What is LeDeR

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1. What is it

The Learning Disability Mortality Review (LeDeR) Programme was established to support local areas to review the deaths of people with learning disabilities and identify learning from those deaths which would inform service improvement.

2. Why it matters - Health inequalities between different population groups has been well documented, including the inequalities faced by people with learning disabilities (LD). Today, people with LD die on average, 15-20yrs sooner than people in the general population, with some of those deaths identified as potentially linked to poor quality healthcare

3. Information – The LeDeR programme reports on deaths of people with LD aged 4yrs and over.

From 1st July 2016 to 31st December 2019 the LeDeR programme has been told about the deaths of 7,145 people.

Most people died from one of five health problems: Pneumonia, Aspiration pneumonia, Dementia, Sepsis & Epilepsy.

4. What does it involve – The LeDeR review is a proactive process, often without a 'problem', complaint or significant event that is undertaken to consider systems, policies and processes. It is NOT an investigation.

The LeDeR review process is described on the LeDeR programme website at

www.bristol.ac.uk/sps/leder

5. Information Sharing – For each death there is an 'Initial Review' – this involves inviting those who knew the person well to contribute their views about the sequence of events leading to death, limited case note review and the completion of a standard review form. At completion the reviewer will decide whether a full multi-agency review is required or not.

6. Key Outcomes / Learning – Learning points and recommendations identified within Initial Reviews are collated and discussed at the Lincolnshire Steering Group. An action plan is formulated focusing on specific areas for improvement across the Lincolnshire System. An Annual report is published both nationally and locally every year. (?link to our report?)

7. What to do next – The overall aim of the LeDeR programme is to reduce premature deaths, improve the quality of health and social care received by people with LD and remove any health inequalities they may experience during their lives. It is essential that LeDeR reviews are completed in a timely way to contribute to improving the care and treatment of people with LD.

https://lincolnshireccg.nhs.uk/about-us/safeguarding/