

Learning from lives and deaths-People with a learning disability and autistic people' (LeDeR).

Annual Report – Easy Read 1st April 2021 to 31st March 2022




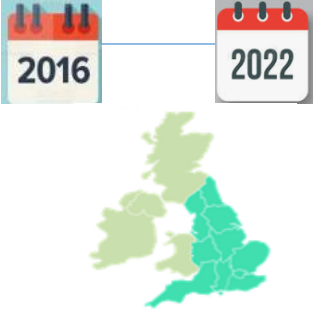


Hazel Moore


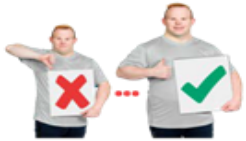

Head of Nursing: NLCCG (on behalf of the 6 CCGs within the Humber and North Yorkshire Health and Care Partnership)

10th June 2022


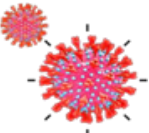


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1.0 Introduction

	<p>Each year, NHS Clinical Commissioning Groups (CCGs) have to write a report about the number of people with a learning disability who have sadly died in their area. This is the 4th Learning Disabilities Mortality Review (LeDeR) Programme Annual Report from the CCG's. The CCG's move on the 1st July 2022 into Integrated Care Systems (ICS's).</p> <p>This the 1st time the 6 CCG's in the new ICS, which will be called The Humber and North Yorkshire Health and Care Partnership, have written a report together, looking at all the deaths of people with a learning disability in the ICS area.</p>
	<p>The LeDeR programme was set up 6 years ago. Every person in England who is over the age of 4 years, who has a learning disability and sadly dies, has their death looked at in the same way.</p>
	<p>We look at every death to see if anything could have been done better and take the learning from the reviews to make changes to the care we provide in our local areas.</p>
	<p>The review is carried out by a person called a reviewer. They look at all the care the person who died received during their life.</p>

	<p>They do this by:</p> <p>Talking to the family or someone who knew the person really well and to people who supported the person during their everyday life.</p>
<p>Medical Records</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>They will review the medical records to look at the care provided to the person.</p>
	<p>The completed review looks for where changes need to be made to make things better for people in our area who have learning disabilities.</p>
	<p>This report tells you about people who have died in the Humber and North Yorkshire Health and Care Partnership area from 1st April 2021- 31st March 2022.</p> <p>It also tells you about the learning we found and where we need to make things better from reviews we did 1st April 2021 - 31st March 2022.</p>

2. What we know about the People who Sadly Died 1st April 2021 – 31st March 2022

	<p>86 people who had a learning disability and sadly died, had their death reported to the LeDeR programme.</p>
	<p>2 of the 86 deaths reported were related to the COVID-19 pandemic which started in 2020.</p>
	<p>Of the 86 people who died:</p> <p>44 of them were men.</p> <p>42 of them were women.</p>
	<p>The average age of the 86 people who had died across the Humber and North Yorkshire area was 60.4 years.</p> <p>The average age of the men who died was 62.8 years.</p> <p>The average age of the women who died was 73 years.</p>



All of the people were of white British heritage. We have identified there may be under reporting from people within our BAME communities across our areas and we need to do more work to make sure all the people who sadly die are reported to the programme so that we can review their death for any learning to improve our services.



47 people died in a hospital.











20 people died in the community. 4 of the 20 people died in a hospice and 16 people died in a residential or nursing home.




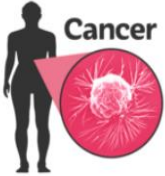
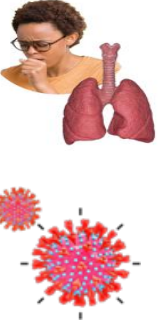
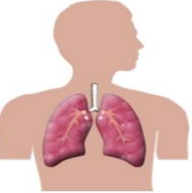
18 people died in their own home or supported living accommodation.

3. What we learnt from the Reviews we Completed 1st April 2021 – 31st March 2022



	<p>66 reviews were completed 1st April 2021 – 31st March 2022.</p>
	<p>36 of these were completed in the time they were meant to be finished in. This is 6 months from the time we know the person died.</p>
	<p>30 of the reviews were not finished in the time they should have been. Some of the delay was because there were not enough people complete the reviews.</p>
	<p>Of the 66 reviews completed:</p> <p>37 of them were men.</p> <p>29 of them were women.</p>

	<p>The average age of the 66 people across the Humber and North Yorkshire area was 59 years.</p> <p>The average age of the men whose death was reviewed was 60 years.</p> <p>The average age of the women whose death was reviewed was 59 years.</p>
	<p>38 people died in hospital.</p>
	<p>17 people died within the community. 4 of the 17 people died in a hospice and 13 people died in a residential or nursing home.</p>
	<p>10 people died in their own home or supported living accommodation.</p>




4. What the Completed Reviews told us about Why a Person Died 1st April 2021 – 31st March 2022

	<p>When a person dies, Part 1a of a Death Certificate tells you what the person died of; this is called the cause of death.</p>
	<p>From the 66 completed reviews, the single most common cause of death within the Humber and North Yorkshire Health Care Partnership area was cancer.</p>
	<p>The second single most common causes recorded were:</p> <ul style="list-style-type: none"> • Pneumonia. This is an infection in a person's lungs and is caused by germs called 'bacteria'. • COVID-19.
	<p>However: Altogether, problems with people's respiratory systems were the most common cause of death.</p>





5. Some Examples of Good Care found in the Reviews 1st April 2021 – 31st March 2022

	<p>Lots of the completed reviews showed good practice across all the areas within the Humber and North Yorkshire Health and Care Partnership. Here are some examples:</p> <ul style="list-style-type: none">• Some reviews told us there was good support from the community learning disability team nurses, supporting care home staff as well as people with learning disabilities.• Some reviews told us that end of life care planning is getting better, involving the person, their family and those that cared for them.• Lots of reviews identified care home staff knew the people they were caring for very well.• A review showed the care home staff had ensured someone living in the care home had a happy life and a dignified death in the home environment.
	<ul style="list-style-type: none">• Many reviews identified good evidence of multi-disciplinary working, good communication between health services and families and evidence of person-centred care and care planning. This included support from staff from the persons care home when they were in hospital which meant the person was supported by people who knew them really well.• Some reviews identified good care planning had taken place to stop people going into hospital when they didn't need to at the end of their life.• Some people had access to a learning disability doctor who specialises in complex physical health and was able to coordinate the medical care the person needed.

6. Some Examples of Things we need to do Better found in the Reviews 1st April 2021 – 31st March 2022

	<p>Some of the completed reviews showed where we need to do better across all the areas within the Humber and North Yorkshire Health Care Partnership. Here are some examples:</p> <ul style="list-style-type: none">• We found that some reviewers had difficulty getting engagement from care homes and GPs for information to complete the reviews.• Not everyone who needs to go into hospital is seen by a learning disabilities nurse.• Information was not always given to people in an Easy Read format.
	<ul style="list-style-type: none">• Some reviews found that there was poor application of the Mental Capacity Act.• Some reviews did not find evidence of mental capacity assessments and Best Interests decision making.
	<ul style="list-style-type: none">• Some reviews showed that there have been improvements in the documentation for end of life care, but many reviews still showed problems with the quality of the documentation completed, or it was not kept up to date.

7. Recommendations from the Completed Reviews 1st April 2021 – 31st March 2022

	<p>There has been a lot of good work going on to make things better for people with learning disabilities living in the Humber and North Yorkshire Health Care Partnership area.</p> <p>From the reviews, we found 4 key areas where we need to do more work to make things better.</p>
	<ul style="list-style-type: none"> • We need to make sure everyone who is 14 years old and over is on their GP learning disability register and is offered their Annual Health Check. • We need to make sure the reviews are completed really well and meet the person's needs.
	<ul style="list-style-type: none"> • We need to make sure all health and care staff are aware of their responsibilities and following the Mental Capacity Act.
	<ul style="list-style-type: none"> • We need to keep working to make sure people coming to the end of their life are recognised early so that decisions can be made with them, and their family and plans made to stop them being taken to hospital if they do not need to go.