NHS
Dorset
Clinical Commissioning Group

NHS Dorset Clinical Commissioning Group

Learning Disabilities Mortality Review (LeDeR) programme – Dorset Framework

Supporting people in Dorset to lead healthier lives

PREFACE

The purpose of this Framework is to detail how the Learning Disabilities Mortality Review (LeDeR) programme is managed within Dorset.

As the LeDeR programme within Dorset evolves this Framework will be amended to reflect current practice.

A	SUMMARY POINTS
• The Learning Disabilities Mortality Review (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 Dorset, the programme is led and managed by NHS Dorset CCG but is delivered in conjunction with health and social care partners within the Dorset community.	

B	ASSOCIATED DOCUMENTS
• Adult and Children Safeguarding policy	

C	DOCUMENT DETAILS
Procedural Document Number	163
Author	Suzie Hawkins
Job Title	Patient Safety and Risk Manager/LeDeR Local Area Contact
Directorate	Nursing and Quality
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E	VERSION CONTROL				
Date of issue	**Version No**	**Date of next review**	**Nature of change**	**Approval date**	**Approval committee /group**
16.07.19	1	16.07.21	n/a	16.07.19	Directors Performance meeting

F SUPPORTING DOCUMENTS/EVIDENCE BASED REFERENCES	
Evidence	**Date**
Learning Disabilities Mortality Review (LeDeR) programme website (and included resources)	n/a
Valuing People - A New Strategy for Learning Disability for the 21st Century, Department of Health and Social Care	2001
CIPOLD (Confidential Inquiry into Premature Deaths of People with Learning Disabilities)	2013
Reviews of child deaths and the interface with LeDeR	Oct 2018

G	DISTIBUTION LIST		
Internal CCG Intranet	**CCG Internet Website**	**Communications Bulletin**	**External stakeholders**
✓	✓	✓	✓

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LEARNING DISABILITIES MORTALITY REVIEW PROGRAMME
DORSET FRAMEWORK

1.0 RELEVANT TO

1.1 The overall aim of the Learning Disabilities Mortality Review (LeDeR) programme is to drive improvement in the quality of health and social care service delivery and to help reduce premature mortality and health inequalities.

1.2 This framework is therefore relevant to all operational and frontline health and social care staff within Dorset.

2.0 INTRODUCTION

2.1 The LeDeR programme was established in 2015 as a response to the recommendations from the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD, 2013). CIPOLD reported that people with learning disabilities are three times more likely to die from causes of death that could have been avoided with good quality healthcare.

2.2 The programme has developed and rolled out a review process for the deaths of people with learning disabilities. The programme aims to help:

- identify what works well to support people with learning disabilities to live long and healthy lives;
- identify factors which may have contributed to deaths of people with learning disabilities so that changes can be made to reduce the impact of these factors;
- develop action plans to make any necessary changes to health and social care services for people with learning disabilities.

2.3 The LeDeR programme collates and shares the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

2.4 Each local area has a designated ‘Local Area Contact’. Within Dorset, the Local Area Contact is employed by NHS Dorset CCG. The role of the Local Area Contact is detailed within Section 6.

2.5 More information about the programme and the review process can be found at: http://www.bristol.ac.uk/sps/leder/about/

3.0 SCOPE

3.1 The LeDeR programme ensures that the deaths of people with learning disabilities aged four years and over are reviewed, irrespective of whether the death was expected, the cause of death or the place of death.

3.2 The LeDeR programme has been established to support local areas to review deaths of people with learning disabilities, and to use the lessons learned to

make improvements to service provision. The LeDeR programme is not an investigation. If, during or after a review of a death, the Local Area Contact has concerns which have not or cannot be addressed within the scope of the LeDeR review process, the Local Area Contact will recommend to the appropriate organisations/bodies the need for a fuller investigation (e.g. Adult Safeguarding Review).

3.3 The LeDeR programme works closely with other existing mortality review processes. More details regarding this close working can be found in Section 8.

3.4 A wealth of information regarding the LeDeR programme can be found on the LeDeR programme website: http://www.bristol.ac.uk/sps/leder/.

3.5 This Framework does not seek to duplicate this information, but to:

- detail the governance and operational arrangements specific to Dorset;
- provide 'signposting' to existing LeDeR information.

4.0 PURPOSE

4.1 This Framework sets out how the LeDeR programme operates within Dorset, and the individuals, teams and groups/committees key to the delivery of the programme.

4.2 The University of Bristol may potentially cease as a supporting function in the future. This framework is therefore an enabling document to allow NHS Dorset CCG and partners to embed the programme within Dorset, the aim of which is to achieve sustainable structures and systems beyond the life of the central delivery team in Bristol.

4.3 To assist in achieving this aim, this framework also outlines the governance structures that NHS Dorset CCG links with, including adult and child safeguarding arrangements and Child Death Overview Panels (Section 8).

5.0 DEFINITIONS

5.1 This procedural document is a 'framework' as it is a broad overview which supports a particular approach to a specific objective.

5.2 The LeDeR programme uses the definition of learning disabilities provided in the 2001 White Paper "Valuing People". For more detailed information about this definition: Briefing paper 1 - What do we mean by learning disabilities.

5.3 A basic definition of a learning disability is as follows:

A person with learning disabilities will have:

- *A significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence) and*
- *A reduced ability to cope independently (impaired social functioning)*
- *Which started before adulthood, with a lasting effect on development.*

(Valuing people, Department of Health and Social Care, 2001)

6.0 ROLES AND RESPONSIBILITIES

University of Bristol

6.1 The LeDeR programme is delivered by a team based at the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It is a support and analysis function. The responsibility for oversight of ongoing structures that facilitate the review of deaths in Dorset, sits with the Director of Nursing and Quality, NHS Dorset CCG.

Director of Nursing and Quality, NHS Dorset CCG

6.2 The Director of Nursing and Quality, NHS Dorset CCG holds Director-level responsibility for the LeDeR programme within Dorset. The Director of Nursing and Quality assigns the day-to-day operational management of the programme to the Dorset Local Area Contact.

Local Area Contact

6.3 The Local Area Contact (and their team) is the link between the LeDeR programme team (in Bristol), the regional Steering Group and the locally delivered programme. Their role is to work in partnership with the Bristol-based LeDeR team and is responsible for:

- receiving notifications of deaths;
- identifying and organising the training of local reviewers;
- allocating cases to local reviewers;
- monitoring the progress and completion of reviews to ensure that they are of a consistent standard and completed in a timely and comprehensive way;
- providing advice and support for local reviewers as necessary;
- attending the quarterly Pan-Dorset Mortality Review Group, as the Group acting as the LeDeR Steering Group in Dorset;
- chairing the quarterly Dorset Working Group and discussing any issues as appropriate;
- organising and chairing the quarterly Dorset Local Reviewers Group and discussing any issues as appropriate;
- chairing the monthly LeDeR Assurance Panel, receiving and signing off completed reviews and recommendations in agreement with the Assurance Panel members;
- anonymising and collating learning points and recommendations and sharing with health and social care providers.

6.4 Within Dorset, the role of the Local Area Contact is held by the Patient Safety and Risk Manager, NHS Dorset CCG. Colleagues within the Patient Safety and Risk team act as '**Secondary Local Area Contacts'** to support the Patient Safety and Risk Manager in their role.

6.5 The national role description for the Local Area Contact can be found via this link.

Local Reviewers

6.6 Local Reviewers are responsible for undertaking robust and high quality reviews of the deaths of people with learning disabilities and are integral to the success of the Dorset programme.

6.7 The role description for Local Reviewers can be found via this link.

6.8 To find out more about becoming a Local Reviewer, please contact the Patient Safety and Risk Team, NHS Dorset CCG on 01305 213599.

7.0 DORSET GOVERNANCE STRUCTURE

Regional Steering Group

7.1 The Regional Steering Group for Dorset is the South West Steering Group. During the pilot of the programme, Dorset was linked to the Wessex Steering Group however changes to the NHS England structure led to the alignment changing to the South West during 2018.

7.2 The Regional Steering Group meets quarterly and attendance by a member of the Dorset LeDeR team is mandatory.

Dorset Steering Group

7.3 The group which acts as the Steering Group for LeDeR within Dorset is the Pan-Dorset Mortality Review Group. The group meets quarterly, is Chaired by the Deputy Director of Nursing and Quality, NHS Dorset CCG and is attended by the Medical Directors for all NHS Provider organisations in Dorset.

7.4 The role of the Pan-Dorset Mortality Review Group is to monitor and develop the effectiveness of mortality review processes across health providers in Dorset, by bringing together representations from provider organisations and those with specific area of interest to share best practice, with the ultimate outcome to reduce avoidable deaths.

Dorset Quality Surveillance Group (QSG)

7.5 The Dorset QSG, which is Co-Chaired by the Director of Nursing and Quality, meets bi-monthly, systematically bringing together the different parts of the system to share information.

7.6 From 2019, a bi-monthly LeDeR Programme update will be submitted to the Dorset QSG, in addition to the latest LeDeR quarterly report.

7.7 Regarding sharing specific learning from one or more reviews, the Pan-Dorset Mortality Review Group (as the Dorset Steering Group) will refer learning to the Dorset QSG if and when required.

Dorset Working Group

7.8 The group which acts as the LeDeR Working Group within Dorset is the Joint LeDeR/Palliative Care for People with a Learning Disability (PCPLD) Network. This group meets quarterly, is co-chaired by the Local Area Contact and is attended by representatives from the NHS, Local Authorities, NHS Dorset CCG and third sector organisations.

Dorset Local Reviewers Group

7.9 All local reviewers are invited to meet quarterly in an informal, supportive and educational environment.

Dorset LeDeR Assurance panel

7.10 The Dorset LeDeR Assurance panel meets monthly to review and sign off completed reviews.

7.11 The Assurance panel can also request further investigation into certain aspects of reviews and/or further clarification prior to sign off.

7.12 During the sign off process, all reviews are graded a score, as follows:

Score	Score description
1	This was excellent care and met current best practice.
2	This was good care, which fell short of current best practice in only one minor area.
3	This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the person's wellbeing)
4	Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death.
5	Care fell short of current best practice in one or more significant areas, although this is not considered to have had the potential for adverse impact on the person, some learning could result from a fuller review of the death.
6	Care fell far short of expected good practice and this contributed to the cause of death.

7.13 The panel members are as follows:

- Patient Safety and Risk Manager/Local Area Contact;
- Patient Safety and Risk Facilitator/Secondary Local Area Contact;
- Patient Safety and Risk Support Officer/Secondary Local Area Contact;
- Named GP Safeguarding Dorset CCG;
- Commissioner, Learning Disabilities, NHS Dorset CCG.

7.14 During the review closure process, the Local Area Team:

- complete the internal LeDeR Assurance panel checklist;
- notify the reviewer that the review has been closed and thank them for their contribution to the LeDeR process. Feedback is given regarding the review and if required, are asked to add/amend any recommendations added during the Quality Assurance panel;
- ask the reviewer who they wish the findings from the review to be shared with, for example the family/relatives/carers, and others they spoke to whilst undertaking the review;
- share the learning with the individuals identified by the reviewer (as above);
- routinely contact the GP practice(s) where the individual was registered to share learning;
- routinely contact the individual(s) who notified LeDeR of the death and the learning from the review.

Terms of Reference

7.15 The Terms of Reference for the meetings listed above are available from the Dorset Local Area Contact.

8.0 LINKS WITH OTHER MORTALITY REVIEW PROCESSES

8.1 The purpose of the LeDeR reviews is not to hold any individual or organisation to account. Other processes exist for that (e.g. safeguarding), including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation. It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them.

8.2 In order to do this in a timely manner, to avoid duplication and to ensure there is no additional distress to the relatives of the individual, reviewers need to be clear where and how the LeDeR process links with other reviews or investigation processes.

8.3 Other investigations or reviews may include, for example:

- Serious Case Reviews (SCRs);
- Safeguarding Adult Reviews (SARs);
- Safeguarding Adults Enquiries (Section 42 Care Act);
- Domestic Homicide Reviews (DHRs);
- Mental Health Homicide Reviews (MHRs);
- Serious Incident Reviews;
- Coroners' investigations;
- Child Death Reviews.

8.4 A briefing paper from the LeDeR Programme on working with other investigation and review processes can be viewed via this link. This paper outlines the remit of other review or investigation processes and provides guidance to the LeDeR Reviewer as to the process to follow. In all cases, the key principles of communication, cooperation and independence should be adhered to.

8.5 A diagram illustrating how the LeDeR process links with the Child Death Overview Process (CDOP) and the individual mortality review processes within individual organisations can be viewed in **Appendix A**.

8.6 Specific guidance in relation to the interface with CDOP was published in October 2018 and can be viewed via this link.

9.0 ADDITIONAL INFORMATION/RESOURCE

9.1 As stated in Section 3, a wealth of information regarding the LeDeR programme can be found on the LeDeR programme website.

9.2 Below is a brief summary of some of the information available on the website, with the pertinent hyperlinks.

Notifying LeDeR of a death

9.3 Anyone can notify LeDeR of a death, including people with learning disabilities themselves, family members, friends and paid staff. Notifications can be made online via this link or by calling 0300 777 4774.

9.4 A poster about how to notify a death is available here. For printed copies, please contact the LeDeR team on leder-team@bristol.ac.uk or call on 0117 331 0686.

Initial and Multi-Agency Reviews

9.5 All deaths of people aged four years and over will receive an initial review. If any concerns are identified about the death, or it is felt that further learning could come from a fuller review of the death, a detailed, multiagency review will be held.

9.6 If there is any doubt whether a multiagency review is indicated, the reviewer should discuss the circumstances with their Local Area Contact, a member of the LeDeR programme team, or another senior level practitioner.

9.7 More information about the review process can be found via this link.

9.8 The Dorset Local Area Team have developed Terms of Reference, which are tailored to each review on a case-by-case basis, for Multi-Agency Reviews. These Terms of Reference are available from the Dorset Local Area Contact.

Information for families and carers

9.9 The review process involves the Local Reviewer contacting family members and/or carers to find out more about their life and the circumstances leading up to the death of their relative or friend. The information available to family and carers can be viewed via this link.

10.0 LEARNING

10.1 As detailed in Section 2.2, the programme aims to help:

- identify what works well to support people with learning disabilities to live long and healthy lives.
- identify factors which may have contributed to deaths of people with learning disabilities so that changes can be made to reduce the impact of these factors.
- develop plans of action to make any necessary changes to health and social care services for people with learning disabilities.

Identifying learning

10.2 As part of the assurance and sign off process, it is the responsibility of the Dorset LeDeR Assurance panel to ensure that identified learning from each review helps to achieve these aims.

10.3 The required 'outputs' of the reviews has changed throughout the duration of the LeDeR programme. The initial reviews required completion of a free-text 'recommendations' section. Later, the review template changed centrally to include an action plan with target date and people or organisations responsible for completing the action. During Q3 2018-19, the form changed again, removing the action plan requirement and reverting to requesting recommendations, however this time in a more structured way (as per the table below).

Identified Issue	Learning	Recommendation to address issue
e.g. Zack was discharged from hospital without the care home staff being trained in catheter care which led to him having a UTI.	*e.g. Nursing staff do not routinely assess specific skills of care home staff before discharge.*	*e.g. Hospital staff must be responsible for ensuring that the skills and capabilities of care home staff are such that they can provide appropriate care before the patient is discharged.*

Sharing local learning

10.4 The Local Area Contact collates and reports the recommendations of the reviews by 'theme' via the quarterly report. This report is sent to a wide range of mortality/learning from deaths, end of life, safeguarding and risk meetings across Dorset.

10.5 As an appendix of the quarterly report, cases which have scored '4', '5' or '6' (as per the scoring in 7.13) are shared as case studies with the associated learning. This can only be done in cases where permission has been given from the individual's family to share the learning in this way.

10.6 From May 2019, learning is also to be shared at the Pan-Dorset Joint Officers Group meeting attended by the Learning Disabilities Programme Lead, NHS

Dorset CCG and their counterparts within the Dorset Unitary Authorities. At this meeting, learning from LeDeR reviews can be linked to existing action plans, as well as identifying any new learning to be addressed.

10.7 Assurance and oversight of local learning is provided by the Dorset Steering Group. This group also provides support to the Local Area Contact and Working Group to affect wider-scale change.

Sharing national learning

10.8 In addition to local monitoring and oversight of recommendations, the University of Bristol collate and analyse summaries of the reviews to create a national, and regional, picture of issues that have arisen. This anonymised information provides an overview of potentially avoidable contributory factors associated with deaths, outlines good practice in preventing early deaths, and enables local areas to compare their experiences with other areas. Such national data collection will also enable improvements in service provision to be monitored over time and the resulting impact on mortality of people with learning disabilities.

11.0 FUTURE PLANS

11.1 Throughout 2018/19, the focus for the Local Area Contact was to imbed the agreed LeDeR governance structure and processes for managing the LeDeR workload.

11.2 The development focus for 2019/20 is:

Information on Dorset CCG website	A dedicated LeDeR page is to be developed on the website of NHS Dorset CCG. A link to this Framework, and easy read information about LeDeR, will be available on this web page.
Easy read information	Easy read information is to be developed about the LeDeR programme, this Framework and the quarterly report findings.
Advocacy and user involvement	It is acknowledged that links with user/carer involvement and advocacy groups need to be developed, particularly in relation to oversight and input into completed reviews at the Assurance Panel.
Learning event	Ideas for a Pan-Dorset learning event in early 2020 are in the early planning stages.

12.0 REPORTING

Reporting to NHS England

12.1 The Local Area Contact is required to submit a quarterly report to NHS England detailing the progress against Key Performance Indicators.

Reporting within Dorset

12.2 The Local Area Contact will produce a quarterly report for health and social care providers within Dorset detailing the progress of the programme and key learning. This quarterly report commenced in January 2019, and the first report covered Q3 2018-19.

12.3 As detailed in section 10.4, this report is circulated widely to interested groups, committees and meetings. To express an interest in receiving this quarterly report, please contact the Dorset Local Area Contact.

Annual reports

12.4 To date, the University of Bristol programme team have produced annual reports each year, detailing the national actions and learning. These reports can be viewed via this link.

12.5 It is recognised that the NHS Operational Planning and Contracting Guidance for 2019/2020 requires a local annual report to be submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews. The first Dorset report will be produced in April/May 2020.

13.0 TRAINING

13.1 The Local Area Contact and Secondary Local Area Contacts have received training from NHS England on the requirements and responsibilities of their role.

13.2 To undertake LeDeR reviews and become a 'Local Reviewer', specific online training (with supported face-to-face training as required) must be completed. Once this training has been completed, the individual will be given access to the LeDeR programme database through which reviews are managed.

13.3 No other LeDeR-specific training requirements have been identified, however work is on-going within Dorset to raise awareness of the LeDeR programme and the process for notifying the LeDeR programme of the death of an individual with a learning disability. This awareness raising is undertaken through meetings, groups, committees and on-line communications.

14.0 CONSULTATION

14.1 This Framework has been subject to consultation and has been reviewed (and commented upon where necessary) by:

- Members of the Pan-Dorset Mortality Review Group;
- Members of the LeDeR/Palliative Care for People with a Learning Disability (PCPLD) Network;
- All Dorset Local Reviewers;
- Named GP Safeguarding Dorset CCG
- Designated Nurse Consultant for Children, NHS Dorset CCG;
- Learning Disability commissioners, NHS Dorset CCG.

15.0 RECOMMENDATION AND APPROVAL PROCESS

15.1 The approval process for the LeDeR programme – Dorset Framework is via submission and subsequent approval by the CCG Executive team at the CCG Directors Performance meeting.

16.0 COMMUNICATION/DISSEMINATION

16.1 As detailed in Section 11, during 2019, a dedicated LeDeR page is to be developed on the website of NHS Dorset CCG. A link to this Framework, and easy read information about LeDeR, will be available on this web page.

16.2 Notice of issue of the first version, and any updated versions of this Framework, will be communicated via the quarterly report.

17.0 IMPLEMENTATION

17.1 As a Framework, this procedural document summarises the current arrangements for the management of the LeDeR programme within Dorset.

17.2 The aspects of the Framework that require implementation (at 21.05.2019; this may be in progress by the time the Framework is approved) are:

- a bi-monthly LeDeR Programme update to be submitted to the Dorset QSG;
- the development of a dedicated LeDeR page is to be developed on the website of NHS Dorset CCG.

18.0 MONITORING COMPLIANCE AND EFFECTIVENESS

18.1 As detailed in Sections 11 and 12, identification of learning, affecting change in practice and reporting progress are the key objectives of the LeDeR programme within Dorset.

18.2 The assurance and oversight of the effectiveness of the LeDeR programme within Dorset in achieving these objectives will be provided by the Dorset Steering Group.

19.0 DOCUMENT REVIEW FREQUENCY AND VERSION CONTROL

19.1 This Framework will be reviewed every two years to take account of any changes in national guidance. Necessary changes throughout the year will be issued as amendments to the Framework. Such amendments will be clearly identifiable to the section to which they refer and the date issued. These will be clearly communicated to those affected.

APPENDIX A

Notification and review of a death of an adult (18+) or child (age 4+) with a learning disability

CDOP process

- Immediate decision making and notifications
- Investigation and information gathering
- Child death review meeting
- LeDeR LAC or reviewer input
- Child death overview panel
- Consolidated form C uploaded to LeDeR system
- Case closed

NB: Every death of an adult with a learning disability that occurs in an NHS Trust should have a preceding SJR/or equivalent retrospective medical case notes review.

LeDeR process

- **Notify ideally within two working days via LeDeR website or phone**
- **Secure email**
  - Local Area Co-ordinator (LAC) to allocate reviewer
  - Reviewer to issue GP information request*
  - Reviewer to liaise with all other agencies to ensure sharing of relevant information
- **Reviewer** - speaks to involved professional for advice on how to approach the family sensitively
- **Reviewer** - contacts family, informs them of the process, seeks their input, and agrees nature and frequency of family updates
- **Reviewer** - collates information and completes documentation to LAC
- **Reviewer and LAC (as appropriate)** – decide if multi-agency review is required
  - **No multi-agency review**
  - **Multi-agency review**
- **QUALITY ASSURANCE: LAC and reviewer (as appropriate)** - discussion to identify gaps in information and agree any additional requirements
- **LAC** submits documentation to LeDeR
- **Case closed.** Final review documents collated by Bristol LeDeR team

POTENTIAL FOR OVERLAP

Individual organisation internal process

- **Death reported using internal mechanisms**
- **Organisation uses internal review mechanisms to conduct review.** e.g. structured judgement review (SJR) or equivalent
- **Review shared with LeDeR system**
- **Case discussed at internal mortality review (within eight weeks of death)**
- **Themes and learning discussed at directorate meeting**
- **Case presented at steering group meeting***
  - Learning and actions identified and service improvements implemented.
  - Service improvements subject to ongoing monitoring via steering group.
  - Family informed of outcome once review has been validated by steering group

Please note: Parts of a process marked with an * may be subject to regional variation. If in doubt consult your regional co-ordinator

APPENDIX B

EQUALITY IMPACT ANALYSIS

Service, Policy or Function	LeDeR
Version Number of EIA	001

Assessor's Name	Suzie Hawkins
Job Title of Assessor	Patient Safety and Risk Manager/LeDeR Local Area Contact
Date of Analysis	21 May 2019
Sponsoring Director/Lead	Vanessa Read, Director of Nursing and Quality
What are the main aims and objectives of the service, policy or function being assessed?	The overall aim of the Learning Disabilities Mortality Review (LeDeR) programme is to drive improvement in the quality of health and social care service delivery and to help reduce premature mortality and health inequalities.

INITIAL SCREENING

What evidence is available to suggest that the proposed service/policy/function could have an impact on people from the protected characteristics or staff?

The below scoring matrix was used/will be used to assess the potential impact.

Perceived Positive Impact	Perceived Neutral Impact	Perceived Disproportionate Impact
+	N	-
Positive impact on a large proportion of protected characteristic groups. Significant positive impact on a small proportion of protected characteristic groups.	No change/ no assessed significant impact of protected characteristic groups.	Disproportionate impact on a large proportion of protected characteristic groups. Significant disproportionate impact on a small proportion of protected characteristic groups.

If all elements of the service/policy/function are analysed as **Neutral Impact** or **Positive,** please proceed to sign off page at the end of the form.

If any element of the service/policy/function is assessed as **Perceived Disproportionate Impact**, continue with the Full Equality Impact Assessment

Protected Characteristic	Analysis + / N / -	Reason for Impact Analysis Provide recent evidence to demonstrate how people with the protected characteristic will be positively/adversely affected by service/policy/ function (*expand cell as necessary*)
Age	N	
Disability	+	The overall aim of the Learning Disabilities Mortality Review (LeDeR) programme is to drive improvement in the quality of health and social care service delivery and to help reduce premature mortality and health inequalities.
Gender Reassignment	N	
Marriage and Civil Partnership	N	
Pregnancy and Maternity	N	
Race/Ethnicity/Nationality	N	
Religion or Beliefs/Spirituality	N	
Gender Men, Women	N	
Sexual Orientation	N	
Staff	N	
Any Other Group *Rural Isolation, Military, Homeless*	N	

List of references – linked to evidence provided
Learning Disabilities Mortality Review (LeDeR) programme website (and included resources)
Valuing People - A New Strategy for Learning Disability for the 21st Century, Department of Health and Social Care
CIPOLD (Confidential Inquiry into Premature Deaths of People with Learning Disabilities)
Reviews of child deaths and the interface with LeDeR

Review of Analysis	
I am satisfied that this service/policy/function has been successfully equality impact analysed. There is no requirement to proceed to the Full Equality Impact Assessment.	
Signed by sponsoring Director/lead:	Vanessa Read
Job title of Director/lead:	Director of Nursing and Quality
Date signed:	18.06.2019