

## ADULTS AND HEALTH SCRUTINY PANEL

7 February 2019

### LEARNING DISABILITIES MORTALITY REVIEW (LEDER)

#### Report of the Strategic Director for People

|                                |   |  |
|--------------------------------|---|--|
| Strategic Aim:                 | Reaching our Full Potential   |  |
| Exempt Information             | No  |  |
| Cabinet Member(s) Responsible: | Mr A Walters, Portfolio Holder for Safeguarding - Adults, Public Health, Health, Commissioning , Community Safety including Road Safety |  |
| Contact Officer(s):            | Kim Sorsky, Head of Service Prevention and Complex Care Services  | 01572 758352<br>ksorsky@rutland.gov.uk       |
|                                | James Lewis, Local Area Contact, LeDeR programme, LLR   | 01164 544839<br>James.Lewis@leicester.gov.uk |

#### DECISION RECOMMENDATIONS

That the Panel;

1. Comments on the joint working across LLR and CCG's which has been established to improve the standard and quality of care for people with learning disabilities.

## 1 PURPOSE OF THE REPORT

- 1.1 To seek comments from the Adults and Health Scrutiny Panel on the initial work and learning from the work completed to date.
- 1.2 To request that the LeDeR programme return to Adults and Health Scrutiny Panel later this year (2019) to present local learning, recommendations and actions plans as to how health and social care services can be improved in Rutland.

## 2 BACKGROUND AND MAIN CONSIDERATIONS

- 2.1 The LeDeR Disabilities Mortality Review (LeDeR) programme was established in response to the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD). CIPOLD (the Executive Summary of which is attached as Appendix A) reviewed the deaths of 247 people with learning disabilities over a two-year period across five Primary Care Trusts in the South West. It found that:

- Men with learning disabilities died, on average, 13 years sooner than men in the general population; women with learning disabilities 20 years sooner
- For every person in the general population who dies from a cause of death relating to the quality of their care, three people with learning disabilities will do so.

The last of the report's eighteen recommendations was that 'A National Learning Disability Review Body to be established'. LeDeR, led by the University of Bristol and NHS England, was commissioned by the Health Equality Improvement Partnership to be this body.

2.2 The aims of the LeDeR programme are:

- 'To support improvements in the quality of health and social service delivery for people with learning disabilities'
- 'To help reduce premature mortality and health inequalities'

2.3 To achieve this aims each LeDeR Steering Group footprint is responsible for reviewing the deaths of all people over four years old with a diagnosed learning disability.

2.4 The reviews will focus on avoidable factors that may have contributed to a person's death, identifying differences in health and social care delivery across England and ways to improve services and prevent death and lastly develop plans of actions to guide necessary changes in health and social care services to reduce premature deaths.

2.5 The learnings from these reviews will form an evidence base for change for Leicester, Leicestershire and Rutland health and social care services. It is anticipated that the first local report will be available spring / summer 2019.

### **3 CONSULTATION**

3.1 Consultation not required as no whole scale changes to services are expected.

### **4 FINANCIAL IMPLICATIONS**

4.1 No financial implications. Current staffing resources are used across health and social care to complete reviews.

### **5 LEGAL AND GOVERNANCE CONSIDERATIONS**

5.1 N/A

### **6 DATA PROTECTION IMPLICATIONS**

6.1 A Data Protection Impact Assessments (DPIA) has not been completed because data governance has been overseen by the national LeDeR programme board.

## **7 EQUALITY IMPACT ASSESSMENT**

- 7.1 An Equality Impact Assessment (EqIA) has not been completed because there are no service, policy or organisational changes being proposed.

## **8 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS**

- 8.1 The LeDeR programme has the potential to greatly improve the quality of services delivered for people with learning disabilities. To do so it relies upon the support of all key local stakeholders. The support that Rutland County Council have provided has contributed greatly to the programme's implementation and delivery.
- 8.2 From a local perspective we are expecting to deliver the first LLR LeDeR report in spring / early summer 2019. Once that report has been developed it is requested that the LeDeR programme can return to scrutiny to share our learnings and actions plans for comment.
- 8.3 From a national perspective the local LeDeR Steering Group is awaiting information from the programme board and NHS England as to the future of the programme beyond April 2019. That being, the Minister for Health has outlined his commitment to the programme in the recently published NHS Forward View.

## **9 BACKGROUND PAPERS**

- 9.1 There are no additional background papers to the report

## **10 APPENDICES**

- 10.1 Appendix 1 – Confidential Inquiry into the Premature Deaths of those with a Learning Disability
- Appendix 2 – LLR LeDeR Information Pack
- Appendix 3 – LeDeR Annual Report (2018)

**A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.**