
- An epilepsy specialist nurse is now in post with the Integrated Learning Disability Service. Things she has achieved so far include :
    - 100% sign off by GP's on Epilepsy Care Plans for people with complex epilepsy
    - All people using the service who are known to have epilepsy now have a Sudden Unexpected Death in Epilepsy (SUDEP) risk assessment
    - Provided epilepsy training to 125 support staff in the last year
    - Made an Easy Read book 'Epilepsy and Me'
- In each project the CLDN will send a formal letter to the GP advising them of any issues raised and recommendations that require follow up. This will also be backed up with a telephone call if the concern requires priority attention. In the event that the monitoring identifies a significant concern the individual will be supported to access appropriate health support

- End-of-Life Care Planning workshops have restarted for the first time since the pandemic, and staff training is planned for later in 2022Specialists from the Integrated Learning Disability Service were very proud to be represented at the Palliative Care for People with Learning Disabilities Network Bi-Annual Linda McEnhill Awards (2021)
  Staff were part of the circle of support for Stuart Hasler and were presented with the award for Providing Outstanding End of Life Support at the ceremony in September 2021

- In making the award, Nikki Fox (BBC Disability Correspondent) said, “The way Stuart was supported to take control of his life and death needed courage and exceptional team working… the panel were unanimous in holding Stuart’s support as one of the examples of outstanding end-of-life support they have ever seen.”
- All those involved were very proud that the Linda McEnhill trophy was awarded to Stuart himself. This is the only time in the awards history it was awarded posthumously to a person with learning disabilities. To again quote Nikki Fox, “ [the panel] wanted to recognise that at the centre was Stuart himself and what he achieved in preparing … talking about it, planning it, organising leaving parties for his staff, it’s so inspirational and it has blown everyone away. He is without doubt the deserving winner”
- The award ceremony can be viewed on the here (above sections starting at 40:20)

As a result, the University of Kingston’s 3 year research project into End of Life Care Planning has been named the ‘Stuart and Victoria’ project. Chris O’Donnell (Enfield LeDeR Local Area Coordinator) and Sarah Pope (Service Manager for Community Learning Disability Nursing) are members of the advisory group.

6.14 Barnet

6.15 Barnet Learning Disability Service

- Clinicians within the community learning disability team worked with GP practices to facilitate the covid-19 vaccination with clinically vulnerable patients who lacked capacity
- Produced resources to facilitate discussions on covid-19 vaccinations and engage in meetings with carers and families
- Supported specialist clinics for learning disability clients who were not able to attend hubs or required reasonable adjustments with a learning disability nurse that knew them and could support them
- Delivered AHC training sessions Learning disability liaison GP nurse together with the GP Liaison nurse
- Delivered a quality improvement project producing a Bottoms Up booklet for carers and families to recognise early signs of constipation
- Facilitated training to local providers on Mental Capacity Act (MCA)
- Supported rolling out the Whzan tool

7.0 Strengthened working with partners

7.1 LeDeR/Safeguarding

An area requiring further strengthening across NCL is the interface between LeDeR and safeguarding adult’s processes. Themes identified during the year by the LeDeR steering group are discussed at the Safeguarding Adults Board (SAR) Subgroup for discussion with updates on progress.

An example of improved and effective interface between LeDeR/ Safeguarding Adults Board SAB is in Haringey. A regular update is now provided to the SAB and the LeDeR steering group chair is now a member of the SAB chairs group which allows for escalations. It has strengthened the link between the LeDeR programme and SAB. There is also a newly established Learning Disability Quality Surveillance group which meets on a quarterly basis where we escalate gaps in commissioning and quality issues.

7.2 London Ambulance Service

In 2021 London Ambulance Service LAS created a Learning Disabilities and Vulnerabilities Specialist role to evaluate and develop the service they provide to patients with learning disabilities. This specialist attended the Camden steering group to discuss learning identified in a review. The review went on to assist as an anonymised case study to support the implementation of a new care pathway within the LAS and we will continue to liaise and share with them any learning that could contribute towards service improvement.

8.0 Summary

2021/2022 has been a year that saw changes for the LeDeR programme with the introduction of a new policy and partnership with SCW and Kings College. Despite challenges adapting to a new system and review process, NCL has successfully completed 93% of reviews since the programme started in 2016 against a target of 100%.

NCL saw a decrease in notifications of death during 21/22 in comparison to 20/21 however, data was in keeping with previous years. Of the reviews that were undertaken, there has been no new emerging themes or concerns. Data indicated an increase in deaths reported of cancer, cardiovascular related illnesses and sepsis. Respiratory illness remains the most frequent cause of death.

Work continues at pace to deliver a number of service improvement projects. AHCs have increased with 69.8% checks achieved against a target of 75%. Further work is ongoing to ensure the accuracy of GP registers and the quality of health actions plans generated from these checks. Work is being undertaken across NCL to support reasonable adjustments and effective information sharing about health related investigations and concerns. It is envisaged that learning from reviews of people with autism without a learning disability in 22/23, 23/24 will improve data about their lives and deaths and assist with identifying themes and trends.

Appendix 1: Acronyms

Acronym	Meaning
ACP	Advanced Care Planning
AHC	Annual Health Check
ASD	Autism Spectrum Disorder
BAME	Black, Asian and Minority Ethnic
NCL CCG	North Central London Clinical Commissioning Group
CDOP	Child Death Overview Panel
CQC	Care Quality Commission
CSU	Commissioning Support Unit
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DHSC	Department of Health & Social Care
EOL	End of Life
HQIP	Healthcare Quality Improvement Partnership
HSJ	Health Service Journal
ICS	Integrated Care System
KPI	Key Performance Indicator
LAC	Local Area Contact
LeDeR	Learning Disability Mortality Review Programme
LD	Learning Disability
LDAP	Learning Disability and Autism Programme
MAR	Multi-Agency Review
MDT	Multidisciplinary Team
MCA	Mental Capacity Act
MEO	Medical Examiner's Office
NQB	National Quality Board
NECS	North of England Commissioning Support
PCN	Primary Care Network
PHE	Public Health England
QA	Quality Assurance
QI	Quality Improvement
SAB	Safeguarding Adults Board
SCW	South, Central and West
SAR	Safeguarding Adults Review
SRO	Senior Reporting Officer
STOMP	Stopping Over Medication Of People With A Learning Disability
STAMP	Supporting Treatment and Appropriate Medication in Paediatrics
SUDEP	Sudden Unexpected Death in Epilepsy

Appendix 2: Quality Improvement project

A Quality Improvement Project to Improve the Experience and Clinical Care of Patients with a Learning Disability at North Middlesex University Hospital.

Dr Grace Smith Locum Core trainee, Haringey Learning Disability Partnership, **Dr Laura Korb,** Consultant Psychiatrist, Haringey Learning Disability Partnership, **Dr Charly Annesley,** FRCP, Consultant Physician and Geriatrician, NMUH Trust Physician Lead for Adult Learning Disability and Autism, **Dr Luke Zhuu** Foundation Doctor, Haringey Learning Disability Partnership

Aims

To improve the experience of patient's with learning disabilities (LD) and their carers at North Middlesex University Hospital (NMUH) by 25%, and to increase the referral numbers to the inpatient LD team by 50%.

Background

The appointment two years ago of a LD physician at NMUH has undoubtedly improved the care and experience of many patients with a learning disability and their care givers. However due to the limited capacity of this service not every patient is reached. It has therefore served to highlight on occasion the huge inequalities that this already vulnerable population faces in our acute hospitals. The QI team therefore set out create simple interventions based on the key findings of the CIPOLD and LeDer reports to try and improve both patient experience and clinical care

Design

Patients or their carer's with an electronic LD flag were surveyed using both easy read (maximum score 15) and non easy read surveys (maximum score 18). Quantitative and qualitative data was collected. Surveys were carried out prior to, and one month after interventions. Teaching was delivered to junior doctors based around the key findings of the LeDer reports and the Confidential inquiry into the Premature deaths of people with learning disabilities (CIPOLD). Doctors were surveyed before and after the teaching using an online questionnaire. Posters including information on how to refer to the LD team were placed around the hospital. Referrals to the team where surveyed both before and after as were the use of Hospital passports

PDSA cycle 1

Plan We planned to measure patient and carer experience via survey. Key areas were communication, medical knowledge, and reasonable adjustments.

Do Easy read and non easy read surveys were distributed to patients identified via electronic tag or referral.

Study We found difficulty in retrieving an adequate number of surveys

Act We increased time spent collecting surveys and ensured each survey given out had a patient sticker attached

PDSA cycle 2

Plan We planned to create a brief clear prompt to assist doctors when caring for those with a LD.

Do Prompt was made printed and laminated. It covered communication, reasonable adjustments, capacity and referral to the inpatient learning disabilities team

Study Junior doctors were asked whether they found the flowchart useful

Act Changes were made according to feedback

PDSA cycle 3

Plan We planned to deliver 45min teaching for junior doctors that was relevant their grade. We decided to use real cases to as from our experience this was the most engaging

Do We delivered teaching over MS teams, group discussion was encouraged to promote a Socratic teaching style

Study Doctors were surveys anomalously before and after the teaching via online survey

Act Changes were made according to questionnaire results

Results

Figure 1: Baseline results. For the easy read score the average was 6.75 out of a possible 18. For the easy read survey the average was 5.75 out of 15.Both quantitative and qualitive data was collected.

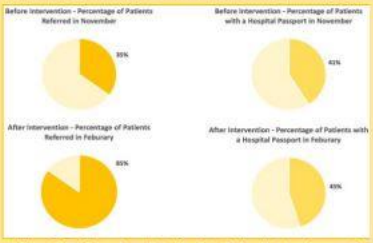

Figure 2. The figure shows that referrals to the inpatient team increased by 41% before and after the intervention's. Hospital passport use increased by 4%.

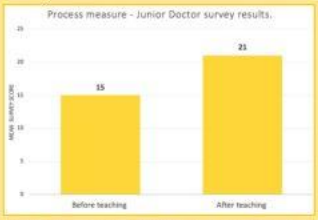

Figure 3. The figure shows junior doctors confidence across various areas increased when measure before and after teaching.