NHS
Stockport
Clinical Commissioning Group

Learning Disabilities Mortality Review (LeDeR) Programme Stockport Annual Report 2019/2020

Stockport LeDeR Steering Group

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

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Responsible committee:	Stockport LeDeR Steering Group Stockport CCG Quality Committee
Supersedes:	LeDeR Mortality Review 2018 Report
Policy Impact:	The National Learning Disability Mortality Review Programme (LeDeR) was established to drive improvement in the quality of health and social care service delivery for people with learning disabilities, by looking at why people with learning disabilities typically die much earlier than average.
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APPROVAL RECORD

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Responsible committee:		

Learning Disabilities Mortality Review (LeDeR) Programme
Stockport Annual Report 2019/2020

This report is the second annual report on the learning from deaths of those with learning disabilities within Stockport. The report covers from December 2018 up until the end of February 2020.

Background

The LeDeR Programme (Learning from Deaths Review of People with a Learning Disability) is being led by the University of Bristol and follows on from the Confidential Enquiry into Premature Deaths of people with Learning Disabilities (CIPOLD); the findings of which demonstrated that on average, someone with a learning disability lives 20 years less than someone without.

Reviewing all deaths of anyone aged 4 years of age and over allows us to examine the circumstances leading to a death. It will also identify any good/best practice to be shared or learning to make improvements to health and care services, improve access to social and health care and address inequality for people with a learning disability.

It is important to stress that the review process applies to all people with learning disabilities, not just those currently known to health and care services. Work has also taken place with community organisations and family/carer forums to notify them of the LeDeR Programme. A comprehensive information event was launched in Stockport in the period before the programme was first implemented in Stockport.

The issues and causes of death identified within the national LeDeR Annual Report, alongside the findings from local reviews reflect the many challenges that people with a learning disability face. In last year's LeDeR report we identified that a person with a learning disability in Stockport was more likely to die 15 years earlier than expected; this disparity has unfortunately increased in the past year, which will require further examination and monitoring within the Local Health Equalities Group and LeDeR Steering Group.

Nationally and regionally work is already happening to help share learning and better direct services to address the themes which arise from mortality reviews. Different stakeholders are working together focusing on their priorities with a view to improving services and reducing premature deaths throughout the area.

Many areas, including Stockport, initially asked for volunteer reviewers. These local reviewers are responsible for undertaking reviews of the deaths of people with learning disabilities, who are registered with a GP within Stockport. Unfortunately NHS England (NHSE) and NHS Improvement (NHSI) were unable to pay reviewers for taking on this role or provide back fill to their organisations, so reviews had to be done as an 'extra' to their substantive role. This meant Local Area Contacts found it difficult to assign reviews due to the reviewers' limited availability, which then created a backlog list of reviews requiring completion.

NHSE and NHSI recognised the delay of reviews and nationally, £5 million investment had been identified to address the review backlog of cases over 12 months old. The money was also identified to improve the quality of reviews and the consistency of the application of the methodology.

The NHS has committed to renewed national action to tackle serious conditions identified as causing deaths in people with a learning disability. NHSE and NHSI have commissioned a review of the alignment of the LeDeR process with other statutory processes (e.g. coroners' inquests and safeguarding investigations), to inform guidance for CCGs and providers.

In 2019 NHSE and NHSI identified further short term funding for the LeDeR programme for the national backlog of reviews. This money was apportioned to individual CCGs and Stockport CCG received £20,000 with a Memorandum of Understanding to ensure any backlog of reviews not being undertaken by the backlog team, are completed by 31 March 2020. However, there will be GM wide and national discussions regarding the future sustainability of funding the programme; in May 2020 the University of Bristol will cease to support the programme, which means NHSE and NHSI will be take over the LeDeR database.

LEDER Rapid Review Process

It was determined by the National LeDeR team that in most cases, the review takes place with full access to at least one set of case notes. Within Stockport in all cases, reviewers have to retrieve information from a variety of sources to gain the whole picture of the person's care and treatment. This can take a significant amount of time on the reviewer's part and impact on the completion of a timely review.

For the purposes of completing backlog reviews, NHSE and NHSI identified that any review waiting over 60 days, could be completed by a Rapid Review (table top) process, which provides an interim solution to aid the reviewer in completing a LeDeR review.

The Rapid Review process is only to be used for the purpose of progressing delayed review cases which have remained uncompleted for over 60 working days.

The Rapid Review process cannot be used for anyone who would trigger a Multi-Agency Review or where concerns about the death are already known or a statutory process has been in place, current or indicated.

Multi-Agency Reviews

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 5 or 6;
- 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.

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.

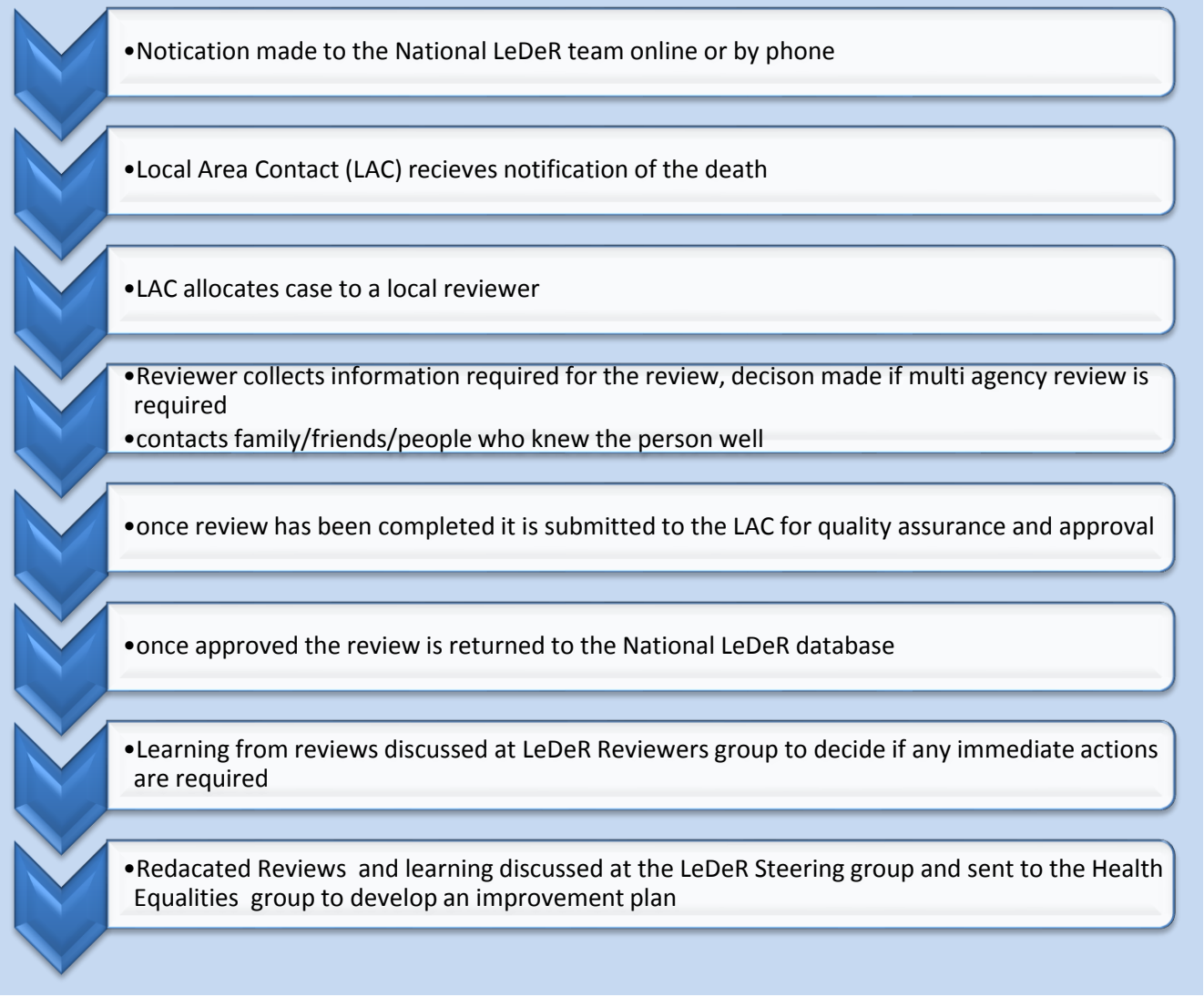
The programme has been given full approval to process patient identifiable information without consent. Specifically, this provides assurance for health and social care staff that the work of the LeDeR Programme has been scrutinised by the national CAG. The CAG is appointed by the Health Research Authority 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/

Child Death Overview Panel (CDOP)

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 Stockport 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.

LeDeR Process in Stockport



Stockport Activity

The LeDeR programme is aimed at making improvements to the lives of people with learning disabilities. Reviews are being carried out with a view to improve the standard and quality of care for people with learning disabilities. People with learning disabilities, their families and carers have been central to developing and delivering the programme. Within Stockport, the programme is led and managed by NHS Stockport CCG but is delivered in conjunction with health, social care, families, carers, advocates and providers within Stockport.

Overall there have been 34 completed reviews since 2017. From the 1st January 2019 to the 29th February 2020 there were 15 reviews completed by our 7 local reviewers. There are currently 15 reviews in progress but not yet completed and 20 outstanding reviews, 10 of which are allocated to the national backlog project, coordinated by NHSE and NHSI.

NHSE have recognised the need to improve care for people with a learning disability and as a result allocated an additional £5 million nationally to fund reviews. A portion of this has been allocated to the national backlog project, allowing NHSE and NHSI to employ a pool of temporary reviewers to allocate reviews to those that are over 12 months old. An agreement of once-only funding was also allocated to the CCG, which has enabled us to tackle the backlog of outstanding reviews requiring completion by local reviewers. This was supported by paying a flat rate to reviewers per completed review which enabled them to complete the review in their own time, as all our 7 local reviewers have substantive, full time posts.

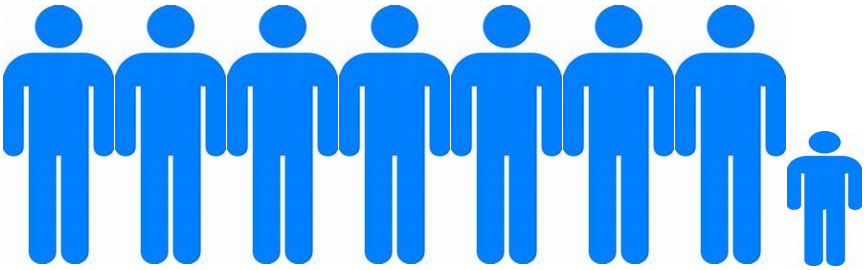
Stockport

In 2019/2020 we had 7 reviewers

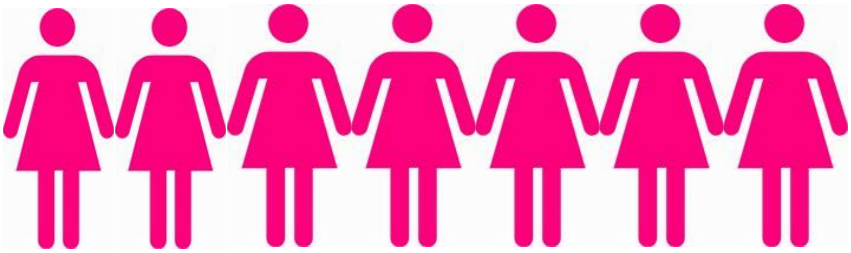
15 completed reviews

15 reviews in progress

20 outstanding reviews
(10 with Stockport)
(10 with the backlog project)



53 % of reviews were male (8 people including 1 child)



47 % of reviews were female (7 people)

Ethnicity

The 2018 National Annual LeDeR Report (May 2019) reported that a quarter (25%) of people from Black, Asian and Minority Ethnic (BAME) groups had profound and multiple learning disabilities, which was twice the proportion (11%) of white British ethnicity. In Stockport, 87% of the LeDeR cases were documented as the person being White British.

Nationally, the percentage of deaths notified from people from BAME groups was lower at 10%, than that from the population in England as a whole (14%). However nationally, children aged 4-17 years had a high proportion as 42% were from BAME groups. In Stockport we had one child who was from a BAME background. Nationally for BAME 18-24 year olds, the proportion was 26% (0% in Stockport) and for people aged 25 years and over it was 7% nationally but only 1 case equates to 7%.

87 % of deaths ethnicity was given as white British (13 out of 15 reviews)

6.6% of deaths ethnicity was given as Pakistani (1 out of 15 reviews)

6.6% of deaths ethnicity was given as Asian/African (1 out of 15 reviews)

Age at time of death

Stockport LD deaths

Average age of death was **58 years old** for LD deaths

Average age for **males 60 years old**

Average age for **females 56 years old**

National LD deaths

Average age for **males 60 years old**

Average age for **females 59 years old**

ONS data for **general population** deaths

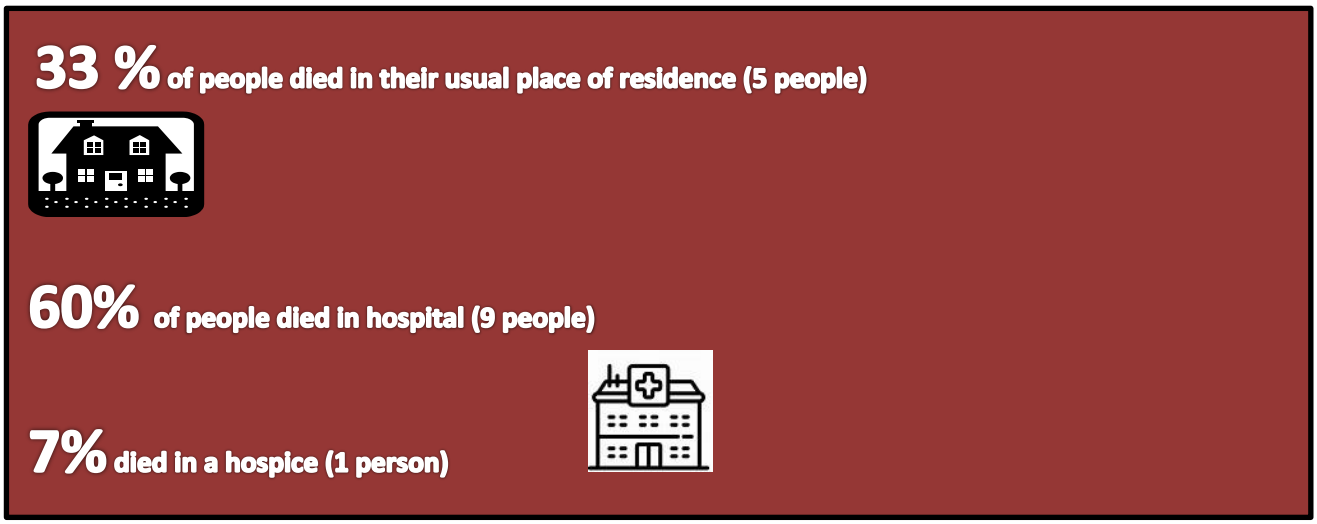
Average age for **males 83 years old**

Average age for **females 86 years old**

The Learning Disability Mortality Review (LeDeR) Programme. Annual Report 2018. University of Bristol Norah Fry Centre for Disability Studies

The Stockport data suggests that the disparity between the age at death for people with a LD (aged 4 years and over) and the general population (all ages) is 23 years for males and 30 years for females.

Place of Death



Grading of Care

At the end of a review, having considered all of 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:

Grading of Care in Adult Cases	Number of Reviews	Percentage
1 = Excellent Care	0	0%
2 = Good care	8	57%
3 = Satisfactory	4	29%
4 = Care fell short of current best practice in one or more significant areas	2	14%
5 = Care fell short of current best practice and some learning could result from Multi agency review	0	0%
6 = Care fell short of best practice resulting in potential for, or actual adverse impact 3	0	0%

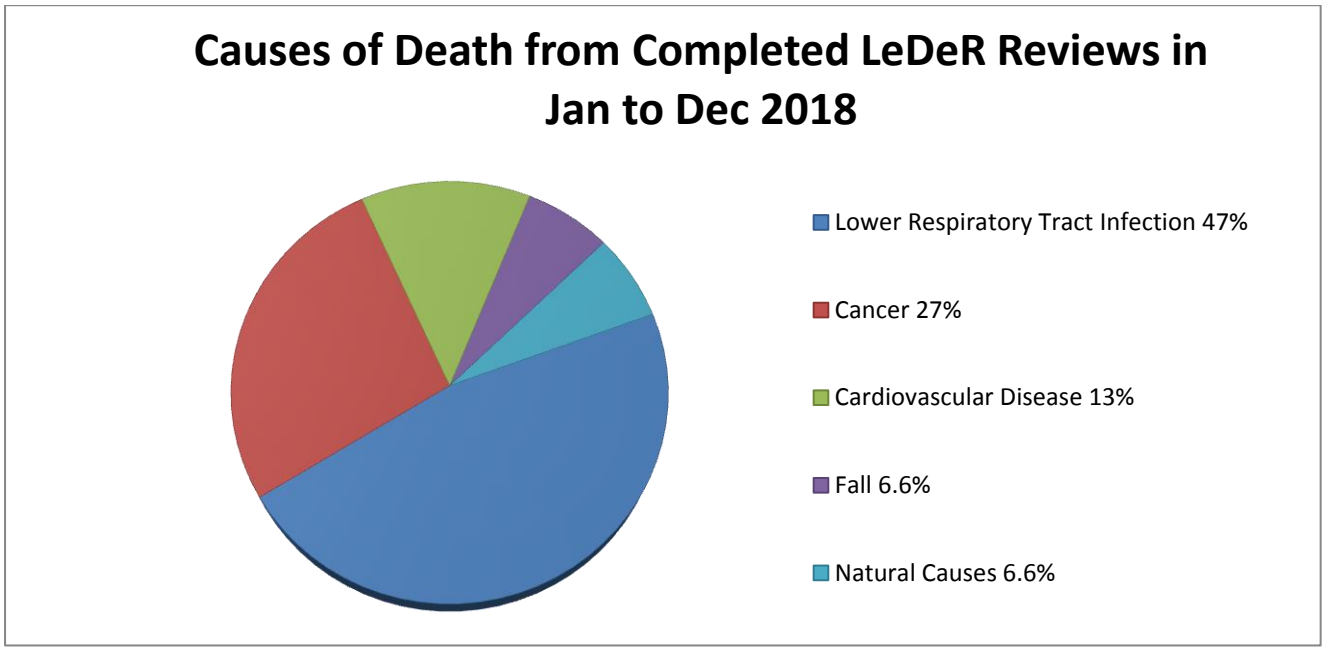
86% of reviews were graded as satisfactory care or above (12 reviews)

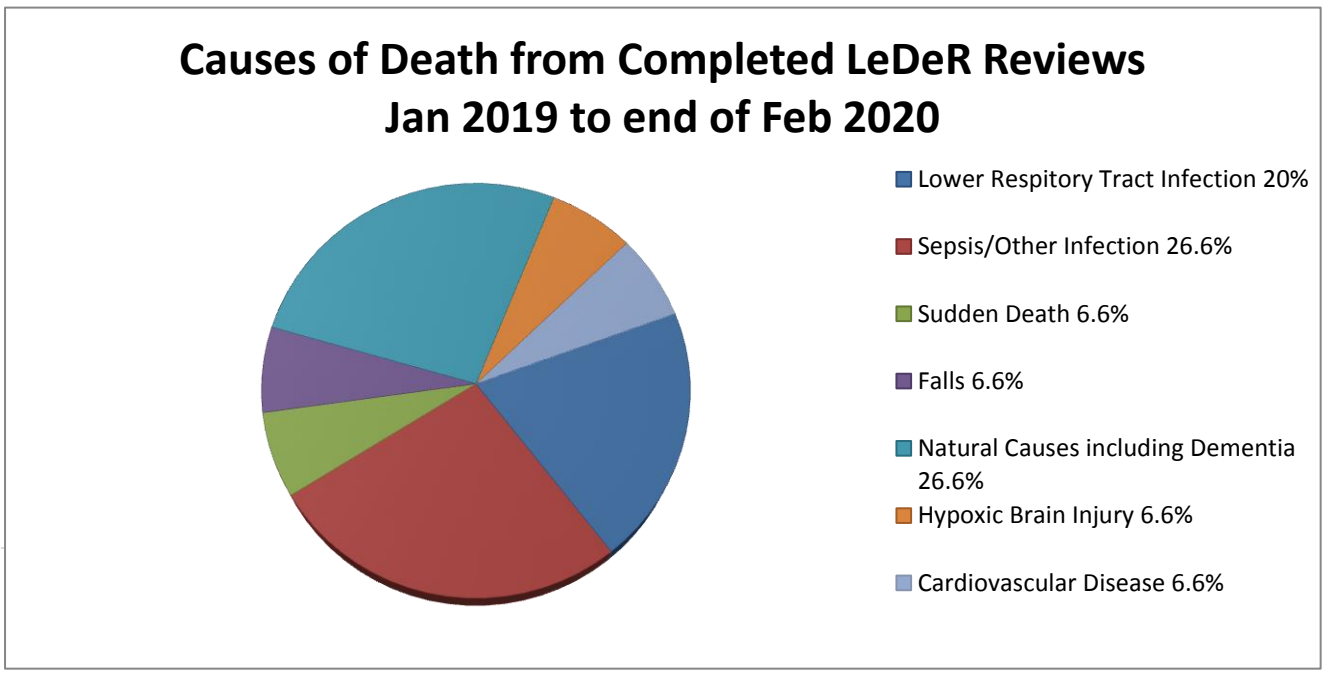
14% were graded as below an acceptable standard of practice (2 reviews)

The child Review was not graded as it was a CDOP review

Causes of Death

These causes of death are the main disease or condition leading directly to death as documented on the reviews.





In 2018 **Lower Respiratory Tract Infections**, which included chest infection, pleurisy, pneumonia and aspiration pneumonia, were the perceived cause of death in 7 out of 15 cases (47%); in the general population, this is approximately 10%. In 2019/2020 lower respiratory tract infections (which include pneumonia, and aspiration pneumonia as a cause of death) have decreased to 3 out of 15 cases (20%), which despite decreasing in Stockport, is still higher than 10% in relation to the general population.

Patients with a learning disability are more likely than the general population to have other conditions that increase their risk of chest infection, for example, swallowing problems or epilepsy that may increase their risk of aspiration. However, even considering this, the proportion of deaths attributed to respiratory infection seems higher than one would expect and highlights the needs for further action for the Health Equalities Group and the LeDeR Steering Group.

The National LeDeR Annual Report published in May 2018 highlighted **Sepsis** as a key contributor to premature mortality, with 11% of deaths being recorded as Sepsis related. In 2018 there was only one death attributed to Sepsis of unknown cause in Stockport. In 2019/2020 Sepsis (including urinary tract infection, gram positive Sepsis, and biliary Sepsis) was given as the main cause in 4 out of 15 (26.6%) cases in Stockport, which is well above the national learning disability average figure given in the national LeDeR report of 7%. Spotting the signs of the deteriorating patient for those who have a learning disability can be difficult to monitor if those who are caring for them are not aware of the individual's normal baseline reading, e.g. temperature, blood pressure, respiratory rates and other signs and symptoms. In Stockport, it is imperative that there is an increased focus on Sepsis for people with a learning disability, in order to raise awareness of prevention, early identification and treatment, for service users, families and paid carers.

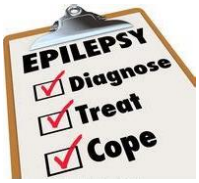
Cardiovascular Disease was associated with one cause of death (6.6%) by Myocardial Infarction (heart attack); this is in keeping with the general population. Whilst death rates from cardiovascular disease have reduced significantly for the whole UK population over the past 20 years, national studies have usually found that people with a learning disability continue to have higher rates of death compared to the general population. Whilst it is difficult to draw too many assumptions from the small number of cases analysed, it is plausible to hypothesize that the increased uptake of the learning disability health check might be improving outcomes for this cohort. The learning disability annual health check will generally include a blood pressure, pulse and the offer of cholesterol/diabetes tests, as well as healthy lifestyle advice, support and health promotion with issues including smoking, alcohol, diet and exercise.

The figures demonstrate a reduction in **Cancer** related deaths from the previous year. The figures given in the national LeDeR report for 2018 determined that 14% of deaths amongst people with a learning disability are attributable to cancer. In the Stockport figures, there were no deaths attributed to cancer from the completed reviews.

Themes Identified from Reviews

Mental Capacity Act 	Application and documentation of the Mental Capacity Act (MCA) by mainstream health and social care services is inconsistent. Of the 14 applicable reviews completed, there were only 3 (24%) reviews which evidenced full MCA and best interest process. There was also evidence of a further 2 cases (14%) having time and specific capacity assessments and best interest decision making documented for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and end of life care. All other reviews demonstrated inconsistent or very limited MCA application with poor documentation. A Deprivation of Liberty Safeguards (DoLS) application was not made despite the person being assessed to lack capacity to care and treatment in the hospital. Despite having significant pressure ulcers, an individual refused care and assessment in a nursing home. Escalation and involvement of safeguarding, multi-agency partners, mental capacity or best interest were not considered.
Annual Health Checks 	Several cases highlighted excellent Primary and Community Care with evidence of proactive, coordinated care, including uptake of the learning disability annual health check in 11 cases (73%). There was no evidence of learning disability annual health checks completed in 2 of the cases and a further 2 cases had evidence of regular GP visits but no annual health checks were documented.
Assessments 	Evidence of inconsistent risk assessments and care plans. No pain assessments or cognitive pain assessments evidenced in 3 cases. Evidence that care plans not being reviewed and updated in primary and secondary care. Reasonable adjustment care plans not being utilised in hospital and medical staff not making reasonable adjustments during their assessments.

Health Screening 	Only 6 cases that were reviewed (40%) evidenced the age and gender appropriate health screening being undertaken, including the review of the child death. 3 cases (20%) evidenced limited screening undertaken, 1 case had no health screening undertaken or documented and in 1 case the service user refused all health screening. In 4 cases (27%) it was not known if screening had been undertaken. There was no evidence of exploration of different options or mental capacity consideration when health screening was abandoned because of the person's distress or also for when an individual refused all screening.
Medication issues 	There was evidence in 12 out of 15 (80%) reviews that the person had an active medication review by their GP occurring within 12 months prior to death, which is positive practice. Appropriate or no pain relief was given as pain was not assessed or recognised. There was limited understanding from staff who did not know the person well as to how their learning disability impacted the person's understanding of why they had to take their medications. Multiple doses of antibiotics were missed in one review. In another review, a family were advised pain medication was given but on later discussion it was found not to have been given.
Communication 	Multiple ward changes in one hospital admission which was distressing for the service user. Confusion of the difference of types of living circumstances, for example staff thought that provision and support in 24 hour supported living tenancy was the same as living in a care home. Lack of communication from the care home to the family after death in relation to personal belongings, which were not kept and disposed of. No evidence that electronic notes made by unregistered staff in community service had been reviewed by qualified practitioners as there was no counter signature. Limited understanding of the differences in Lasting Power of Attorney for Health and welfare/property and financial affairs and how this determines best interest decision making. Important service user information not being shared and handed over internally or externally.

Delays 	Delays were found in: • Sepsis diagnosis which meant a delay in treatment • Observations being undertaken • Diagnosis • Recognition of approaching end-of-life • Screening
Dementia and Epilepsy  	6 out of 15 people (40%) had a diagnosis of dementia and epilepsy alongside their learning disability and 4 people (26.6%) had a documented cause of death as dementia as the disease or condition leading directly to death. People with a learning disability, especially people with Down's Syndrome are well recognised to be at increased risk of dementia. In the context of pre-existing learning disability, dementia will often commence at a younger age than the general population, may be more difficult to recognise and diagnose, may progress more rapidly and is likely to present additional challenges in providing care, for example around mental capacity. The frequency of epilepsy occurring in people with a learning disability is higher than in the average population and increases in proportion with the severity of their disability. About 1 in 3 people (32%) who have a mild to moderate learning disability also have epilepsy. The more severe the learning disability, the more likely that the person will also have epilepsy A further 2 cases (13%) had a diagnosis of epilepsy and both were female. Of the 6 people who had a diagnosis of dementia and epilepsy, 2 (33%) were female and 4 (67%) were male.

Positive Practice Identified in the Completed Reviews

There is evidence of positive practice from the reviews undertaken from January 2019 up until the end of February 2020 and these include:

- **Excellent end of life care:**
  - Good communication with families around end of life decision making and care;
  - Multi-disciplinary discharge to ensure person died in their own home;
  - DNACPR plans in place and discussed with family and carers;
  - Effective advanced care planning by GP;
  - Personal and family views and listened to acted upon.

- **Appropriate DNACPR application,** 13 cases had the appropriate DNACPR documentation and discussions evidenced which is excellent practice. There was no evidence of discussions in the Child Death Overview Report in relation to DNACPR, however, the child was on life support in Intensive Care and his family and professionals made the decision to turn off the life support, which would support that end of life decision making and care was in place and discussed. In the case of the unexpected sudden adult death, the person had gone to bed and was found deceased the next morning. Emergency services were called and it was determined that the person had unfortunately died at some point in the night, so resuscitation was not undertaken and the person was certified deceased.

- **Safe effective discharges from hospital and good multi-agency communication.**

- **Good record keeping overall.**

- **Ensuring the involvement of advocacy services.**

- **Person centred support.**

- **Dedicated provider staff.**

- **Increased use of the Learning Disability Passport -** All patients with a learning disability should have easy access to the passport to share with health care staff if they go into hospital. The passport is designed to give staff helpful information that isn't only about illness and health and can include any useful information such as likes and dislikes, favourite food and drinks, hobbies or interests.

- **The provision of reasonable adjustments.**

LeDeR Steering Group

In Stockport we are fortunate to have an established LeDeR Steering Group. The purpose of the Steering Group is to work in partnership to support, promote and implement the process for reviewing deaths of people with learning disabilities. The group has a responsibility to consider the lessons learned from the reviews and any subsequent improvement to care provision in Stockport.

The LeDeR Steering Group provides independent scrutiny and challenge to monitor and develop the effectiveness of mortality review processes across providers in Stockport. The Steering Group brings together representations from all areas of Stockport including commissioners, provider organisations and those representatives with a specific area of interest to share best practice, with the ultimate outcome to reduce avoidable deaths in people with a learning disability in Stockport.

Membership

- Clinical Director (GP)
- Executive Nurse NHS Stockport CCG
- Service Manager Community Learning Disability Team (And Commissioning function for SMBC)
- Joint Commissioning Lead – NHS Stockport CCG
- Primary Local Area Contact - NHS Stockport CCG
- Secondary Local Area Contact – NHS Stockport CCG
- Representative from Safeguarding partnerships Children and Adults (tbc)
- Head of Safeguarding - Stockport NHS FT
- Head of Service Adult Social Care - SMBC
- Director of Public Health - SMBC
- Service Lead Community Learning Disability Team - SMBC
- Representative of people with learning disabilities and their families
- Representative from Stockport IMCA service
- Representative from Independent Care Provider organisation
- Family Member/Carer
- Reviewer

Members review programme direction and make decisions to ensure that:

- Partners work together to support the success of the programme and make sure that no single interest will undermine the programme;

- All risks are assessed and managed well, putting in place actions and contingency plans for all high impact risks;

- The time and resources needed for the programme objectives are available;

- Recording of programme information is accurate and coherent;

- Support is available for the Local Area Contact;

- The progress of the overall programme is monitored and any remediable action is undertaken;

- Learning found from the reviews is disseminated across the Stockport Health and Social Care system;

- Scrutiny of anonymised case reports pertaining to deaths or significant adverse events relating to people with learning disabilities, for publication in the LeDeR Programme repository in order to contribute to collective understanding of learning points and recommendations across cases.

Greater Manchester (GM) Learning Disability Strategy Implementation

As part of the Learning Disability Strategy Implementation, each locality has now submitted their draft delivery plan and 'Good Health' is one of the 10 priorities within the Strategy. The good health strategy includes:

- Reviewing the GP learning disability registers and set targets for more people to access good quality annual health checks;
- Reviewing and embedding the learning from mortlity reviews across GM;
- Embedding STOMP (Stopping the over medication of people with a learning disability, autism or both) into the GM medicines management strategy and increase awareness of peoples rights for medicaiton reviews
- Work with the GM Cancer Leads to improve cancer screening rates for people with a learning disability.

These plans will be monitored quarterly via the GM Learning Disability Delivery Group and will also provide an assurance to the wider system that as GM, we are delivering on our commitments. The plans will be scrutinized by the Confirm and Challenge Group on a regular basis. All ten of the GM localities are part of a collaborative process whereby colleagues leading on different priorities share and learn from each and actively identify an opportunity to work together on certain priority areas.

The work of the GM Health Inequalities Working Group is one of the mechanisms to provide GM solutions to problems and challenges identified in individual localities; In Stockport we now have the Stockport Health Equalities Group.

Screening and Flu vaccinations

CCG	Coverage of population	Breast Screening		Colorectal Screening		Flu vaccination %
		LD%	Gen Pop %	LD%	Gen Pop %	
Stockport CCG	86%	44.4 %	62.8%	84.7%	79.6%	47.2% (better than GM %)
Greater Manchester	81%	48.4 %	62.4%	69.9%	75.9%	41.7%

Figures from Greater Manchester Health and Social Care Partnership

2019/20 Public Health England figures up to January 2020 demonstrate that the influenza vaccine in targeted groups uptake was 41.8% for patients under 65 years in a clinical risk group, 41.9% among pregnant women and 71.1% in patients aged 65 and over.

Progress in Stockport for the Learning Disability Strategy

A Pathway for EOL is being created with key people, to be implemented utilising the North West model and local Pennine pathway.

There is now a permanent Health Facilitator to drive up Annual Health checks, access to screening and use of Health Action Plans.

The 'Blue Butterfly' emblem is now embedded into the Local Foundation Trust. There is a Learning Disability Inpatient Care Pathway and a planned roll out of a standardised training package. There is also a MCA/DOLS training toolkit in place and staff prompt cards are available. There are also reasonable adjustment care plans available.

Next Steps in Stockport

- Ensure the STOMP and STAMP (Supporting treatment and appropriate medication in paediatrics) is rolled out across Stockport by partners. NHSE and NHSI launched STOMP and STAMP to make sure that people with a learning disability, autism or both are only prescribed the right medication at the right time, for the right reason;

- Working group to implement Health Inequalities policy as part of the learning disability strategy implementation;

- Increase the uptake of age and gender appropriate health screening utilising the Learning Disability GP Liaison Role in order to increase awareness;

- Continue to share the learning into action and consideration of a learning event during 2020/21;

- Increase the numbers of reviewers to reduce the length of time it takes for a review to be assigned;

- Note the continued backlog and difficulties in allocating reviews within 6 months of them being notified, which is being reduced to 3 months in April 2020. Possible consideration of developing a business case for investment in an employed part-time reviewer;

- To increase the awareness of Sepsis in people with a learning disability including prevention, early identification and treatment amongst people with a learning disability, their families and paid carers;

- The reviews have identified inconsistences and issues with the level of knowledge about the MCA amongst professionals, as well as concerns about capacity assessments not being undertaken and best interest processes not being followed. The Stockport Safeguarding Adults Board is conducting a multi-agency mental capacity audit to establish the level of knowledge of the application of MCA in Stockport, to identify gaps in practice, identify and share good practice and identify the best way we can increase professionals' knowledge, confidence and competence with the understanding and

application of MCA. Ensuring that mental capacity assessments are completed fully, appropriately and in a timely manner, will need commitment from all agencies.

- Further assurances are requested from the Stockport Health Equalities Group that providers are implementing the learning from reviews, to ensure robust processes and procedures are in place across Stockport to address the lessons and themes found in the completed reviews.

Conclusion

The LeDeR process is now well established in Stockport. There have been challenges with use of the LeDeR system and capacity of reviewers to complete the work. In addition, other statutory processes such as the coronial process have created an unavoidable delay in the LeDeR review timescales. This has been raised by the Local Area Contacts to NHSE as part of their review of the LeDeR process.

The level of understanding and awareness about care and support for individuals with learning disabilities has improved in Stockport. Over 2019/2020 we have developed better partnership working, which facilitates joint learning and promotes more co-ordinated care for the individuals.

Stockport's focus remains that the learning and recommendations coming from completed reviews are translated into service improvements and examples of best practice are shared via the LeDeR Steering Group and the Health Equalities Group, alongside completing reviews efficiently.

The LACs are proposing a business case for the CCG for a part time LeDeR Nurse who can support the reviewers and provide training of the identified learning.