

LeDeR- The Learning Disabilities Mortality Review Programme

Christine Hobby- Designate Nurse Safeguarding Adults- Local Area Contact
LeDeR

Sally Ryan- Named Nurse Safeguarding Adults- Local Area Coordinator LeDeR



What is LeDeR?



LeDeR is the first national programme of its kind 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 health and social care for people with Learning Disabilities.

1. Death by Indifference Mencap (2007) – Six Lives
2. Confidential Inquiry into premature deaths of people with learning disabilities CIPOLD (2013)- review of 247 deaths
3. An independent review of deaths of people with learning disabilities or Mental Health problems in contact with Southern Health NHS Foundation Trust MAZARS (2015)

Who are we reviewing?



- All notified deaths of people with learning disabilities aged 4 years and over.

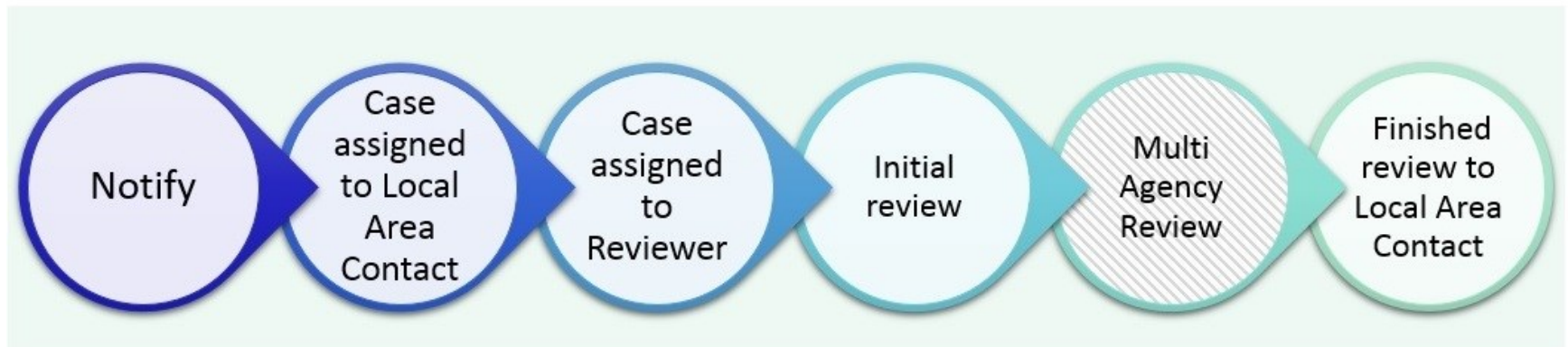
In Suffolk, there is an administrative alert in place for Primary Care, to prompt them to notify a death to the National LeDeR Programme and to upload case notes for review.

Section 251 Approval

(Ref: 16/CAG/0056) Allows the sharing of confidential patient information *without consent* for reviews of deaths and service improvements.

Local Agreements Local Data agreements and protocols through Local Steering Groups

The LeDeR Review Process



National LeDeR Findings (Annual Health Checks)



- **Annual health checks are offered- poor uptake.**

Issues with people with learning disability understanding the need for annual health check. Need for good preparation for Annual Health Check. Further work with care staff to support and facilitate annual health checks.

- **Inconsistency in quality of annual health checks**

Risk with standardising annual health check, may mean other health issues are not explored. Key known health issues eg Constipation not explored in annual health check

- **Outcome from annual health check**

People with Learning Disability understanding what to do following the annual health check and it leading to Health Action

LeDeR Local Redacted Review Findings

P\$ had not had a full Annual health Check for several years. His GP had sent invites for health check appointments. Did his carers and family understand the importance? When he did not attend, this was not followed up

Annual health reviews did not happen despite annual invites/requests by GP practice. Carers unable to justify why these did not occur. GP did not know why not followed up by surgery

X did not appear to have an advocate. Their voice was not at the centre of planning individualised care. (need to have more context to this- care where? And impact)

The contact from primary care was very limited. X's surgery had not attained the LD Annual Health Check CCG specified requirements

A formal learning Disability Annual check was never undertaken

XP's Annual health Check was of poor quality

There was no evidence of a health action plan following S's annual health check.

ANNUAL HEALTH CHECKS

A map of the East of England region, including Essex, Suffolk, Norfolk, and parts of Cambridgeshire and Hertfordshire. The map is rendered in a light blue color and is centered on a white background. The text "Thank you" is overlaid in the center of the map in a large, bold, black font.

Thank you