

A CROSS-SYSTEM PROGRAMME TO IMPROVE THE HEALTH OF PEOPLE WITH A LEARNING DISABILITY AND REDUCE HEALTH INEQUALITIES IN SALFORD

OVERVIEW

The Learning Disability Mortality Review Programme (2020) highlighted that people with learning disabilities face serious health inequalities and have a lower life expectancy, dying on average 25 years sooner and often from treatable and avoidable conditions. The NHSE 'learning from deaths of people with a learning disability (LeDeR) programme' was set up to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and reduce health inequalities. Analysis of LeDeR reviews in Salford has repeatedly shown themes in Primary Care, including:

- Low uptake of the Learning Disability Annual Health Check and variance in the content and quality of the health check across practices
- Low uptake of flu vaccinations and cancer screening
- Limited examples of joint working between GP practices and the specialist Learning Disability Service (LDS)

Funding from NHS Salford CCG and the Regional LeDeR Team was acquired to fund a dedicated Learning Disability Nurse to support Primary Care improvement initiatives in the above themes, develop closer working relationships between GP practices and the LDS and develop systems to sustain joint working. The role also included on-going completion of Salford's LeDeR reviews, presentation of cases at the LeDeR Steering Group and follow-up as required.

Although some delays and changes to project objectives have been experienced due to Covid-19, many objectives have been met and clear health gains for people with a learning disability have been demonstrated. Achieving these improvements at such a difficult period for health and social care services is highly encouraging for what might be achieved going forwards.

ACTIVITIES AND OUTCOMES

OBJECTIVE 1: Data Quality Improved

Data from each GP practice LD Register was collected and cross-matched with data from Adult Social Care. Analysis showed 715 duplicates in the list of 2189 records. 271 people were removed from the list following investigation with GPs, and 329 people were added. 105 people with LD had not been coded as such, and 51 people had been incorrectly coded as having an LD.

A "master" register was created, of 1387 individuals, which was used to track all people with a learning disability by name and per GP practice and monitor uptake of specific interventions e.g., Covid vaccination

OBJECTIVE 2: Vaccine Uptake Improved

- Learning Disability Nurses trained to administer flu and covid vaccinations
 - Easy read covid and flu information leaflets were produced
 - A dedicated telephone covid vaccine booking line was set up
 - People with learning disabilities and their carers were offered the option of having a flu/covid vaccine at home
 - Dedicated learning disability sessions were held at covid vaccine hubs and within higher education colleges
 - The LD register was used to track uptake and support follow-up of DNAs
- Flu vaccine uptake in this group of patients in 2020-21 was 65.9%, up from 61% in 2019-20 and 41% in 2018-19
- Covid-19 vaccine uptake has achieved 85.9% with 1st vaccine, 83.1% with 2nd and 82% with booster.

Salford's LD Covid vaccine work has been highlighted by NHSE regional publications as good practice, featured in a NHS UK webinar to support Covid vaccine uptake for people with LD and/or autism and won several awards.

- Winner of the following awards:
- GM Health and Social Care Award Winner 2021 Inclusion Champion
 - Northern Care Alliance, Salford Care Org. Customer Experience Award 2021
 - Northern Care Alliance, Customer Experience Award 2021 (overall winner)
 - Regional Winner, Covid Response Award, NHS Parliamentary Awards 2022

NEXT STEPS

- Embed learning into practice; Community LD Team (CLDT) to review existing roles & responsibilities with recognition to learning and benefits of the project.
- Allocation of named link nurse to each GP practice, 5 nurses for 38 practices
- Restart recruitment of Champions as Covid pressures on practices ease
- Continued commitment from primary care to work in conjunction and in partnership with the CLDT and linked nurses to embed learning and approach
- Explore funding options available for additional B6 nurses to undertake direct casework and support Primary Care with vaccinations and health checks
- Explore admin requirements and funding options, to oversee the ongoing processes that the project has identified and implemented

KEY OBJECTIVES

- 1 Improve quality and accuracy of GP registration of people with LD
- 2 Support GPs with implementation of reasonable adjustments to increase the uptake of immunisation programmes
- 3 Develop a single LD Annual Health Check Assessment (14-plus), implement and support uptake
- 4 Identify an 'LD Champion' within each GP Practice/PCN and an associated link LD Nurse programme for each neighbourhood.
- 5 On-going completion of Salford's LeDeR reviews within 6m timescale, present cases at LeDeR Steering Group and follow-up as required



Co-produced LD Health Check video (Scan QR or go to: youtu.be/XSu5osuBZcw)



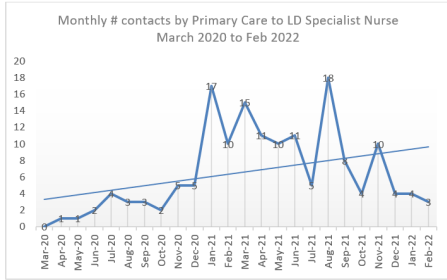
OBJECTIVE 3: Standardised Health Checks

- A new, standardised Learning Disability Annual Health Check template was introduced, which included an easy read invite letter, pre health questionnaire and the option to populate a Health Action Plan
 - The importance of continuing to complete the health check was promoted during the Covid-19 pandemic
 - Where a lower-than-expected uptake was seen, practices were contacted to discuss any barriers
 - A video to promote uptake was co-produced with people with LD (see above)
- Health check uptake in 2020-21 was 72%, up from 52% in 2019-20 and exceeding the NHSE expected standard of 67%

OBJECTIVE 4 Improved GP Practice links through SPOC

Recruitment of champions was significantly impacted by the pandemic. In the interim, there has been a Single Point Of Contact system established to the LD Specialist Nurse

Contact themes included: Vaccines (n=44), individual patient support (n=30), registering patients (n=25), community team (n=24) and health checks (n=18)



OBJECTIVE 5: LeDeR Reviews Completed & Learning Actioned

LeDeR reviews were completed in compliance with the 6mo review window, and findings were presented back to LeDer Steering Group and learning acted upon



Example: in one review, a family reported being saddened that they had not received a bereavement card from services following the death of their daughter. A bereavement card (left) was co-produced with people with LD and X's family, with the design being created by a local art group for people with learning and physical disabilities. This card is now sent out to all families known to the Learning Disability Team following the death of a loved-one

This initiative won a CCG Excellence Award in June 2020 and has been promoted as a piece of good practice by NHS England and NHS Improvement (LeDeR Programme).

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