South Central Networks

NHS South Central

Learning Disability Network

‘The Acute Care Experience’

Good practice guidance in the management of admissions to the general / acute care setting of people with Learning Disabilities

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Purpose of this paper

This paper is designed to help providers and commissioners of health care services respond to some elements of ' 'Health Care for All' – the report of the independent inquiry into access to healthcare for people with learning disabilities'. It does this by providing some practical advice on the steps commissioners and providers should take to improve the acute care experience of people with Learning Disabilities. This does not represent a complete response to the 'Health Care for All' report.

This paper is intended to have two main uses:

- Section 1: To act as a check list for acute care provider organisations to use when reviewing the systems and processes that they have in place to support high quality care of people with learning disabilities.
- Section 2: To act as a check list for commissioners when reviewing their contracts with their acute care providers.

Introduction

With prevalence in the general population of 0.4 -0.9 %, people with learning disabilities, who have higher than average health care needs, can be expected to represent 1-2% of the general hospital population.

This client group has particular needs and there is ample evidence that as they are in transition into, through and out of acute care episodes these needs are not always met.

The purpose of this paper is to offer brief good practice guidance and some key principles that will help Trusts and their commissioners to ensure they have developed a rounded and complete response the needs of this vulnerable client group as they are in transition into, through and out of the acute 'physical health care' setting.

Provenance

The contents of this brief paper captures local good practice shared when provider Trusts within South Central SHA responded to a local survey conducted by the South Central Learning Disability Networks on the MENCAP 'Death by Indifference' report. This paper also draws on good practice sourced by the LD network from around the country with respect to the LD acute care pathway. This paper has been amended and approved by a working group with SHA wide representation from Health and Social care.

Legal Framework

The Disability Equality Duty requires that providers of services make reasonable adjustments to ensure that disabled people receive equitable access (physical and cognitive) to an equitable quality of provision and achieve equitable outcomes.
Commissioners are required to ensure that providers from whom they commission services are compliant with the legislation.
To hold a license as a Foundation Trust it is a prerequisite that the Trust complies with all legislation.
Thus the Disability Equality Duty provides a legal framework that requires care providers and their care partners to realise their ambitions to provide high quality care to disabled individuals:

all statutory organisations are required to make 'reasonable adjustments' to their services when they know a disabled group or individual might be disadvantaged by an unadjusted provision.

Trusts are also required to comply with the Disability Discrimination Act 2005 and Mental Capacity Act 2005

This paper captures good practice that can be viewed as a set of reasonable adjustments.

Section 1: 10 Good practice recommendations for providers

To be successful in providing high quality care acute providers will need to have collaborated with partner organisations and will need to have achieved buy-in from across the local health economy. That joint commitment will be demonstrated by the setting up of agreed systems and good practice – examples of which are identified below.
Points 1 and 2 below are particularly important – a champion at board level with accountability for the quality of provision to people with LD and a local forum that provides a vehicle for collaborative working. Points 3 – 10 represent potential achievements or activities for the LD lead and the local LD forum.

Structures

Providers should have:

1. A named Board level lead for LD in each organisation as a specific role rather than part of the Protection Of Vulnerable Adults (PROVA) agenda (to which links should be made). This individual should be responsible for providing reports to the Trust Board that demonstrate the provision of 'adjusted services' to this client group and take a lead role in involving people with LD in the business of the trust – especially service planning.

2. A learning disabilities local forum or steering? working group across health and social care (this may include voluntary sector input (e.g. Mencap) with responsibilities for developing
   a. Local performance measures
   b. Local Audit
   c. Should coordinate integrated responses to complaints, compliments and comments, where appropriate

3. Formal arrangements with the local LD provider to provide support to the acute trust when caring for someone with challenging behaviour. Shared care is a desirable model when caring for people with moderate to profound LD. The working group can be a vehicle for developing these arrangements and embedding them in practice. In the acute setting there should be a link health professional role in each clinical department and ideally the provider Trust should employ a health professional whose job is learning disabilities liaison.

General / Acute provider training and education

4. Training and Staff development (examples of good practice):
   a. Awareness training for all Staff on the needs of people with LD
   b. Physical health needs of the LD patients
   c. Communications training
   d. More in depth training for key staff
   e. Regular refresher training
   f. Incorporate into induction
   g. Seminars from LD providers

h. Using people with LD to deliver some training

Managing admissions

5. Where possible use routine planned admissions.
   a. Referring health professional to identify that the referred person has a learning disability – to enable the receiving hospital to respond appropriately
   b. Receiving Hospital consider use of 'Easy read' letters
   c. Use pre-clerking to introduce the person to the care environment.
   d. Medical Notes flagged with a coloured sticker indicating more information is contained in the record about how best to consider and meet the persons needs
   e. Departmental link health professional alerted to admission
   f. Links made with Community LD Team – who can contact the patients to discuss any issues the admission may generate and who link back to share planning with the acute trust.
   g. Well planned discharge –case management approach when preparing for discharge

6. Day Case admissions
   a. Treat as much as possible as elective admissions – address all points
   b. LD team may consider supporting the patient throughout the day if beneficial

7. Emergency admissions
   a. Staff in A&E (or admitting unit if patient admitted bypassing A&E) will establish who supports the patient in their usual place of residence and inform them of the admission.
   b. Alert link person in A&E department if available and link person in admitting ward/ department

Patient Information

8. For the person with LD in their usual place of residence
   a. Patient held records that capture how the person is usually – developed by the LD provider with the person. This should be kept ready updated and available (consider 'message in a bottle' method) and is used to accompany the person with LD into the Acute care setting. The information will include:
      i. Their likes and dislikes
      ii. Information on the best approach to communication and care.
      iii. The record would include information about the individual's usual medical care (medications etc).
      iv. Next of kin information
      v. N.B. This record can be added to where necessary during the persons acute hospital stay to inform care in the recovery phase and/ or subsequent care
      vi. Record of rehabilitation carried out in the usual place of residence (e.g. physiotherapy exercises)

9. Information supplied by the Acute Trust
   a. Local LD resource packs – source of information for department / ward staff
   b. 'Easy read' information for people with a LD
   c. Have strategies in place to manage communication (possibly Makaton training)
   d. Special consideration around Consent of people with LD
   e. Using people with LD (local groups will be available) to 'road test' your information

10. Allow carers to provide care and support. Listen to them – they know the person for whom they care. Involve carers in the assessment process, throughout care giving and in discharge planning.

Section 2. Commissioner Checklist

Structures

Commissioners should expect the following to be in place:

1. Acute provider should have a named board level LD lead
2. A local working group should be in place, should have membership from (as a minimum): the acute provider, PCT, LD provider and local authority, lead commissioning organisation. A copy of the group's annual work programme (responsive to local needs with identifiable outcome measures) should be available on request. The working group will be responsible for conducting and reviewing periodic audit re: acute LD care. This audit will include the points in this paper.
3. The acute provider should be able to demonstrate an effective and timely means whereby it can identify the need for and then obtain specialist LD advice and support in the care setting.

General / Acute provider training and education

Commissioners should expect the following:

4. The acute provider should be able to demonstrate a reasonable proportion of its staff (numbers to be locally determined by the working group) have received awareness training with respect to the special needs of people with LD. Optimally that training will have included input from specialist LD providers and people with LD. The training should NOT be confined to front line and care staff only – middle and senior managers should also be exposed to training. Some staff may have more specialised training. Optimally, LD liaison posts will be in place.

Managing admissions

Commissioners should expect the following:

5. The Provider should be able to provide a copy of the locally agreed acute care pathway (a framework for which will have been provided by the South Central LD network). Key features of this should be demonstrably in place – and reflected in the audit conducted by the working group.
6. There should be evidence that the acute care provider addresses communication needs of this group – easy read letters, information, consent forms, communications books in departments. Service users should report that advocacy services are in place and effective.
7. Length of stay (LOS) and admissions data should be made available allowing:
    a. Comparison of the Length of Stay (LOS) of people with LD and a common physical condition with the general population and the same physical condition – a set of 'marker' conditions (including medical conditions (e.g. COPD) and surgical procedures (e.g. inguinal hernia) should be agreed by the working group. LD LOS should not be significantly discrepant.
    b. High numbers of unplanned admissions of people with LD should be investigated

Suggested Metrics

Training

- Number of staff in organisation
- Number of nursing staff in organisation
- Number of staff who have received LD awareness in last year

- Number of nursing staff received LD awareness in last year
- Total number of staff who have received LD awareness training
- Total number of nursing staff who have received LD awareness training

Admissions

- Number of admissions overall
- Number of admissions of people with Identified LD
- Number of emergency admissions
- Number of emergency admissions of people with LD
- ALOS for marker conditions (suggested COPD and inguinal hernia)
- ALOS for marker conditions for people with LD

Audit

- Audit(s) conducted (re items above)
- RAG rating
- RAG rating improvement

Other indicators

- Number of Complaints from people with LD
- Untoward incident reports re people with LD
- Deaths whilst in care of people with LD