

Safeguarding Adults Week – LeDeR

Today, we are focusing on safeguarding adults within the health agenda. Peter Warburton, Lead Nurse for Safeguarding Adults provides some information on the Learning Disabilities Mortality Review Programme:

The Learning Disabilities Mortality Review (LeDeR) Programme is a world-first. It is the first national programme of its kind aimed at making improvements to the lives of people with a learning disability. People with a learning disability, their families and carers have been central to developing and delivering the programme.

The LeDeR programme is coordinated by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. The overall aim of the programme is to drive improvement in the quality of health and social care services delivery and to help reduce premature mortality and health inequalities for People with a learning disability.

The LeDeR Programme collates and shares the anonymised information about the deaths of people with a learning disability so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements both locally and nationally.

The Confidential Inquiry into Premature Deaths of People with a Learning Disability (CIPOLD) reported the median age at death for males was 65 years. Men with learning disabilities died on average 13 years earlier than men in the general population. Median age at death for women was 63 years showing that women with learning disabilities died on average 20 years earlier than women in the general population. As a result, all deaths of people with learning disabilities aged 4 years and over must be reviewed using the LeDeR framework, regardless of whether the death was expected or not, the cause of death or the place of death.

The reviews aim to positively influence practice and policy by:

- Identifying the potentially avoidable contributory factors related to deaths of people with a learning disability.
- Identifying variation and best practice in preventing premature mortality of people with learning disabilities.
- Developing action plans to make any necessary changes to health and social care service delivery for people with learning disabilities.

Each borough across London has a “LeDeR Local Area Contact” normally this person is employed by the Clinical Commissioning Group (CCG).

The role of the Local Area Contact is primarily being the main link and lead for all LeDeR work locally as well as receiving notifications of deaths of People with a learning disability, allocation and oversight of reviews of deaths and leading on learning from reviews being put into action.

In Kingston the Local Area Contact is the Designated Nurse for Safeguarding Adults at the CCG.

All Local Area Contacts from the 6 CCG's in South West London (Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth) work together to ensure that there is no backlog of reviews and that knowledge and resources are shared across the south west London area.

So far in Kingston we have held a big learning event in conjunction with Kingston Hospital on Tuesday 30th July. The event was well attended by 50 attendees from parent and family representatives of people with a learning disability and local health and social care staff. As well as presentations from external speakers on learning from the LeDeR reviews from a national and local perspective there was also a Q and A session held for members of Mencap.

Further work we would like to focus on following learning from reviews is “recognising the deteriorating patient”. This work will involve developing and supporting training for families and support staff who care for people with a learning disability in the community to be able to have the skills to recognise and support someone when they are becoming seriously unwell.

For information on the LeDeR annual report and action into learning report please look at the attached links below.

<http://www.bristol.ac.uk/sps/leder/resources/annual-reports>

<https://www.england.nhs.uk/publication/leder-action-from-learning>

For further information on the Learning Disability Mortality Review please contact:

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