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Leicester, Leicestershire and Rutland LeDeR Annual Report June 2021

Easy Read version

This is from 1 April 2020 to 31 March 2021

Leicester City Council

NHS
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Leicestershire County Council

NHS
Leicestershire Partnership NHS Trust

Rutland County Council

NHS
University Hospitals of Leicester NHS Trust

Contents

This is a report for the learning from deaths review of people with a Learning Disability (LeDeR) programme in Leicester, Leicestershire and Rutland.

You might need someone to help you read this report.

A review means looking at things that have happened.

A report means telling you about the things that have happened.

We have been working hard to look at the care of every person with a Learning Disability who has died during the year.

LeDeR is about understanding how health and social care can be made better for people with a Learning Disability.

We want to provide the best care for everyone with a Learning Disability who lives in Leicester, Leicestershire and Rutland.

LeDeR helps health and social care services to make good changes and help people with a Learning Disability.

Introduction

This is the second annual report for Leicester, Leicestershire and Rutland (LLR) learning from deaths.

When someone in LLR with a Learning Disability dies a LeDeR review learns about their life and the services that helped them.

Deaths of children with a Learning Disability are reviewed by the child death overview panel. We call this CDOP.

It is important that we keep learning from the reviews to make sure people with a Learning Disability live longer, healthier lives.

LLR Learning Disability and Autism partnership board supports what LeDeR does.

We always make sure LeDeR reviews are done to a high standard.

We learned a lot about why people with learning disabilities are dying.

This helps us to work out what needs to change to make things better.

We work with people with learning disabilities their families, carers and friends.

What we did after the last report

We have 2 new nurses, Rebecca and Siouxie.

This is Rebecca.

This is Siouxie.

Some reviews are waiting to be started.

Some reviews that we started are not finished yet, because other people are involved like police, safeguarding or coroners.

Coroners are people who work to find out why a person has died.

Covid 19 made it difficult for reviewers as some of them had to go to work in a different job.

We looked at information from the review into Oliver McGowan's death.

The Government said there should be training for staff who work with people with a Learning Disability or Autism, or both.

You can find out more about that review here: http://bit.ly/LeDeRolivermcgowan

Information from reviews

More than a million people live in Leicester, Leicestershire and Rutland.

In all of England, the average age for men to die is 61. For women it is 59.

In LLR the average age to die for men and women is 59.

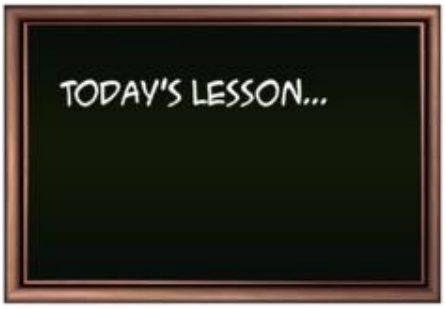
Lots of our people are from ethnic minority groups, but LeDeR doesn't hear about them all.

We have a doctor who is going to try and find out why.

How to make things better

The ways we can make things better are listed here.

Listen to people with Learning Disabilities, their families and carers.



Help people understand the difference between Learning Disability and a learning difficulty.

Make sure we do mental capacity assessments.

Communicate well with other people and providers.

Make sure people know Learning Disability isn't a reason for someone to die.

Check how we work to make sure we haven't missed anything.

Make sure everyone is offered an annual health check.

Support people to attend health appointments.

Make sure that any information we use is up to date.

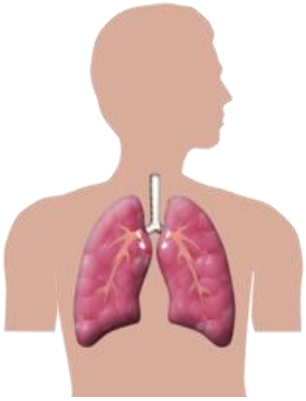
Languages people speak

In LLR less people speak English as their main language than in other parts of England.

English (89%)
Gujarati (4%)
Punjabi (1%)
Polish (1)
Urdu (less than 1%)

In LLR there are more people from an Asian or other ethnic group background compared to other parts of England.

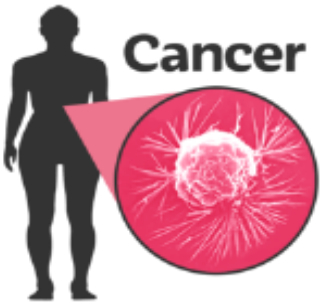
What people died from in our area



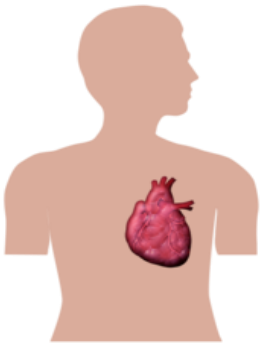
Nearly half of the people died from breathing problems.

This is much higher than other parts of England.

Smaller numbers of people died from other things that we have put in a list.



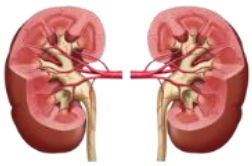
Cancer



Heart problems

Epilepsy

Dementia



Problems with kidneys

Bowel problems

Choking

For a small amount of people, we did not find out why they died.

Covid-19

16 people died because of COVID-19.

All the LeDeR reviews said how good or bad the healthcare was.

Half of the people said we did okay, and others said we did good.

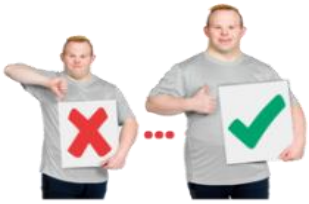
What we learned

We learned that there are 4 main things we need to do better.

Learning and training

Communicating better

Making sure information is up to date



Making sure we all do things the same way

Who will make changes

The report told us there is still work to do with this list of people.

Doctors' surgeries

Care providers

Health professionals

Hospitals and hospital staff

Lots of these changes were very small and have already been done

Plans for the future

In March 2021 a new policy came out called *Learning from lives and deaths – People with a Learning Disability and autistic people (LeDeR) policy 2021*.

The new policy says we will review the deaths of people with a Learning Disability and people with Autism and people with both.

There are two sets of people that deserve a special thank you.

Our LeDeR reviewers

Families, friends, carers and health and social care

professionals who help us with reviews.

Thank you for reading this report.

We have started thinking about what to write in next year's report and may ask you to help us.