Learning Disability Mortality Review (LeDeR) Annual Report 2019/20

HMR deaths of people with Learning Disabilities notified to LeDeR programme
1 July 2019 to 31 March 2020

18 deaths notified

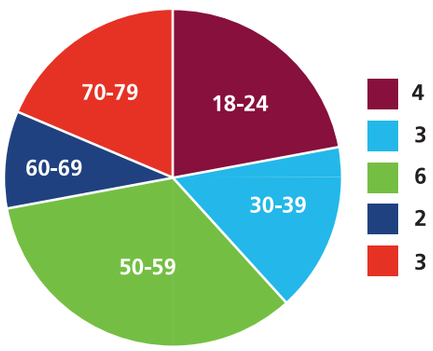
Examples of good practice

- Medication Reviews
- Reasonable adjustments
- Use of hospital passports
- Use of familiarisation and de-sensitisation techniques
- Individual GP practice relationships with their patients with LD

Areas for improvement

- Learning Disability Awareness training for practitioners
- Improve uptake of Annual Health Checks
- Mental Capacity assessment and best interest decisions
- Reporting of deaths among people from Black, Asian and Minority Ethnic (BAME) groups

Age at death



Gender

Ethnicity

White British	12
Asian British	4
Chinese	1
Not known	1

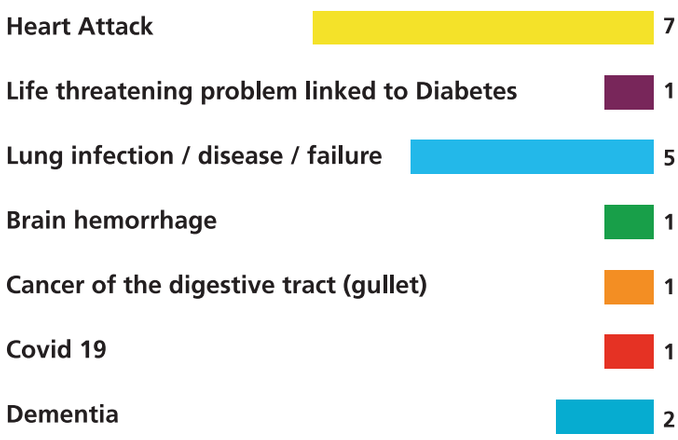
Level of disability

Mild	5
Moderate	7
Severe	3
Not known	3

Place of death

Hospital	Usual residence	Outside of UK
10	7	1

Cause of death



Between 1 July 2019 and 31 March 2020 one review was completed which indicated that care fell short of expected good practice, 13 evidenced good care, 3 satisfactory care.1 review could not be graded as the individual died outside of the UK.

National LeDeR report 2019 www.bristol.ac.uk/media-library/sites/sps/leder/LeeR_2019_annual_report_FINAL2.pdf

NHS
Heywood, Middleton and Rochdale
Clinical Commissioning Group