



Roll out of the Learning Disabilities Mortality Review programme (LeDeR) Important information for Acute General and Specialist Hospitals

The purpose of this communication is to advise you about the LeDeR programme and how you might be asked to participate in it, together with the basis by which patient identifiable information can be shared with the review team.

Your support in this service improvement initiative is key. Please read and cascade this information to appropriate teams within your organisation for their information and action.

The LeDeR programme has been commissioned by NHS England to support local areas in England to [review the deaths](#) of people with a learning disability to:

- Identify common themes and learning points and
- Provide support to local areas in their development of action plans to take forward the lessons learned

There are two specific ways that healthcare professionals may be involved in the LeDeR Programme:

- I. One is with regard to [notifying the death](#) of **any** of their patients with a learning disability.
- II. The other is to **input** into [a review into the circumstances leading to the death](#), of those aged 4 years and over. This may involve sharing information about a patient who has died or participating in a multi-agency review where knowledge and perspectives in primary care will be of significant importance. More detailed information about this is in the attached FAQs.

Important: The LeDeR programme has established pilot sites in each region of England. The pilot sites have now shared their learning and the programme is being rolled out across the rest of that region. Please refer to the LeDeR website for further details.

Legal basis for sharing patient identifiable information

The LeDeR programme is part of a [suite of programmes](#) previously known as confidential enquiries. It has approval from the Secretary of State under section 251 of the NHS Act 2006 to process patient identifiable information without the patient's consent.

Service condition 26 of the NHS Standard Contract requires any provider of services to the NHS to participate in the projects within the National Clinical Audit and Patient Outcomes Programme relevant to the Services.

The LeDeR programme strives to ensure that reviews of deaths lead to learning which will result in improved health and social care services for people with learning disabilities. It is not an investigation nor is it aimed at holding any individual or organisation to account. If individuals and organisations are to be able to learn lessons from the past it is important that the reviews are trusted and safe experiences that encourage honesty, transparency and the sharing of information in order to obtain maximum benefit from them.

For FAQs and further information about the programme, please contact the LeDeR team at:
E: leder-team@bristol.ac.uk T: 0117 331 0686 W: www.bristol.ac.uk/sps/leder