Learning Disabilities Mortality Review (LeDeR) Programme

NHS
Norfolk and Waveney
Clinical Commissioning Group

Norfolk and Waveney Learning Disability Mortality Review Annual Report

What is the Learning Disabiltity Mortality Review (LeDeR) Annual Report ?

It is a document that looks into **why people with a learning disability have died** in Norfolk and Waveney

It helps us to understand **what we can do** to help give people with a learning disability **longer and healthier lives** in the future

This report has been written by the **Norfolk and Waveney Learning Disability Mortality Steering Group**

This group is co-chaired by **Sarah Jane Ward**, Associate Director of Quality in Care NHS Norfolk and Waveney Clinical Commissioning Group, and **Andrew Borrett**, an Expert by Lived Experience

The group **includes** people with **learning disabilities and autism**

How do we look into the reasons that someone with a learning disability has died?

The Learning Disabilities Mortality Review (LeDeR) programme is led by the University of Bristol

It helps local areas to **review the deaths of people with learning disabilities** aged over 4 years of age.

Local reviews of deaths look into what could have been **done differently to avoid the person dying** and to make a plan to help stop people with learning disabilities dying younger

In Norfolk and Waveney we have worked hard this year to **carry out more reviews**

Anyone can tell the LeDeR team at Bristol about someone with a learning disability who has died

This can be done using an **online form**:

https://leder.nhs.uk/report

Although this has been another difficult year for everyone, we have continued to improve how we **communicate** with people with learning disabilities, their carers, and professionals

What does our report tell us this year?

We received **77** notifications of people with learning disabilities who had died

This included **two (2)** that were for **children and young people**

In Norfolk and Waveney the **average age** when a person with a learning disability dies is **61 years old**

This is a lot **younger** than for people who do **not** have learning disabilities

Most people **died in hospital**

The most common cause of death was a **respiratory condition**

Most people received **good care** but we found some cases where the care had not been as good as it should have been

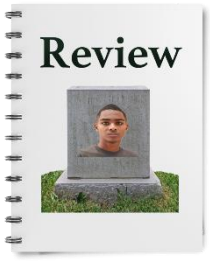
We need make sure all people with learning disabilities, their carers and professionals know how to make **reasonable adjustments** so everyone can get the care they need

	We need to make sure that **Mental Capacity Act Assessments** are carried out when needed
	We need to **help** more people have their **annual health check**
	We need to make sure that carers and professionals are **looking out** for signs that someone is starting to be **unwell**

How have we helped people with learning disabilities during the Covid-19 pandemic?

	**Accessible clinics** were set up across Norfolk and Waveney to help people with learning disabilities and autism to **get their vaccination**
	We have helped people with learning disabilities to **travel more freely**
	We have provided **advice and support**
	We held live **video events** which helped us find out more about what people with learning disabilities need

What are we going to do next?

	We will **finish all reviews** that are still waiting to be done
	We will include **people with autism** in a new LeDeR policy
	We will continue our **Learning into Action** work and we will check that what we are doing is working well
	We will do more to support people from **ethnic minorities**
	We will do more to **improve life expectancy** of people with learning disabilities

The Learning Disability Mortality Review (LeDeR) Programme Annual Report for April 2020 to March 2021 is available on our website:

https://www.norfolkandwaveneyccg.nhs.uk/health-services/learning-disbability