NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

LeDeR Annual Report Oxfordshire

OSAB
Oxfordshire Safeguarding Adults Board

For the period 1st April 2022 – 31st March 2023

* BOB ICB became one organisation on 1st July 2022 but this report relates to the Oxfordshire place aligning with the local safeguarding board boundaries.

Content

Executive Summary

NHS Oxfordshire Clinical Commissioning Group

Local reviewer arrangements

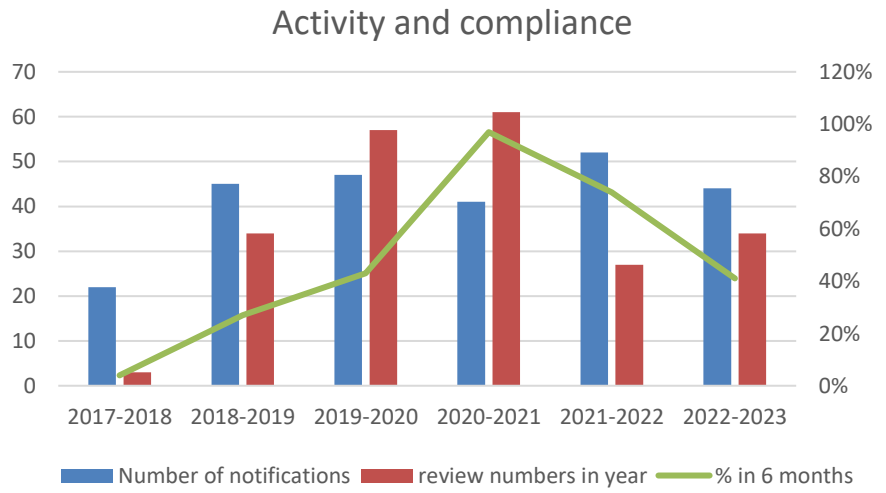
- The Oxfordshire Safeguarding team, within the ICB, has been coordinating the review process supported by the OSAB business unit. In 2023-2024 this is changing to new arrangements following the ICB restructure. The coordination will move to the Quality Improvement Manager. .
- Provider teams and support organisations contribute records and information which is centrally collated and written up ready for the reviewer.
- The reviewer is responsible for contacting the family and carers, ensuring their contribution is integrated into the review documentation. Analysis and identification of learning points in undertaken.
- In 2022-23, 100% of reviews were completed by BOB ICB reviewers from within the Oxfordshire Safeguarding team. The reviewer profile includes frontline staff who contribute effectively and offering real- time learning. This year they have been focused on supporting care provision.

Performance:

- 44 notifications in the year 1 April 22 - 31 March 23. A further three notifications were received, but were closed due to being out of scope, and are not included in this report.
- 34 reviews completed this year (including some cases from previous years).
- 41% of the reviews were completed within six months of notification..

Learning from the reviews:

- Conversations about death and dying are never easy, but where they have been proactive there is evidence of much greater levels of understanding. There are also more opportunities to represent views and wishes of an individual more effectively in times of crisis and sadness.
- There is evidence of some excellent multiagency working crossing acute and community services.
- Healthcare provision remains fragmented at times and there needs to be more work to ensure that annual health checks and health action plans are linked in order improve healthy living and better understanding of health needs.
- To ensure a safe and effective discharge, a solid discharge planning procedure should be put in place that involves next of kin and allied health providers. The process should include; checks on caregivers' physical health and abilities, competency in planned discharge care updates for family, and that mutual agreement on discharge arrangements have been completed.
- Developing anticipatory end of life plans has been recognised as good practice and is valued by friends and family and carers. More work is needed to make this consistent.



Introduction

- This is the sixth Annual Report collating learning from the mortality reviews of those with a learning disability using the learning disability death review (LeDeR) framework. This programme was commissioned and is overseen by NHS England.
- The review process is a strongly supported partnership activity in Oxfordshire, with membership from a wide range of organisations. This report presents the findings from 34 case reviews undertaken in 2022-2023.
- The LeDeR review process was affected this year by the development of the ICB. It has prompted different ways of working and closer working relationships across the BOB ICB. It has also created a challenge to the oversight and follow up of learning and action which is required at both place and system. The OSAB has remained the partnership with oversight of this work.
- This report was completed and presented before the national report was published. National comparators within this report are therefore from the previous year so can only be used for guidance.

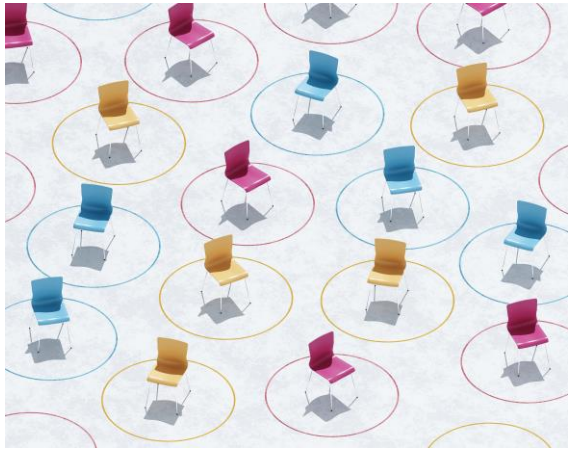
Acknowledgements

- The Oxfordshire steering group continued to support reviews. Resource pressures and increased workload have led to less activity this year but the commitment to learning and improving service provision and person centred care remains paramount.
- Oxfordshire Association of Care Providers (OACP) has been an extremely valuable partner, disseminating resources information and advice over the past year. It has also been instrumental in providing a platform to promote learning in a virtual way, which has enabled learning from the mortality reviews to be shared in a timely manner.
- During the past year Oxfordshire Family Support Network (OxFSN) and My Life My Choice (MLMC) have been instrumental in continuing to raise issues, ask challenging questions and voice the concerns of those living with a learning disability. They have maintained close contact, and we have been able to offer feedback and assurance as a result of this. There have also been opportunities to share experiences through the learning events and activities.

Key Findings

- There is evidence of some excellent multiagency working crossing acute and community services, creating good joint care. However, for many health care provision remains fragmented at times. There needs to be more work to ensure that annual health checks and health action plans are linked to improve healthy living and better understanding of health needs of those working to support individuals.
- Annual health checks have improved in consistency of completion the past year, however the correlations with the provider held health action plans remains limited or missed. An example of this is the lack of coordinated approaches to age-appropriate screening being completed with correct preparation and planned reasonable adjustments.
- Conversations about death and dying are never easy, but where they have been proactive there is evidence of much greater levels of understanding. There have also been more opportunities to represent views and wishes of an individual more effectively in times of crisis and sadness.
- Developing anticipatory end of life plans has been recognised as good practice, valued by those who are mourning a loved family member or friend.
- Mental Capacity Act related record keeping is weak or non-existent in both health and social care records in relation to best interest decisions. An example is where age-appropriate health screening has not been undertaken, there is no evidence of Best Interest Decision making having been undertaken, or consideration of how to adjust the screening to incorporate reasonable adjustments.
- To ensure a safe and effective discharge, a solid discharge planning procedure to be put in place that involves next of kin and other allied health providers. The process needs to include ensuring that checks on caregivers' physical health abilities, competency in planned discharge care updates for family, and mutual agreement on discharge arrangements have been completed.
- There was evidence where the anxiety and concerns felt by families are actively recognised and skilfully incorporated into care and treatment plans families reports of quality of care improved. Staff need to be encouraged and supported to make this a core element of care and treatment planning and delivery.

We need to connect and communicate to get better together.



Governance arrangements

- In 2016, Oxfordshire introduced a Vulnerable Adults Mortality steering group (VAM), as a valued subgroup of the Oxfordshire Adult Safeguarding Board (OSAB). It follows the LeDeR (learning disabilities mortality review programme) methodology, to ensure that all deaths of those with a learning disability are reviewed in a consistent manner.
- The administration of the Oxfordshire Vulnerable Adults Mortality process is hosted in Oxfordshire by the ICB Oxfordshire place based Safeguarding team. The Chair is the Designated Nurse and Safeguarding Lead, who is also the Local Area Contact (LAC) for Oxfordshire.
- The VAM steering group has chosen not to confine reviews to those with a diagnosed learning disability but uses the term 'vulnerable adult'. Professionals and practitioners are encouraged use their judgement and if they believe that an individual's vulnerability contributed to their death, they should make a referral to VAM requesting a review.
- The steering group has representation from providers and families as core members, creating an inclusive approach. Every review is taken to the VAM steering group for actions to be assigned and learning points shared. Completion is then the responsibility of the assigned person.
- During 2021-2022, those living with a learning disability were provided with updates, through My Life My Choice and Oxfordshire Family Support Network. Their roles within the VAM steering group have been strengthened in 2022- 2023 with them becoming a member of the steering group.
- Reporting has been to the CCG governing body through the Quality Committee, into the joint commissioning teams to inform service development and into the Oxfordshire Safeguarding Adult Board through the sub group reporting processes, resulting in regular Executive updates. Annual reports are presented to both and published alongside the Safeguarding Adult Board Annual report, on the OSAB website. In 2022-2023 it was expected that the LeDeR learning and reporting would be into the Learning Disability ICB programme board, collating learning with the Buckinghamshire and Berkshire West place based LeDeR teams. However this has not been finalised at the time of report writing.
- When the death of a person with learning disabilities occurs, mandatory review processes (such as Safeguarding Adult Reviews, Coronial processes and Serious Incident Processes) need to take precedence. The LeDeR process aims to ensure that a coordinated approach is taken to the review of the death, in order to minimise duplication and bring in the learning disabilities expertise. For children aged 4+ the Child Death Review Process (CDOP) will run concurrently with the LeDeR process, using the CDOP reports. Within Oxfordshire this process is also hosted by the ICB.
- During 2021-2022 the review programme was expanded to include those living with a clinical autism diagnosis. Within Oxfordshire during 2022-2023 only 1 such review has been undertaken. Expansion of the reviews in this area is anticipated following some publication by NHS England, due in Summer 2023.
- Within Oxfordshire there is an information gathering stage prior to assigning the review to a reviewer. This has improved efficiency, maintaining a robust and effective process. It has been possible using this process to triage cases, identifying key expertise required to undertake the review, and to improve the timeliness of completion. Reviewers have been able to use their clinical expertise to focus on family involvement and analysis of care and treatment.
- Work has been undertaken with Oxfordshire County Council to develop a more robust monitoring overview process for the identified priorities ascertained from the Learning Disabilities and Autism annual reviews . This has resulted utilising the Oxfordshire Learning Disabilities & Autism Improvement Board, which brings together commissioners and partners across health, social care and housing services to oversee the development and delivery of services for people with learning disabilities and / or autism.

Equality Impact

Public bodies have legal duties to eliminate unlawful discrimination, advance equal opportunities and promote good relations between people. Actively considering the ethnicity of an individual is essential to proactively explore any relationship between mortality and ethnicity.
According to the Office for National Statistics (ONS) Census 2021 survey, 13% of the total resident population of Oxfordshire was from an ethnic minority background, compared with 18% across England. According to the January 2021 Schools Census, 29% of pupils in state primary schools (in years 1 to 6) and 27% of pupils (years 7-11) in state secondary schools in Oxfordshire were from ethnic minority backgrounds. Across Oxfordshire's districts, Oxford has the highest proportion of ethnic minority pupils and pupils whose first language isn't English. All districts aside from West Oxfordshire have a higher proportion of ethnic minority pupils and pupils whose first language isn't English in Primary year groups (years 1-6) than in Secondary year groups (years 7-11).

As at 30.04.2023, according to JSNA data, there were a total of 3,022 people with learning disabilities (all ages) registered with GP practices within the boundaries of BOB (Oxfordshire) Integrated Care Board. There is no reliable data about heritage of these individuals readily available. What can be reported is that 92% of the reviews undertaken were on those with a white British heritage, this compares to the general local populace being 64%.

Ethnicity

The table shows the ethnicity breakdown of the people whose lives and deaths we reviewed this year.
It has not been possible to draw any conclusions from this analysis.

One limitation of this data is that only 4% of those deaths reviewed were of a non-white British heritage and 2% did not have a record or heritage in records provided by providers.

In 2021-22, the percentage of white British cases was 94%, Asian cases was 4% and not stated made up the remaining 4%

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	41	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1
% of all reported deaths	94	0	0	2	0	0	0	0	2	0	0	0	0	0	0	0	0	2

Deaths of People in our area:

Pen Portrait 1 – Supporting family engagement

Cara was a 78 year old who lived in a supported living facility. She was very close to the support staff and had an active social life, going out for coffee and socialising with housemates. She lived in this facility for 35 years and felt very much at home there.

Cara had family living overseas who she was in regular contact with, including their sister who, prior to COVID, would visit 4 times a year and stay connected via telephone on a weekly basis. Family was very important to Cara; she had photos of special people around her house and her family was actively involved in conversations about Cara's care and wellbeing.

During the pandemic, Cara found it difficult to understand why she could not leave the house and go about normal activities, such as going for coffee with housemates. The provider was able to install a large screen in the home so that Cara could see her family and speak to them. This helped Cara feel connected to their family and offered reassurance.

When Cara was diagnosed with metastatic cancer, conversations about her care took place with the medical team as well as her sister. Cara's sister was able to help Cara's voice be heard and share what her wishes would be, including her wish to die at home and avoid hospital.

Cara was well supported to access technology which would support them to stay in contact with the people important to them. The family were kept informed at a difficult time and the provider made every effort to assist communication.

Cara's review showed:

- How important it is for people with learning difficulties to be facilitated to maintain connections with their loved ones.
- The value added by families being involved in conversations about care and support.
- How utilising new technology can improve quality of life, whatever age the person is.

Deaths of People in our area:

Pen Portrait 2 – Supporting patient's wishes to remain in their own home

Dave was a 54-year-old who was provided a live in care package for himself and his siblings. Following the death of his parents, two of the siblings moved into supported living but Dave and his sister remained in the family home, as was their wish. He was described as a 'charming gentleman who really loved his family'.

It was important to Dave that he be supported to continue living in his own home. He had social time at his day centre where he would see his brother and enjoyed walking his dog and watching his television.

A care package was provided for the Dave and his sibling which included support in tasks such as meal preparation and domestic duties. Later in life, and after a 2-month long hospital admission, this was progressed to a live in care worker who would support with personal care, medication and PEG feeding. Dave frequently saw his GP, attended annual health checks, and had a health action plan produced. Transport to the GP practice was normally facilitated by the day centre but during COVID this was not possible. The GP organised for the District Nurse to attend a home visit, which supported his wish to stay at home.

What we learnt:

- The importance of appropriate discharge planning. Dave returned home with further limited mobility and it is thought he should have been supported during his admission to mobilise. This would have possibly given him more independence when he returned home.
- The wellbeing benefits of being supported to stay at home, if that is the wish of the person. Dave was described as happy, charming man and was very relaxed and comfortable in his home.
- Reliance on a day centre service to access primary care was not sustainable through COVID and it would have been beneficial to have a contingency plan for occasions the day centre was unable to provide this. Had Dave had face to face appointments when necessary with his GP over COVID, management of his diabetes could have been improved.

Pen Portrait 3: The value of friendship and community

Michael was an 81 year old man with a severe learning difficulty. However, other than management of diabetes he did not require much medical care. Michael was diagnosed with Prostate Cancer after a long and healthy life. Michael was supported to die at home in his own bed. Following his death the GP wrote a letter of commendation to the support staff for their ‘exemplary care’.

Michael was supported throughout his life to maintain strong relationships with those he cared about. He was able to live with his family for a long period of time before moving into supported living but maintained a strong relationship with his sister and her partner.

In the supported living facility he was supported to take part in holidays and learning new skills, such as swimming. Michael developed strong friendships with his housemates and was supported to engage with them outside the home, even when Michael’s care needs changed. This included attending a day centre, visits to coffee shops and regular visits to the pub where he would have a pint and a meal. Michael was described as having many friends including a special friend called Karen. He was supported to meet up and keep in touch with Karen throughout his later life.

Michael was also supplied with all the equipment he needed to keep him safe and comfortable when his condition progressed. This included a pendant alarm, bed sensor and hospital bed with air pressure relief mattress. He also had a hoist for moving from the bed to his wheelchair, which his carers were trained to use. He had 1:1 care provided and his carers learnt how to read Michael’s expressions to respond to his needs. Michael had enjoyed gardening and growing vegetables in the garden and later in life was supported to spend time in the garden and eat his meals out there.

What we learnt:

The importance of person centred care and understanding the people we support on a personal level.

The value of supporting those we care for to maintain contact with significant people in their life as well as supporting them to continue activities they enjoy.

IMPACT- some quotes from families and carers

"He was loved at the care home and that he felt safe and that is all I wanted. Just before his 80th birthday the care home had a party for him which he really enjoyed."
- Quote from deceased person's family member

"One of the OUH doctors was ambivalent about my sister's care, but she was transferred to another medic, and he was fantastic. We were supported to think about her end of life and where this was best met. I also praised the emergency services for their care and treatment of my sister on her last day."

- Quote from a deceased person's sister

"The GP felt that lots of adjustments were made to facilitate his access to health care. He was surrounded by carers who knew him very well and could often tell if he was unwell or had an infection."

- GP Feedback

"Their own GP care was excellent and were able to give more time for the end of life discussion in terms of best treatment options."

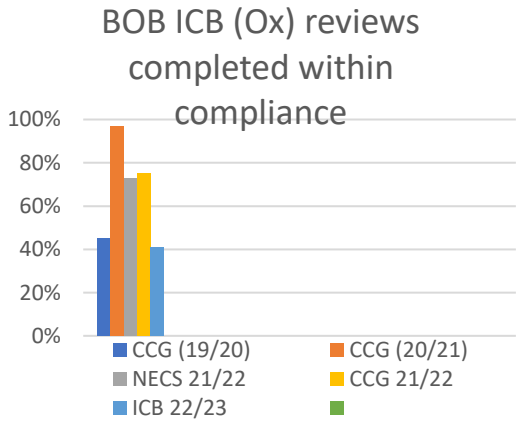
- Family feedback

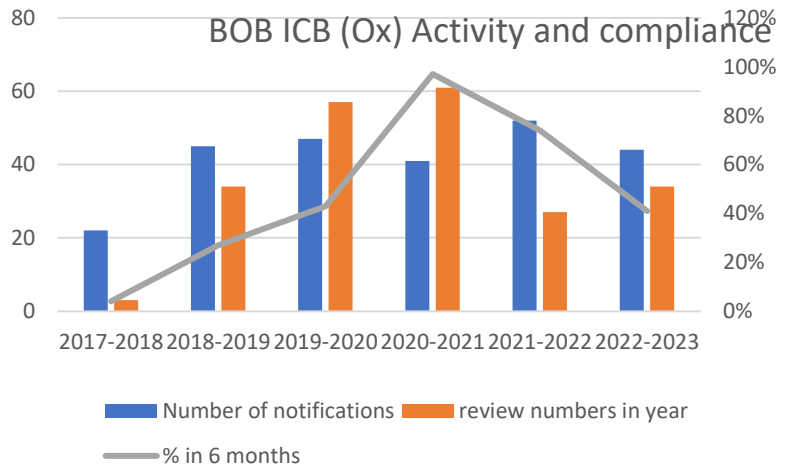
"Mr. W remains very complimentary of the care that his brother has received and he feels the staff has gone above and beyond to ensure he remained comfortable in familiar surroundings during his end-of-life care."

- Quote from deceased person's brother

Data Set: Performance

	Notifications No. & %		Completions No. & %		Focussed Reviews	% of all Reviews completed within compliance:
2020/21	41		61		5	97
2021/22	52		27		7	74
2022/23	44		34		6	41





Performance:

All data reflects Oxfordshire not the full ICB

- 44 notifications in the year 1 April 22 - 31 March 23.
- 34 reviews completed this year (including some cases from previous years). (UoB platform closed to review access 1 March, NHS Digital platform opened in June 2021).
- 41% of the reviews were completed within six months of notification. This reduction is largely due to long-term absences within the team and the increased workload which resulted.

Local Reviewer arrangements

- The Oxfordshire Safeguarding team, within the ICB, has been coordinating the review process supported by the OSAB business unit In 2023-2024 this is changing to new arrangements following the ICB restructure. The coordination will move to the BOB quality improvement manager.
- Provider teams and support organisations all contribute records and information, which is centrally collated and written up ready for the reviewer.
- The reviewer is responsible for contacting the family and carers, ensuring their contribution is integrated with the review documentation, undertaking the analysis and identification of learning points.
- In 2022-23, 100% of reviews were completed by BOB ICB reviewers, all from within the Quality Directorate Safeguarding team. The reviewer profile includes frontline staff and these in the past have been found to contribute effectively, offering real time learning. This year they have been focused on supporting care provision.

Data Set: Demographics, Age(local data)

All Adults with learning disabilities who died in 2022-2023:

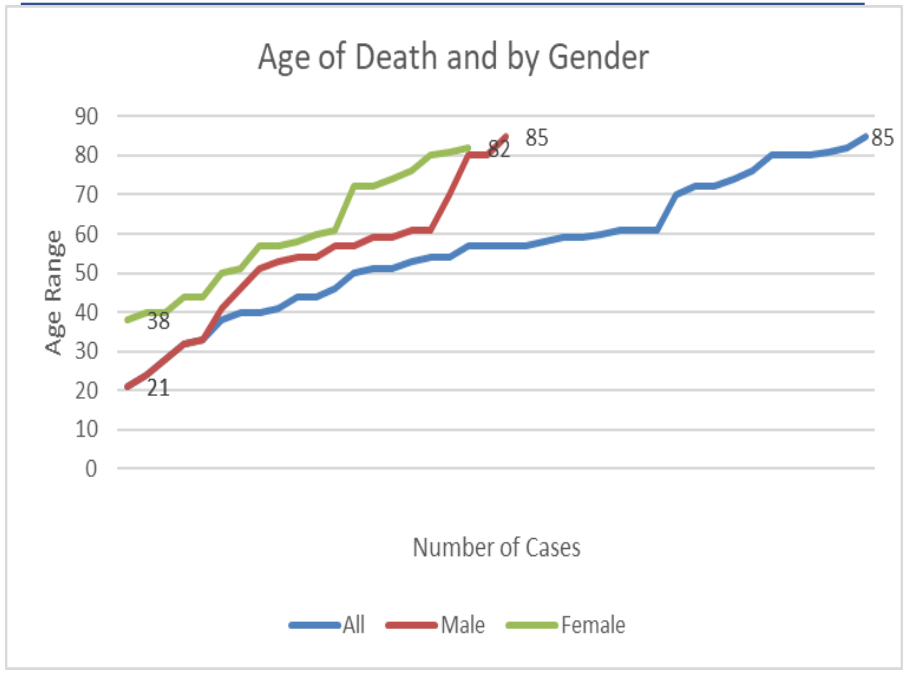
- There was a total of 40 deaths
- The range of age at death was 21 – 85
- The mean average age of death was 56
- The median average age was 57

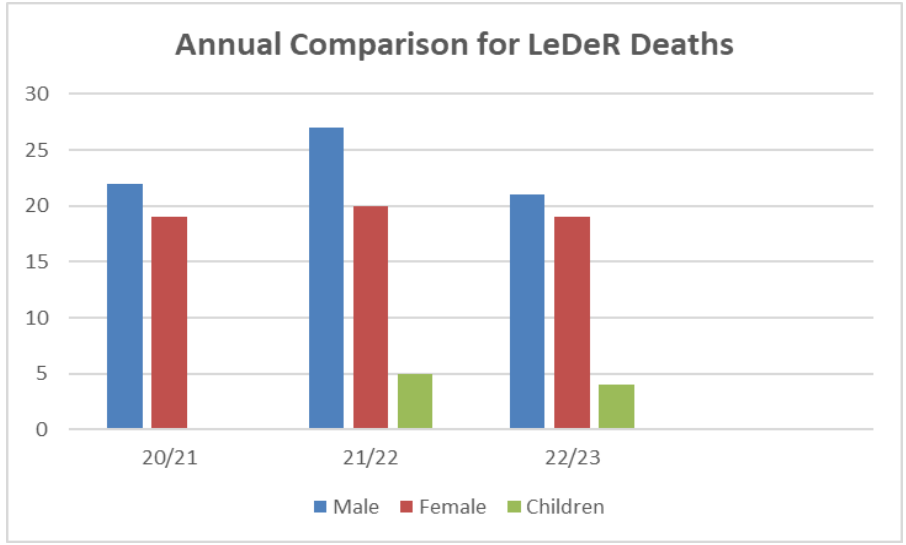
Women with learning disabilities who died in 2022-2023:

- There was a total of 19 deaths
- The range of age at death was 38 – 82
- The mean average age of death was 60
- The median average age was 58
- Female life expectancy in the general population of UK is 83 (2021 data).

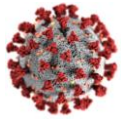
Men with learning disabilities who died in 2022-2023:

- There was a total of 21 deaths
- The range of age at death was 21 – 85
- The mean average age of death was 53
- The median average age was 54
- Male life expectancy in the general population of UK is 79 (2021 data).





All Adults with learning disabilities who died from confirmed or suspected COVID-19 in 2022-2023:



- There was only 1 death attributed to Covid

All deaths related to COVID-19 were reviewed and all care provision was provided according to family and personal wishes. Respiratory specialist support was offered in all cases.

Comparative data from the past three years is not showing significant differences in relation to median age of death. Small numbers result in any statistical differences being difficult to establish but in the future, it is anticipated that the larger BOB ICB data set may enable this to be analysed more thoroughly.

Children with learning disabilities who died in 2022/2023:

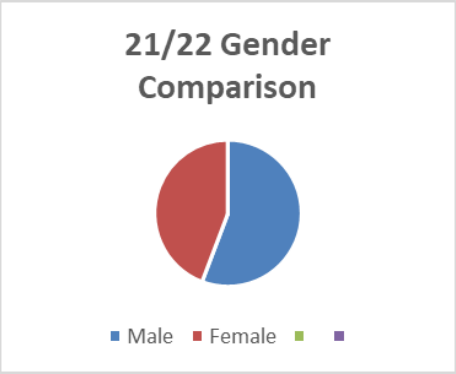
- There was a total of 4 deaths
- The range of age at death was 14 – 16
- The mean average age of death was 15
- The median average age was 15

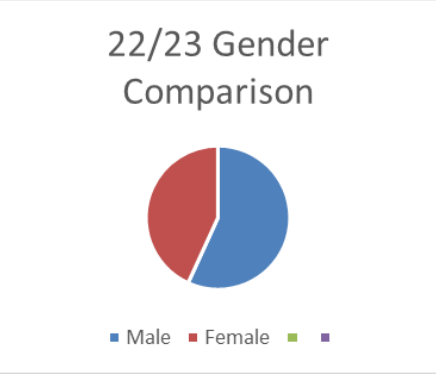
Data Set: Demographics(from local data)

- **Gender**

Gender variance is very similar this year to last year. This is in line with those registered on GP lists.

	2021/22		2022/23	
	Male	Female	Male	Female
No.	29	23	25	19
%	56	44	57	43





In both genders the age of death remains below the average in the general population. It is lower than last year due to there being four under 18s who died in this year with complex conditions. All of those under 18 who died were believed to have exceeded their life expectancy.

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

Those living with a learning disabilities have a wide range of skills, abilities and capabilities. Their requirement for any support or assistance to live their lives to the full is diverse. A scale is used to assist in describing the severity of this disability. Local authorities and GPs have different registers and locally both are used to identify the understanding of support needs for an individual.

A person who is said to have a **mild learning disability** is usually able to hold a conversation, and communicate most of their needs and wishes. They may need **some** support to understand abstract or complex ideas. People are often independent in caring for themselves and doing many everyday tasks. **Moderate disability** is defined as observable delays in the development of speech or motor skills, which may be accompanied by physical impairments. Individuals with moderate disability possess basic communication skills and are able to maintain self-care.
Someone who has a **severe learning disability** will have little or no speech, find it very difficult to learn new skills, need support with daily activities such as dressing, washing, eating and keeping safe.
A profound and multiple learning disability (PMLD) is when a **person has a severe learning disability and other disabilities** that significantly affect their ability to communicate and be independent. Someone with PMLD may have severe difficulties seeing, hearing, speaking and moving.

Level of Learning Disability	21/22 No (27)	22/23 No (34)
Mild	7	8
Moderate	6	7
Severe	6	11
Profound/Multiple	1	2
Unknown	7	6

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.

The unknown cases were due to the detail not being established following the new forms and process. Subsequently, all reviewers are asked to confirm the level of LD as part of their review.

Data Set: Cause of Death.

- **Cause of Death**

The most common cause of death this year was Cancer.
The number of deaths from this was 7 which is 21% of all deaths 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	Cancer	1	Cardiac
2	Cardiac	2	Learning Disability
2	Dementia	3	Epilepsy
3	Pneumonia	3	Downs Syndrome
3	Respiratory Failure	3	Renal

For the first time since commencing LeDeR reviews, cancer has become the leading cause of death, with cardiac causes being the top secondary cause. Respiratory illness remains very prevalent, however the potentially preventable causes of death have altered in this year.

- **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

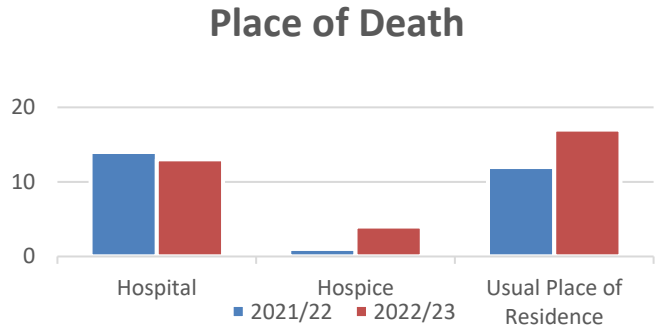
The DNACPR decision-making process should always take account of the benefits, risks and burdens of CPR and consider the individual person's wishes and preferences, the views of the healthcare team and, when appropriate, those close to the person.
Hospital trusts and other providers are legally obliged 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 several systems, considering 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. This remains a focus for reviews to assess the use of this decision-making process.

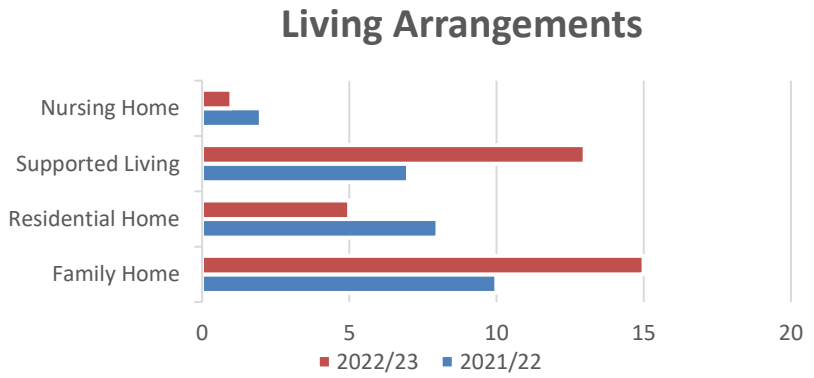
Of the 34 completed reviews during 2022/23, a DNACPR was recorded in 17 cases (50%)
In 10 situations they were identified as being completed and followed correctly.
No evidence was found of any care restrictions or altered pathways for these individuals than would be expected from any other population group.
Conversations with next of kin were seen to have taken place in all cases, although some families found the conversation inappropriately timed.
In 14 situations it was reported that there was no DNACPR in place for the individual who died and all treatment was offered appropriately.

Data Set: Place of Death and Living Arrangements

In 2022-2023 more examples were seen in which an individual living with a learning disability was offered alternative end of life locations compared to previous review data. Fast track palliative care assessments resulted in families and individuals being offered a wider range of end-of-life options. Families have been very complimentary of this service when it has been used.



Place of Death				
	2021/22		2022/23	
Hospital	14	52%	13	38%
Hospice	1	4%	4	12%
Usual Place of Residence	12	44%	17	50%



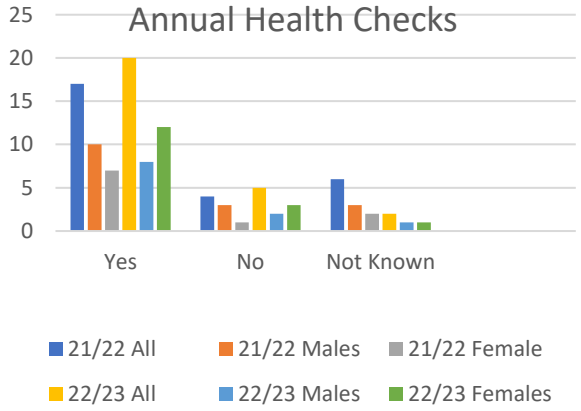
Living Arrangements				
	2021/22		2022/23	
Family Home	10	37%	15	44%
Residential Home	8	30%	5	15%
Supported Living	7	26%	13	38%
Nursing Home	2	7%	1	3%

The range of living arrangements reflects the diversity of settings in the local area. In 2022-2023 there will be more care consideration of the support and advice provided to those living in family homes, which on the cases seen this year were very limited

Data Set: Cause of Death.

- **Annual Health Checks**

Table and chart below show the number of annual health checks completed in 2022-2023. There continues to be lack of cross referencing between GP based annual health checks and provider/ care health action plans, which results in actions and activities not always being mutually understood or completed, such as screening.



Annual Health Checks Completed in Last 12 Months				
	2021/22		2022/23	
Yes	17	63%	20	74%
No	4	15%	5	18%
Not Known	6	22%	2	8%

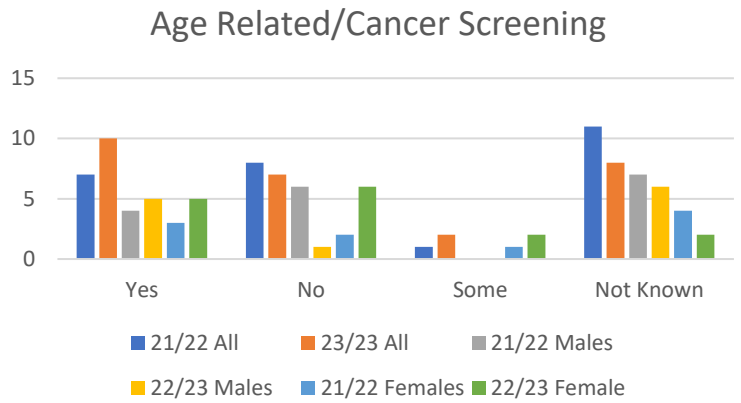
During the year linked to assessing proactive health action plan and national requirements data on how many had retinal screening patients with LD and diabetes. Numbers of patients included in the sample for some practices are low but the summary in the past 12 months

Across Oxfordshire of those living with a learning disability there are
- 28% of those with type 1 diabetes have had retinal screening
- 33% of those with type 2 diabetes have had retinal screening

This will be part of the action plans for improvement in 2023-2024.

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

Age related screening completion remains low, and in 2022-2023 needs to be more closely assessed to consider the reasons why age appropriate screening is either not offered or not taken up.
Offers of screening are nationally generated, these letters are not in easy read or basic format. Additionally, local sites do not review any information prior to appointments about whether an individual may require any reasonable adjustments. This finding has been feedback to the national team.



Age Related/Cancer Screening				
	2021/22		2022/23	
Yes	7	26%	10	37%
No	8	30%	7	26%
Some, but not all	1	3%	2	7%
Not known	11	41%	8	30%

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

Noted to have been good links and conversations about best interests as health deteriorated. Planned and supportive palliative care package put in place

Since this death, the provider has rolled out employee wide training for Dysphasia and how to safely implement SALT support for all clients.

Family and carers worked together with GP to find the best pain management plan for patient.

End of life plan made with individual and support team. All of her wishes were met. Although unable to die at home, her wishes for a cremation and the specifics of where her ashes were to be scattered were adhered to.

Locum SW acted as a voice for patient by way of communicating with the GP and provider to ensure positive outcomes.

Paramedic team liaised with GP and hospital, to assist in decision making.

LeDeR Project: Health Resources Online

Funding from NHS England to improve and support local service development projects awarded. Project commissioned in March 2022, due for completion October 2023

Building on the successful "Wednesday At One" series and other excellent materials and activities already in place create an online accessible health resource portal

Aim: to create a resource that meets the information needs of a range of individuals, families, support staff and people with learning disabilities and autism, which is Easy to Find, Easy to Navigate and Easy to Read

Initiated in Oxfordshire and extended into a joint project with Berkshire West in May 2022. Links into the Physical Health Strategy and identified local expertise from all providers. Who all assisted in scoping resources.

A co-production project coordinated by Oxfordshire Family Support Network (OxFSN) with My Life My Choice and many other teams, now involved in testing the online site.

The platform launch is planned for November 2023. It will be hosted and maintained by OxFSN, with all project partners committing to maintaining and sharing updated links and resources as they develop.

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

Family proactive support and needs assessments are required to fully understand the issues a family is living with and offer appropriate support.

Active communication to plan and support transfers of care is required so all fully understand the needs and can confirm they have the skills to offer the right care.

Transition must be a planned and structured process that promotes a shared understanding of issues risks and needs.

Ensuring suitable number of staff on site to support clients to ensure they are safe and their particular needs are met

Review of waiting lists, to ensure patients on these lists are contacted to review their needs.

Use of advocate nursing service to support patients while in hospital

Action from Learning: Local Priorities for delivery in 2022-2023 based on the learning from reviews locally and nationally