

LeDeR Easy Read Report

Introduction



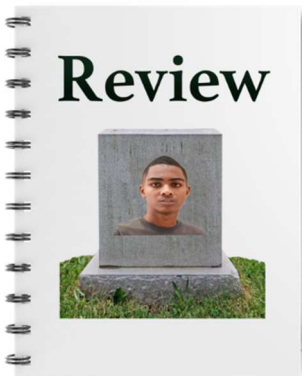
Some people will need someone to help them to go through this information so that they understand it.

This person may be a member of staff, someone from your family or a friend.



NHS Leicester, Leicestershire, and Rutland produce a report every year looking into the deaths of people with learning disabilities (LD) and autistic people in our area.

The LeDeR programme was set up in 2017.



What is LeDeR?

- LeDeR means Learning from Lives and Deaths of people with a learning disability and autistic people.
- If someone over 18 with a learning disability or autism dies in England, it can be reported to LeDeR.
- Special reviewers look at the person's care and support.

The aim is to learn lessons and make care better.



About this report

This report looks at deaths in Leicester, Leicestershire, and Rutland from 1st April 2024 until 31st March 2025.

The report shows:

- How many people died
- What they died from
- What we learned
- What needs to change

What we found from the completed reviews:



- 90 people who died were reported to LeDeR
- Most of these people had a learning disability
- Most of these people were between the ages of 61 and 70
- Most of these people were men



Ethnicity

- Ethnicity means your race or background, e.g. Black, White or Asian.
- Most of the people who were reported to LeDeR were White British.
- It is important that more people from other races or backgrounds are reported to LeDeR when they die.



We need to understand different cultures better so everyone gets good care.

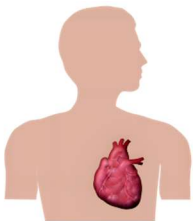
1.



Cause of death:

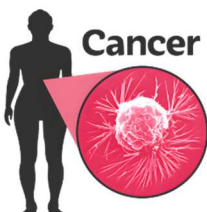
When a person dies, Part 1a of a Death Certificate tells you what the person died of; this is called the **cause of death**.

2.




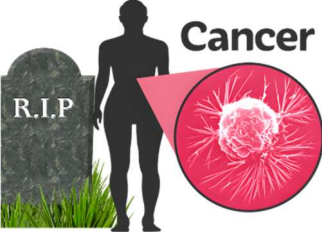


- The most common cause of death was respiratory (breathing) illnesses.
- The second most common cause was heart problems (cardiovascular disease).
- The third most common cause was cancer.
- 1 person died from COVID-19



3.



What else we learned this year that could be done better:

	<ul style="list-style-type: none"> • There were some problems with the Mental Capacity Act (2005) – this law checks if people can make decisions about their care.
	<ul style="list-style-type: none"> • Fewer people with learning disabilities and autistic people are using cancer screening programmes.
	<ul style="list-style-type: none"> • Fewer women are having cervical screening (where a doctor or nurse checks inside your vagina to make sure it is healthy)
	<ul style="list-style-type: none"> • More people with learning disabilities died from cancer this year.

Positive practice and what went well this year:

	<ul style="list-style-type: none"> • Many people with learning disabilities had annual health checks.
	<ul style="list-style-type: none"> • A blood test clinic was set up for people who need extra help.

	<ul style="list-style-type: none"> • More people had STOMP reviews (to check medication use).
	<ul style="list-style-type: none"> • A new combined annual health check project has started. <ul style="list-style-type: none"> ○ This is for people with Learning Disabilities, severe mental illness, and autism.
<p>Top ten learning points from the completed reviews:</p>	
	<ol style="list-style-type: none"> 1. It is very important that more people from non-white races or backgrounds are reported to LeDeR when they die.
	<ol style="list-style-type: none"> 2. Staff need to understand the Mental Capacity Act (2005).
	<ol style="list-style-type: none"> 3. Guessing someone's weight is unsafe. Special weighing scales are available to use.
	<ol style="list-style-type: none"> 4. People with challenging behaviours need clear care plans and future planning.
	<ol style="list-style-type: none"> 5. End-of-life care should be talked about at the right time.

	<p>6. More people need to go to cancer screening.</p> <ul style="list-style-type: none"> Information about cancer screening must be clear with reasonable adjustments.
	<p>7. Some people with LD and autistic people are not able to communicate when they are in pain or when they feel unwell.</p> <p>There are communication passports and a DISDAT (Disability Distress Assessment Tool) that are available to use.</p>
	<p>8. Breathing problems must be found early and treated.</p>
	<p>9. Heart disease is a major cause of death – healthy eating, exercise, and healthy weight are important.</p>
	<p>10. Work is being completed on developing a specialist clinic for people with complex needs who need extra support to have a blood test.</p>
	<p>The learning from this report will help improve care for people with learning disabilities and autistic people in Leicester, Leicestershire, and Rutland.</p>



Useful links

[Annual health checks ER v3](#)

[Healthy Living ER v10](#)

[Resources – LLR HWP](#)

[Reasonable Adjustments Digital Flag – LLR HWP](#)

[Learning from lives and deaths – People with a learning disability and autistic people \(LeDeR\) – LLR HWP](#)

[Support available for people with a learning disability – LLR HWP](#)