LeDeR Annual Report
Surrey Heartlands CCG / ICS

For the period 1st April 2021 – 31st March 2022

NHS England and NHS Improvement

Content

Acknowledgements

Surrey Heartlands ICS / CCG would like to thank everyone who has contributed to the LeDeR reviews. We would particularly like to thank the families and carers of those who have lost someone dear to them. Your voice has been invaluable in helping us learn about your loved one's experience, and of your experience, of using local health and social care services. We would also like to thank you for taking the time to tell us about each person and helping us understand their life and what was important to them. This has helped us to better understand what works well and identify areas that we need to improve on.

We would also like to thank those of you who gave us feedback about the LeDeR programme and how it made you feel.

Thank you to local service providers who have given us information to help us complete the reviews. We acknowledge the pressure providers have been under lately due to the Covid pandemic and thank you for giving the LeDeR programme the attention it requires. Without this information we would not understand the care provided to each person.

Lastly, thank you to the LeDeR reviewers who have strived to truly understand the people at the heart of the LeDeR reviews. Not only do the reviews show an understanding of each person as an individual, they also reflect what was important to each person throughout their life.

Executive Summary

This is the third LeDeR annual report published by Surrey Heartlands CCG / ICS.

LeDeR reviews the deaths of people with learning disabilities who are aged 4 years old and over. In 2021, the LeDeR programme expanded to include reviews of the deaths of autistic people. Surrey have not received any notifications relating to the death of an autistic person to date.

This report will highlight the work that Surrey Heartlands CCG / ICS have taken to complete the LeDeR reviews for the deaths that have been reported to Surrey Heartlands CCG / ICS from 1st April 2021 to 31st March 2022. It will also tell you what we have learned from any reviews completed within this time period.

In May 2021, the first LeDeR governance panel was held. LeDeR reviewers attend this meeting to present their review. The governance panel then discuss the review findings and agree a set of actions for service improvement across the system. Every three months the meeting takes the form of a business meeting where the themes of the reviews are considered and an update on the delivery of LeDeR strategy is provided. This new way of working will ensure the programme continue to deliver the commitments set out within the LeDeR strategy.

Since our last report there has been extensive progress to reduce health inequalities and premature mortality for people with learning disabilities and Autistic people. This is a great start, however, as this report will demonstrate, there is further work yet to be done.

Executive Summary- Key Findings

- 94% of the deaths reported to LeDeR between April 2021 and March 2022 were in relation to people who are white British.
- Women with learning disabilities, in Surrey, die 20 years sooner than women who do not have learning disabilities.
- Men with learning disabilities, in Surrey, die 14.7 years sooner than men who do not have learning disabilities.
- In 40% of the reviews completed, the person died as a result of Aspiration Pneumonia. This is a significant increase from last year where 7% of the deaths were due to aspiration pneumonia.
- Pneumonia and Bowel related complications were joint 2nd primary cause of death. Both respectively accounted for 10% of deaths in this reporting period.
- There was a significant reduction in deaths due to Covid 19 in this reporting period. 4 people died from Covid 19 this year.
- Of the deaths reviewed, 80% of people had a DNA CPR in place at the time of their death.
- 80% of people had a DNACPR in place at the time of their death. Over half of these were in place prior to the person's last episode of ill health however only a third of these decisions were reviewed.
- The reviews carried out this year found that 83% of people had their annual health check. This is more than last year when only 68% people had their annual health check. 20% of the annual health checks were felt to be ineffective.
- There was limited information in relation to screening however it remains that the evidence would suggest that many people with learning disabilities have not had screening carried out. The reviews noted that easy read information was noted to have been used in 3 cases.
- 9 people were noted to be on 10+ different medications. An audit has been commissioned to look into polypharmacy in further detail.
- There have been 5 choking deaths reported since the start of the LeDeR programme in Surrey. The LeDeR team are currently working with local speech and language therapists and safeguarding teams to review the learning from LeDeR and Safeguarding enquiries, review the local training content / policies and develop a system action plan around choking.

Introduction

The LeDeR Programme reviews the lives and deaths of people with a learning disability and autistic people. Reviews of the deaths of Autistic people were introduced in April 2021 however Surrey Heartlands CCG / ICS have yet to receive any notifications relating to autistic people who do not have a learning disability.

Surrey has a population of 1,185,200. Of those, around 21,800 adults have a learning disability and around 9,086 adults are autistic. Around 4,500 have both a learning disability and Autism (ONS 2017). Surrey Heartlands CCG / ICS review the deaths of people across the Surrey Heartlands area. This includes East Surrey, Surrey Downs, North West Surrey and Guildford and Waverley. The LeDeR programme will help Surrey Heartlands CCG / ICS understand the experience of people with learning disabilities and autistic people when accessing health and social care services. It will demonstrate what is working well and what areas need to improve.

Governance arrangements

- NHS England published the new LeDeR policy in March 2021. This policy set out that as of June 2021, LeDeR responsibility should sit with the Integrated Care System (ICS). As a result, Surrey Heath and North East Hampshire and Farnham areas moved to within the Frimley ICS.
- Surrey Heartlands CCG /ICS maintain responsibility for the delivery of the LeDeR programme for East Surrey, Surrey Downs, North West Surrey and Guildford and Waverly.
- In response to the requirements of the LeDeR Policy 2021, Surrey Heartlands LeDeR Governance panel was set up with the first meeting taking place on the 26th May 2021. This panel review any focused reviews that have been completed and agree system actions and has representation from local system partners, family representatives, experts by experience and Healthwatch.
- The meeting format was reviewed in early 2022 and it was agreed that every third meeting will now take the form of a business meeting where we discuss general learning from LeDeR, review the LeDeR strategy and progress on the delivery of the strategy.
- The LeDeR programme continues to report into the Surrey Heartlands ICS Quality and Performance Board and the Surrey Learning Disability & Autism Programme Board.
- In turn, the Surrey Learning Disability & Autism Programme Board reports in to the Surrey Learning Disability and Autism Strategy Board.
- Ultimately the work of the Surrey Learning Disability and Autism Strategy Board feeds into the Surrey Health and Wellbeing Board.

Deaths of People in our CCG/ICS: Pen Portraits

Sam was a 74-year-old gentleman who had a mild learning disability, schizophrenia and epilepsy. He lived in a nursing home, which is where he died. He was able to communicate his needs verbally. He attended a boarding school for children with school for young people with learning and additional needs when he was small. He did not like the first school therefore moved to a different boarding school at 15 years old where he was able to learn woodwork and made friends with others.

Sam married his wife when he was 21 years old, they had 5 children together. Sam had 5 grandchildren in total. He later separated from his wife and continued to live with his brother. He moved into a nursing home in 2008, where he called his home until he died in 2020. He appeared very happy there, he was very fond of the staff.

Sam loved to listen to 60s and 70s pop music, which was a shared interest with his mother and something they used to enjoy doing together. Sam particularly loved to listen to Elvis and they would regularly have live music from an Elvis impersonator at his home, which Sam loved. He would walk from his bedroom, back to the dining room, where the live music was and enjoyed this very much.

Claire was described as a kind lady who really enjoyed food, listening to music and a cuddly toy of Bagpuss. She was 57 years old and had a diagnoses of Down Syndrome, Autism, Dementia and Epilepsy.

Claire had limited verbal communication throughout her life but due to her dementia diagnosis was non-verbal in her later years. She would love to listen to people talking to her and would blow people kisses who she liked to be with. She had a close relationship with her mum who is described as a big influence in her life, until she passed away. She also had a sister and a brother who saw Claire often and were involved in all decision making.

Claire enjoyed playing with tea sets with support staff at her home. She appeared to have a good relationship with staff and others that lived in the home and would go on day trips such as London Zoo. Claire did not enjoy the rain and would not like to go on day trips if it was raining.

Pen Portraits continued:

Stan was a 53 year old gentleman who lived with his sister and brother in law. Stan and his Mum had lived with his sister and her family since the death of his father. He was a gentleman with a moderate learning disability, tuberous sclerosis, epilepsy and autism, conditions which his Mum also has. He had attended Day services however, the year prior to his death decided that he no longer wished to attend.

Stan lived in a busy household and was a very loved member of the family. His sister described him as a happy, gentle and kind man. He loved music, especially Michael Jackson. He loved singing and dancing and watching you tube. Stan also loved food and had a particular love of Christmas and Easter. He loved electrical equipment especially radios and watches.

Jo, 73 lived with her husband, and enjoyed her independence until she became acutely unwell in 2020. She and her husband used to enjoy frequent trips on the bus to do their shopping and she liked to cook. They would often refuse to open their door to social care or other officials, and when a social care assessment took place in 2018, Sandra declined all support and it was felt that she had capacity to do so.

IMPACT(some quotes from people/famillies)

"We just want to talk about it (his brother's experience of care) and know that things will improve and people will learn."

Brother

"I want to say thank you to all those involved in the LeDeR programme, for all of their hard work in improving services for people with learning disabilities. My son received very good care but I recognise that not every body with a learning disability receives the level of respect, care and understanding that my son did. I'm very thankful for the professionals who work to ensure all people do."

Mum

Equality Impact

Surrey Heartlands CCG / ICS set out our vision for people with learning disabilities and Autistic people, we believe that everyone with a learning disability and / or Autism should have access to high quality health and social care services that meet their individual needs. By learning from past experience, we can continually improve services to ensure people stay healthy, are supported to make informed decisions and get the support they need if they become unwell or are approaching the end of their life.

This will help to ensure Surrey is a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no one is left behind. The Surrey LeDeR programme remain committed to improving equity for people who are known to experience health inequalities.

Ethnicity

The table to the right shows the ethnicity breakdown of the people whose lives and deaths were reviewed this year. It demonstrates that 97% of these individuals ethnicity was recorded as White. 94% of people reported their ethnicity as White British and 3% reported being 'Any other White Background'. The remaining 3% reported that the individual's ethnicity was 'Other Ethnic Group- not Stated'.

The 2020- 2021 LeDeR report found that 87.7% of the deaths reported to LeDeR were in relation to people whose ethnicity was White. The 2011 census reported that people who reported their ethnicity as White British made up 83.5% of the Surrey population therefore people who are from Mixed/ Multiple ethnicity groups, Asian or Asian British, Black or Black British or any other ethnic group are underrepresented within the Surrey Heartlands LeDeR findings. Surrey are committed to understanding this finding in more detail and will work with our local authority colleagues to understand the mortality data in more detail.

Ethnicity	White				Mixed/Multiple ethnicity groups				Asian or Asian British				Black or Black British			Other Ethnic Groups		
	British	Irish	Traveller or Gypsy	Any other White background	White & Black Caribbean	White & Black African	White & Asian	Any other mixed background	Indian	Pakistani	Bangladeshi	Any other Asian background	Caribbean	African	Any other Black background	Chinese	Any other ethnic group	Not stated
No. of reported deaths	29	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
% of all reported deaths	94%	0%	0%	3%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%

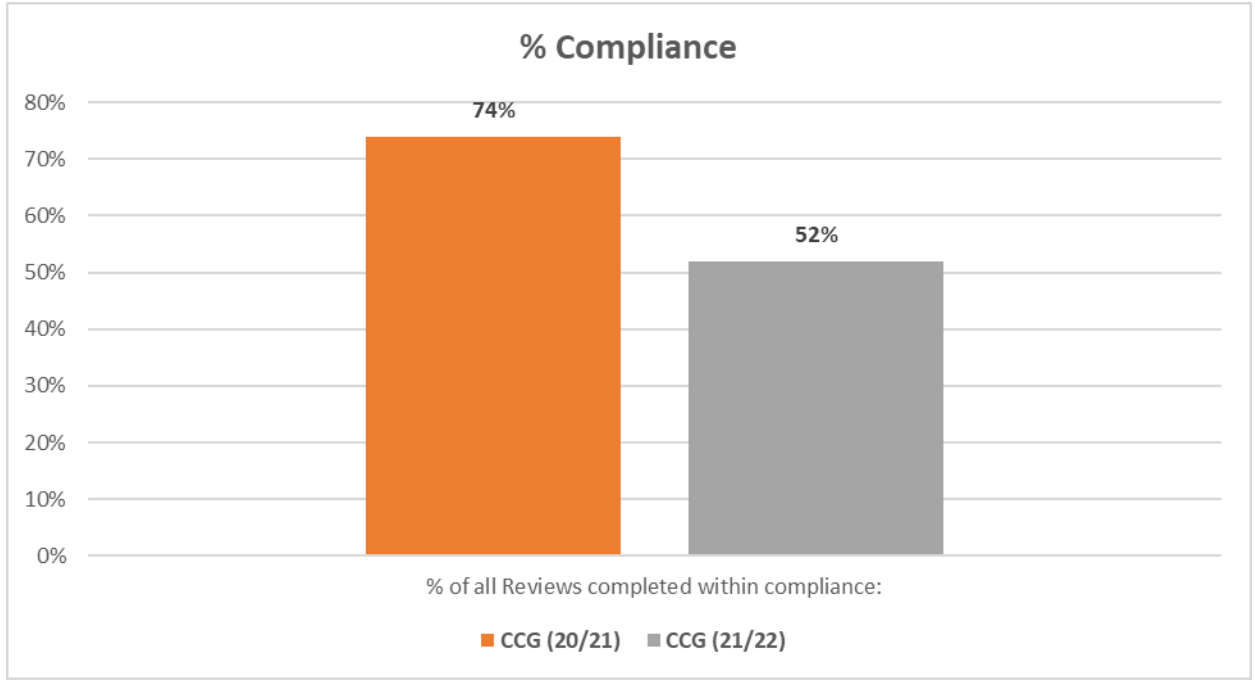
Data Set: Performance

	Notifications No.	Completions No. & %		Focussed Reviews	% of all Reviews completed within compliance:
2020/21	118	106	90%	6	74%
2021/22	71	31	80%	14	52%

In 2021/ 2022 there were 71 notification received. This is significantly lower than last year but in keeping with figures prior to the Covid pandemic. Of these 71 notifications, 39 required completion within the same timeframe (6 months from receipt of notification). 31 of these reviews have been completed. This represents 80% of the reviews requiring completion. Five of the reviews due completion are currently on hold awaiting other investigation processes to be finalised. These processes include; Serious Incidents, Safeguarding enquiries and Coroners inquests. 2 of the remaining outstanding reviews are currently in progress. These cases are taking slightly longer than the compliance timeframes due to the complexity of the health needs of the individuals and in one case, we are awaiting information from another region of England.

14 of the notifications made are focused reviews. Nine of these have been discussed to date and recommendations agreed. To ensure the focused reviews do not cause a delay in completion, meetings will be arranged by exception if there are too many cases to be discussed within the existing meeting structure.

The reviews have been completed within the NHS England timeframes (6 months from notification being received) in 52% of the cases. As stated above 5 reviews are on hold whilst awaiting other processes to be finalised prior to being signed off at panel. Further to this, all other cases other cases with the exception of two are affected by awaiting completion of another investigation process or inquest and also awaiting additional information from a provider.



Local Reviewer Arrangements

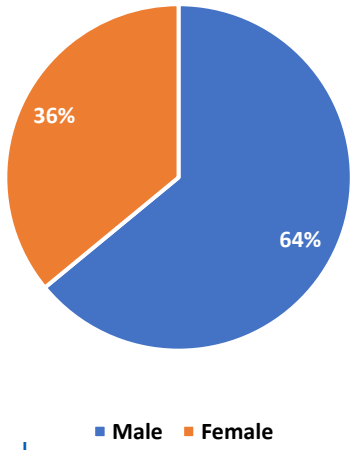
Surrey Heartlands CCG / ICS continue to employ a LeDeR co-ordinator to oversee the LeDeR programme across Surrey Heartlands.
We currently have 6 bank reviewers employed by the CCG/ ICS. Each of the reviewers have completed the LeDeR training and have a mix of skills they bring to the role. These include; patient safety, community learning disability nursing, acute nursing, psychologist, Continuing health care and acute liaison experience. 5 out of the 6 reviewers have a background in learning disability nursing and 1 has a background in acute nursing.
We continue to explore recurrent funding for substantive employment for the reviewers.

Data Set: Demographics(from local data)

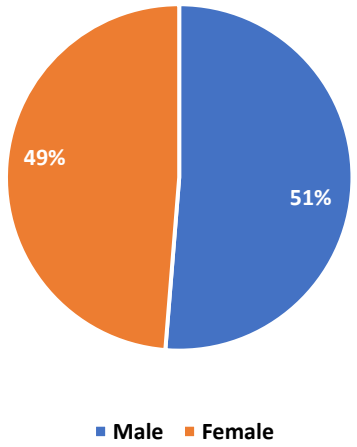
- **Gender**

This year, 51% of the deaths reported to the Surrey Heartlands LeDeR programme were male and 49% were female. Last year saw an increase in the number of male deaths reported to LeDeR (64%) however this years findings are more in keeping with the pre-pandemic findings in 2019 / 2020 which were 52% male and 48% female.

	2020/2021	
	Male	Female
No.	73	41
%	64	36



	2021/2022	
	Male	Female
	20	19
	51	49



- **Level of Learning Disability(if known)**

For every review carried out the level of learning disability for that person is confirmed and recorded as either mild, moderate, severe or profound/multiple. The information below shows the breakdown of this information for all of the people reviews have been completed for in the last year.

Level of Learning Disability	No.	%
Mild	10	32
Moderate	11	36
Severe	6	19
Profound/Multiple	3	10
Unknown	1	3

Of the reviews completed, 32% of the individuals had a mild learning disability, this was similar to previous years (29%) and in keeping with last year's National LeDeR report findings. There were 36% of reviews completed for people who had a moderate learning disability. This an increase from the previous year where 31% of the reviews related to someone with a moderate learning disability. The number of reviews completed for people who had a severe learning disability has decreased substantially from previous years (31% to 19%). 10% of the individuals whose life and death was reviewed had a profound learning disability and in 3% of the cases the level of learning disability was unknown. This was usually due to an assessment never have been carried out or the information was not available to the reviewer.

Data Set: Demographics, Age(local data)

All Adults with learning disabilities who died in 2021-2022:

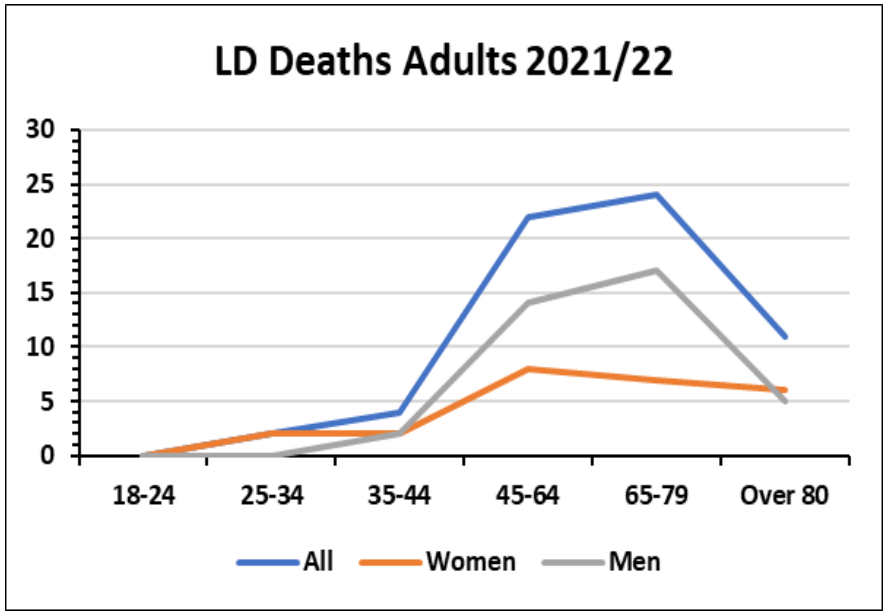
- There was a total of 66 deaths
- The range of age at death was 30 – 98
- The mean average age of death was 65
- The median average age was 66

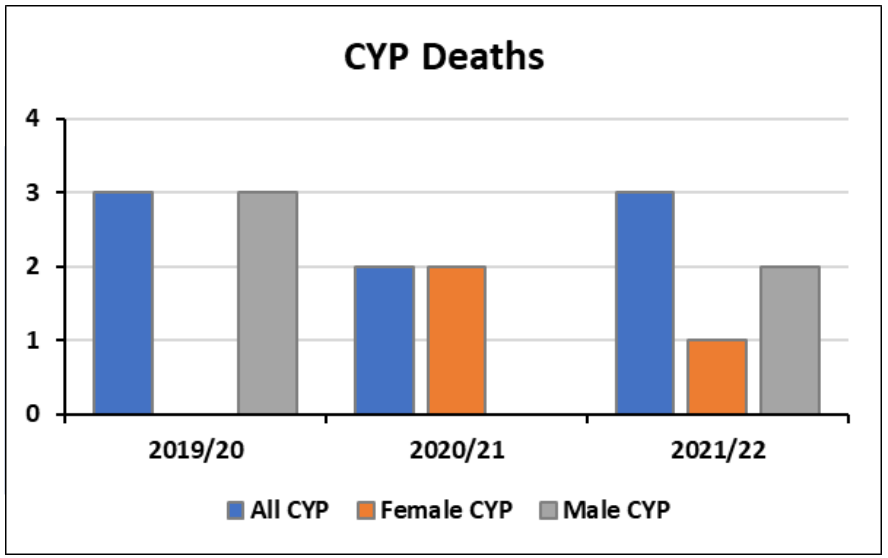
Women with learning disabilities who died in 2021-2022:

- There was a total of 25 deaths
- The range of age at death was 30 – 98
- The mean average age of death was 64
- The median average age was 65
- Female life expectancy in the general population of Surrey Heartlands CCG is 85.0.

Men with learning disabilities who died in 2021-2022:

- There was a total of 38 deaths
- The range of age at death was 37 – 88
- The mean average age of death was 65
- The median average age was 67
- Male life expectancy in the general population of Surrey Heartlands CCG is 81.7.





All Adults with learning disabilities who died from confirmed or suspected COVID-19 in 2021-2022:

- There was a total of 4 deaths
- The range of age at death was 63 – 76
- The mean average age of death was 70
- The median average age was 71
- No. of women who died 1 confirmed
- No. of men who died with suspected Covid

There has been a marked reduction in deaths from Covid 19 in this reporting year. Only 4 people have died from Covid 19 in comparison to 51 people who died last year.

Children with learning disabilities who died in2021/2022:

- There was a total of 3 deaths
- The range of age at death was 12 – 14
- The mean average age of death was 13
- The median average age was 13

Data Set: Cause of Death.

- **Cause of Death**

The most common cause of death this year was Aspiration Pneumonia. The number of deaths from this was 12, which is 40% of all deaths reviewed this year.
The table below shows the top 5 primary and secondary cause of death

No	Primary Cause of Death	No	Secondary Cause of Death
1	Aspiration Pneumonia	1	Seizure
2	Pneumonia	2	Dysphagia
3	Bowel related death (1 infarction / 2 intestinal obstruction)	3	Ischemic heart disease
4	Covid19	4	Learning disability
5	Myocardial infarction	5	Acute kidney Injury, Cardiac Arrest, Peri-colic adhesions, Coronary Artery Atherosclerosis, Covid 19, Dementia, Frailty, Mesenteric Thrombosis, Pneumonia

Aspiration pneumonia was recorded as the main cause of death in the reviews completed this year. It accounted for 40% of the deaths reviewed. This is a significant increase since last year which was only 7%. It is proposed that this is a priority area going forward.
The joint second most common cause of death was Pneumonia and Bowel related complications (2 bowel obstructions and 1 intestinal infarction). 10% of the people died due to this. Last year the percentage of people who died from Pneumonia was higher (23%). Bowel related issues did not feature in the top 5 causes of death in last year's report.
7% of deaths were due to both Covid19 and Myocardial infarction. Last year Covid 19 was the top cause of death, accounting for 31% of the deaths recorded.

Ischemic heart disease is noted as the third most common secondary cause of death. This is important to note given the recent findings from an annual health check analysis which will be discussed later in this report.

- **DNACPR – Do not attempt cardio-pulmonary resuscitation**

A DNACPR decision is designed to protect people from unnecessary suffering by receiving CPR that they don't want, that won't work or where the harm to them outweighs the benefits

The DNACPR decision-making process should always take account of the benefits, risks and burdens of CPR and consider the individual person's wishes and preferences, the views of the healthcare team and, when appropriate, those close to the person.
Hospital trusts and other providers are legally obliged to have a clear DNACPR policy for staff to follow. It must be accessible so that patients and/or their families are able to understand the decision-making process.

During the first wave of the Covid-19 pandemic, concerns were raised about the potential for "blanket" decisions being made around resuscitation, particularly for more vulnerable populations. As a result, the Care Quality Commission undertook a review of practice across a number of systems, taking into account the understanding and application of the Mental Capacity Act both when it comes to clinical decision making and taking into account the views of individuals. DNA CPR completion was reviewed as part of the LeDeR reviews carried out ain Surrey Heartlands.

Of the deaths reviewed, 80% of people had a DNA CPR in place at the time of their death.
Over half of these were in place prior to the person's last episode of ill health. DNA CPR decisions should be reviewed each time the person's situation changes i.e. when the person leaves hospital, however just under a third of the LeDeR cases completed showed that the DNA CPR decision had not been reviewed.

Quality issues were noted in 6 of the reviews completed in relation to the DNA CPR decision. The concerns included; in 5 of the cases reviewed there was no evidence of a DNA CPR conversation. Sometimes this was not found in either the notes or on the DNA CPR form. This would indicate that the Mental Capacity Act is potentially not being followed in relation to these cases, if those individuals lacked capacity to make this decision. On occasion the forms were found to be poorly completed. Examples of this include the next of kin's details being missing from the form, on one occasion the Mental Capacity Act section of the form was found to be blank and on 2 occasions the learning disability liaison nurses raised concerns about the reasoning for the DNA CPR decision.

Data Set:

- **Annual Health Checks**

Of the deaths reviewed, 83% of people had had an annual health check in the last twelve months. This is significantly more people than last year where only 68% of people had an annual health check within the previous twelve months. Of the 83%, 60% of the cases reviewed the annual health check led to a health action plan being completed. This was an improvement from last year.

The LeDeR reviews in Surrey Heartlands also looked at the quality of the annual health checks and what action was taken as a result of them. It was difficult to comment on the quality of the annual health checks as often the information available was limited however in around 20% of the annual health checks they were felt to be ineffective. Reasons for them being considered ineffective included: health check did not cover the areas required within the national template, no physical examination offered, the screening section of the health check was not completed, recent hospital admissions / health issues were not discussed as part of the health check, annual health check carried out via phone and there was no discussion about recent issues with constipation / bowel health despite several recent attendances / admissions relating to this.

To complement these findings Surrey CCG / ICS are working with local experts by experience, carers and providers to understand the impact of Covid 19 and to hear about their experience of annual health checks and accessing health care in general. The report will tell the ICS what local people with learning disabilities want in terms of healthcare.

In order to better understand the health inequalities faced by people with learning disabilities, Surrey have commissioned a review of the findings from annual health checks. This work cross referenced the findings from the LeDeR reviews alongside the findings from the annual health checks. It will be used to inform and plan future workstreams. In particular it identified the overlap between modifiable factors to address weight issues, type 2 diabetes, and hypertension thus impacting on the causes of mortality.

- **Role of cancer screening if appropriate to your area**

Although some information was available for many of the completed reviews, the data remained sparse and made it difficult to get a true understanding of the uptake of cancer screening in people with learning disabilities. Often carers were unable to tell the reviewers if screening had been undertaken.

A commitment to increasing the uptake of screening in people with learning disabilities was made in the Surrey Heartlands LeDeR Strategy. To drive this work forward, a meeting is now in place which is jointly chaired between the Screening and immunisation team at NHS England and is attended by the learning disability and quality leads from the CCG along with the local learning disability community team and primary care liaison services. Each screening programme will have a task and finish group to tailor any work specific to that programme. At present the focus of this work is the development of a pathway between the GP learning disability lists and the screening hubs / leads.

One area which was found to require improvement is the utilisation and offer of easy read information. The reviews found evidence of this used on one occasion in breast screening and twice in cervical screening. This may have been utilised in more cases however the reviewers could not see evidence of this.

It is suggested that a health inequalities screening role should be considered to improve the uptake of screening in Surrey.

Data Set:

- **Medication**

Polypharmacy and constipation prescribing were highlighted as a priority in the 2020 / 2021 LeDeR annual report. As a result, additional data around medication was collected. This was available in 27 reviews. Of the 27 reviews, 9 people were found to be on 10+ regular medications. Of the 9 people, 3 were on 10 regular medications, 2 people were on 11 medications daily, 2 people were on 12 medications daily, 1 person was on 11 medications and 1 person was on over 20 medications.

In response to this, Surrey Heartlands have commissioned Surrey Choices to undertake an audit of medication prescribing in people with learning disabilities in Surrey. The programme will specifically look at polypharmacy and constipation prescribing. The programme is due to commence in June 2022 and the findings will be written up to inform future work required.

- **Choking**

There have been 5 deaths in Surrey related to choking since the start of the LeDeR programme in Surrey. There have also been choking incidents reported through the safeguarding team at the CCG, as a result, Surrey Heartlands have commenced work to address any issues relating to choking and the use of de-choking devices in Surrey. This includes working with local providers to review training content and policies across Surrey Heartlands.

- **Constipation**

As mentioned in the medication section, prescribing in relation to constipation was also an area of focus. In order to understand this in more detail, additional data was also collected in relation to constipation. 21 people were found to have attended their doctor or been receiving treatment for constipation. Only one of these individuals was not on laxative medication to treat this. 11 out of the 21 people had a care plan regarding their bowel care. Of the 11 care plans, they all covered dietary advice to manage bowel health. Only 5 out of the 11 care plans had advice regarding activity or physical exercise.

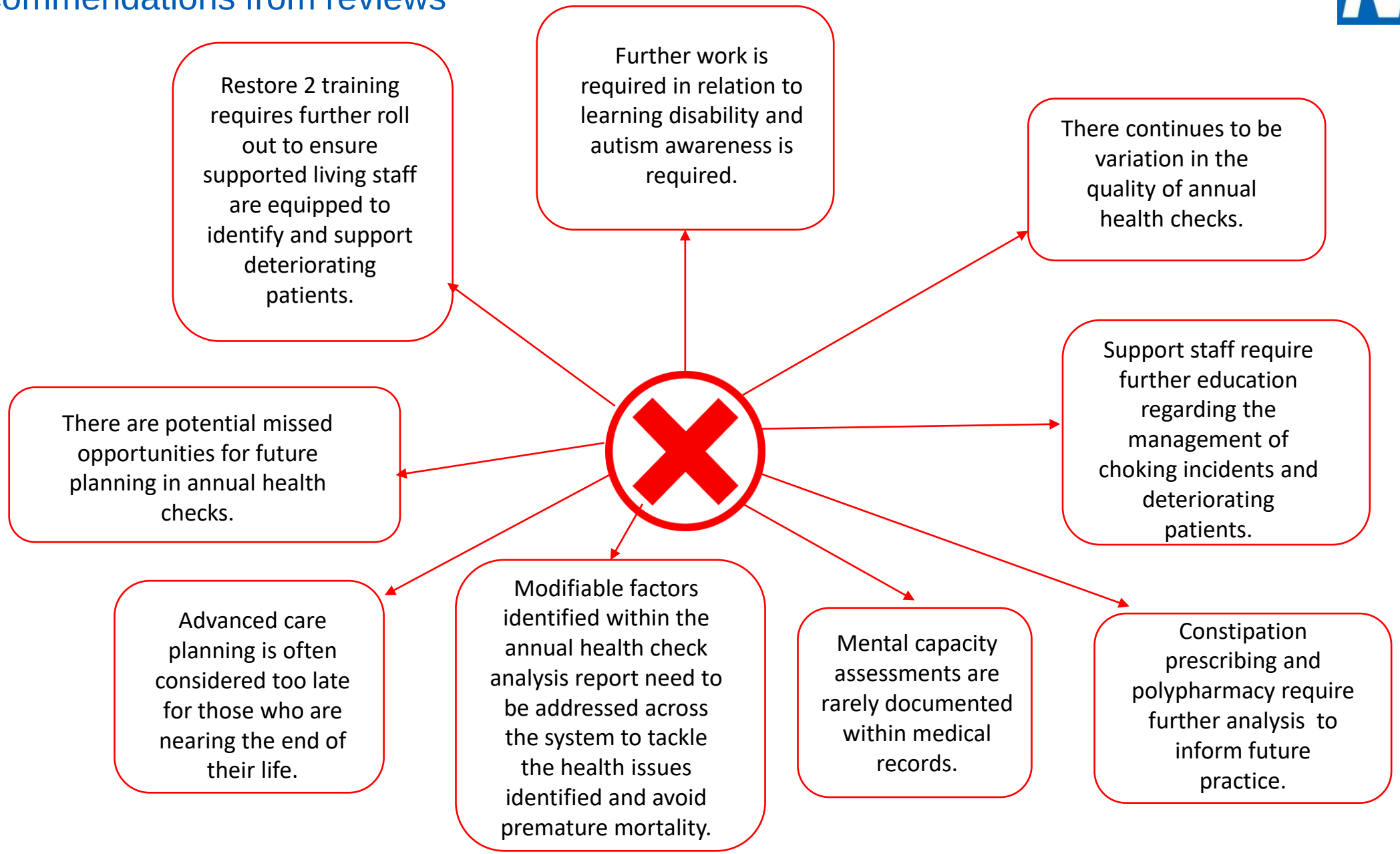
In most cases the care plan was felt to be effective, however in 2 cases it was difficult to evidence if it was effective.

4 of the people who were receiving treatment for constipation experienced overflow diarrhoea. This is when soft faecal matter by passes a hard lump of faeces. 3 of these individuals were prescribed medication to treat diarrhoea.

Surrey Heartlands are planning an event related to bowel health in July 2022. It is suggested that further work is required in this area, both around education for families and care staff and also health professionals.

Action from Learning:
What best practise and positive outcomes have been learned from the reviews

Action from Learning: What areas for improvement were identified in recommendations from reviews



Action from Learning: What has been done to address the learning/themes in the national and local LeDeR reports?

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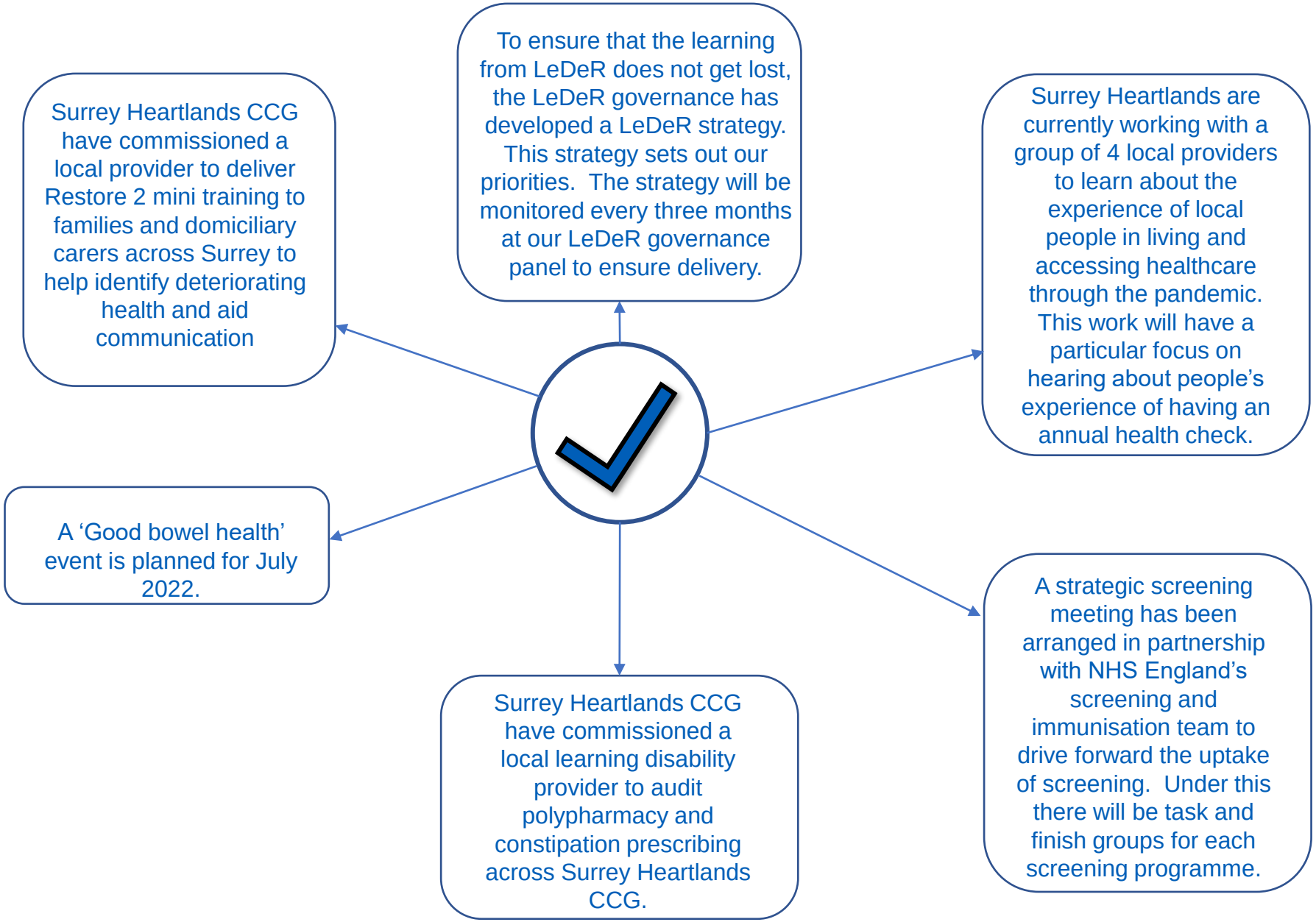
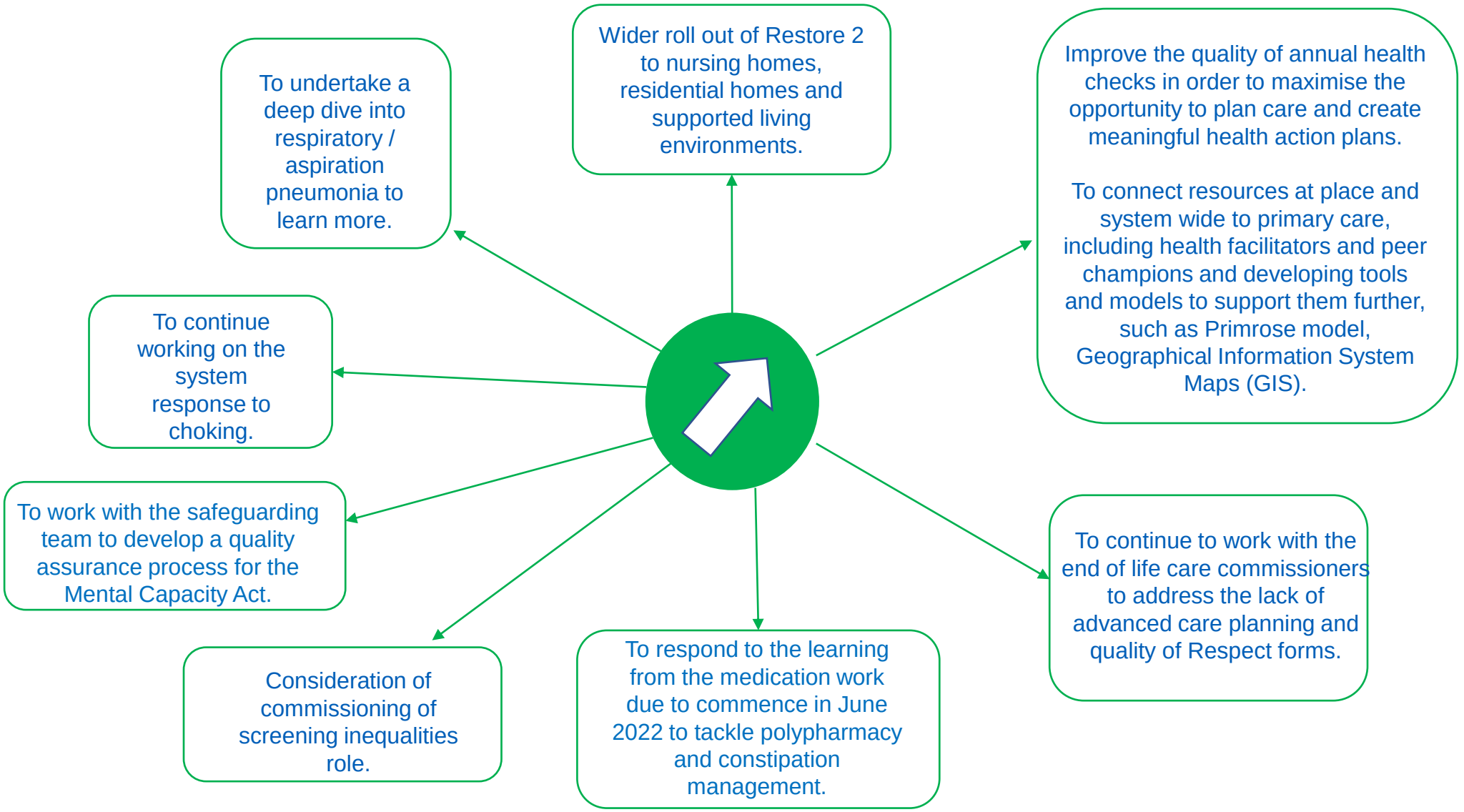


Action from Learning: Local Priorities for delivery in 2021-2022 based on the learning from reviews locally and nationally



Action from Learning:
The evidence base for local priorities in 2021-2022

- The evidence base for the local priorities are the findings of the recent annual health check analysis, coupled with the learning from the LeDeR programme both locally and nationally.
- The Primrose model is a large scale study being carried out by University College London in relation to predicting cardiovascular disease risk in people with severe mental illness. The learning from this programme will be considered in relation to the system response to the annual health check analysis.
- Learning in relation to polypharmacy has also been identified within the National LeDeR reports and is also currently being considered by NHS England as an area requiring further work. The polypharmacy and constipation prescribing audit will inform any additional work required within these areas.
- The findings from a deep dive into respiratory / aspiration pneumonia will inform the system wide response to tackling aspiration pneumonia as the leading cause of death in people with learning disabilities.

Action from Learning: Evaluating the Impact

What is in place to monitor and review action plans /service improvements to ensure that they are implemented and effective in improving care, reducing inequalities & saving lives:

- The LeDeR Governance panel have created a LeDeR strategy which sets out a commitment to service improvement in relation to the LeDeR findings.
- An implementation and monitoring plan is in place for the strategy.
- This plan will be reviewed at the quarterly LeDeR business meeting.

How we will evidence that service improvements are making a difference to people with a learning disability and their families:

- Surrey Heartlands CCG / ICS quality leads will continue to engage with providers to monitor the implementation of service improvements in response to the learning from LeDeR.
- The governance panel and LeDeR business meeting will monitor the themes and trends from reviews within their meetings.
- Local service user groups will be consulted on their experience of using local services.
- Audits will be undertaken to monitor any changes implemented as required.