West Yorkshire
Health and Care Partnership

NHS West Yorkshire
Integrated Care Board

West Yorkshire Integrated Care Board

LeDeR

(Learning from Lives and Deaths of People with a learning disability and autistic people)

Annual Report

2023 – 2024

Easier to Read summary

Introduction

This is the easy read summary of the West Yorkshire Integrated Care Board LeDer Annual Report for 1st April 2023 to 31st March 2024.

You can see the full version of the report by clicking on this link:

[The Learning Disability Mortality Review (LeDeR) - Learning from Lives and Deaths :: West Yorkshire Health & Care Partnership]

LeDeR is learning from the lives and deaths of people with a learning disability and autistic people.

It was set up in 2017 as lots of people with a learning disability, autism or both were dying earlier than they should do and from things they shouldn't die from.

Bradford District and Craven
Health and Care Partnership

The LeDeR programme for West Yorkshire is hosted by Bradford District and Craven Health and Care Partnership.

It covers the whole of the West Yorkshire area – Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield.

A LeDeR review does not look at a person's full health and social care records. It looks at the main things that could have affected their health outcomes.

It looks at things that were done well and things that could have been done better.

NHS England

Examples of these things are then shared with other health and care partnerships all over the country.

This helps to make sure that everyone has the same chance of good health as others.

It also helps to stop people dying sooner than they should have done.

Family members often know the most about the care the person received. Sharing their experience will help other people with a learning disability and/or autism.

The reviewer will also speak to the persons GP or look at their GP records.

They will have a conversation with at least one other person who was involved in the care of the person who died. This might be a support or care worker.

Sometimes a focused review will take place. This means the review will go into more detail about the things that happened. A family can request a focused review.

What we found out

181

The team received 181 notifications of deaths. 9 of these were not reviewed because the people did not have a formal diagnosis or they lived out of the area.

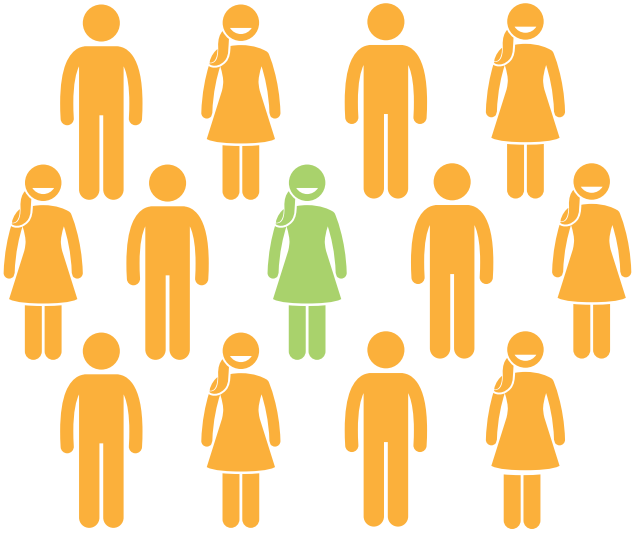
There were a few more notifications than the year before. Most of the reviews have been closed but some are not complete.

This is because we are waiting for more information or because the family have asked for more time.

We also have some challenges within our team.

There have not been many notifications for autistic people in our local area or across the country.

We need more reports so we can improve the care for autistic people without a learning disability.



The main causes in the 2022 national report were suicide, drug or alcohol, and accidental death like falls.

Other causes were respiratory (breathing) conditions, heart and stroke related.

- 56

- 59

Just under half of the people reviewed were female and just over half were male.

The average age of death for people with a learning disability was 57 years. For women it was 59 years and for men it was 56 years.

Over half of people with a learning disability died before they were 65.

This is much younger than people without a learning disability.

Just under half died in hospital. The rest of the people died where they usually live, in a residential or nursing home and in a hospice.

Most of the people were from a white background.

The rest were from an Asian or Asian British background, or other background.

70% of the people had received a Covid-19 vaccination. One person died from Covid-19.

Most people had received their annual health check. Most of the people had more than 2 health conditions.

Lots of the people who died had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place.

This means if your heart or breathing stops the healthcare team will not restart it.

The top 5 causes of death were:

- Respiratory. This is anything to do with breathing
- Aspiration. This is when something you swallow goes into your airways or lungs
- Cancer
- Cardiovascular. This is your heart and blood vessels.
- Brain-related

There are some differences in the information compared to last year.

You can see this in the full version of the report.

[The Learning Disability Mortality Review (LeDeR) - Learning from Lives and Deaths :: West Yorkshire Health & Care Partnership]

The review looked at all the things that had been done well across our 5 places in West Yorkshire. This is called ‘good practice’.

The good practice will be shared with other areas to help to make things better.

Some of the good practice in this report includes:

- There was lots of good team work to provide the best care
- There was good communication and involvement of family during a hospital stay
- Recognising that a family needed support due to English not being their first language
- Supported living staff were able to stay with a patient while in hospital so the patient didn’t get distressed
- Cultural needs were met

There are lots of other examples of good practice that can be seen in the full report.

Some of the things that the LeDeR team have been doing to raise awareness

- Attended events during Learning Disability Week
- Bradford District and Craven Health and Care Partnership Cancer and Wellbeing event.
- Hosted the first West Yorkshire LeDeR learning event

- Delivered presentations across West Yorkshire
- Provided updates 4 times a year to our local places – Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield

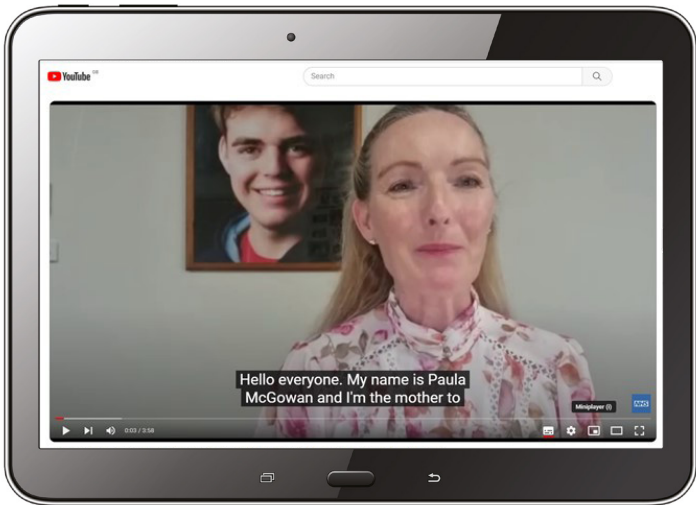
Oliver McGowan training

The Oliver McGowan training was set up to provide training to healthcare staff on learning disability and autism.

The training is co-delivered by trainers with a learning disability and autism.

Click on these links to find out more about the training

The Oliver McGowan Mandatory Training on Learning Disability and Autism e- learning



There is also a YouTube video you can watch:

Paula McGowan: The Oliver McGowan Mandatory Training on Learning Disability and Autism - YouTube

NHS West Yorkshire
Integrated Care Board

West Yorkshire Integrated Care Board (ICB) is working with Inclusion North and Cloverleaf Advocacy whowill co-deliver the training.

You can find out more about Oliver by clicking here:

www.olivermcgowan.org/

The Mental Health, Learning Disabilities and Autism Programme

Our Learning Disability Challenge shares the work we do to transform care for people.

It has themes of Start Well, Live Well, Age Well and Working with people with learning disabilities.

Our programme supports our partnerships big ambition to reduce the gap in life expectancy.

This means making sure people with mental health conditions, learning disabilities and/or autism live as long as everyone else.

Our key priorities for 2023-2024

These are the most important things for us to work on. They include:

- Carry on making sure that people know about the LeDeR programme. Make sure the process is understood
- Keep improving to make sure that reviews give a clear understanding of lived experience

- Continue to host learning events across the whole of West Yorkshire
- Use the findings to support learning from deaths and to improve services.

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