County Cabinet
May 2018

Report of the Cabinet Member Adult Social Care and Health Services

Introduction

Following the publication of the recent report by the Learning Disabilities Mortality Review (LeDeR) Programme into the deaths of people with learning disabilities, I have been asked by Councillor Hannaford to report on *'our views on these matters and provide a Devon perspective*'.

Response

Health inequalities persist between different population groups and between local authorities. People with learning disabilities have markedly poorer health than their non-disabled peers and have a high prevalence of diagnosed health problems.

The Learning Disabilities Mortality Review (LeDeR) programme recently published its study into the deaths of people with learning disabilities. The full report indicates that this inequality continues and can be accessed here https://www.hqip.org.uk/wp-content/uploads/2018/05/LeDeR-annual-report-2016-2017-Final-6.pdf, along with the easy read version here https://www.hqip.org.uk/wp-content/uploads/2018/05/LeDeR-annual-report_Easy_read.pdf

An initial review is not triggered by a particular circumstances, it is undertaken to identify whether there are any areas of concern in relation to the care of the person who has died, or if any further learning could be gained from a multi-agency review of the death that would contribute to improving practice

The national programme has developed a review process for the deaths of people aged 4 years and above with learning disabilities. Between July 2016 and November 2017, the national programme was notified of 1311 deaths. By November 2017, the programme had reviewed 103 of these deaths across the programme areas.

Of the 103 reviews that had taken place, reviewers indicated that in 13 (13%) of these cases there should be a further multi-agency review because their health had been adversely affected by one or more of the following:

a) delays in care or treatment;
b) gaps in service provision;
c) organisational dysfunction; or
d) neglect or abuse

The most commonly reported learning and recommendations in the study were made in relation to the need for:

- Inter-agency collaboration and communication;
- Awareness of the needs of people with learning disabilities; and
- The understanding and application of the Mental Capacity Act (MCA).

Wider Devon Context

The two Devon CCGs established a LeDeR Steering Group, which operates across wider Devon, which includes Torbay Council, Plymouth City Council, and Devon County Council footprints, in November 2017. This group is working across the Devon health and care system, along with a team of reviewers to share the learning.

Whilst it is too early to benchmark our performance, it was anticipated during the scoping that wider Devon would receive approximately 1-2 referrals per week. The current referral rate is as expected. There have been 40 referrals to date across the wider Devon footprint, with 37 either being reviewed or on hold. Three cases have been completed so far, and the learning from these will be disseminated across the system.

There are 36 health and care trained reviewers across wider Devon, with 4 from Devon County Council.

Since the report was published, we have pulled together leads from across the health and care system to address the recommendations within the report which will be shared with both the Learning Disability Partnership Board at their next meeting in July, and with the Devon Safeguarding Adults Board.

The Devon STP is refreshing the strategy for how adults with learning disabilities are supported across the health and care system to ensure that alongside promoting the independence of people with disabilities, we also reflect the recommendations from this study.

Councillor Andrew Leadbetter
Cabinet Member
Adult Social Care and Health Services