Southend Essex and Thurrock LeDeR Action Plan **Actions**

Issue	Recommendations	Local	Lead	National	Timescale	Measure
1. Frailty and Deterioration	Earlier treatment when carers first identified the person was "off colour" plus referral for NGT in community may have helped give XX the strenth to withstand infection	1.1 provider forums to be mapped and communications planned to include national information 1.2 Health and Wellbeing Strategy for LD to be established covering social prescribing, care navigation, and accessible information 1.3 results of national working groups to be circulated when known	Public Health(Krishna Ramakhelawon)	sepsis and pneumonia working groups Flu vaccine programme		Carers can identify changes in health and know what to do to get the relevant help and prevent deterioration/crisis
	social care staff failed to identify the deteriorating patient					
	The process to access funds for someone who has a deputy under court of protection is clear and functions well in day to day life but when the individual has rapidly deteriorating health and unplanned interventions the system is slow and cumbersome There needs to be a process to bypass this or more advanced planning to ensure this is not the case	Item to be agreed at the next meeting				
	multiple attendance at A&E should trigger action	1.5 LD Dynamic Risk Register (currently held by Essex Learning Disability Partnership ELDP) to be expanded to raise health alerts. Criteria and mechanisms to be developed across organisations including LD Liaison nurse flagging and Primary Care.	HPFT (Wellington Makala)			There is a shared system for identifying and escalating risks to health across health and social care When risks are identified, health and social care intervene to prevent escalation/deterioration
	People at high risk of falls and reduce mobility should be escalated					
	Multiple (old) fractures should be escalated					
2. Long Term Conditions	improved care is needed for people with learning disabilities who have diabetes with a holistic person centred approach to their care and NICE guidance followed.	2.1West, Mid and South STP Diabetes leads to consult and agree a systematic approach	STP Diabetes Leads			People with Long Term Conditions will have access to best practise. Adults and Families will have access to accessible information on LTCs Reasonable adaptations will be made to specific pathways
	Review people with epilepsy on LD registers and if they are on AEDs, effect this is having and whether MCA/best interest is required	2.2 Awareness on AED effect on bone health and management to be circulated to families and social care providers	Inder Sawnhey			
	DNAs (E.g. for cardiac appt) should be escalated	see multi disciplinary working below				
	Seriousness of condition not understood by carers	2.3 Health awareness to be raised through care provider networks. People living independently at risk. 2.4 Accessible information to be collated on LTCs 2.5 role of advocacy and waits to be explored 2.6 Annual Health Check results including Health Action Plan to be widely shared and named coordinator identified.	? Lindsay Darby ?			
	Support for understanding/catheter management should be escalated to specialist services	2.4 Information on available services, resources and how to access to be collated	CCG commissioner of urology service			
3. Dysphagia	SALT recommendations for modified diet should be transferred home on discharge from acute hospital	3.1 LD Hospital liaison nurses to raise with forum and internal processes	Sarah Haines			
4. MDT Working	Communication across agencies- insulin dose had been reduced by Guys hospital - XX was taking the previous higher doses.	to be discussed at next meeting (Medicines Management Committees to be consulted)				
	An individual with learning disabilities needs a profession to coordinate their care to provide consistency and ensure that treatment is prompt. This needs to be a professional who is involved in their care	4.1 Mechanisms to be identified which will support communication and care coordination across organisations 4.2 Families and social care providers to be supported to recognise health needs, symptoms and how to support good health and wellbeing overall. 4.3 Purple book to be reviewed and consulted on SET-wide use. LAC to bring info to next meeting 4.4 Results of national working group to be circulated when known.	Comms Lead (Claire Routh) LAC to set meetings for review of Purple Book	NHS Digital Shared Care Record Named Social Worker Pilot LD Standards NHS Accessible Information		People with multiple conditions will have a care coordinator and a person-owned record and a single plan.
	Identify whether persons on LD registers have a care coordinator					
	No monitoring/care coordination in place despite disalysis stopped/poor control of disabetes and all other health needs/bowels					
5. End of Life	A person from the care home should have been involved in acute care planning and could have brought in family. He might not have died alone.	5.1 "My Care Choices" Register or alternative to be considered across 3 STPs with potential to extend to LD. 5.2 Processes for using this register to share information across a range of organisations to be considered. 5.3 "Thinking Ahead" and other End of LIfe resource to be reviewed and communication plan agreed.	DoNs (Patricia D'Orsi)			People will be supported to plan their end of life and their wishes will be implemented
	Early referrals should be made to palliative care team					
	Preferred place of death should be identified early					
	Where a ppd is identified, these wishes should be planned for and achieved					
	Communication around terminal status needs to be better handled between acute hospitals and families					
	EofL care needs to be discussed earlier with the patient and those who are supporting so that it is re planned rather than crisis support					
	support staff who are familiar with needs, should be available in hospital					

	anticipatory meds should be available over BHs so that people can pass away at home					
	Patients should go from hospital to outpatientwithout being discharged home when in poor physical condition					
6. Communication	SALT recommendations should be implemented to support patient's communciation	6.1 flagging system to raise awareness of specific reasonable adjustments to be explored (ref purple book or tech solutions) 6.2 findings on national LD Awareness training to be fedback when available 6.3 information on AAC support, SALT services, ICE, apps etc to be collated and circulated	Comms Lead and LAC			Reasonable adjustements in general and for each specific person will be well understood and implemented across health and social care services
	Hearing aids should be available in hospital (glasses and other aids also relevant)					
	reasonable adjustments should be made to support communication					
7. MCA	People with LD should be encouraged to make whatever decisions they have capacity to make and if unable should still be involved in/contribute to decision making	7.1 long waits for advocacy to be investigated 7.2 Gaps in skills or capacity to properly support people with LD to understand (including availability of accessible information) to be raised 7.3 Each organisation to audit/review recording of MCAs	Social Care Leads/MCA leads	MCA Forum		MCA will be understood and fully implemented so that people with LD can make informed decisions wherever they are able
	Completion of MCA would facilitate engagement of patient and appropriate decision making					
	MCA should be completed and in medical records					
8. Health Insight	There should be evidence of understanding of health needs and consequence of refusals	8.1 accessible health information to be available in libraries, GP surgeries, community venues 8.2 information on what to ask for at a Health Check to be collated 8.3 Good practise on AHC completion to be circulated	Comms Lead and LAC			People are able to easily access information about health and what resources/services are available to them locally
	Safeguarding alert should be raised for ongoing self neglect	see also points under 7.2 above				
9. Living arrangements	Delays in moving people to appropriate provision should be avoided	Item to be agreed at the next meeting				
	The diabetes team should have greater involvement with decision making on care and placement needs for their patients with LD					
	professionals need to make their recommendations for care of a patient with learning disabilities known to the funding authorities					
	More action should be taken when living arrangements are harmful (E.g. financial abuse by neighbour or lack of services due to place)					
	Health care professionals need to understand supported living					
	When a person moves home a full history should come with them including care plans					
	homes should actively communicate with theh hospitals rather than waiting for information					
	Remote placements for those with mobility problems not appropriate					
10 Coroner/cause of death	Liaise with coroner about use of cerebral palsy as a primary cause of death on certificate	10.1 Details to be shared directly with Coroner who will feedback to Steering Group. 10.2 Acute hospitals will share mortality review process with LAC for sharing and early learning	LAC/Coroner Sarah Haines			learning disability and conditions which do not lead to death will not be listed as cause of death
11. DNACPR		11.1 LD Hospital Liaison nurses to share process for review of DNACPR	Ld Hospital Liaison Nurses (Sarah Haines)			LD or a presumption about the person's quality of life because of LD will not be used to justify DNACPR
12. Children's	Suggest sharing of care across boundaries	Item to be agreed at the next meeting				
	Recommend universal assessment for clients with LD during transition age					
13. Cancer		13.1 screening nurses in primary care to be considered 13.2 Cancer scanning pathway for those requiring sedation/GA/alternatives to be raised at LD Hospital Liaison nurse forum and shared.	CCG DoNs (PD) Liaison Nurses (SH)			