

<b>8 October</b>		<b>ITEM: 8</b>
<b>Thurrock Health and Wellbeing Board</b>		
<b>SET LeDeR End of Year Report</b>		
<b>Wards and communities affected:</b> all	<b>Key Decision:</b> Acknowledgement of Report	
<b>Report of:</b> Rebekah Bailie, Integrated Learning Disability Health Commissioner (acting on behalf of Collaborative Forum of CCGs and LAs across SET)		
<b>Accountable Head of Service:</b> Not applicable report produced by Council Partner		
<b>Accountable Director:</b> Roger Harris, Corporate Director Adult's Housing and Health		
<b>This report is public</b>		

## Executive Summary

The LeDeR End of Year Report and accompanying documents highlight the issues impacting on people with Learning Disability and their premature deaths. People with learning disability across Southend Essex and Thurrock die on average 20 years younger than other people in the population and experience health inequalities which impact on their quality of life.

A joined-up approach between all aspects of health and social care must be taken to address the issues raised. The LeDeR Action Plan 2020-2021 outlines the priorities for the year and has been agreed by the LeDeR Steering Group and the Health Equalities Board, both of which have representation from Thurrock.

### 1. Recommendation(s)

#### 1.1 To acknowledge and agree the LeDeR report and action plan

### 2. Introduction and Background

2.1 LeDeR is a national programme which was implemented across SET from September 2017. All deaths of people with learning disability from 4 years upwards are reviewed. Deaths of children and young people 4 – 18 years are reviewed by the Child Death Review Team and the recommendations incorporated into the overall LeDeR information. Deaths of adults 18 years and above are reviewed by a dedicated team of reviewers managed by the Integrated LD Health Commissioning Team.

- 2.2 Between the beginning of the programme in SET and the end of the 19-20 year there were 272 deaths of people with Learning Disability. At the end of March 137 reviews had been completed with 318 recommendations identified. (These are summarised by organisation and cross-system issues in the LeDeR Themes document)
- 2.3 Pneumonia is the leading direct cause of death (on part 1a of a death certificate) often as part of a pattern of early frailty and deterioration (45 years onwards). Aspiration pneumonia (caused by swallowing difficulty) was the second cause and cancer the third. Underlying cardiac issues were prevalent and need further investigation.
- 2.4 More people with learning disability die in hospital than in the rest of the population and there needs to be earlier and better end of life planning.
- 2.5 We have a small number of people from BAME backgrounds and need to have better understanding and representation of issues which impact. All but one of the BAME deaths were of children.
- 2.6 Most care was good or satisfactory. There are some examples of excellent care, but a similar level of very poor care which impacted on the death. We need more established processes to alert quality and safeguarding issues to councils and CCGs.
- 2.7 The details of the LeDeR findings can be found in the End of Year Report and the data for Thurrock can be found in the supporting data.

### **3. Issues, Options and Analysis of Options**

- 3.1 Having analysed the recommendations and identified themes, the key areas for priority were identified as:
  - 3.1.1 Annual Health Checks – all people with learning disability over the age of 14 years should receive an LD Annual Health Check.
  - 3.1.2 Frailty – all parts of the health and social care system need to work together to identify, prevent and manage early frailty in people with LD
  - 3.1.3 Dynamic Support Register – Essex Learning Disability Partnership – provider of specialist LD health services have been commissioned to develop this DSR for their caseload and to broaden this to include information from all other agencies.
  - 3.1.4 Care coordination – it is vital for someone to have an overview of the person's health and wellbeing, liaising across health and social care to ensure there is a joined up assessment of need and plan for delivery. ELDP will start a pilot this year and expand.
- 3.2 The details of the deliverables and outcomes for the priorities can be found in the LeDeR Action Plan.

### **4. Reasons for Recommendation**

- 4.1 It is recommended that the Board acknowledge and agree the LeDeR Report and Action Plan in order to make meaningful change for the people with Learning Disability in Thurrock.

## **5. Consultation (including Overview and Scrutiny, if applicable)**

- 5.1 The Report has been presented to the SET Experts by Experience Forum and a representative from Thurrock attended this and the Health Equalities Board.
- 5.2 Representatives from Thurrock CCG and Adult Social Care are invested in the LeDeR programme and attend the Steering Group, Quality Panel and working groups.

## **6. Background papers used in preparing the report**

This report is the presentation of:

- a) SET LeDeR End of Year Report 2019-20
- b) SET LeDeR Action Plan

Also see accompanying documents for further detail and information

- c) SET LeDeR Themes 2019-20
- d) Supporting data

## **7. Appendices to the report**



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### **Report Author:**

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