

**Learning from the lives and deaths of people
with a learning disability and autistic people
(LeDeR)**

**Annual Report (2020/2021) update to
Herefordshire Learning Disability Partnership
Board**

September 2021

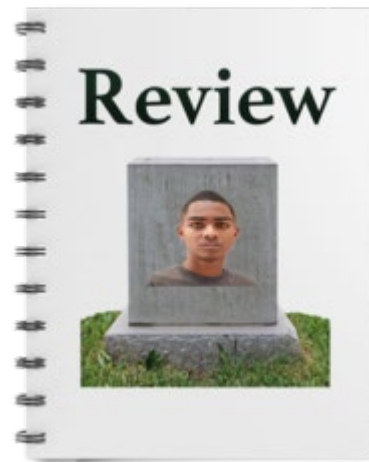
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**Herefordshire and
Worcestershire**
Integrated Care System

Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR)

NHS Herefordshire & Worcestershire CCG
2020 / 21 Annual Report (Easy Read).

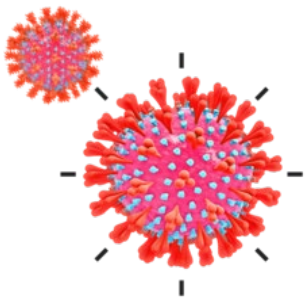
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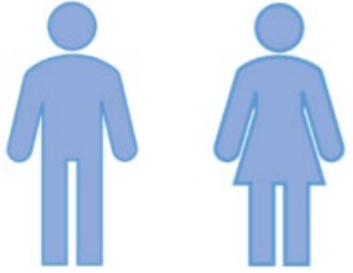
From April 2020 – March 2021



- We received 11 notifications that people with a Learning Disability living in Herefordshire had died. There were 36 notifications for Worcestershire.
- 90% of reviews completed after June 2020 were within 6 months.
- We start more reviews within 91 days. The average start time in Herefordshire is 148 days, from 227 days last year. In Worcestershire the average start time is 78 days from 166 days last year.
- A shortened review was completed for all COVID notifications so we could learn about themes more quickly (we did a full review too).



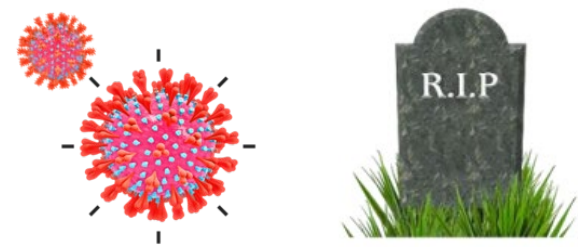
What we found out.



- In Worcestershire the average age of death for men has increased, for women it has stayed the same. In Herefordshire the average age of death for both men and women improved.
- The balance of deaths between men and women is the same as for the rest of England, slightly fewer women than men.
- Over 53% of deaths happened where the person usually lived in Worcestershire, last year less than 40% of deaths happened at home. In Herefordshire at least 55% of people have been supported to die at home over the past 3 years.
- Illnesses that affect breathing and lungs are still the most common causes of death.
- Deaths from bowel impaction are now below the English National Average.



COVID



- We do not yet know how deaths in Herefordshire and Worcestershire due to COVID compare to other areas.
- In the first wave of COVID nearly all of those with a Learning Disability who died of COVID were women who lived in care settings.
- Most people with a Learning Disability who died of COVID had mild to moderate disabilities.
- Most had a high Body Mass Index.
- In the second wave we saw far fewer deaths of people with a Learning Disability



What we need to do better.



- Not many people from Black or Asian backgrounds are notified to the programme. We need to make sure that we are getting all of the information about our local population.



- We need to understand how best to prevent obesity and help people lose weight.



- We need to understand why local people have higher than the national average levels of underlying health conditions such as mental illness, epilepsy and constipation.



- We need to improve the quality of Annual Health Checks to make sure that everyone is supported to have vaccinations and health screening.

Care quality

(Herefordshire
notifications)

No cases notified during 2020/21 were listed for Coroner Inquest

No case reviews completed in 2020/21 were graded as receiving poor care

Click to add text

One case was referred for Safeguarding Adult Review – Rapid Review process identified that overall care was satisfactory, no care gaps were considered contributory, and learning was shared.

Excellent examples of ReSPECT plans, personalised end of life care and dying in preferred place (usual bed).

Recommendations from Herefordshire reviews

Mental capacity assessment and Best Interest decisions
(particularly for refusal of treatment, DNAs or perceived
intolerance/ reluctance)

Reasonable adjustments for Out Patient settings

Bowel health-uptake of bowel cancer screening, continence
assessment and support with management

Annual Health Check (AHC) completion and quality

Health Action Plan arising from AHC

Priorities (3 Year plan)

Modifiable factors for respiratory conditions- vaccination (COVID, Flu, Pneumococcal), dysphagia assessment / management and dental health.

Annual Health Checks –completion rates and quality

Mental Capacity and Best Interests training and support

Bowel Health

ReSPECT awareness and informed completion

Awareness of LeDeR (notification assurance) and scope (Autism)

3 Year Strategy (to include ICS governance changes and alignment with other processes including Medical Examiner Office)