Learning Disabilities Mortality Review (LeDeR) Programme

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(2015-2018)

Improving the standard and quality of care for people with learning disabilities

University of BRISTOL

NHS England

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP), on behalf of NHS England.

Leaflet for professionals V1.3

Who are we?

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It is being delivered by a team based at the University of Bristol, led by Dr Pauline Heslop.

Why is the LeDeR programme necessary?

The LeDeR programme was one of the recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD)[1].

CIPOLD reported that for every one person in the general population who dies from a cause of death amenable to good quality care, three people with learning disabilities will do so.

One of the key recommendations of CIPOLD was for the greater scrutiny of deaths of people with learning disabilities. In this way, potentially modifiable circumstances leading to a death could be identified and avoided in the future through improvements to health and care services.

[1] CIPOLD was a Confidential Inquiry into the deaths of people with learning disabilities that took place between 2010-2013.

What does the LeDeR Programme do?

The LeDeR Programme supports local areas in England to review the deaths of people with learning disabilities aged 4 years and over.

A confidential telephone number and website enables families and other key people to notify the LeDeR team of the death of someone with learning disabilities.

An initial review of the death will then take place. The purpose of this is to provide sufficient information to be able to determine if there are any areas of concern in relation to the care of the person who has died, and if any further learning could be gained from a multiagency review of the death that would contribute to improving practice.

If indicated, a more in-depth, multiagency review will be conducted.

As part of the review, the local reviewer would speak to family members, friends, professionals and anyone else involved in supporting the person who has died to find out more about their life and the circumstances leading to their death.

When is the LeDeR programme coming to my area?

The programme of reviews is being extended across all of England during 2017.

For further information about the LeDeR programme

If you would like further information about the LeDeR Programme, please contact:

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