



NHS Frimley LeDeR Report

Learning from the lives and deaths
of people with learning disabilities
and autism.

April 2023 – March 2024



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NHS Frimley ICB



The **Frimley Integrated Care Board (ICB)** helps local services to work together:



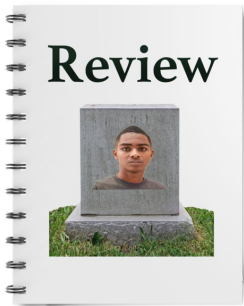
- hospitals
- social services
- community health services

We work in:



- Slough
- Windsor and Maidenhead
- Bracknell Forest
- Surrey Heath
- North-East Hampshire and Farnham

About LeDeR



When someone with learning disabilities or autism dies, we learn about their care and support.

This is called a **LeDeR review**.



LeDeR reviews help us to make **health and care services** better.



Health services – some examples:

- hospitals
- GPs



Care services – some examples:

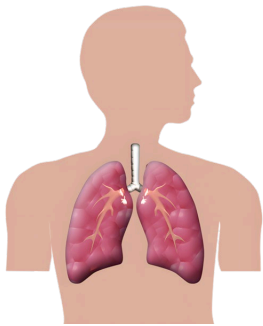
- care homes
- help in your own home

About this report

This report tells you:



- how many people's deaths were reported to LeDeR between April 2023 and March 2024



- the reasons why the deaths happened



- things we have learned



- our plans for making health and care services better



Learning and improving

The things we learn from LeDeR reviews help us to:

Make care better

We find out about poor care.

We do things to make it better.



Reduce health inequality

Health inequality is when some people have worse health and care than other people. This happens because of things like disability, race, and where people live.



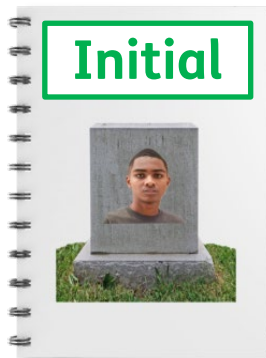
Prevent early deaths

Good care helps people to be healthier and live longer.



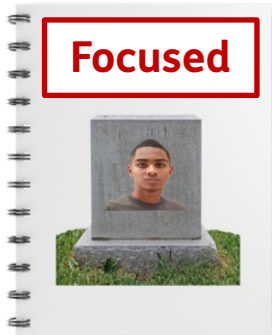
LeDeR reviews

There are 2 types of LeDeR review:
initial and **focused**.



Initial

Every death which is reported to us gets an **initial review**.



Focused

We do a detailed **focused review** when the person who died:

- had autism but not a learning disability
- was from an ethnic minority
- did not get good care or treatment



Our work this year

This year we have:



- employed 2 new reviewers



- improved how we check the quality of reviews



- finished reviews more quickly



- involved more people, with different skills, in checking and finishing reviews

This year's reviews

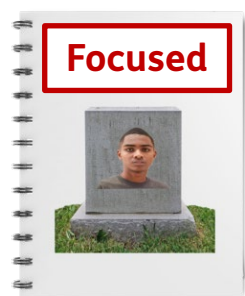


39 deaths were reported to us this year: **19** male, **20** female.

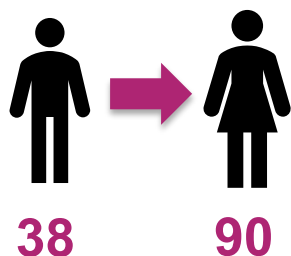


2 of these were children.

These reviews were done by the Child Death Overview Panel.



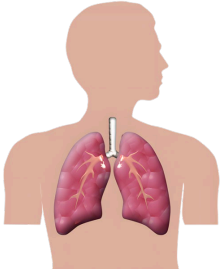
3 of the deaths reported to us needed focused reviews.



The youngest adult was **38**.

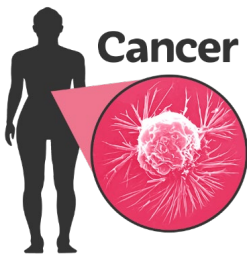
The oldest was **90**.

Reasons why people died



Chest infection or pneumonia

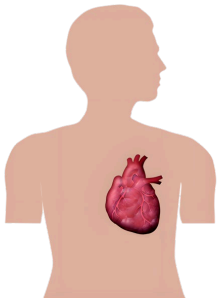
6 people



Cancer

Cancer

5 people



Heart problems

5 people



Dementia

2 people

Other reasons

6 people



Ethnicity

34 people were White and British

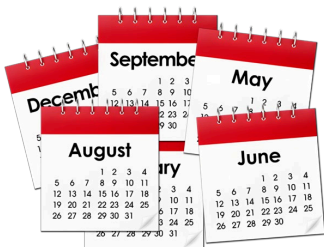


3 people were from other ethnic groups. For example, Pakistani, Caribbean.



2 people did not have information about ethnicity recorded on their review.

The time it takes to do reviews



1 in 5 reviews were finished within 6 months.

Our 3 priorities



We look for **themes** during reviews.

Themes are similar things that happen to lots of different people.



Themes help us find the most important things to work on: our **priorities**.

Our 3 priorities this year are to:



1) Check and improve the quality of Annual Health Checks

2) Support more people to get screened for cancer

3) Get better at noticing when a person's health starts to get worse



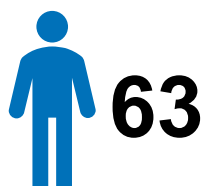
Things we have learned



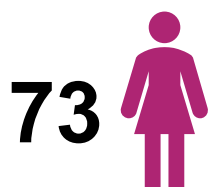
Every review tells us about things that went well, and things that could be better.



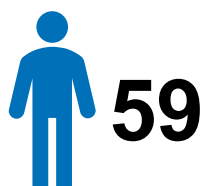
[The full LeDeR report](#) gives you 4 stories:



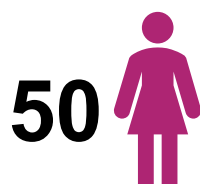
- a 73-year-old man with severe learning disability and autism



- a 73-year-old woman with a moderate learning disability



- a 59-year-old man with a moderate learning disability



- a 50-year-old woman with a mild learning disability

Things that went well



We heard about good care and support:

- good support from a learning disability specialist team



- excellent care from hospital staff

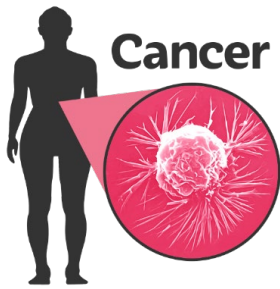


- extra support with medicines, vaccinations and blood tests



- good support for a bereaved family

Things to improve



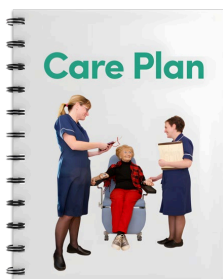
Cancer screening: more support to get tests to check for signs of cancer.



Annual Health Checks: more people need to get their checks.



Health passports: they help hospital staff to learn about the person. We heard about them not being used.



End of life care: people should have a care plan about what should happen



Communication with families needs to be better.

Making changes

LeDeR Steering Group

We make sure the things we learn make a difference. We do this by working with other groups and organisations.



For example:

- Learning Into Action Group
- Local Safeguarding Boards

Strategy for 2023 - 2026

We have a plan about how we will help people with learning disabilities and autism. There are 14 things we want to work on.



Contact us



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