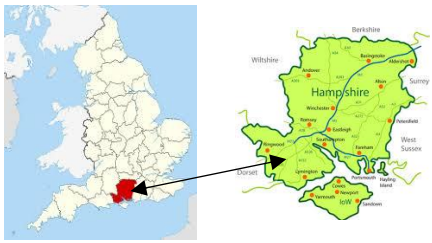
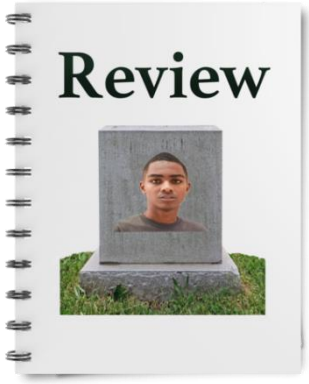
The Learning Disability Mortality Review (LeDeR) Programme

Southampton Hampshire, Isle of Wight & Portsmouth (SHIP)

Annual Report 2020/2021

	We are a group of people who plan health services and support for people with Learning Disabilities. We are called commissioners. We work in Southampton, Hampshire, Isle of Wight and Portsmouth.
	It is sad when someone with a Learning Disability dies. It is important when someone's dies that we find out if they had the best care when they were alive and when they died. Lots of health workers are reviewing the deaths of people with a Learning Disability.
Learning Disabilities Mortality Review (LeDeR) Programme	We work together as part of The Learning Disability Mortality Review Programme. Mortality means death. We need to learn from mistakes and make things better, and also share the good things
University of BRISTOL	The University of Bristol set up the Learning Disability Mortality Review Programme.
2nd 	This is our second local report.

How do we do this?

We have trained health workers who review deaths.

They talk to people who cared for the person, including their family.

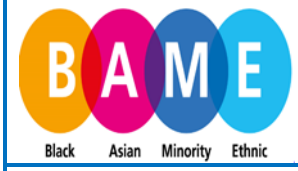
When a review is finished the information is sent to Bristol University and NHS England

Every year a big national report is written about all deaths reviewed in England.

The report helps the NHS and other services learn how to provide better care.

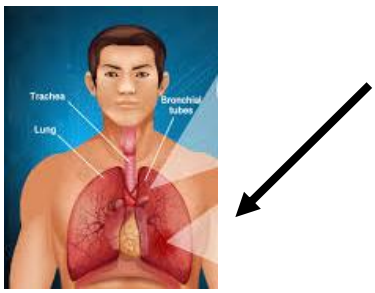
This report is our own local report and includes some people who died of Covid-19

What did we find?

145	We looked at the deaths of 145 people. They died from 1st April 2020 to 31st March 2021
 Men (63%)	More than half of the people who died were men.
 Women (37%)	A smaller number who died were women.
	2.1% of people who died were from Black, Asian or Minority Ethnic groups
	About half of the people died in hospital.
	Reviewers said that 63% of people had care that met, or was better than best practice

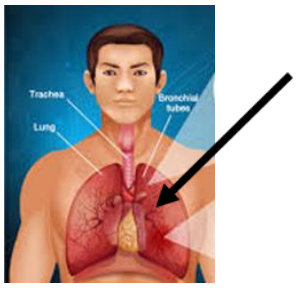
Reviewers said that for 93% of people there had been one or more examples of good practice by people involved in their care. This included GP`s, hospitals and care homes

What did people die from?



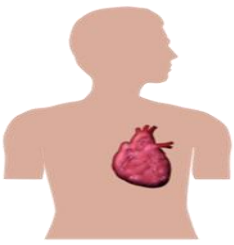
The 5 main causes of death were:

1. Pneumonia. This is where your lungs get infected. It makes you feel very poorly.

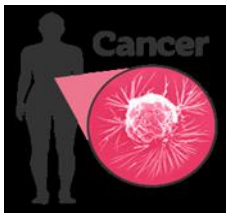


2. Aspiration pneumonia. This is where food or drink goes into your lungs. It causes infection.

3. Covid - 19



4. Cardiac arrest. This is when your heart stops.

	5. Cancer. This is when bad cells grow in parts of your body. They make you feel very ill.
We found lots of good things in the reviews 	
	During Covid-19 staff used PPE that would not make people anxious or upset
	Person centred plans written by GP`s
	Families are being listened to, and included in the persons care and treatment when in hospital

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<td>Hospital Passports and Health Action Plans are being used</td>
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<td>Changes were made to make sure that relatives or carers of the person who had a Learning Disability could visit them in hospital when this was not allowed for other people</td>
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<td>Care providers have been given equipment to measure oxygen levels</td>
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<td>Telemedicine
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<td>Some care home staff have already had training to know when someone is becoming ill, and can call a new team for help by phone or video</td>
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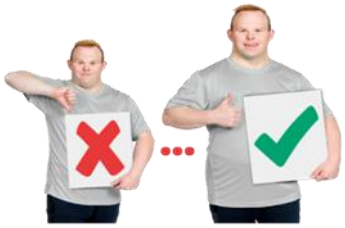
<td colspan="2">We found out some things that need to be better
  </td>
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 	Individuals need to be involved in decisions about DNA/CPR where possible and their wishes included in their hospital passport. Process must be followed DNA/CPR means if your heart or breathing stops carers or health workers will not try to restart it
	Some health teams who support people at the end of their life may not have enough experience to support someone who has a Learning Disability and should have training
	GP`s need to check on people if they don't come for their appointments and they need to make sure reasonable adjustments are in place
	GP`s need to make sure that anyone who has a Learning Disability is on their register

	Anyone who has a Learning Disability and lives in a care home should have a named GP that they can see when they need to
	Everyone who has a Learning Disability should have an Annual Health Check and Health Plans should be shared with people who know them
	There were some delays at first with Covid testing
	Learning Disability services did not always help residential care homes with PPE and training for Covid
	Reasonable adjustments were not made someone went into hospital The hospital Learning Disability Nurse was not contacted to help.

What needs to be done?

	GP`s need to make sure everyone who has a Learning Disability is invited to an Annual Health Check.
	Reasonable adjustments need to be in place for GP and hospital appointments
	Increase the number of Learning Disability Friendly GP practices
	Work with people so they understand what DNA/CPR means for the person (decisions about what to if someone's heart stops or they stop breathing)

 	All care home workers need training to quickly know when someone is becoming ill, and what they need to do
	Share what we have learnt from the reviews and what we need to still do
	Train more reviewers
 	We hope this report was helpful We will do another report next year 2022