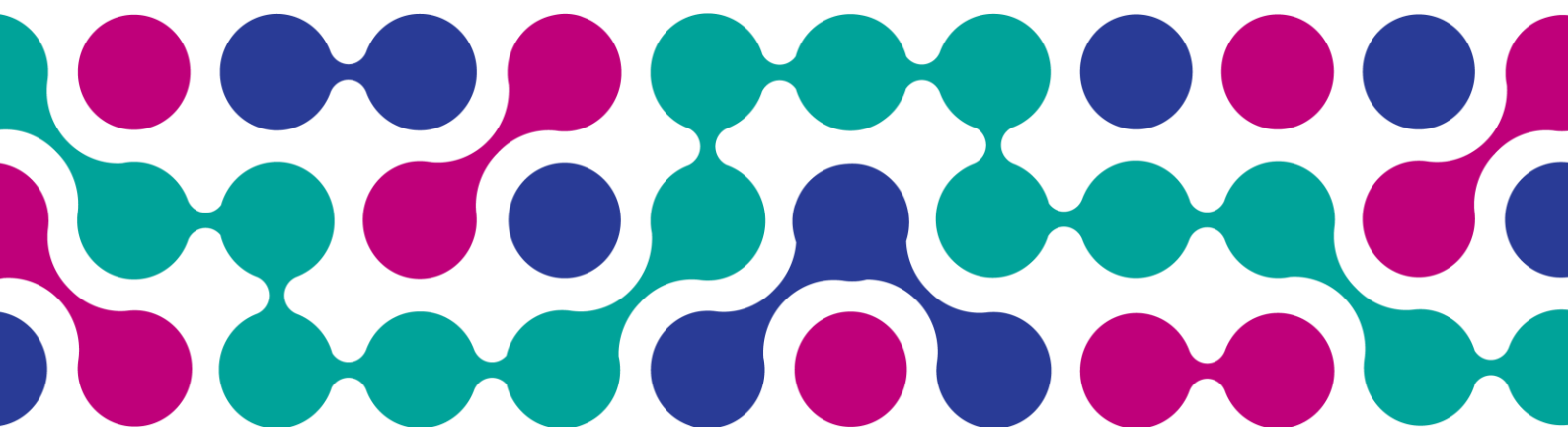


LeDeR Annual Report

Learning from lives and deaths – People with a learning
disability and autistic people

2024-2025

November 2025



| Information Reader Box | |
|--------------------------------|---|
| Directorate | Purpose |
| Community and Planned Care | Consultations |
| Corporate Affairs | Guidance |
| Delivery | Report |
| Finance, IT and Estates | Resources |
| Medical | Tools |
| Mental Health and Primary Care | |
| Nursing and Quality | |
| Place, CYP and LDAN | |
| Document Information | |
| Document Purpose | To provide an annual summary of LeDeR notifications and system actions taken by BSW ICB to reduce health inequalities for people with a learning disability and autistic people. |
| Document Name | Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB LeDeR Annual Report 2024–2025 |
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| Description | This report provides an overview of LeDeR notifications received in 2024–2025 and outlines actions undertaken across BSW to address health inequalities and improve outcomes. No full reviews were completed during this period due to transition and capacity factors. The report highlights ongoing system learning and improvement work. |
| Cross Reference | <ul style="list-style-type: none"> • BSW Integrated Care Strategy 2023–2028 • NHS England LeDeR Policy (2021, updated 2023) • BSW Learning Disability and Autism Delivery Plan |
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| Author | Reuben Collings, Clinical Operations Delivery Lead |

Opening Remarks

As the Clinical Lead for Learning Disability and Autism for BSW Integrated Care Board, I want to begin by paying my deepest respects to every person with a learning disability or who was autistic who has died during this reporting year. I also extend my sincere sympathies to their families, carers, and loved ones. Every life is unique and meaningful, and each loss deserves to be understood with care, compassion and accountability.

It is with deep regret that the ICB acknowledge we have been unable to complete LeDeR reviews this year. This reflects a lack of capacity in the local system, not a lack of value placed on the lives and contributions of those who have died. We are taking active steps to resolve this and remain committed to reviewing these deaths with the dignity and seriousness they deserve.

While the absence of reviews is a significant gap, this report also recognises the determined and progressive work taking place across BSW to address the stark health inequalities that continue to affect people with a learning disability and autistic people. Providers and system leaders across health and care have demonstrated leadership in embedding reasonable adjustments, strengthening neuroinclusive practice, and challenging systemic barriers to equitable care.

Importantly, our work is not driven by compliance but by values, ensuring our services recognise neurodivergence as a natural part of human diversity. True transformation means placing people with lived experience at the heart of every decision, shaping priorities, and holding the system to account.

As the NHS moves forward with system transformation under the 10-Year Plan, we must ensure people with a learning disability and autistic people are not left behind. Too often, this population is treated as an afterthought in wider strategic planning. That must change. True transformation requires that people with lived experience are at the heart of every decision, shaping priorities, designing services, and holding the system to account.

Our goal is a future where people with a learning disability and autistic people are seen, heard, and included from the outset, not added in later. That is how we will prevent avoidable deaths. That is how we will ensure longer, healthier, and more connected lives for all.



Reuben Collings RN QN

Clinical Operations Delivery Lead
for Learning Disability, Autism and Neurodivergence and LeDeR Local Area
Contact

Executive Reflection

Improving outcomes for people with a Learning Disability and Autistic people is at the heart of our BSW system commitments. We acknowledge that whilst we have not been able to undertake new LeDeR reviews, we continue to use the learning from previous reviews to support the transformation of our commissioned services with a focus on early intervention and prevention. This opportunity for reflection and learning will ensure that we are well prepared for future arrangements and guidance that may emerge from national reforms.

Meanwhile we are continuing to work with people with lived experience and our system partners to co-design new community pathways that will importantly align with the new neighbourhood health agenda. We will be ensuring reasonable adjustments are made to help people stay healthy in their local community whilst commissioning specialist support services for those who need it.

We are committed to our work continuing to embed the principles of the Learning from Lives and Deaths (LeDeR) Programme across all partner organisations.



Laura Ambler

Executive Director of Place for Bath and North East Somerset
Executive Lead for Learning Disability, Autism and Neurodivergence

Message from the Chief Nurse Officer

The LeDeR Annual Report again highlights the essential need to learn from deaths and incidents in which people with a learning disability or who are autistic have come to harm. It remains unacceptable that individuals in these groups are more likely to die prematurely, experience avoidable harm or receive a poorer standard of care than those without a learning disability or who are not autistic. The ICB has a clear mandate to improve health outcomes and reduce health inequalities, as set out within the NHS Oversight Framework 2025 to 2026. LeDeR supports this mandate by identifying systemic disparities, and we will continue to commission and deliver evidence based interventions and care pathways that improve outcomes for every person with a learning disability or who is autistic.

Although no reviews have been completed during the reporting period, learning has still progressed. This report outlines several initiatives and changes in service delivery that will support the improvements required.

My thanks go to everyone for their continued commitment and dedication to achieving the progress we are striving for.



Gill May

Chief Nurse Officer

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Executive Summary

This year, BSW Integrated Care Board (ICB) has continued to embed the principles of the Learning from Lives and Deaths (LeDeR) Programme across all partner organisations. The system remains committed to learning from every death of a person with a learning disability or autism. Key achievements include strengthened multi-agency governance, expanded community transformation through HCRG Care Group, development of The Kingfisher, a specialist mental health hospital for people with a learning disability and autistic people and improvements in acute, mental health, and ambulance services. The work across BSW continues to reflect our values of inclusion, equity, and accountability.

Introduction

This report sets out the position of BSW ICB in relation to the Learning from Lives and Deaths programme during the reporting year April 2024 to March 2025. It acknowledges the absence of completed reviews in the period but provides an account of the proactive measures taken to improve outcomes for people with a learning disability and autistic people.

The LeDeR programme, established in response to longstanding evidence of health inequalities and premature mortality, remains an important mechanism for learning and improvement. However, its future is currently being considered by NHS England and the Department of Health and Social Care as part of the wider NHS reforms. The ICB is therefore awaiting national direction before committing to future delivery arrangements.

In the meantime, we are clear that the values and principles of LeDeR, including recognising avoidable variation, addressing systemic discrimination, and ensuring that every death is treated with respect and seriousness, remain essential whether or not the programme continues in its current form. Current statutory and quality-driven mortality, incident, and safeguarding investigations continue in BSW, ensuring that learning is identified and acted upon without delay.

Governance and Strategic Context

During this reporting year, BSW ICB has continued to maintain oversight of the LeDeR function through its established Learning Disability, Autism and Neurodivergence (LDAN) Delivery Group. Following a change in role for Lynette Glass, responsibility for LeDeR is now with the Clinical Lead for Learning Disability, Autism and Neurodivergence, supported by a multi-agency steering group in collaboration with Local Authorities, Safeguarding Adults Boards, and system provider partners, ensuring that learning translates into operational and commissioning practice across health and social care.

The programme's governance has been integrated into the ICB's wider quality assurance processes, ensuring that notifications of deaths have been appropriately logged, triaged and monitored, even where a review could not be commenced. The LeDeR Programme reports directly to the Quality Outcomes Committee, ensuring clear lines of assurance to the ICB Board. We would like to extend our sincere thanks to Lynette for her leadership, professionalism and tenacity in taking the LeDeR programme forward across BSW, and for embedding a culture of learning, compassion and accountability that continues to shape the system's approach today.

The ICB's approach has been informed by national LeDeR policy and by the statutory duties of Integrated Care Boards under the Health and Care Act 2022, the Equality Act 2010, and the NHS Constitution. We have also ensured alignment with safeguarding and mortality oversight structures, and have taken into account the emerging expectations under the Patient Safety Incident Response Framework (PSIRF).

Should LeDeR not continue at a national level, it is the view of BSW ICB that its purpose and principles must be preserved through robust provider-level governance. This would require the integration of mortality review processes into PSIRF arrangements, ensuring that the deaths of people with a learning disability and autistic people are consistently considered within routine mortality surveillance, and that thematic learning is systematically identified, acted upon, and shared across the system.

Review Activity and Notifications

No LeDeR reviews were completed during this period. The reasons for this are multifactorial, including limited reviewer capacity, changes to national commissioning arrangements for the reviewer workforce, and the transition period linked to national policy review. All deaths notified to the ICB have been logged in line with NHS England processes, and cases have been triaged for potential future review should capacity or policy allow.

While the absence of reviews represents a lost opportunity for specific case-based learning, it does not mean that learning and improvement have stalled. The ICB has continued to apply historic LeDeR findings and national thematic learning to ongoing quality improvement work.

Historic LeDeR learning themes on aspiration pneumonia, constipation, diagnostic overshadowing, and the importance of reasonable adjustments continue to shape quality priorities and provider assurance work.

| Locality | LeDeR Notifications | Population (approx.) ¹ | Notifications per million population |
|------------------|---------------------|-----------------------------------|--------------------------------------|
| BaNES | 12 | 200,000 | 60 per million |
| Swindon | 24 | 230,000 | 104 per million |
| Wiltshire | 32 | 515,000 | 62 per million |
| BSW Total | 68 | 945,000 | 72 per million |

Table 1: LeDeR Notification Date 2024/2025 (Source: LeDeR Notification Platform)

During 2024–2025, BSW ICB received **68** LeDeR notifications, an increase from 53 in the previous year. The majority of notifications related to people with a learning disability, with most deaths occurring in adults aged between 18 and 64. There continued to be a slightly higher number of male deaths in Swindon, reflecting a consistent local trend, while gender distribution in BaNES and Wiltshire remained balanced.

Hospital settings were the most common location of death, followed by usual residence. The highest number of notifications were reported by the Royal United Hospitals Bath NHS Foundation Trust, followed by Avon and Wiltshire Mental Health Partnership NHS Trust, Great Western Hospitals NHS Foundation Trust, and Swindon Borough Council.

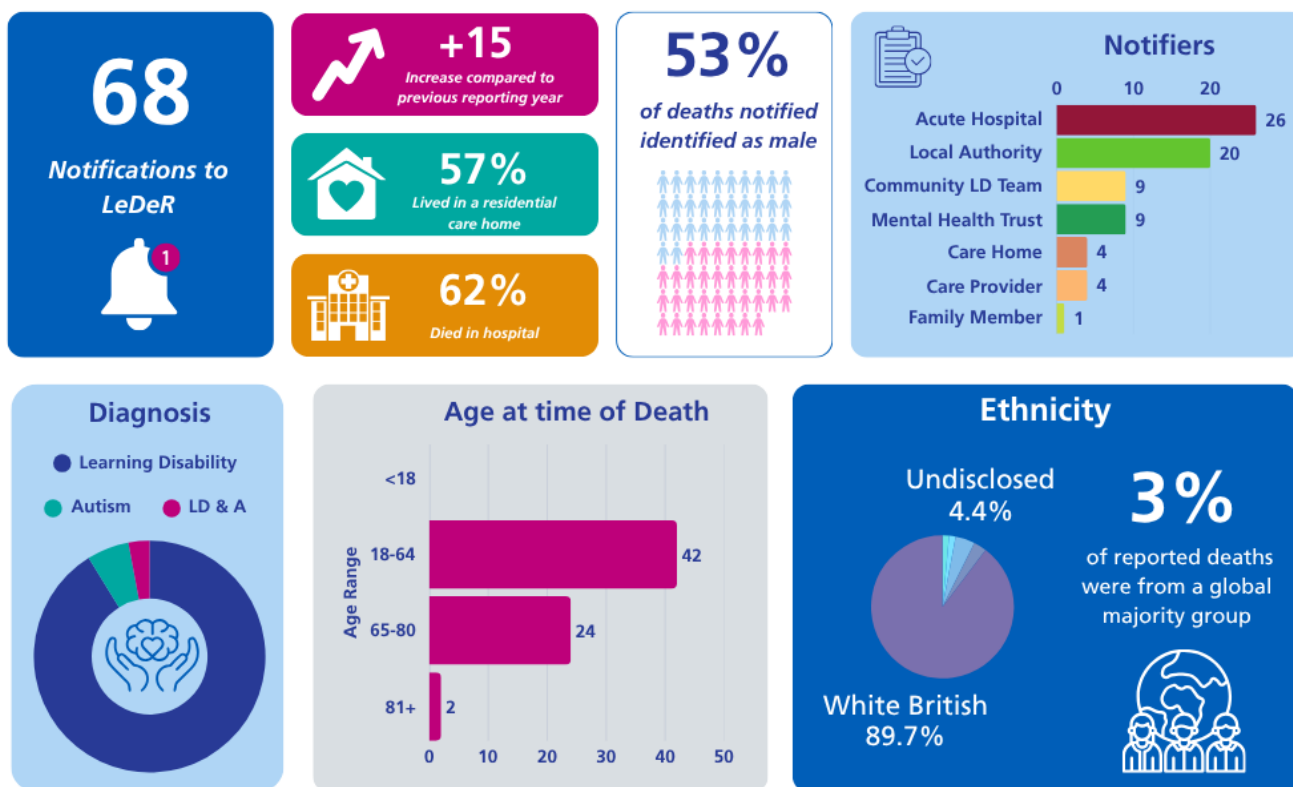
The continued rise in notifications highlights both improved recognition and reporting, and the persistent health inequalities faced by people with a learning disability and autistic people. This

¹ Office for National Statistics (2024)

report reaffirms BSW ICB's commitment to addressing these disparities with compassion, accountability, and collaboration across the system, ensuring that learning from every life continues to inform better care and outcomes.

NHS LeDeR Notifications Summary 2024/2025

Bath and North East Somerset, Swindon and Wiltshire



Data Source: LeDeR Notification Platform, NHS England

System-wide Improvement Work

Throughout 2024/2025, the ICB and its partners have undertaken a sustained programme of work to reduce health inequalities for people with a learning disability and autistic people. This has included embedding reasonable adjustments across primary, community and acute care, strengthening the visibility and accessibility of the Reasonable Adjustment Flag, and integrating this data into care coordination pathways.

The ICB has worked with providers to develop neuroaffirmative approaches to service delivery, recognising neurodivergence as a natural form of human diversity rather than a deficit. This has informed training, service design and communication strategies. Annual Health Check performance has improved in both uptake and quality, with a specific focus on younger people and, people from global majority backgrounds.

In acute care, providers have adopted hospital passports, enhanced liaison nurse functions and implemented audit tools to monitor compliance with best practice. The South West Regional Front Door process, in which BSW ICB plays a key leadership role, has introduced additional clinical oversight of specialist hospital admissions, ensuring that decisions are person-centred, proportionate and in the individual's best interests.

NHS Bath and North East Somerset, Swindon and Wiltshire ICB

Learning Disability and Autism Keyworker Service

The BSW Learning Disability and Autism Keyworker Service continues to play a pivotal role in reducing the risk of hospital admission for children and young people with complex needs. Keyworkers have strengthened proactive multi-agency case coordination, ensuring earlier intervention, improved family experience, and more consistent application of trauma-informed practice.

Recent learning has focused on embedding the Keyworker model within wider community mental health transformation, ensuring that escalation processes link directly to Dynamic Support Registers (DSRs) and Care (Education) and Treatment Reviews (C(E)TRs). Reflective practice sessions and family feedback have led to improvements in communication, documentation, and timely information sharing with education and social care partners. Outcome monitoring demonstrates early impact, with more consistent attendance at multi-agency reviews and fewer escalation cases requiring crisis intervention or reliance on inpatient care and treatment.

Partnership in Neurodiversity in Schools

BSW ICB has worked closely with local authorities and education partners to establish the **Partnership in Neurodiversity in Schools (PINS)** programme. This initiative supports schools to recognise and respond more effectively to the needs of neurodivergent pupils, reducing reliance on crisis referrals and promoting inclusion

Learning from LeDeR reviews highlighted the importance of early recognition of distress in educational settings and the link between school exclusion and later mental health deterioration. The PINS pilot has resulted in increased staff confidence in reasonable adjustments, improved access to early help, and strengthened escalation pathways to community LD/A teams. Ongoing evaluation is informing expansion and sustainability planning across all three localities. Evaluation findings will inform an expansion to a further 40 schools across BSW 2025/26, with an emphasis on sustainability and consistent access.

Dynamic Support Register

The Dynamic Support Register (DSR) is now fully operational across BaNES, Swindon and Wiltshire, with improved functionality and standardised processes for identifying and monitoring individuals at risk of admission.

Learning from LeDeR has informed enhanced oversight of reasonable adjustments, communication needs, and physical health concerns within the DSR framework. A structured data review process ensures that learning from C(E)TRs, mortality reviews, and quality assurance meetings is systematically reflected in the DSR and subsequent clinical actions. Recent developments include a procurement of a new digital platform to support live meeting management, action tracking, and automated reporting to improve continuity of care and transparency across agencies.

Care (Education) and Treatment Reviews (C(E)TRs)

C(E)TRs continue to be a cornerstone of BSW's approach to admission prevention and quality assurance for people with a learning disability or autism. Learning from LeDeR has reinforced the importance of family and expert-by-experience involvement, particularly in ensuring that communication, physical health, and trauma-informed care are explicitly addressed within reviews.

An internal audit of C(E)TRs has led to improved documentation standards and clearer escalation routes when recommendations are not implemented. The process is now aligned with the Patient Safety Incident Response Framework (PSIRF), ensuring that mortality learning and safety improvement work are interconnected.

During 2024–2025, the ICB established a C(E)TR Oversight Panel with representation from health, social care, education and lived experience partners. The panel reviews the quality and outcomes of C(E)TRs across BSW, ensuring that recommendations are implemented, themes are identified, and learning informs both commissioning and clinical practice. This has strengthened accountability, consistency, and shared understanding of what high-quality, person-centred reviews should deliver.

Assuring Transformation

BSW ICB maintains robust monitoring of inpatient data through the Assuring Transformation dataset, triangulated with DSR and C(E)TR intelligence. Learning from LeDeR reviews has strengthened the governance of inpatient oversight, particularly around discharge planning, consent, and Mental Capacity Act compliance.

Monthly inpatient oversight panels now include a focused discussion on systemic learning, ensuring that insights from deaths, near misses, and quality concerns are rapidly translated into service improvement actions. Collaborative working with NHS England South West has also improved regional consistency and assurance in reporting.

Annual Health Checks

BSW ICB has maintained a **75% target** for Annual Health Checks (AHCs), which was achieved across all localities during this reporting year. This reflects continued collaboration between Primary Care Networks, Community Learning Disability Teams, and partner organisations to promote equitable access and high-quality delivery.

Further work has been undertaken to develop and share communication materials aimed at increasing awareness and uptake, particularly among families and carers. Future priorities include enhancing the quality of follow-up actions arising from AHCs as part of Health Action Plans, improving access to wider health screening, and implementing sensory checks for children and young people in special schools during 2025–2026.

These actions support BSW's ongoing commitment to reducing health inequalities and ensuring that people with a learning disability and autistic people receive proactive, preventative, and person-centred healthcare.

Oliver McGowan Mandatory Training

The continued roll-out of the Oliver McGowan Mandatory Training (OMMT) across BSW remains a key part of the system's commitment to improving care for people with a learning disability and autistic people. BSW has achieved strong engagement from NHS providers, primary care, and social care partners, ensuring that staff receive the right level of training appropriate to their role.

The BSW Academy has been instrumental in coordinating the delivery of OMMT and embedding learning across the health and care workforce. Training evaluation has demonstrated increased staff confidence in supporting people with learning disabilities and autism, with measurable improvements in the application of reasonable adjustments.

The Transformational Training Partnership Award was presented to BSW ICB and Swindon Advocacy Movement for their delivery of the Oliver McGowan Mandatory Training. The award recognised the passion, teamwork, and commitment to true co-production within the training. Together, they have demonstrated that when people with lived experience lead training, the whole system becomes more inclusive, confident, and connected. Co-trainers sharing their lived

experiences have brought powerful stories to life, leading to genuine change in practice for our workforce and the people we support across BSW.

This work will continue under in 2025/26, ensuring sustained focus on embedding learning across the system.

Learning Disability and Severe Mental Illness Vaccination Project

BSW ICB's Learning Disability and Severe Mental Illness (LD/SMI) Vaccination Project aimed to improve vaccine accessibility, confidence, and uptake within vulnerable populations. Working closely with local authorities and care providers, vaccination hub teams offered on-site vaccination clinics, educational sessions, and training opportunities across BaNES, Swindon, and Wiltshire.

While engagement varied, learning identified that some settings declined offers due to perceived challenges around consent, highlighting the need for more personalised engagement and relationship-building with service managers. Events in Wiltshire and BaNES successfully combined vaccination delivery with wider health promotion through Making Every Contact Count (MECC) conversations and easy read health resources.

Future work will focus on developing co-produced, accessible vaccination education materials, piloting transport support in Swindon to improve accessibility, and embedding training within LD/SMI settings through a more tailored, person-centred approach. Collaborative planning with local authority partners and the BSW LDAN Commissioning Hub will ensure joined-up delivery and sustainability.

Learning has highlighted the need for relationship-based engagement with care settings and personalised support around consent and communication. These insights are informing future equitable vaccination delivery models across BSW.

Avon and Wiltshire Mental Health Partnership NHS Trust

AWP remains committed to improving outcomes for people with a learning disability and autistic people by reducing health inequalities and preventing premature mortality. The Trust's Mental Health, Learning Disability and Autism Improvement Group, led by the Deputy Chief Nursing Officer and Consultant Nurse for LD and Autism, provides governance and strategic oversight for this work.

Key workstreams include:

- **Workforce Development and Training:** Embedding LD and autism awareness across all staff training, promoting trauma-informed care, Positive Behavioural Support (PBS), and Green Light Champions in every team.
- **Service Accessibility and Reasonable Adjustments:** Implementation of a digital Reasonable Adjustment Flag, staff confidence-building, and audits to improve physical and communication accessibility.
- **Quality Assurance and Audit:** Annual Green Light Toolkit audits to benchmark progress and identify service improvements aligned to NHSE LD Benchmarking standards.
- **Reducing Restrictive Practice:** Expanding PBS and de-escalation strategies, and embedding **STOMP** principles to reduce over-medication.
- **Specialist Support and Clinical Pathways:** Ensuring timely access to LD and autism clinicians, integrated physical and mental health care, and clear crisis and complex needs pathways.

Recent achievements include successful delivery of Reasonable Adjustment Awareness Week (November 2024), which improved staff engagement and confidence, and the planned trust-wide rollout of PBS training using a train-the-trainer model for 2025/26. The latest Green Light Toolkit audit showed improved application of reasonable adjustments and access to specialist input, with ongoing work to strengthen cross-boundary collaboration and environmental accessibility.

AWP continues to align LeDeR learning with mortality surveillance and serious incident reviews, ensuring that lessons from deaths lead directly to quality improvements in care and safety across all services.

The Kingfisher

The Kingfisher represents a direct response to learning identified through the LeDeR programme, particularly in relation to timely access to specialist mental health care, reduction of restrictive practice, and the need for trauma-informed, person-centred approaches for autistic people and people with a learning disability.

Developed in partnership with BSW ICB, experts by experience, and system partners, The Kingfisher combines community outreach with specialist inpatient provision to support individuals at risk of hospital admission or placement breakdown. Its design reflects LeDeR findings that highlight the consequences of delayed intervention, diagnostic overshadowing, and insufficiently adapted care environments.

The service model prioritises:

- Early identification and proactive support to prevent crisis escalation.
- Skilled, multidisciplinary input led by clinicians experienced in learning disability and autism.

- Reduction of restrictive interventions through Positive Behavioural Support and trauma-informed care.
- Co-production with people with lived experience to ensure that care delivery reflects individual strengths and preferences.

The Kingfisher model is expected to reduce out-of-area placements and shorten lengths of stay through proactive community intervention and specialist outreach. Through this model, AWP and BSW ICB are operationalising LeDeR learning into everyday clinical practice, ensuring that people receive the right care, in the right place, at the right time.

Royal United Hospital NHS Foundation Trust

The Royal United Hospitals Bath NHS Foundation Trust has made significant progress in improving care for people with a learning disability and autistic people, embedding LeDeR learning into everyday clinical practice and workforce development.

Key achievements this year include:

- **Makaton training** launched Trust-wide, improving communication and inclusivity by equipping staff with skills to engage effectively with patients who use Makaton.
- **Learning Disability and Autism Champions huddles** held quarterly, focusing on autism awareness, early recognition of deterioration, mouth care, and advance care planning.
- **Appointment of a dedicated Learning Disability Nurse**, strengthening specialist advocacy and support for patients across hospital services.
- **Updated hospital and maternity passports**, developed with partners to ensure individual needs, communication preferences, and reasonable adjustments are clearly recorded and acted upon.
- **Introduction of learning disability and autism cards and posters** to enhance visibility, awareness, and identification across clinical areas.
- **Development of easy-read patient information**, including an end-of-life care guide, supporting accessible and compassionate communication throughout the patient journey.
- **Co-production of the Vulnerable People Strategy**, informed by people with lived experience, setting a clear vision for inclusive care and prioritising the development of dedicated Learning Disability and Autism strategies by 2026.
- **Promotion of Martha's Rule**, ensuring families and carers can raise safety concerns and access rapid review mechanisms when they feel a patient's needs are not being met.

These developments reflect the Trust's ongoing commitment to inclusivity, accessibility, and person-centred care. Through the implementation of LeDeR learning, RUH continues to

strengthen staff confidence, embed reasonable adjustments, and ensure that people with a learning disability and autistic people receive equitable, safe, and compassionate healthcare. The Trust plans to publish a dedicated Learning Disability and Autism Strategy in 2026 to sustain and expand this work.

Great Western Hospital NHS Foundation Trust

GWH continues to demonstrate a strong commitment to learning from LeDeR reviews, integrating findings into governance, training, and service improvement. The Trust reviews every death of a person with a learning disability or autism using LeDeR methodology, complementing structured judgement reviews and the Medical Examiner's process. Learning is reported quarterly and monitored through the Learning Disability and Autism Forum and the Maternity, Adult, and Children's Safeguarding Forum.

Local learning for 2024–2025 mirrors national themes, with aspiration pneumonia remaining the most common cause of death. Key areas for improvement identified through reviews include consistent application of the Mental Capacity Act, ensuring best interest processes are followed, improving diagnostic access for inpatients, and strengthening safe discharge planning.

Actions and improvements in response to LeDeR learning include:

- Development of an **adult diagnostic (radiology) pathway** to enable timely access for patients with learning disabilities and autistic people.
- Collaboration through the **Integrated Front Door Project** to improve patient experience and streamline care.
- A new **waiting list prioritisation system**, using digital flags via the Integrated Care Record (GraphNet) to identify and prioritise appointments for vulnerable patients.
- Implementation of a **reasonable adjustments pathway** in front door services and a review of the electronic outcoming system to ensure vulnerability codes are visible to clinicians.
- Introduction of **communication aids and folders** on base wards, led by Speech and Language Therapy, to improve staff–patient communication.
- Promotion of **virtual Makaton training** and regular bespoke **MCA Masterclass sessions**, reinforcing legal and communication competence across the workforce.
- Delivery of the first **Annual Trust Regional LD and Autism Conference** (April 2025), focused on emergency department practice, with plans to continue annually.
- Establishment of a **multi-agency discharge hub** to enhance safe and coordinated discharge planning.

These initiatives illustrate how GWH continues to act on LeDeR learning by improving accessibility, communication, and the safety of care for people with a learning disability and autistic people.

Salisbury NHS Foundation Trust

At Salisbury NHS Foundation Trust (SFT), activity that plans, implements and monitors progress on improving outcomes for people with a learning disability and autistic people is coordinated through the Learning Disability and Autism Operations Group. This group provides oversight of a dedicated workplan, with progress reported through the Integrated Safeguarding Committee and the Mortality Surveillance Group.

The workplan is informed by:

- Annual LeDeR Reports and “Deep Dives”
- The Annual BSW LeDeR Report
- The annual return for the NHS England Learning Disability and Autism Improvement Standards
- The NCEPOD clinical audit on emergency care
- Feedback from patient safety investigations and LeDeR primary reviews
- Learning from Deaths and Care

Between April 2024 and June 2025, seven deaths were notified to LeDeR, with a further death outside hospital highlighted for review.

Emerging themes include:

- The care of patients with respiratory infections that were not responding to GP interventions and required acute admission
- Good evidence of reasonable adjustments, including consistent use of Hospital Passports and proactive involvement of next of kin and care providers
- Collaborative Best Interest Decisions for patients with inoperable presentations or chronic conditions with poor prognosis, ensuring compassionate and person-centred decision-making

Learning into Action

The Trust continues to engage actively in the BSW-wide roll-out of the Oliver McGowan Mandatory Training (OMMT). By the end of March 2025, 35% of staff are expected to have completed the training. Feedback has been excellent, with participants reporting greater awareness of reasonable adjustments and the value of Hospital (Health) Passports.

Increased use of alerts on the electronic patient record system to identify people with a learning disability or autism has improved operational practice, including:

- Enhanced triage of waiting lists, reducing time to first appointment through the Trust's Improving Together methodology
- Focused screening and triage in the Emergency Department (ED), improving patient and carer experience and supporting early identification of needs
- A new anaesthetic pathway encourages multidisciplinary discussion for patients who lack capacity and may display behaviours that challenge, ensuring that decisions around diagnostic imaging under general anaesthetic are made in their best interests.

The Trust has also developed a Learning Disability Forum for adults, supported by PALS. The group is growing in confidence and will play a key role in improving accessible information and inclusive communication across the organisation. In addition, new communication resources within the ED and Acute Medical Unit are supporting inclusive assessments and enabling patients to be more involved in their own care planning.

Areas for Further Focus

- A Reasonable Adjustment Assessment will be embedded in the design of the new shared Electronic Patient Record (EPR) to ensure all staff consider reasonable adjustments as part of every patient interaction.
- The Trust recognises that the absence of completed and aggregated LeDeR reviews at system level limits opportunities to understand how care across primary and acute interfaces influences outcomes. This remains a key area for future development.
- Future sustainability of OMMT requires continued focus, as current funding arrangements are due to end in March 2026 and an alternative funding source has not yet been identified.

SFT remains committed to embedding learning from LeDeR and patient safety investigations into everyday practice. Through its operational group, strong governance structures, and co-produced initiatives, the Trust continues to build an inclusive, responsive, and person-centred approach to care for people with a learning disability and autistic people.

South West Ambulance Service NHS Foundation Trust

The South Western Ambulance Service NHS Foundation Trust (SWASFT) has published its Learning Disability and Autism Plan (2025–2028), setting out a clear commitment to improving care and outcomes for people with a learning disability and autistic people. The plan aligns with the NHS Learning Disability Improvement Standards by focusing on giving people their rights, involving and listening to them, and ensuring that staff have the right skills and training.

Key priorities include:

- **Developing a LeDeR process within SWASFT** to review deaths of people with a learning disability and autistic people and ensure that learning informs continuous service improvement.
- **Working collaboratively** with people with lived experience, carers, and partners to make ambulance services more inclusive, accessible, and better understood.
- **Building a skilled workforce** through role-appropriate training in communication, reasonable adjustments, and autism awareness.
- **Improving accessibility** by producing easy read and inclusive information, promoting the use of reasonable adjustments, and ensuring compliance with the Equality Act 2010.

The plan highlights SWASFT's focus on tackling health inequalities, reducing premature mortality, and embedding person-centred, trauma-informed care across all emergency and urgent care settings. Through this structured and co-produced approach, SWASFT aims to ensure that people with a learning disability and autistic people receive fair, compassionate, and high-quality care across the South West.

HCRG Care Group

HCRG Care Group has been commissioned to deliver **Integrated Community Based Care** across Bath and North East Somerset, Swindon, and Wiltshire (BSW). This includes all **Community Learning Disability and Autism (LD/A) services**, forming part of a wider transformation to create more accessible, coordinated, and equitable support for people with a learning disability and autistic people across the system.

Central to this transformation is the development of **Integrated Neighbourhood Teams (INTs)** that bring together community health, primary care, and social care professionals to deliver personalised and responsive care closer to home. The model ensures that individuals with complex needs can access joined-up multidisciplinary support through local networks that understand their community context.

Key priorities within the new model include:

- Establishing a **dedicated single point of access** for all community LD/A services, simplifying navigation for people, families, and professionals.
- Developing an **all-age neurodevelopmental pathway**, supporting smoother transitions and reducing diagnostic variation across localities.
- **Harmonising services** across BSW through a consistent **stepped care model**, ensuring support is proportionate, preventative, and aligned to individual needs.
- Embedding LD/A expertise within **Integrated Neighbourhood Teams** to strengthen inclusion, proactive care, and early identification of health inequalities.
- Co-producing pathways and resources with people with lived experience to ensure services remain person-centred, trauma-informed, and accessible.

This transformation reflects key **LeDeR learning themes** around accessibility, early intervention, and integrated working. By aligning LD/A services within Integrated Community Based Care and INTs, HCRG Care Group aims to create a system where people receive the right care, in the right place, at the right time, reducing inequality and improving life outcomes across BSW. This transformation directly supports the Core20PLUS5 approach to reducing health inequalities and aligns with the Building the Right Support programme, ensuring national consistency in approach and local flexibility in delivery.

Looking Ahead

The future of the LeDeR programme is currently uncertain. Should national policy confirm its continuation, BSW ICB will review its delivery model to ensure the capacity and capability to undertake timely and high-quality reviews. Should it be stood down, we will work with providers to ensure that the key elements of mortality review – transparency, thematic learning, and accountability – are embedded within organisational governance frameworks, particularly through PSIRF within the local Quality Schedule contract requirement.

Irrespective of national policy direction, the moral and legal imperative to address health inequalities and prevent avoidable deaths remains unchanged. This will require continued collaboration across all sectors, co-production with people with lived experience, and sustained focus on inclusion in every element of the NHS 10 Year Plan and its successor reforms.

Conclusion

Although no reviews were completed during 2024/2025, BSW ICB has continued to prioritise action to address the systemic issues that contribute to premature mortality among people with a learning disability and autistic people. The absence of reviews should not be mistaken for inaction; rather, this has been a year of consolidation, improvement and preparation for whatever future arrangements emerge from national reform.

What is certain is that the lives of people with a learning disability and autistic people matter deeply. Their rights to equitable healthcare, dignity and respect must be at the centre of our work. Whether through the continuation of LeDeR or through new arrangements, our responsibility to learn from lives and deaths will remain.