Learning Disabilities Mortality Review (LeDeR) Programme

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(2015-2018)

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

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

Leaflet for families V2.3

Who are we?

The Learning Disabilities Mortality Review (LeDeR) Programme is based at the University of Bristol and managed by Dr Pauline Heslop.

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

The Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

Why is the LeDeR programme necessary?

CIPOLD reported that some people with learning disabilities were dying sooner than they should. Some of the reasons for this were related to the standard of health and social care that they received.

One of the key recommendations of CIPOLD was for us to look in more detail into the deaths of people with learning disabilities. In this way, we would be able to identify common issues or problems that might have led to these deaths. Once these issues are identified, improvements to health or social care could be made.

We also want to look at what helps some people to live longer, healthier lives than other people and to share this learning.

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. If necessary, a more in-depth review will be carried out involving people from health, social services and other agencies.

We know it is important to hear your views

The local reviewer would like to talk to family, friends and other key people about the life and circumstances leading up to the death of their relative or friend.

We hope by looking at the deaths of people with learning disabilities and finding out from families and others what, if anything, could have been done differently, that this will help improve the health and social care for people with learning disabilities in the future.

We will also do a number of associated projects to help us find out how many people with learning disabilities die each year and why.

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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