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Learning from lives and deaths - people with a learning disability and autistic people (LeDeR)

Action from learning report 2024/25

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Contents

Action from learning case studies (2024–25)

The seven case studies in this report demonstrate how Learning from Lives and Deaths, People with a Learning Disability and Autistic People (LeDeR) reviews, have been translated into practical action across integrated care boards (ICBs) in England. Taken together, they show how ICBs in the seven NHS England regions have addressed common challenges such as inequitable access, structural barriers and unwarranted variation by implementing targeted and sustainable interventions.

Each region's case study has a different focus with different challenges. However, each identifies the key challenges, interventions and primary areas of impact with a view to making it as easy as possible for health professionals in other areas to see how to adapt the learning to their local context.

Regional case studies at a glance

Region	Focus	Challenge	Intervention	Impact
Midlands	Healthy weight and living	Poor physical health outcomes	Learning Disability Register-led population analysis	Improved identification and targeting
London	Cancer screening	Inequitable access and identification	Inclusive pathway redesign	Improved access and experience
South West	Missed appointments	System barriers mislabelled as “DNA”	“Was Not Brought” policy with safeguarding follow-up	Improved follow-up and reduced risk of people being lost to care
North East and Yorkshire	Epilepsy (SUDEP)	Preventable mortality and variation	System-wide safety checklists	Improved risk management
North West	Elective care	Inequitable waiting experiences and inconsistent support	Co-produced regional improvement framework	Improved system understanding and equity-focused action
South East	Community dental services	Inconsistent reasonable adjustments	Reasonable Adjustment Passport	More equitable access
East of England	Skin moisturisers and fire safety	Fire-related injury and harm	Training, prescribing alerts and safety audits	Improved awareness, confidence and safety practice

Foreword

I joined NHS England as Medical Director for Mental Health and Neurodiversity in June 2024 and I continue to be impressed by the range and quality of service improvements that integrated care boards (ICBs) are implementing year on year as a result of local Learning from Lives and Deaths, People with a Learning Disability and Autistic People (LeDeR) reviews. LeDeR Action from Learning reports share this learning nationally. They aim to improve the quality, safety and equity of care provided by the NHS for people with a learning disability and autistic people, reducing some of the major health inequalities they experience.

This Action from Learning 2024/25 report responds to feedback from front line clinicians by being shorter and with a stronger focus on system delivery rather than condition-specific activity. It includes a wide range of examples from across the NHS that showcase effective local practice and which I hope will support and inspire further improvement in your local services.

I recognise, as do you, that more still needs to be done and that this remains a challenging time for integrated care boards (ICBs). I want to personally acknowledge the progress already made and the ongoing commitment and effort shown by system partners to drive improvement and improve the health outcomes for people with a learning disability and autistic people. LeDeR reviews and Action from Learning reports continue to be vital mechanisms for understanding where change is needed and for improving outcomes across the country.

Dr Adrian James

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NHS England

East of England – skin moisturisers (emollients) fire safety project

The challenge

Norfolk and Waveney faced ongoing issues with fire-related injury and harm linked to the use of skin moisturisers (emollients), including multiple fatalities reviewed through LeDeR reviews. Moisturisers (or emollients) are widely used for skin conditions and are available both by prescription and over the counter. National data from the MHRA reported 53 fire fatalities related to emollient-contaminated fabrics between 2010 and 2018, but recent studies suggest emollients may be involved in more than 1 in 20 (6%) of all fire deaths in the UK and 1 in 4 (25%) of fire deaths where clothing or textiles were the first item that caught fire. Despite previous efforts with Norfolk Fire and Rescue Service (NFRS) and the Safeguarding Adults Board, repeated incidents highlighted the need for further action to address learning from LeDeR reviews and create lasting changes in care provision.

The response

A multi-disciplinary working group led by the LeDeR team was established to respond to this recurring patient safety issue identified in mortality reviews. Working across health, social care, fire safety and carer networks, the group used a live action log to coordinate practical changes in care and risk management. Six training sessions were delivered to more than 700 health and care professionals, students and family carers, with an online recording made available to widen access and support sustainability. Recognising that the risk extended beyond learning disability and autism services, the work focused on building awareness and capability across the wider system, particularly for people at greatest risk.

Key interventions

- Multi-disciplinary working group and live action log
- Education package: webinars, online training, easy-read leaflet
- Mandatory training proposal for providers
- Collaboration with carer advocacy groups
- Data grab and care plan reviews by community teams

- Prescribing software alert flags
- Fire safety audits and guidance from NFRS
- National awareness campaign video

Impact

The project strengthened clinical and care practice by increasing recognition of fire risk from skin moisturisers and embedding this into routine safety processes. Feedback showed that 93% of respondents felt more confident in their knowledge of the risks and how to reduce them, supporting safer practice across health and care settings. Its impact was also reflected in practical changes including prescribing alerts, care plan reviews, fire safety audits and wider inclusion of fire risk in care assessment and advice. This supported earlier identification of people at greatest risk and a more consistent approach to risk mitigation across services.

The work also had wider system impact beyond the local area. It informed national awareness activity through collaboration with the National Fire Chiefs Council, was recognised through regional and national awards, and was published as a case study in December 2025. Colleagues in Suffolk have also built on the approach, suggesting it provided a transferable model for strengthening patient safety in other areas. The work has been written up and published in a paper: O'Connell & Pinto (2025). Emollient and fire safety project - a case study. *National Back Exchange Column Digital, 24-26*.

Advice for others

The biggest challenge was coordinating colleagues across the system without additional resources. Success relied on the commitment of the team to make positive change for vulnerable people. All tools and resources are available online and free to access.

https://nwknowledgenow.nhs.uk/content-category/prescribing-pharmacy-and-medicines-optimisation/pathways-and-prescribing-guidance/skin/emollients/

Sustainability

The project is embedded through training proposals, online resources, and ongoing collaboration with fire safety and prescribing teams. Data collection and care plan reviews continue, and the approach is being expanded in Suffolk.

London – improving inclusive access to cancer screening pathways

The challenge

Autistic people and people with a learning disability experience persistent inequalities in access to cancer screening services. In London, system mapping and learning from LeDeR reviews highlighted wide variation in how people were identified, invited and supported to attend cancer screening appointments. This was compounded by limitations in national screening systems, including inconsistent recording of learning disability and autism identifiers, which reduced visibility of need and limited the opportunity to provide targeted outreach.

Recording of reasonable adjustments across screening providers, primary care and learning disability teams was also inconsistent. As a result, adjustments were not applied reliably and patient experience varied significantly. Knowledge and understanding of learning disability, autism and inclusive practice had been embedded as business as usual among some service providers. In others, staff knowledge was more limited, and adjustments were reactive or dependent on individuals. This variation increased the risk of delayed diagnosis, missed opportunities for early detection and poorer outcomes for autistic people and people with a learning disability. These issues were further compounded by poor IT interoperability and limited ability to identify people with a learning disability and autistic people consistently across systems.

A deliberate system-level approach was needed to redesign screening pathways to make it easier for people with a learning disability and autistic people to access the screening programme.

The response

In response, London screening coordinators worked closely with local cancer alliances, adult screening programme providers, ICB learning disability leads and borough-level teams. The aim was to map existing reasonable adjustments, ongoing pilots and wider improvement activity across all adult screening programmes.

Detailed submissions captured the range of activity already underway and highlighted areas of innovation. These included a more inclusive bowel screening pathway in one ICB and InHealth's AAA Health Equity and Inclusion Action Plan, which embeds patient-specific adjustments within the Screening Management and Referral Tracking (SMaRT) system.

Cross-cutting themes were identified across the submissions, including IT constraints, inconsistent recording of adjustments, variable workforce capability and gaps in contracting expectations. These findings are being used to inform development of a regional model of implementation. This will set out minimum standards, stronger governance, clearer local and national data requirements, improved training and regional key performance indicators to support more equitable screening access.

Impact

This work has had immediate impact by giving London a clearer picture of where autistic people and people with a learning disability are being well supported in cancer screening, where inequities persist and where action is most urgently needed. It has shifted the issue from being understood as a series of isolated local concerns to a shared regional priority, providing evidence to inform commissioning and improvement planning at local and national level.

By identifying practical models already supporting more inclusive care, including targeted bowel screening support and InHealth's AAA approach, the work has also created a stronger basis for scaling what works, reducing unwarranted variation and embedding equity more explicitly into screening delivery.

Over time, the work will help create a stronger foundation for consistent reasonable adjustments, better population visibility and more equitable uptake, helping to reduce avoidable inequalities in early diagnosis and cancer outcomes.

Sustainability

Sustainability will depend on embedding minimum standards for reasonable adjustments into routine pathway design, strengthening data quality and IT

interoperability, and maintaining collaboration across screening providers, ICBs, Cancer Alliances and learning disability partners.

Longer-term progress will also require equity-focused key performance indicators, stronger governance arrangements and more consistent use of commissioning and contracting levers. This will help ensure improvement is systematic and sustainable, rather than relying on local enthusiasm or short-term initiatives.

Useful links and resources

The National Cancer Plan for England: delivering world class cancer care

NHS screening - NHS

Screening programmes across the UK - GOV.UK

South West – reframing “did not attend” to “was not brought”

The challenge

LeDeR reviews showed that missed appointments for people with a learning disability and autistic people often reflected system-level barriers rather than individual choice. Barriers included inaccessible communication methods, digital exclusion and lack of follow-up when appointments were missed. In some cases, care homes did not respond promptly to appointment requests, resulting in rejected referrals, missed annual health checks and lost opportunities for screening and vaccination. Health professionals did not consistently follow up to understand why appointments were missed or to consider whether reasonable adjustments were required.

Treating missed appointments as “did not attend” risked reinforcing inequalities and allowed people to fall through gaps in care and safeguarding processes.

The response

The ICB learning disability and autism GP clinical lead worked in partnership with safeguarding colleagues to develop a “was not brought” (WNB) policy. The policy reframes missed appointments as a potential indicator of risk rather than non-compliance. It encourages professionals to apply professional curiosity when appointments are missed, prompting follow-up, consideration of reasonable adjustments and assessment of any safeguarding concerns. The policy places clear expectations on services to understand barriers to attendance rather than attributing responsibility solely to the individual.

Initially rolled out in primary care, the policy was subsequently shared across health and social care providers. It aligns safeguarding practice with preventative approaches and clarifies system-wide expectations for follow-up and communication.

Impact

The introduction of the consistent, Bristol, North Somerset and South Gloucester wide “was not brought” approach improved follow-up when appointments were missed and

reduced the risk of people being lost to care. It strengthened safeguarding responses and supported a shift in professional culture towards shared responsibility for access.

Sustainability

The policy is live in general practice and is under review for adoption across all health and social care providers in the ICB. Embedding the approach into routine practice supports longer-term consistency and helps prevent people from being lost to services.

North East and Yorkshire – reducing preventable epilepsy-related deaths (SUDEP)

The challenge

Epilepsy is a major cause of preventable mortality, with people with a learning disability facing a significantly increased risk of sudden unexpected death in epilepsy (SUDEP). Learning from LeDeR reviews and regional benchmarking showed that this risk was not simply a result of individual clinical decisions, but of wider system fragmentation. People with a learning disability often experienced inconsistent risk assessment, poor communication between organisations, and limited involvement of carers and support providers in safety planning.

Across North East and Yorkshire, variation was identified not only in the use of SUDEP and seizure safety tools, but in how epilepsy risk was assessed, recorded, shared and acted on across the system. Different organisations were working to different standards, risk information was not consistently visible within records, and responsibility for monitoring and mitigating risk was often unclear.

This created missed opportunities for early intervention, weakened continuity of care and contributed to avoidable harm. Reducing epilepsy-related deaths therefore required more than promoting a checklist: it required a coordinated system-wide response to create shared standards, clearer accountability and more consistent, cross-sector working.

The response

Partners across North East and Yorkshire agreed a coordinated system-level approach to reducing epilepsy risk. This involved workforce training, systemwide communication and production of support materials including translated materials. The aim was not simply to encourage use of SUDEP and seizure safety checklists, but to embed them as a shared framework for identifying, documenting and responding to risk across services. This positioned the checklist as a tool for improving consistency and shared accountability across the system, rather than as a standalone clinical intervention.

The focus was on making structured safety conversations part of routine practice, improving visibility of risk within records, and strengthening joined-up care planning

between NHS services, social care and support providers. Shared learning from LeDeR and regional benchmarking reinforced the importance of common standards, proactive risk management and clearer responsibilities across organisational boundaries.

Teams were encouraged to use the checklists during routine reviews to support meaningful, repeated conversations with people with epilepsy and their carers, rather than as a one-off assessment. This helped create a more coordinated model of care in which risks could be recognised earlier, documented more consistently and acted on more effectively across different settings.

Impact

The work improved visibility and understanding of epilepsy risk across the system and increased routine use of structured safety tools within everyday practice. It strengthened consistency in how risk was recognised, documented and responded to across organisational boundaries, helping to reduce variation between services.

By creating a shared approach to epilepsy risk management, the initiative supported earlier intervention, clearer accountability and better continuity between health, social care and support providers. It also increased the likelihood that carers and support staff were included in safety planning and understood their role in reducing risk.

Overall, the approach moved epilepsy risk management from being dependent on individual practice to being better supported by the wider system, contributing to a more preventative and person-centred model of care and helping reduce the risk of avoidable harm.

By establishing clear expectations, practical steps, and cross-system support, the ICB created a unified approach to SUDEP risk reduction grounded in evidence-based tools and collaborative working.

Sustainability

Embedding SUDEP and seizure safety checklists into routine reviews, documentation and shared care processes supports long-term consistency and sustainability. By integrating the approach into normal pathways rather than relying on ad hoc use, the system is better able to maintain a consistent standard of epilepsy risk management over time.

The approach also reduces reliance on individual champions by strengthening shared expectations, clearer responsibilities and cross-system ways of working. This increases organisational resilience and makes it more likely that good practice will continue despite workforce or service changes.

Over time, this creates stronger system capability to identify, monitor and respond to epilepsy risk proactively, supporting safer and more coordinated care for people with epilepsy.

Midlands – supporting healthy weight and living for people with a learning disability

The challenge

People with a learning disability experience significantly poorer physical health outcomes than the general population, including higher rates of underweight, obesity and long-term conditions such as diabetes and heart disease. National evidence, including learning from LeDeR reviews, consistently highlights increased levels of preventable morbidity and premature mortality linked to lifestyle-related risk factors such as physical inactivity and nutrition.

Partners in Leicester, Leicestershire and Rutland (LLR) Integrated Care Board, identified that their existing health intelligence did not provide a sufficiently complete picture of learning disability population need. They were relying on national data and this meant that gaps in routine weight monitoring were not clearly visible, particularly for people with limited contact with primary care or people facing barriers to attendance. As a result, there were less opportunities to identify weight-related risk early and to intervene preventatively or reactively.

The response

Partners across LLR used the learning disability register to undertake a population-level analysis of Body Mass Index (BMI) data for people with a learning disability. This provided a more complete and reliable picture than before and enabled individuals who had not received a weight check in the previous 12 months to be identified and proactively targeted through outreach with healthy weight and exercise interventions and support.

The data helped primary care, community services and commissioners to agree aims aligned around a shared evidence base.

The ICB's Learning Disability and Autism Collaborative developed healthy living toolkits tailored for individuals and workforce training to improve skills assessing the weight and nutritional needs of people with a learning disability.

Learning from LeDeR reinforced the importance of addressing modifiable lifestyle risks as part of wider efforts to reduce premature mortality.

Impact

The data improvements enabled a shift towards population health management, focusing on prevention, early intervention and reduction of health inequality. Local understanding of healthy weight risks and needs among people with a learning disability improved, as did proactive early identification of people requiring follow-up. It enabled more targeted preventative support and made it easier for commissioners and service providers to align their approach using shared data.

Tailored training and practical resources helped staff to feel more confident about recognising and responding to nutrition and BMI-related concerns.

Sustainability

Sustainability has been supported by embedding use of the GP learning disability register into routine population health and intelligence-gathering processes, reducing reliance on one-off audits. This enables ongoing identification of unmet need among the local population of people with a learning disability and supports continued proactive targeting of local healthy weight action.

Longer-term sustainability is supported through shared system ownership, continued use of tailored resources and training, and improved access to healthy weight learning and support linking into wider learning disability improvement activity.

Advice for others

- Staff confidence can significantly impact on care. Look at workforce capability and the support they need and provide learning opportunities.
- Healthy weight initiatives for people with a learning disability must be held collectively across health, social care, and commissioning; isolated interventions are unlikely to succeed.
- It is important to engage with people with a learning disability and carers to understand current barriers, and factor this into your approach.
- Obtain local data to identify gaps and support with demonstrating the need for change and focus within this area.
- Embed nutrition, hydration, and physical activity within everyday care, pathways, and policies to ensure it becomes part of usual practice and so that improvements are sustained

Resources

Healthy Living Toolkit (free access) available on:
https://leicesterleicestershireandrutlandhwp.uk/about/collaboratives/lda-collaborative/new-healthy-living-toolkits/

North West – improving the wait for elective care for people with a learning disability and autistic people

The challenge

Long waits for elective care can exacerbate physical deterioration, anxiety and safeguarding risks. Delays may also increase the risk of diagnostic overshadowing, where symptoms are overlooked or misattributed, and can lead to worsening pain, reduced mobility, avoidable admission, carer strain or crisis presentation. For people who already face barriers to access, the elective backlog risks compounding existing inequalities unless systems act deliberately to identify need and respond early.

Across the region, systems and trusts are at different stages of maturity in identifying, supporting and prioritising people with a learning disability and autistic people on elective waiting lists. Challenges included inconsistent visibility of learning disability and autism status within waiting list data, variable use of reasonable adjustment flags, and limited communication and support while people waited, meaning some patients were not easily identifiable within elective pathways, reducing services' ability to anticipate need, plan adjustments and respond to emerging clinical risks.

Data and engagement highlighted several recurring issues. Many patients and carers reported receiving little active support or guidance while waiting, despite the impact on their mental and physical health. Clear, regular and accessible communication was not consistently in place, and patients often lacked realistic expectations about waiting times or clarity on who to contact with concerns. This increased the risk that deterioration would only be recognised when intervention became more complex and outcomes potentially poorer.

Variation in leadership, governance and clinical prioritisation also contributed to different experiences across the region. Some organisations had strong executive sponsorship and clearer routes for escalation; elsewhere, progress depended on a small number of committed individuals rather than embedded processes. Identification and recording of reasonable adjustments is improving but remains inconsistent, while fragmented data systems and variable coding limited the ability to track need, monitor inequalities and target support reliably. Reliance on specialist individuals creates fragility and makes spread harder to sustain.

The response

In January 2025, the North West Elective Care Board commissioned a region-wide programme, delivered in partnership with NHS England's regional team and the improvement unit to create a shared understanding of inequalities in elective care and a practical framework for improvement. The work looked at: evidence and learning; data and system insight; patient and carer voice; clinical and professional engagement; and co-production of solutions. It combined desktop research, analytics engagement, patient and carer surveys, and stakeholder workshops to identify barriers, highlight good practice and develop a practical approach that trusts and systems can adapt locally. A key strength was bringing together clinical, operational, analytical and lived experience perspectives, rather than treating elective recovery and health inequalities as separate agendas; creating a fuller picture of where risk sits in the pathway and where improvement would have most value.

The resulting framework was designed as a tool to support local implementation, peer learning and more consistent action across organisations at different stages of maturity. It sets out a shared vision for improving readiness, experience and outcomes while waiting, alongside practical actions that trusts and partners can tailor to local context.

Impact

The programme was designed as a foundation for improvement rather than a single intervention and has already had important impact. It established a shared regional understanding of the clinical, operational and communication risks experienced by people with a learning disability and autistic people while waiting for elective care. This repositioned the issue from a specialist concern to a mainstream quality, safety and recovery issue.

The programme also developed a co-produced framework to support consistent, equity-focused action, giving trusts and systems a clearer basis for reviewing pathways, strengthening waiting list oversight and identifying where local processes need to change. It strengthened collaboration between elective care leads, learning disability and autism teams, data and analytics functions, and lived experience partners, creating better conditions for spread by linking improvement to wider elective recovery and governance arrangements.

A further impact has been to make visible the practical changes needed to improve patient safety and experience while people wait, including more reliable identification

of people requiring support, more consistent recording of reasonable adjustments, clearer accessible communication, and earlier escalation where risk changes.

Advice for others

Secure strong leadership and project management from the outset. Improvement is more likely to gain traction where there is visible executive sponsorship, clear governance and alignment with wider elective recovery priorities. Combine data with lived experience and clinical insight; none of these alone is sufficient to understand risk or design workable solutions.

It is also important to communicate the “why” behind improvement so that staff understand this is about safer, more equitable care rather than an additional reporting requirement. Build improvement into existing pathways and operational processes, rather than relying on passionate individuals, and agree early how success will be measured. Attention to data quality, information governance and routine monitoring will make it easier to track progress, demonstrate impact and sustain improvement over time.

Sustainability

Sustainability depends on embedding this work within routine governance and elective recovery processes. The approach is championed by senior leaders, supported through monthly board reporting and dedicated roles. Monitoring of waiting lists and analysis by deprivation and ethnicity continues, ensuring health inequalities remain visible within ongoing performance oversight.

The intention is to build the framework into standard operational practice across trusts and systems. Sustainable improvement will require strong routine processes, clearer data flows, wider workforce capability and local ownership, so that progress is resilient, scalable and less dependent on individual champions. By aligning this work with mainstream elective recovery and quality improvement arrangements, the region has laid the foundations for change that is more likely to endure and deliver lasting benefit for patients.

South East – reasonable adjustment passport in community dental services

The challenge

People with a learning disability and autistic people experience significant barriers accessing community dental services. Common challenges include anxiety, communication difficulties and sensory sensitivities, which are often compounded by inconsistent identification of needs and poor sharing of information about reasonable adjustments between services.

Within community dental services, lack of a consistent mechanism to record and communicate individual-specific adjustments meant that people were frequently required to explain their needs repeatedly. This contributed to distressing experiences, missed or delayed care and avoidable deterioration in oral health.

The absence of a standardised approach limited staff confidence and reduced the ability of services to plan appointments effectively, increasing inequalities in access and experience.

The response

In response, the ICB introduced a reasonable adjustment passport within community dental services. The passport provides a structured, person-centred way to capture, record and share individual-specific adjustments, including communication preferences, sensory needs and practical considerations for appointments.

The passport supports continuity of care by ensuring that information travels with the individual and is accessible to all relevant staff. It reduces the need for people to repeatedly describe their needs and supports teams to plan appointments more effectively.

The approach aligns with wider system priorities on inclusion, accessibility and reducing health inequalities, and supports workforce confidence by providing clear guidance on how best to support each individual.

Impact

The introduction of the reasonable adjustment passport improved the quality and consistency of clinical care by giving dental teams better information about individual needs before the appointment. This supported more effective planning of reasonable

adjustments, reduced anxiety triggers and helped clinicians adapt communication and the care environment to keep patients comfortable and engaged during treatment. It also reduced the need for people to repeatedly explain their needs and strengthened continuity across appointments. Feedback suggested the passport was particularly valuable in identifying factors that caused the person to feel overwhelmed or distressed, helping teams deliver more personalised care and reducing barriers to access for autistic people, people with a learning disability and other anxious or vulnerable patients.

Sustainability

The passport is designed to be scalable and transferable across services and settings. It needs to be introduced at the first appointment to address digital exclusion and as part of the new patient registration process. Embedding it into routine practice supports long-term consistency, reduces duplication and strengthens system capability to deliver accessible care. In time, the passport can be incorporated into the reasonable adjustments digital flag.

Acknowledgements

This LeDeR action from learning report gives examples of the vital work that has been delivered across the NHS and by our partners, working with self-advocates and self-advocacy groups, parents/carers, the charity and voluntary sectors, and our colleagues in social care. None of these efforts would be possible without family members, health and social care staff and many others contributing to a LeDeR review by sharing their experience of the life and death of a loved one or someone in their care. We would like to express our sincere gratitude to you all.

We would like to recognise and thank everyone whose work, campaigning or self-advocacy continues to inform, challenge, change and reduce health inequalities among people with a learning disability and autistic people.

We highly value our Independent Advisory Group whose members include people with a learning disability, autistic people, parents and carers, and representatives from the charity and voluntary sectors. They inform and enrich our work. Please see Appendix 1 for its membership.

We are also supported by our academic partnership, comprising King's College London, University Lancashire and Kingston University of London, which produced the LeDeR Annual Report 2024 as well as the Staying Alive and Well Group who support their work and produced this year's easy read and video versions of the LeDeR annual report (https://www.kcl.ac.uk/research/leder).

Finally, we are grateful to the LeDeR workforce and partners in ICSs across England for their continued efforts to address local LeDeR findings and to improve the health and lives of people with a learning disability and autistic people.

Appendix 1

Membership of Independent Advisory Group

Association of Directors of Adult Social Services (ADASS)	London School of Hygiene and Tropical Medicine (LSHTM)
Autistica	National Autistic Society
Care England	Mencap
Department of Health and Social Care (DHSC)	Office for Health Improvement and Disparities (OHID)
Dimensions	Pathways Associates
Down's Syndrome Association	People First Merseyside
Health and Wellbeing Alliance	Race Equality Foundation
Inclusion North	Royal College of General Practitioners (RCGP)
Institute of Health Equity – University College London	Royal College of Psychiatrists
Learning Disability England	Stop People Dying too Young
Learning Disability Professional Senate	Voluntary Organisations Disability Group (VODG)
Local Government Association (LGA)	