Final report of the Specific Needs Access Project (SNAP) pilot

February-July 2009

Compiled by: Judi Thorley (Project Lead) with Project workers: Julie Farrar, Karen Hibell, Claire Furniss, Katy Rolfe and Dianne Thorpe

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Executive summary

The six month project commissioned to look at the needs of 'vulnerable' people when going into hospital has found evidence of a recognition of and willingness to make 'reasonable adjustments' to ensure that people with a learning disability in North Staffordshire receive a fair and equal service at University Hospital of North Staffordshire (UHNS). The project team noted examples of good practice where a wide range of staff and departments had changed significantly processes and procedures to ensure that the individual's needs associated with their learning disability and/or mental health condition were recognised and planned for. Staff required support and advice to consistently meet individual needs and training to raise their awareness and understanding. The benefits of having a team of staff with specialist knowledge within the hospital environment impact on the patient and carer experience within the hospital and back in the community but also on staff confidence. The co-ordination and partnership working that the team provide and/or facilitate can lead to cost savings in addition to the quality of the experience. Staff at UHNS acknowledge that they sometimes get things wrong and want to make sure that they get it right.

Key findings

- Good practice:

The project team identified existing good practice within some wards and departments. The good practice observed took into consideration the individual's additional needs associated with their pre-existing condition. One of the key aspects noted relating to good practice was liaison and collaboration with those that know the person well to support effective planning.

- Patient journey:

The need to implement an admission and discharge care pathway that supports effective planning through the use of a Traffic Light Assessment, Risk Dependency and Support Assessment was very evident. Despite some good practice that was identified the project team noted examples where things broke down in relation to planning and making 'reasonable adjustments' due to communication issues and co-ordination

- Communication:

A re-current theme from both staff and patient/carer questionnaires was difficulties with communication both with the patient and/or carer and with other professionals working within the hospital and in community.

- Training:

The project team delivered a range of training for different levels of staff. This took the form of 1 hour sessions taking advantage of the staff 'handover' time within the ward or department and 3 hour workshops. The advantage of the ward or department based sessions were that staff who work together could discuss issues specific to their area. Staff were asked to identify what they felt to be their training needs; communication, consent and capacity, reasonable adjustments and accessible information were the key themes.

- Patient/Carer Questionnaires:

Patient/carer questionnaires were completed and key themes emerged relating to communication, consent, cognitive and physical environment, reasonable adjustments and planning and attitudes.

- Gaps in services

The project team were able to clearly identify gaps in current provision that led to frequent attendances, revolving door attendances and delays in discharge.

- Cost /benefit analysis

The project team have been able to identify several aspects of the patient journey where potential cost savings can be made. The project team found that a very high percentage, approximately 75% of patients identified as repeat attendees had an existing mental health or learning disability need. The project team also noted a number of delayed discharges and/or extended stays due to issues relating to consent and capacity.

Recommendations

1. Development of Psychiatric liaison service

Currently the Psychiatric Liaison Service is only able to provide self harm clinics Monday to Friday and as identified in the report there is a clear need for a service that identifies and works with patients who regularly attend the Emergency Department. With little investment see option 1 and 2, the needs of this group of patients could be addressed as part of the vulnerable adults service.

2. Repeat attendees

There are significant numbers of repeat attendees to the Emergency Department. In order to support these individuals to have fair and equal access to a wide range of services to meet their health and social needs specific targets to identify and then work with these patients both within the UHNS and back into the community have been incorporated into option 1a,b and 2.

3. Vulnerable Adults Admission care pathway

Through implementation of the tracking/flagging system potential vulnerable adults would be identified and their needs visible throughout the UHNS. The aim of this care pathway would be to assess each person's needs and identify clear interventions to support a positive and effective hospital stay. Incorporating the traffic light assessment and risk, dependency and support assessment the admission care pathway would ensure a collaborative and person centred approach to individual care. Areas of potential risk for the patient would be identified and interventions and support planned and implemented to reduce these. Referral to and involvement from the SNAP team within the admission and discharge process would lead to reduced likelihood to re-attend, reduced length of stay and increased appropriate use of primary care services.

4. Vulnerable Adults Discharge care pathway
The potential additional needs that an individual with a pre-existing condition may have needs to be considered very early on in the admission process as these may impact on the discharge plan and require co-ordinated and collaborative working. The current hospital discharge policy reminds staff to consider the persons additional needs such as learning disability but as indicated from the findings requires clarity as to who takes responsibility to co-ordinate this. The SNAP team linking back into community could provide this necessary co-ordination.

5. Training
The need for ongoing training for existing and new staff has been clearly identified from the SNAP pilot. In order to change culture and attitudes and support staff at the UHNS to take responsibility for ensuring that additional needs associated with the persons learning disability or mental health need are not only recognised but also addressed a comprehensive rolling programme of teaching for all levels of staff is required. As identified earlier the SNAP team noted an increase in staff referrals following training and also the SNAP teams visibility in the UHNS. Staff felt able to raise queries and importantly make suggestions to support individuals. Training should be mandatory not just as part of induction but ongoing. In addition there needs to be training about the UHNS, care pathways and the vulnerable adults or SNAP service. There also needs to be training delivered to patients and carers and staff working with these vulnerable groups of patients in the community.

6. Consent and Mental Capacity
There needs to be more in depth and focused training relating to consent and mental capacity. As highlighted in the report some clinicians are not following the principles as set out in the Mental Capacity Act (2007). It is suggested that mandatory training about the Mental Capacity Act is reviewed and joint training delivered. A leaflet informing patients and carers of the procedure re consent and capacity needs to be developed to ensure increased understanding and to support informed input into the process.

7. POVA
As discussed earlier the SNAP team updated the Vulnerable Adults training for the UHNS it is recommended that this training is delivered by mental health, learning disability professionals and service users (as in option 1, 2 and 3).

8. Enteral Feeding Policy
The UHNS accepts and implements the recommendations from the SNAP team in relation to enteral feeding.

9. Traffic light assessment
The benefits of using the traffic light risk assessment are wide ranging and it is suggested that the use of this assessment for all patients who receive care from nursing or residential homes would ensure improved communication and reduce risks associated with patient care needs. The training developed by

the SNAP team if delivered as suggested would ensure that all UHNS staff understand and use the assessment.

It is recommended that the commissioners introduce the use of the traffic light assessment for all nursing and residential homes as part of their contract agreement.

10. Risk, Dependency and Support Assessment
This assessment ensures that any areas of risk and vulnerability are identified and support needs planned and agreed to. Implementing this assessment would irradiate the financial battles that often occur when a patient has additional support needs. To support the effective implementation of this assessment the UHNS would need to agree and implement a protocol regarding the payment of additional staff where indicated, for specialist learning disability or mental health staff a service level agreement would need to be in place.

11. Accessible information
The development of more accessible information is required throughout the UHNS. Information given to patients in the Emergency Department and letters sent to invite patients for appointments and/or investigations should be the priority.

12. Pocket size information
Information about reasonable adjustments, the Mental Capacity Act, POVA flow chart and the Emergency Department Protocol to be added to this existing resource.

13. Mystery shopper approach to reviewing care
People with learning disability, mental health needs and family carer's to be invited to regularly involved in audits and reviews of services at the UHNS. Their findings/feedback should be presented to the Board and used to improve services.

14. Signage
A review of bedside information is currently taking place at the UHNS as part of the productive ward programme. The SNAP team have been asked to contribute to this regarding accessible information. It is recommended that this continues. The signage within the new build needs to be accessible to all, the steering group can support with this.

15. Changing places toilet
The UHNS needs to ensure that appropriate changing facilities are in place within the new build.

16. Emergency Department protocol
The Emergency Department Protocol needs to be formally agreed through the UHNS governance processes and should continue to be part of the regular teaching to ensure that it is implemented consistently.

17. Steering group
It is recommended that the Terms of Reference of the UHNS learning disability steering group are reviewed in light of the Option implemented as a result of this report.

18. Disability Equality Scheme
Work with people with learning disability and family carers to review Disability Equality Scheme to ensure that it includes and reflects the reasonable adjustments required by people with learning disability.

Option appraisal

There are four potential options for provision of a future service which are based on the findings from the project. There is a table included that shows how the options would support or not compliance with the Care Quality Commission (CQC) additional performance indicator for access to health for people with learning disability.

1. Introduction to the SNAP report

1.1 Introduction

Over recent years there has been a significant focus on meeting the needs of vulnerable people when they use mainstream health services, (Disability Rights Commission, 2006, Academy of Royal Colleges 2008, NHS Confederation Briefing, 2009). The recent Mencap report 'Death by Indifference', Mencap, (2007), highlighted six accounts of 'alleged' unnecessary deaths as a result of institutional discrimination and indifference within hospital, primary care and local authority services. The subsequent inquiry commissioned by the Department of Health and led by Sir Jonathon Michael resulted in publication of a comprehensive document 'Healthcare for all' in July 2008. This inquiry makes ten clear recommendations that have subsequently been accepted by the Department of Health within the Valuing People Now strategy published in 2009. In March this year (2009) the Health and Local Authority Ombudsmen investigation report into the six lives identified in the Mencap (2007) report was published. This report supported the ten recommendations made by Sir Jonathon Michael and made the following additional recommendations;

- ALL NHS and Social care organisations in England to review urgently the effectiveness of the systems they have in place to enable them to understand and plan to meet the needs of people with learning disabilities and the capacity and capability of the services they provide and/or commission for their local populations to meet the additional and often complex needs of people with learning disabilities
- Those responsible for regulation to satisfy themselves, individually and jointly that the approach taken in their regulatory frameworks and performance monitoring regimes provides effective assurance that health and social care organisations are meeting their statutory and regulatory requirements in relation to the provision of services to people with learning disabilities; and that they should report to their respective boards within 12 months.
- The Department of Health should promote the implementation of these recommendations, monitor progress against them and publish a progress report within 18 months.

Despite all public organisations having a legal duty to make 'reasonable adjustments' to meet the needs of disabled people and a responsibility to publish how they will achieve equitable services within their Disability Equality Scheme (Disability Discrimination Act 2005) many organisations fail to meet fully their obligations. The report that follows contains the findings of a six month project that was commissioned to identify what systems and resources are required within the UHNS to provide a fair and equitable service that complies with the above legislation.

Michael (2008) identified the role of Learning Disability Nurses working within acute settings to support and develop effective and positive experiences of using mainstream healthcare for people with learning disabilities. Improved experiences are fostered through the breaking down of barriers, making reasonable adjustments and raising staff awareness. Having skilled Learning

Disability Staff working as acute liaison nurses has demonstrated improved outcomes for individuals and cost savings (Pointu,2009 and Garvey, 2009). This improvement in services and impact on cost has also been identified as a positive outcome of the psychiatric liaison role within acute settings (NHS Confederation, 2009). Following the Mencap report 'Death by indifference' (Mencap, 2007) the UHNS and Combined Healthcare NHS Trust established a steering group, one of the outcomes of which was to submit joint bids to NHS Stoke and North Staffordshire PCT's to consider the need to commission an acute liaison service for people with learning disabilities. Commissioners rightly highlighted that people presenting in acute services with additional needs is wider than just people with learning disability and therefore commissioned a six month pilot project to scope the potential support and advice needs of people with:

- Learning disability
- Mental health needs
- Autism spectrum disorders
- Conditions of older age including dementia

This report is presented with case studies integrated into each section that highlight findings including benefits of implementing a vulnerable adult's service.

2. Background to and Implementation of project

2.1 Commissioned outcomes

The six month pilot project commenced in February 2009.
The pilot project was commissioned to scope the potential support and advice needs of people with:

- Learning disability
- Mental health needs
- Autism spectrum disorders
- Conditions of older age including dementia

Specifically the project was required to:

- Provide advice and support to patients with pre-existing conditions falling into the above categories, and their carers, family and staff involved in their care
- Develop an operational policy and recording/tracking system
- Collate information re the number of people (including age, ethnicity, gender) with pre-existing condition attending A&E and their pathway e.g. blue light, walk in, reason for attendance, presenting problem, diagnosis and disposal
- Identify if Stoke or Staffordshire resident
- Identify if known to services
- Numbers of people admitted for two days or less and any gaps in hospital service that may impact upon individual care and treatment
- Identify any gaps in community/primary care service that may delay discharge, or adequate support on return home
- Make recommendations re what would work best to create capable and supportive environments
- Identify existing good practice including resources available or planned
- Provide training programmes for hospital staff, identify priority work areas and resources required
- Develop and implement a patient satisfaction questionnaire
- Develop and implement a staff questionnaire

2.2 Planning and implementation of project

In order to achieve the above an operational policy was developed. Throughout the first month the SNAP team developed information leaflets for patients and/or carers. This provided information about SNAP and 'opened the door' for future contact if the SNAP team were not involved during actual admittance or attendance. An information leaflet for staff was developed which includes information about the SNAP team, referral and support and advice available.

The service operated Monday to Friday between the hours of 9-5pm. Although the initial service agreement with the commissioners identified scoping of A&E only, the project lead highlighted that this is not the only admission or contact portal and that individuals would need to be followed up and supported in main admission areas. This was agreed to and therefore the team provided input into many areas. During the first month contact with key staff were arranged (including professional heads, matrons, sisters,

Emergency department doctors, links with departments and wards (this included links with named individuals and attendance at team communication meetings), terms of reference for the existing learning disability steering group were reviewed and re drafted to ensure the project was supported and monitored throughout it's duration and that the hospital trust board, through the chair of the steering group (Deputy Director of Nursing, UHNS), were familiar with the project. It is important to note the UHNS Trust Board commitment to the development of a service to ensure that people with learning disability and all 'vulnerable' patient groups are able to access and receive an effective and fair experience when using hospital services.

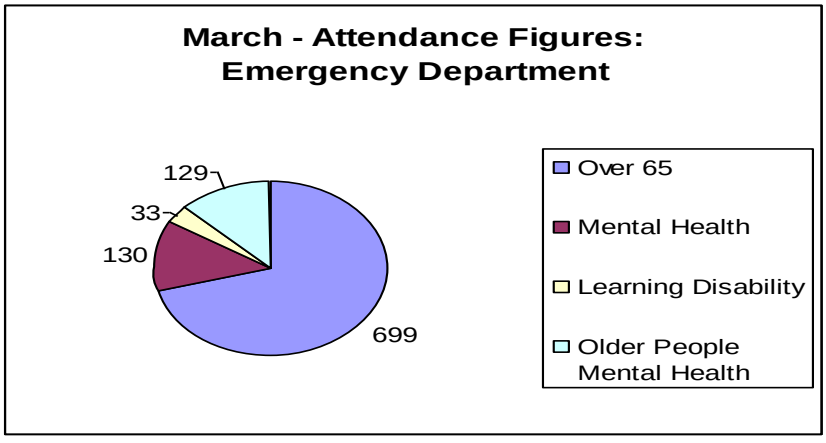
2.3 Departments and ward areas covered

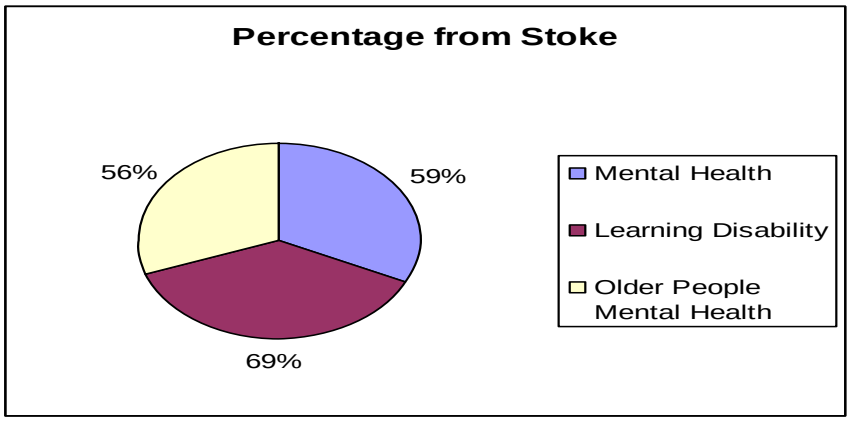
The following departments and wards have had input from the SNAP team:

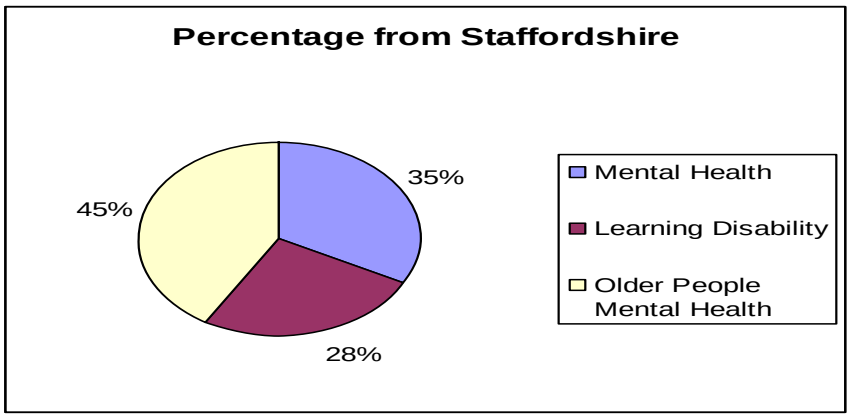
- Emergency Department which now includes Medical Assessment Unit, Clinical Decision Unit, Primary Care Urgent Care Unit, Medical Receiving area and Minor Injuries
- Short Stay Unit
- GP/ Elderly Frail ward-Ward 21
- Surgical Admissions/assessment unit
- Pre Assessment
- Central Outpatients
- Heart Attack Centre
- Day Surgery 105
- Wards both medical and surgical
- Heywood Walk in Centre

2.4 Attendance figures: Emergency Department:

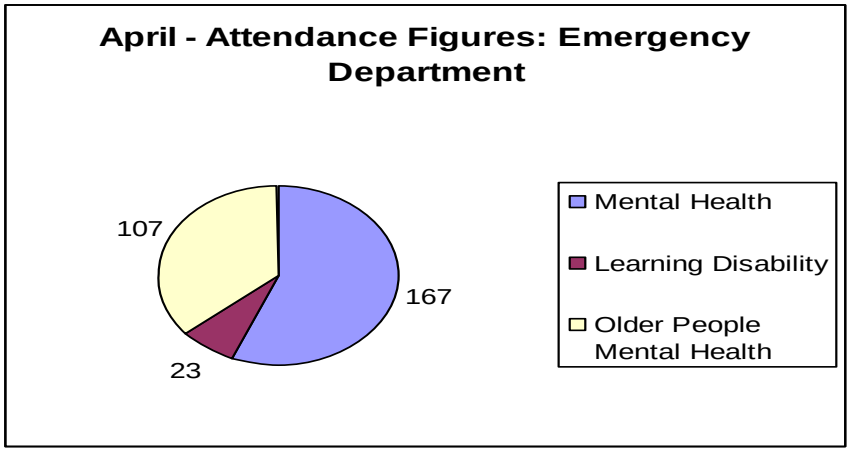
In March there were a total of 8,936 attendances (estimated according to casualty card numbers) at the Emergency Department. Of these 4,813 casualty cards were reviewed by the SNAP team. The SNAP team noted a significant high number of older patients who did not have any of the pre-existing conditions identified in 2.1, these figures were recorded for March only and as a total not split for Stoke and Staffordshire. The figures break down as follows from the 4,813 cards reviewed:

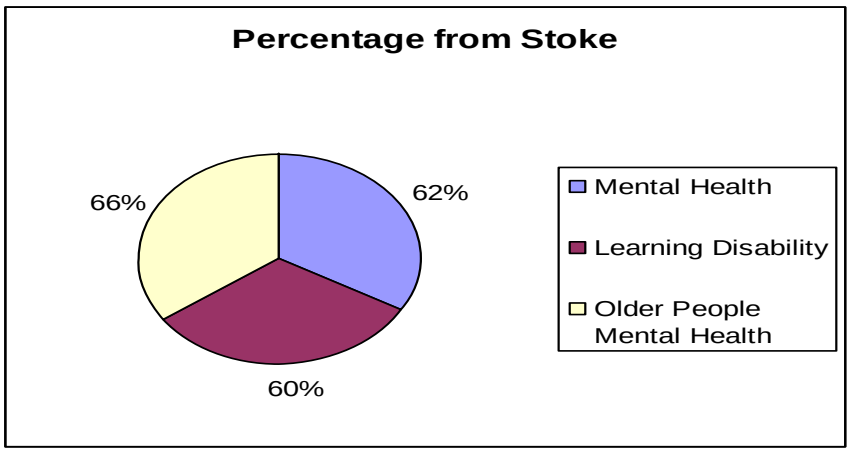


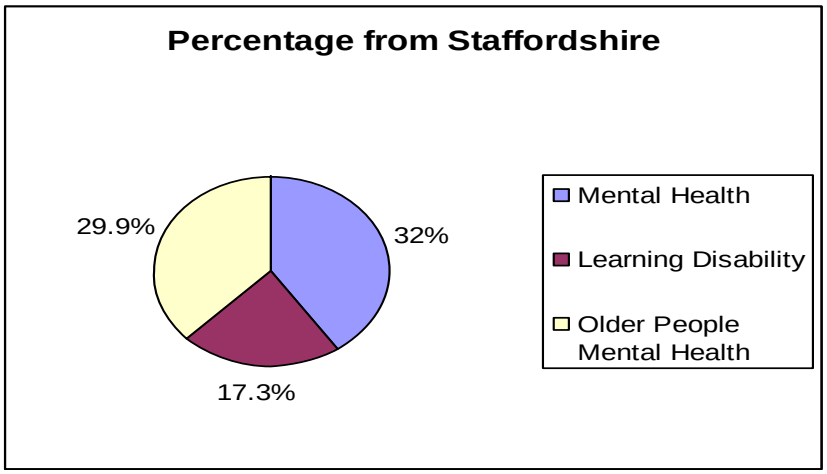




In April there were a total of 8,364 attendances (estimated according to casualty card numbers) at the Emergency Department. Of these 4,648 casualty cards were reviewed by the SNAP team.
The figures break down as follows from the 4,648 cards reviewed:







In order to meet the commissioned outcomes it was agreed that for May and June referrals would come from the wards and departments at the UHNS and specialist and primary care colleagues as opposed to reviewing the casualty cards.

Of significant importance is the fact that direct referrals for learning disability accounted for the majority, approximately 60% of those received by the SNAP team throughout May, June and July 2009.

The suggested reasons for this which were supported by staff feedback through the questionnaires are as follows; that there are already some existing services in place for people with mental health needs. Identification of additional mental health needs is not easy, particularly as patients often did not disclose their mental health needs. Generally the patients physical/medical needs were seen as a priority and any mental health need that may have contributed to attendance/admission were not addressed.
The services already in place i.e. discharge liaison, psychiatric liaison lack overall co-ordination and have a slow response time thereby increasing the length of stay for patients.

The SNAP team, UHNS and PCT's recognise an area for further work is that of repeat attendees, and it is known that most patients who frequently attend the Emergency department do so because of their untreated mental health problem.

2.5 Referral systems
Two different referral systems were implemented; referral form and blue sticker on casualty notes; telephone and clinical audit led referral, however the number of referrals remains dependant upon staff awareness of individual needs. Therefore the referral system needs to link with the tracking/flagging system. On seeing the alert staff would read the details and follow the individual plan if one is in place and contact the SNAP team to provide advice and support during the actual visit, complete the traffic light assessment and risk, dependency assessment if required.

Most referrals for people with learning disability came via telephone; staff seemed to like the fact that their referral was responded to very quickly, instantly felt supported and reassured about their practice. It needs to be remembered that raising staff awareness to the possible needs of people with learning disability and mental health needs through training and education increases staff understanding and leads to an increase in referrals. This indicates the success of having one central number for referral, which if linked to the tracking/flagging system would ensure a robust method of identifying patients with pre-existing conditions and the implementation of reasonable adjustments.

2.6 Operational policy and recording/tracking system

As mentioned previously hospital staff and colleagues in specialist services were made aware of the service and how to contact the team. This involved taking part in department and ward meetings, linking to the Matron and ward manager meetings and other existing forums within UHNS.

The project lead researched the issue of implementing a tracking/flagging system. In Leicester City a system has been developed through a Pacesetters' bid, (Pati, 2009) The hospital Electronic Patient Record (EPR) system is used to 'flag' patients with a learning disability. This is done by cross referencing the GP Quality Outcome Framework (QOF) registers and the Local Authority registers of people with a learning disability, then entering the details onto the hospital electronic system so that a flag appears indicating that the patient has additional needs and may require' reasonable adjustments' to be made. The Leicester system has only been implemented in outpatient/planned admissions not in the emergency department.

In UHNS the EPR system is also used and following discussions with the EPR manager a tracking/flagging alert is already in use and can be added to, to include people with learning disability and mental health needs.

Lead clinician in Emergency Department for repeat attendees ensures that those who present in the Emergency Department 3 times in 3 months or more are identified as potential 'vulnerable adults' using the EPR alert system. Therefore using local data i.e. repeat attendees, Quality Outcome Framework and Local Authority registers a tracking/fagging system can be implemented at the UHNS that follows the person through the hospital and indicates the need to consider additional support. For example looking at different ways of communicating (including accessible letters to invite for an appointment), longer appointments that are first or last on the list, waiting times, separate waiting areas and other 'reasonable adjustments'. The benefits of using this type of tracking system would be to improve multi-disciplinary working ensuring higher quality of care, a positive patient experience, increased efficiency with potential cost savings due to reduction in attendance of repeat attendees through input from the SNAP team to co-ordinate primary care services, maximise the patients understanding of their own health needs and when and where to access primary and acute services.

Using this system requires input to ensure that it is 'live' and acted on. With a team in place to take responsibility for inputting the alert for the

tracking/flagging system and a rolling programme of teaching proposed in option 1 and 2 at the end of this report, a collaborative and robust approach would ensure that staff at UHNS know about the system, what to do if an alert shows, how to enter an alert and who to contact for support and advice.

Heywood walk in centre

In May 2009 a meeting was held with commissioners. At this meeting commissioners requested that the SNAP provide one months input into the Heywood walk in centre. Due to timescales the SNAP team were not able to meet with the full team at the Heywood or provide training. Information about the project was provided and staff from SNAP visited the Heywood once weekly. Referrals averaged 2 weekly and were varied for people with learning disability and mental health needs. Environmentally there was no evidence of reasonable adjustments within the walk in centre, for example it was not very clear where to stand, sit etc.

3. Creating capable and supportive environments

3.1 Emerging needs

Older Peoples' Mental Health

There are two discharge liaison nurses for older people with mental health needs whose role is changing; as well as trying to prevent delayed discharges they are finding themselves providing more of a liaison role i.e. teaching, facilitating, advising and writing care plans to support management of patient's mental health needs not just their medical/physical condition.

After the SNAP had been running for two months the UHNS implemented a frail elderly service whereby patients who meet the criteria for frail elderly do not go to the Emergency Department but straight to another smaller ward with beds not trolleys that has significantly improved the experience for frail elderly patients and impacted on waiting times and pressure of work in the Emergency Department. As a result of this service provision, many referrals for older people with mental health needs came from the ward.

Adult Mental Health

As already stated there is a training need for hospital staff to consider a person's mental health needs.

There is currently a limited Psychiatric liaison service which provides self harm clinics Monday to Friday. With more investment this service could be extended to focus on frequent attendees, most of whom re-attend due to their untreated and undiagnosed mental health need.

A fifth of those frequent attendees identified by the project presented with overdose whilst intoxicated and a large percentage also had a current psychiatric history. However it was noted that many frequent attendees were not identified by the project and came to light through information supplied by Emergency Department consultant. These patients appeared more likely to have potentially undiagnosed psychiatric disorder, i.e. anxiety and somatoform disorders.

The SNAP team worked with both those identified as having an existing mental health needs and some of the repeat attendees and a reduction in attendance was seen, in section 6 details of cost savings relating to this can be found. This work included follow up support and 'listening', contacting/liaising with professionals involved in the patients care, making appropriate referrals and/or signposting as necessary and where appropriate bringing together all staff involved including community, specialist and acute services to develop and agree a management plan.

Learning Disability

As no current liaison service for people with learning disability exists the team noted a higher rate of referrals from department and ward areas for this patient group. The figures reported in section 2.4 of this report reflect the numbers of patients coming through the Emergency Department based on review of casualty cards as opposed to referrals. Referrals received from hospital and community staff for May and June 2009 was as follows:

Stoke: May 23
June 21
Staffordshire: May 12
June 9

3.2 Support, reasonable adjustments

The team found that generally staff needed support and advice to address needs arising from the persons pre-existing condition. Staff expressed a lack of confidence about interacting with a patient who did not use words to communicate. Although there were some examples of accessible information there is not enough and it is not standardised. The Hospital toolkit has provided staff with a range of information to aid communication with people with learning disability and other patient groups whose first language is not English and/or who have communication difficulties. In order to meet its legal obligations under the Disability Equality Duty (2005), Standards for Better Health(DH,2008) and the recently issued additional Care Quality Commission (CQC) indicator re Access to mainstream healthcare (CQC, 2009) UHNS needs to review it's systems of communication to ensure that these are accessible to all. Option 1 and 2 in the recommendations would ensure that this issue is addressed.

When discussing making 'reasonable adjustments' generally staff felt that they were not able to make these but through discussion it was evident that staff did not understand what these adjustments might be and in some cases were making them anyway, see section below highlighting existing good practice.

3.3 Patient journey including existing good practice

One of the issues affecting the patient experience/journey was the passing on of information and lack of a tracking/flagging system. Due to the issue of different types and quality of information coming with the patient important aspects of an individuals care were not always picked up on or passed on. Following introduction of the traffic light assessment and through consistent support via the SNAP team including training, information completed on the traffic light assessment has followed the person through the hospital and back into community. Staff in pre assessment and central out-patients have been completing these assessments for people and then ensuring that the admitting area/ward uses this to inform care planning and delivery.

In some areas ward teams have demonstrated a willingness to be very flexible in their approach to providing care. In day surgery there are several examples where the ward staff have made reasonable adjustments, for example: supported an individual to wear their own clothes to theatre, not have to lie on a bed/trolley but to walk or be pushed in a wheelchair to theatre, to wait on the car park until 10 minutes before theatre time and then be contacted by mobile phone, different specialities have come together and used the same theatre time whilst the patient is under a general anaesthetic to carryout different procedures or investigations.

The SNAP team have been able to support staff and role model approaches to facilitate patients who are very frightened within the hospital setting to have

'familiarisation' visits, just coming to the hospital initially then visiting the ward, 'playing' with the blood pressure cuff and other equipment. The team have also provided good practice guidance around things like taking blood, staff using a butterfly needle having gained the trust of the patient. Using the traffic light assessment and ensuring that this follows the patient through their hospital journey.

3.4 Emergency Department Protocol

The SNAP team adapted the attendance/admission protocol for the Emergency department which was originally developed in 1998 when there was a short term funded acute liaison post. This has been implemented and has led to reduced anxiety for a number of patients which in turn has meant that they have been more compliant with interventions. Staff have, as part of their training, had the opportunity to talk through the protocol. The continued input of training to make sure that protocols such as this are followed is essential as previous experience has shown that staff do not always use/follow the protocols unless they have regular opportunity to discuss. There is also training required within the community with both family and paid carers to raise awareness of the protocol. The benefit of having both the Emergency Department protocol and the SNAP team to liaise and support admission/attendance of vulnerable adults with complex needs was highlighted during the project.

3.5 Pocket size information and contact List

Within the Emergency department each member of staff has a pocket size information card that has several pieces of information that is used on a daily basis. This includes information re mini mental testing. Staff in the department use this on a regular basis and therefore this presents as an opportunity to ensure that information is there at a glance for staff. It is recommended that the information about reasonable adjustments, Mental Capacity Act core principles, POVA flowchart and Emergency Department protocol is added to this.

The SNAP team has been able to provide each ward and department with an up to date contact list for specialist services. Staff identified how difficult it was to know who and how to contact specialist services.

3.6 Consent and Mental Capacity

One of the common themes emerging from referrals, training and discussion with staff was that of mental capacity of patients and consent to treatment. Many staff appeared confused and in some cases unaware of the guiding principles and their own role within the assessment of mental capacity under the Mental Capacity Act (MCA, 2007). Some areas commented that although some of their staff had received the Trust training on the MCA it would be useful to have focused training within their area. This would also enable a team approach to be taken, allowing for improved understanding of individual roles and approaches to issues relating to capacity and consent. The SNAP team were involved in cases where patients' treatment was either a) withheld for long periods of time due to queries over mental capacity or b) due to a perception by staff of a patient making an unwise decision; the patient was delayed in their discharge whilst attempts were made to have a further review

of the patients' capacity. The SNAP team has been able to promote a team approach to the assessment of mental capacity and with a visible presence within the UHNS the team has also been able to offer advice and support.

3.7 Traffic Light assessment

Disparity in the quality of information/communication provided by or for patients with pre-existing needs was noted to be a significant problem faced by staff working in the UHNS. This issue on occasions led to hospital staff not recognising when they needed to make reasonable adjustments. The SNAP team promoted the use of the Traffic Light Assessment with planned and emergency attendances and admissions which led to a more positive experience for both the patient and staff.

3.8 Risk, Dependency and Support Assessment for Patients with a Learning Disability

One of the issues that the SNAP team came across was who provides additional support for a person with a learning disability or mental health need when they come into hospital and if they require it. In some areas staff at UHNS made assumptions about an individual patient's level of need and would then request input from family or paid carers or 'expect' that this input would be given. If the patient with the learning disability or mental health need lives at home there is often an expectation that family carers will provide support to meet any additional needs that the person has. This might include feeding the person who is unable to feed themselves and changing the person and seeing to their personal care. In addition it seems that sometimes assumptions are made about the person's ability to cope in a ward environment. For those patients who live in a staffed home it is expected that support will be 24 hours, this is not always necessary and providers can struggle to give this level of support.

The Risk, Dependency and Support Assessment was developed originally in Edinburgh and has been adapted since. It is designed to be completed at the earliest opportunity with any patient with learning disabilities being admitted to hospital. The assessment is for hospital staff to complete with the people who know the patient well, e.g. family and/or paid carers. Through completing the assessment with the people that know the person well, any likely areas of vulnerability and risk can be identified and effectively planned for. The assessment uses a rating scale to be able to identify if any additional support is needed and if it is who can most effectively provide this. By implementing this assessment tool it ensures that everyone involved in the patients hospital stay/care knows what is happening. It is based on needs that the person may present with as a result of the pre- existing condition and ensures that patient safety is maintained. Disruption for the patient, family and paid carers, hospital staff and other patients is reduced, leading to a more positive experience for everyone. In some cases it leads to appropriate early discharge and the implementation of 'reasonable adjustments' that save money.

3.9 Vulnerable adults-Admission Care Pathway, tracking/flagging system

To ensure that vulnerable adults are identified it is essential to implement a tracking/flagging system. As discussed earlier it is possible to implement a tracking/flagging system within the UHNS using the EPR and patient alert. It should be noted however that this system relies on the staff member to check electronically what the alert says and despite concerns previously raised by clinicians within the UHNS the system does not allow for 'uploading' of information, is not 'in your face' i.e. not highly visible and would require ongoing updating and training with all UHNS staff to ensure that it was effective. The SNAP team noted that there was often a lack of follow up letters to the GP, on speaking to Emergency Department staff it was suggested that this is due to poor inputting of clinically relevant information on EPR, leading to a lack of meaningful GP letters and questionable clinical data input by data clerks. This issue could potentially lead to incorrect tariff submission by the UHNS which would lead to underfunding. Part of the role of a vulnerable adult service or SNAP would be to implement the tracking/flagging system and then 'police' how this works, this would include ensuring adequate and timely inputting of data and review of individual plans. An admission care pathway would ensure that the traffic light assessment and risk dependency and support assessment were completed as soon as possible for all potential vulnerable adults. This would trigger a referral to the vulnerable adults or SNAP service. The service can then offer appropriate intervention, support, advice, ad hoc training and sign posting to other services. The report of the consultation to review 'No secrets' (DH, 2000) published on 21st July 2009 identified the following key points regarding vulnerable adults;

- Safeguarding requires empowerment/ the 'victim's' voice needs to be heard.
- Empowerment is everybody's business, but safeguarding decisions are not.
- Safeguarding Adults is not like Child Protection.
- The participation/ representation of the people who lack capacity is also important.

The admission care pathway and provision within the UHNS of a vulnerable adults service will ensure that individuals are empowered through staff taking on their responsibility, raising awareness of a potential vulnerable adult leading to visibility and co-ordinated input to support individuals to make informed choices, use services appropriately and expect and receive high standards of care. In the case review into the murder of Steven Hoskins (2007) both Steven and the perpetrator of his abuse and subsequent murder were known to services and the review found that every part of the service system had 'significant failures' in rescuing him. However no one took responsibility. The implementation of the above admission care pathway and input from a vulnerable adults service or SNAP would lead to a comprehensive service response to supporting vulnerable people that facilitates:-

- Improved quality of care via additional support may reduce the need for repeat attendances

- Care co-ordination to support identification of and planning for risk factors, address the 'niggling concern' i.e. staff may have a slight worry about a piece of information but feel that this does not merit a vulnerable adult referral
- Assisting UHNS staff to review risk factors will speed up decisions and lead to better partnership working with the patient and community services

3.10 Culture and attitudes

To make sustainable change in services for vulnerable people there needs to be a 'shift' in culture and attitudes. Diagnostic overshadowing is the term used to describe when the person's learning disability or mental health need is identified as the cause for presenting symptoms particularly those symptoms that challenge health staff e.g. challenging behaviour (DH, 2006, Mencap, 2007 and Michael, 2008). The SNAP team started to see a shift in thinking particularly towards repeat attendees. This shift was felt to be due to the visibility of the SNAP team who were able to offer advice and support and importantly follow up attendees to review the support they have or indeed in some cases lack of support in the community. Many repeat attendees used the Emergency Department as a primary care service and in some cases this clearly linked to a feeling of not being listened to in the community. Within the training provided the SNAP team got staff to reflect and challenge themselves about their attitudes and values. This was done sensitively and was found to be very effective. Culture shift requires recognition of what the current situation is, what part each individual plays in this, why this might be happening and where the organisation and each team within that wants to get to. Attitudes build up over time and become ingrained into the culture, only through consistent challenge and reflection can this change. The SNAP team experienced a willingness and enthusiasm to provide a complete service, many staff recognising that often patients don't always get the best service to meet their individual needs. In the Emergency Department, pre-assessment and day surgery staff viewed the SNAP team as part of their team, requesting support and advice; this signified a 'shift' in culture leading to positive outcomes for patients.

4 Training

4.1 Summary of training

The original proposal and service agreement for the project identified the need for training programmes for hospital staff. The operational policy for the project stated that project workers would provide monthly training for staff in admission areas, with other ward areas being invited dependent on patient journey, and that project workers would also carry out pre and post training questionnaires.

The project team developed a programme of training which was aimed at ward based staff, was given during the handover period between shifts and lasted 45 minutes. The objectives of the training were to

- Raise awareness of the needs of people with learning disabilities or mental health problems
- Increase the skill and confidence of staff in meeting these needs
- Increase knowledge and understanding of challenging behaviour
- Challenge stigma and prejudice
- Introduce the Hospital Toolkit

In addition to the regular ward based training for staff the team also delivered two half day training sessions aimed at more senior staff, these sessions covered drivers for change, health inequalities, reasonable adjustments and capacity/consent issues.

4.2 Key findings from the pre- and post training questionnaires

Out of 400 circulated questionnaires a total of 149 were returned

PRE TRAINING										
INTEREST IN TRAINING				**TRAINING TOPICS REQUESTED**				**KNOWLEDGE OF PROTECTION OF VULNERABLE ADULTS POLICY**		
Autism	**Mental Health**	**Learning Disability**	**Older People with MH Needs**	**Communication**	**Overview of Specific Needs**	**Info to improve service for patients and staff**	**Managing Challenging Behaviour**	**Yes**	**No**	**No Reply**
68.3%	**74.1%**	**75.8%**	**76.6%**	**11.6%**	**9.1%**	**5%**	**2.5%**	**51.6%**	**42.5%**	**5.8%**

POST TRAINING						
PERCENTAGE OF STAFF WHO FELT MORE CONFIDENT IN TREATING/CARING FOR PATIENTS FOLLOWING TRAINING				**KNOWLEDGE OF PROTECTION OF VULNERABLE ADULTS POLICY**		
Autism	**Mental Health**	**Learning Disability**	**Older People with MH Needs**	**Yes**	**No**	**No Reply**
25%	**44.4%**	**52.8%**	**50%**	**71.2%**	**23.4%**	**5.2%**

Based on the above response the team devised training that was interactive and dynamic; the audience discussed barriers to good communication and participated in role-play scenarios designed to encourage empathy and good communication.

During discussion with nursing managers it was agreed that the team would develop and enhance the current Vulnerable Adult training provided by UHNS and would make recommendations to improve the current Mental Capacity Act training.

The general comments made were that knowledge of resources available had increased staff's confidence; when asked if staff had been made aware of any new resources 53% answered affirmatively and mentioned the hospital toolkit, particularly the communication book and the 'traffic light' system.

4.3 The toolkit 'My next patient has a learning disability: A Toolkit for Supporting People with Learning Disabilities; Helping me to care for you, and involving others'

In March 2008 UHNS learning disability steering group facilitated a conference about 'Death by Indifference'. An action/outcome from the conference was a proposal for the development of a resource pack to help support healthcare professionals to care for people with a learning disability. UHNS and Keele University, put a bid together to develop a toolkit, this bid was presented to the SHA and was successful. As a result of this, a toolkit was developed by a group of people led by Dr Sue Read, Reader in Learning Disability Nursing at Keele University which was launched in May 2009. The SNAP training programme was timed to follow the launch as it was thought that an important part of the training would be to promote the use of the toolkit.

The toolkit is a pack containing information from sources such as Mencap, RCN and NHS Trusts which includes posters, leaflets, a DVD giving an example of good practice from the UHNS and a CD of document templates.

There are two resources which generated a lot of positive feedback; 'The Hospital Communication Handbook' (Valuing People 2008) is a laminated flipbook containing useful pictures and photo symbols to aid communication and was designed to give hospital staff basic information about the communication needs people may have.

The Health Assessment for people with learning disabilities: traffic light system (Gloucestershire Partnership NHS Trust) is a document designed to accompany the patient on their journey through the hospital system; the 'red' section contains vital information about the person, i.e. contact details, allergies, medication etc, the 'amber' section lists information on activities of daily living and the 'green' section gives the person a chance to express their likes and dislikes.

4.4 Feedback from training:

Direct Quotes:

- Very valuable, excellent information well presented. A very useful session which raised my awareness, I will take this back to share with colleagues.

- The DVD was very powerful, there is a need for training for all grades, easy access to a liaison service and improved pathways through out-patients clinics etc.

- Very interesting, informative and thought provoking, I will speak to the Clinical Nurse Specialist in our area about the toolkit and to see if we can implement any changes to improve our service.

- This training should be mandatory (over 50% of staff made this comment)

- There is a need to make this team/service more widely known; there must be a lot of patients who would benefit from your input.

- Good training, very eye opening in terms of what people with specific needs may perceive or understand in an acute hospital setting and how important it is to potentially prevent escalation of behaviour or situations.

- This made me think about my own practice and how I might affect patient's experience

- The role play was really good, I don't think we (staff in general hospitals) always pick up on body language and gestures

- When someone doesn't talk I never know whether to talk to them or their carer. The training has made me realise that I need to talk to the person and listen to the carer too. Having the communication booklet has been really useful.

General feedback:
The Hospital Communication Handbook:

- It is useful for anybody who has communication difficulties
- Emergency Department staff reported that they had used it successfully with a range of patients, some for whom English was not their first language and others whose pre-existing conditions affected their communication and cognition
- Staff working with people with dementia or on stroke wards thought it would be of use in their clinical area
- Many staff expressed an interest in having pictures of equipment or procedures specific to their clinical area

The Hospital Assessment: traffic light system:

- Staff felt that it would be useful to have this assessment as it would be standardised and easily recognisable. At present care settings for people with learning disability, mental health needs or older people with mental health needs usually send in some information with the person but this can vary considerably in presentation, relevance, ease of understanding and does not always contain the right information about the individuals support needs e.g. communication etc.
- Staff felt that the traffic light assessment contained all the relevant information. Staff also commented following training that they appreciated how the traffic light assessment could be a good way for them to build up a relationship with an individual.

4.6 Resources and further training

Staff were asked what other support or resources they would like to have in treating/caring for these patient groups, 58.8% would like a liaison service or appropriate professional that they could contact for advice and support to develop individual care plans and teaching, 23.3% said they would like additional resources such as picture charts, leaflets and other written information, and 15% would like a carer who knows the patient to be present.

Further training

When asked if they would be interested in attending further training 83.4% of staff wanted more training on mental health needs and older people with mental health needs, 80.5% wanted more training on learning disability and 69.4% on autism.

Senior nursing staff have asked for training specific to their clinical area so that the team can offer information pertinent to their area of speciality.

Feedback from patient/carer questionnaires highlights a need for training for ALL staff within the UHNS including reception, porters and security staff.

A team commissioned as a result of this project would be committed to providing an on-going rolling programme of training to fulfil these requests.

5. Gaps in Support impacting on care and discharge

5.1 Interface with and gaps in primary care and gaps in hospital care

Admission:

One of the most beneficial areas of liaison for the SNAP team has been working with patients and family and paid carers prior to their admission into UHNS. Referrals have come from within UHNS such as the pre assessment clinics, and also from primary care e.g. from colleagues working in community nursing, social work, and health facilitation. The SNAP team have been able to support attendance at the clinics as appropriate, go out into the patient's home to complete the traffic light assessment, use accessible information, build-up relationships and confidence both with the patient, family or paid carers and hospital staff. This liaison has led to a better patient experience and importantly cost savings associated with reduction in non attendances at clinics and allocation of appointments to other patients. This has been achieved by the SNAP team completing the required documentation for pre assessment with the patient and their paid and /or family carers at home. In addition this has prevented an often distressing visit to hospital with cost implications for the provider of the patients care. The SNAP team have also been able to facilitate familiarisation and desensitising visits to support a reduction in anxiety for the patient, this emphasis on good planning has ensured that intervention has happened in a timely manner which has reduced the impact on primary care services. It should be noted that this intervention potentially prevented a cost associated with the patient not attending for the appointment.

Patients admitted to Surgical Assessment Unit (SAU) who have self harmed are given appropriate physical treatments. However, due to the patient through put of that department there is not the time to wait for patients to receive a psychiatric assessment. Patients following self harm are therefore sent home without assessment. This scenario also occurs when patients attend SAU with mental health needs secondary to their physical presentation. Staff expressed verbal concern about this situation but in a busy department did not know how to improve it. The SNAP team were able to provide advice on what psychiatric services the patient was using and who to liaise with within that service. This provided a link for the patient to receive follow up from their care team. The SNAP team could provide advice on what psychiatric services the patient was using and who to liaise with within that service. This would provide a link for the patient to receive follow up from their care team. Potential savings/benefits from implementing both a vulnerable adults service and enhanced Psychiatric Liaison service are as follows;

- With appropriate psychiatric intervention may reduce admissions to acute hospital.
- Reduction in length of in-patient stays on acute wards whilst awaiting review from on-call psychiatrist which can take up to a week in hospital.
- Improved/developed relationship between specialist services and UHNS

Discharge:
UHNS has a comprehensive discharge policy that is based on the Department of Health guidance. Representatives from Combined Healthcare NHS Trust have previously contributed to the review of the discharge policy. There is a hospital discharge liaison team and discharge facilitators. In the discharge liaison team there are two mental health trained staff whose role appears to be working well in ensuring a productive and positive hospital stay. They are able to give focused advice and support for people with mental health needs, either previously or newly diagnosed and in ensuring that multi-disciplinary planning takes place well in advance of discharge. These nurses are however finding that referrals for under 65's are increasing due to the lack of an adult liaison psychiatry service on the wards.

This same support however is not available to people with a learning disability. The SNAP team had experience of potential unsafe discharges whereby the patient has rightly been identified as medically fit for discharge, however lack of consideration of their existing condition, change in needs, additional support that may be required in the home environment would have led to an unsafe discharge

The SNAP team has been able to apply the principles of care co-ordination and bring together all the relevant people involved in an individual's ongoing care to ensure that a comprehensive care and or management plan is discussed and agreed to. Through this process, discharge has then progressed without delay, therefore reducing delayed discharge cost implications. Also through timely discussion relating to discharge and individual need the SNAP team have been able to work with hospital and community staff to reduce length of stay, e.g. in one case where the patient was declared fit for discharge the staff from the residential home, the SNAP team and the hospital dietician all had concerns about the nutritional intake of the patient. The SNAP team arranged a multi-disciplinary meeting on the ward and suggested input from the residential home at every mealtime for 4 days with accurate recordings. Bloods were taken prior to the intervention and after, then the intake and the blood results were reviewed and the multi-disciplinary team agreed a discharge plan which was successfully facilitated. Based on the available information it is believed that this lady would have presented back to the UHNS soon after discharge without the above support. The SNAP team have continued to offer support and advice to this person and her carers in her home.

5.2 Repeat attendees
UHNS has an internal system to identify and monitor repeat attendees, this information is shared with the PCT on 3 monthly basis Repeat attendees are those who have had 3 attendances or more in 3 months. The SNAP team was able to cross reference the repeat attendees report with their referrals and then follow up post attendance. The SNAP team found that 66% of those followed up were already known to mental health and learning disability services. The SNAP team made the professionals who were involved with the patient aware of the attendance and a supportive visit to the patient was carried out. For some patients this additional support led to them feeling less

anxious and reassured that they have a contact point to discuss their health and well being. In some instances the follow up contact to professionals already involved led to a review of the individuals' management plan.

It is worth bearing in mind that patients presenting with solely either substance or alcohol misuse were screened out of the adult mental health referrals. However, 40% had alcohol as secondary to their presentation. These findings concur with the recent NHS Confederation Briefing Paper (2009) on the importance of liaison services to reduce length of stay and address issues around repeat attendances. This paper cites a potential cost saving of £37,974 per annum when a pathway to facilitate rapid (but appropriate) discharge is implemented. This could be achieved through joint working, tracking/flagging patients, assessing their needs and clear planning that links back into the community through the vulnerable adults or SNAP service. Commissioners may wish to consider developments to the Alcohol and Drugs Service in Staffordshire (ADSIS) to address the themes identified above.

Only 4% of patients identified had schizophrenia recorded in their notes and although this is a small percentage, their needs are often complex and staff report anxiety when treating these patients.

Following review of the Emergency Department casualty cards a small but significant number of repeat/frequent attendee's were identified from a local secure unit. The unit offers secure facilities for people with learning disability and additional mental health needs. A visit was arranged to the unit and the following identified as potential reasonable adjustments to improve the patient experience and importantly reduce attendance:

- For the unit to be able to liaise with the hospital via the SNAP team. This would allow for discussion about the patient's needs and establishment of a suitable treatment regime. The contact person within the SNAP team could follow the patient through the hospital system and continue to liaise with both the unit and hospital staff where appropriate.
- SNAP team intervention would help to improve understanding of the patient's needs. For example the patient has come from a secure facility and not a community home and therefore has restrictions due to risk factors, Sections of the Mental Health Act etc. Whilst hospital staff do not need to know a patient's full history they need to be made aware of risks and restrictions in order to make reasonable adjustments, minimizing potential harm and improving the quality of care. This could involve simple measures such as arranging a time for the patient to attend and with planned admissions ensuring that, for example, someone with a diagnosis of autism is first on the surgical list and thereby reducing waiting time and distress.
- A greater understanding of each others roles and responsibilities would help to foster increased respect and appreciation of the work involved in delivering quality care for patients from a secure unit. Completion of the traffic light assessment would allow for discussion on aspects of personal care and agreement on who does what.
- Hospital staff could be advised on how best to approach a patient, i.e. some may require low arousal and others removal of items that may

pose a risk in the room. It may even be more beneficial to triage the patient in the vehicle bringing them to hospital; this is an approach that the Emergency Department has been happy to facilitate in the past.

- Advice to hospital staff would also include security staff as at times their skills are needed but without an understanding of the situation it may exacerbate things further.

It is suggested that a vulnerable adults or SNAP service could work with the UHNS, primary and specialist services to follow up repeat attendees who are tracked/flagged as vulnerable due to their frequent presentations which would lead to potential savings/benefits:

- Reduced time spent in departments as care carried out more effectively and efficiently.
- May reduce frequency of attendances as greater understanding of needs is developed by the individual and staff.
- Reduction of length of patient stay as decisions could be reached in a timely manor
- Increased autonomy and empowerment of patient through agreed management and care plans

5.3 Complex cases

One area of work that has developed for the SNAP team is that of working with individuals who present with complex health needs and due to the complexity fall into the category of vulnerable adult. Through application of care co-ordination principles the SNAP team has been able to support UHNS to bring together the range of professionals involved in an individuals care and agree a management plan that everyone including the patient is aware of. In one case in particular the individual and their family have been very happy with the outcome of the care co-ordination, voicing that they are now reassured that UHNS know how to support the individual.

5.4 Discharge planning-the need for reasonable adjustments

Often people with additional health needs due to a pre existing condition, such as learning disability or mental health, will need additional support to that usually offered to function well in their own environment. The need to have a robust discharge plan that clearly states who, how, when and what is essential and sometimes due to internal and external pressures there is not always the attention to detail in planning to ensure that individual needs are met. The SNAP team found that 60% of patients with learning disability required additional input in the community to sustain them in their own environment, in some cases the SNAP team provided this support and made referrals to health facilitators and/or community nurses to continue the input support. Some of the reasons for this were found to be due to assumptions made about paid carer's knowledge and skills to care for a patient whose needs had changed. Discharge information was found to be unclear in some cases and therefore led to both paid and family carers not understanding fully the intervention at home and then re-attending within 48 hours.

It is fair to say that with longer life expectances and increased complex needs and proposed reprovision plans for local learning disability services that this percentage would significantly increase.

5.5 Admission of 2 days or less

In the original specification the SNAP team were asked to look at issues associated with admissions of 2 days or less. There was a view held by commissioners that these short admissions could be reduced or prevented with additional resources in the community.

The evidence from the referrals that the SNAP team worked with does not support this. Evidence indicates that the introduction of such interventions as 'intravenous access at home' and 'stay at home scheme for older people with mental health needs' and the care home liaison team has made a significant difference to length of stay and reduction of inappropriate admissions. During the project, with input from the SNAP team with one gentleman with a learning disability and complex needs who lives in a health provided home was able to be discharged with Invetero (I.V) access for antibiotic treatment. Without the support of the SNAP team despite the I.V access at home being available it is believed that this would not have happened.

There is currently no stay at home scheme or care home liaison service for people with a learning disability which would be very valuable in supporting people not to present at UHNS or to return home sooner following admission. Option 1 would provide the opportunity to implement these in full and option 2 would provide the opportunity to partially implement.

5.6 Specialist services

There is a need to provide training and awareness sessions about the UHNS and care pathways for admission, discharge etc for staff working in mental health and learning disability within both health and social care. A greater understanding of the role of the UHNS and what it can provide for patients would lead to better advice being given to individual patients around their health needs and which service to access. The vulnerable adults service or SNAP would provide that valuable link back to specialist services, alerting learning disability or mental health services to the patients admission/attendance and providing that opportunity to co-ordinate, plan and provide a clear picture of individual needs and how best to meet these. Improved relationships and partnership working has the potential to reduce inappropriate attendances and improve patient overall health through early and co-ordinated intervention.

6. Cost/benefit analysis

6.1 Delayed discharge/reduced length of stay

Patients with a learning disability who had a prolonged stay in hospital due to issues around consent, systems and resources not being in place for discharge and lack of co-ordination/communication and consideration of needs associated with learning disability accounted for 1.4% of total referrals in May 2009 and in June 0.9% of total referrals. As identified from the patient/carer questionnaires issues relating to capacity and consent affected the length of time that some patients remained in hospital for. Using person centred approaches to assess and plan for individual needs, producing an agreed Health Action Plan (HAP) would empower individuals and family carers and facilitate timely and effective decision making. Option 1 would provide the resource/expertise to co-ordinate individual care needs, leading to safe discharge planning that potentially reduces length of stay. In a recent study reporting the impact of implementing an acute liaison service for people with learning disabilities a reduction of 8% from 12% to 4% was noted in stays of 40 days or more, over 50% of patients with learning disability now have a stay of under 10 days compared with only 30% prior to implementation of the service (Pointu et al, 2009). Implementing a vulnerable adult's service would facilitate the support, teaching and processes required to impact on length of stay.

Communication difficulties experienced by 1 patient with learning disability led to delays in progressing with intervention to insert a PEG tube. The number of professionals involved and clarity about responsibility for actions further delayed intervention. The SNAP team were able to co-ordinate intervention, assess communication needs and develop and agree a Health Action Plan.
In 2 cases delayed decision making due to mental capacity issues led to prolonged stays. In one case a lady with learning disability was declared medically fit for discharge during the ward round on a Friday morning, hospital staff wanted the discharge back to the ladies residential home to happen that afternoon. When the SNAP team and hospital dietician were informed they queried arrangements within the residential home to meet her changed needs. This had not been discussed and was potentially an unsafe discharge. The SNAP team made arrangements for the regime to be reviewed and residential staff to come to the hospital leading to a safe and timely discharge.

It is difficult to give an average cost for a hospital stay as this depends upon the reason for the stay however it is clear from the project findings that a vulnerable adults service through co-ordination, liaison, teaching and planning would reduce length of stay and delayed discharge. Evaluation of data relating to average length of stay could be used to evidence benefits to the patient and cost savings.

6.2 Reduction in attendances (repeat attendees)

Some of the patients that the SNAP team has worked with have been highlighted within UHNS as repeat attendees. Through follow up with the patients and carers a better understanding of the patients needs has led to the development and implementation of care plans that minimise risks, make

recommendations about approaches to individuals, e.g. there was one patient who particularly enjoyed visiting the Emergency Department and was found less likely to self injure and therefore less likely to need to visit the department if a 'low stimulus' approach was used.
Alerting specialist health colleagues already working with individual patients to the fact they have had an attendance or admittance to UHNS led to appropriate sharing of information about individual patient needs even when the patient was having difficulty communicating this for themselves. Some patients reported feeling reassured and supported when advised by UHNS staff that they had liaised with specialist health staff. This liaison and co-ordination led to reduced length of time spent in the department and in some cases reduced attendances in the following month.
The SNAP team cross referenced referrals for March, April and May 2009 with the 707 total number of repeat attendees at the UHNS during those same months and found that 79 of the referrals were identified as repeat attendees. The average attendance was 3.85 visits. If option 1 was implemented and a reduction by 1 attendance was aimed for this would lead to potential cost savings in a 3 month period as follows:

- Minor Injury Tariff of £59 = Potential saving £4,661
- Standard Tariff of £80 = Potential saving £6,320
- High Cost Tariff of £109 = Potential saving £8,611

In option 1 ALL repeat attendees would be followed up therefore the potential saving for 3 months would be:

- Minor Injury Tariff of £59 = Potential saving £41,713
- Standard Tariff of £80 = Potential saving £56,560
- High Cost Tariff of £109 = Potential saving £77,063

6.3 Savings in hospital services and specialist service

The need for improved communication and understandable/accessible information has come through as a strong theme from the pilot project. There is a potential cost saving in reduction in re-attendance if patients are given access to information that they understand, access to support as needed and are involved in the planning of their care. Development of accessible information in particular letters sent out to patients for appointments ensures that patients understand what is required of them. Accessible information could benefit a wide range of patients who use UHNS services and reduce the numbers of patients who Did Not Attend (DNA).
Sharing of information and co-ordination of input from specialist services allows for appropriate planning regarding ongoing support for patients in receipt of a specialist service. Often specialist services are not made aware of an individual's admission or attendance which might impact on planned appointments, treatments etc.

6.4 Co-ordination and planning

Through a person centred and co-ordinated approach patients have been supported to have necessary pre-assessment checks within their own environment with support from specialist health staff. The individual feeling more relaxed in their familiar environment is less disrupted and distressed. This approach also led to 'freeing up' of a clinic appointment.

Some patients may require sedation to get them to necessary appointments or to undergo investigations. With appropriate planning and co-ordination these appointments and investigations can go ahead causing minimal disruption to the patient, UHNS staff and other patients.

Speciality	First Appointment Single Professional	First Appointment Multi-Professional
Gastroenterology Surgery	£130	£259
Gastroenterology	£158	£166
General Surgery	£146	£168

The above are costs per person and for initial appointment only. Potential cost savings relate not only to missed appointments, planning for best use of theatre time and use of equipment but also cost to service providers as often people with complex needs require 2:1 staffing to maintain the individuals safety.

Due to additional needs associated with pre-existing conditions some patients may find it very difficult to wait in a busy waiting area and also for any length of time, without planning and flexibility as described above patients may not wait for their appointment therefore leading do costs incurred as illustrated.

Applying the principles of care co-ordination has led to a better working relationship between, hospital and community staff. This appreciation of roles and increased understanding of patient's additional needs has ensured that person centred approaches have been adopted to plan and deliver care.

7. Qualitative findings from patient and/or carer questionnaires

Over 74 questionnaires were completed. The findings from the patient and/or carer questionnaires have been reviewed and key themes have been reflected as a percentage under each of the 4 areas covered in the questionnaire i.e. Admission, investigation, treatment and discharge.

7.1 Admission

ADMISSION					
COMMUNICATION					
There was a lack of Easy Read Communication	**There was an assumption that carer would speak on behalf of patient**	**Felt that staff did not have time to communicate with patient or carer**	**Reporting of medication issue which was felt due to poor communication between staff**	**Agreed that staff explained well to patient and carer**	**Patient/carer agreed that were comfortable to ask any questions**
20.51%	**7.69%**	**7.69%**	**2.56%**	**20.51%**	**48.71%**
ENVIRONMENT					
Felt that the waiting area was a problem	**Felt that there was no suitable toilet/changing facilities**	**Considered poor parking facilities**	**Reported that had to ask for basic provisions**		
15.38%	**2.56%**	**2.56%**	**5.12%**		
ATTITUDES					
Felt that staff did not have time to look at the Traffic Light Assessment or care plans	**Felt that doctor/staff did not include carers in decisions**	**Felt that staff were abrupt or impatient**	**Felt that staff were friendly and welcoming**		
15.38%	**2.56%**	**5.12%**	**25.64%**		
REASONABLE ADJUSTMENTS					
Reported seen promptly	**Reported that put on the triage list to reduce waiting**				
5.12%	**5.12%**				
PLANNING					
Patient/Carer gave prior notice of attendance	**Carer reported that they found Hospital Assessment Forms useful**				
12.82%	**5.12%**				

The feedback from the patient/carer questionnaires showed that individuals often felt that information was not accessible, in particular information leaflets

and letters sent out by the hospital. Some individuals did feel that communication was good, for example feedback from one individual mentioned that “It can be reassuring to have complicated medical terms explained in a more straightforward way”, however, others felt that they were not given time to speak, with one individual reporting “I was not given time to talk and that in turn made a difficult situation dangerous”. A carer fed back that “We were impressed that staff included Peter in everything and talked directly to him”, however many other questionnaires, in particular from individuals who were accompanied by carers reported that staff spoke directly to the carers instead of the patient. Based on this feedback, the SNAP team organised communication training to increase the confidence, skills and knowledge of staff, to aid successful communication. The communication book was reported to have been a great use in aiding communication for individuals with a learning disability, hard of hearing or those who had difficulties with the English language.

Environment:
The general theme from the feedback was regarding the waiting room being unsuitable, as one individual reported “the waiting room was a bit boring, would have liked some magazines….a shame we had to wait so long, I thought they had forgotten us”. Other issues were regarding the changing areas/toilet facilities; “There was no specific changing area to meet Rita’s needs”. A general theme was also that there was a lack of signage in accessible formats, which caused confusion to patients within the hospital.

Attitudes:
A variety of feedback was received regarding staff attitudes on admission, with some individuals reporting feeling that staff were friendly and welcoming, however, it was also reported that staff were abrupt and that there was a lack of use of care plans, in particular regarding mental health needs.

Reasonable adjustments:
It was reported in some cases that individuals were seen promptly and put to the front of the triage list to reduce waiting, however, this should be occurring on a more regular basis, as it was also reported that many individuals became increasingly anxious due to a long waiting room or lack of a quiet side room for them to wait in.

Planning:
One carer reported that “we found the hospital assessment very useful and would definitely use it again for all clients prior to admission”. Another good example of planning was the contacting of ward sister’s prior to attending, which ensured that the individual could receive the level of care they required. There was also positive feedback regarding the planning and adjustments carried out in pre assessment and day surgery, to aid the individual to have a more positive hospital experience.

7.2 Investigation

INVESTIGATION					
COMMUNICATION					
There was a lack of Easy Read Communication	**Staff did not ask about patient individual communication needs**	**Carers felt that they had to take the lead in ensuring that patient had been fully informed**	**There was an assumption that carer would speak on behalf of patient**	**Reported that staff did not seem to recognise pain symptoms and carers had to request medication**	**Reported that staff spoke clearly and directly to patient**
15.38%	**5.12%**	**5.12%**	**5.12%**	**2.56%**	**23.07%**
ENVIRONMENT					
Felt that the waiting area was a problem	**Felt that there was no suitable toilet/changing facilities**				
15.38%	**2.56%**				
ATTITUDES					
Felt that staff were abrupt or impatient	**Felt that staff were friendly and welcoming**	**Reported that staff gave time and space when needed**			
5.12%	**28.21%**	**20.51%**			
WAITING TIMES					
Felt waiting time to be seen in triage or minors was much longer than expected					
10.25%					
REASONABLE ADJUSTMENTS					
Reported investigations and procedures done quickly	**Reported that carers allowed to assist or complete procedures**	**Reported that investigations were done in the patients home**	**Reported that they were given a side room without asking**		
5.12%	**7.69%**	**5.12%**	**15.38%**		
PLANNING					
Carer reported that they found Hospital Assessment Forms useful					
7.69%					

Communication

In general the theme was that information was not accessible. It was often reported that individuals did not feel that information was fully explained to them regarding procedures, as one individual said “No explanation has ever been given to me about what the tests show or how the results may be used

in my treatment". Another individual became extremely anxious whilst waiting for results of a MRSA test, which felt was an unnecessary distress to the patient. Via the project report and verbal feedback the team is recommending that staff explain to patients that they will be informed with a specific time frame if the MRSA results are positive. It was also reported that staff often spoke directly to carers or assumed that individuals could not communicate as they had a carer with them, which in turn frustrated the patient.

Environment:
Waiting for an investigation seemed to be a problem for individuals, with some reporting it to be too noisy or boring. Some were offered a separate, quiet side room, however this was not always the case. In particular the availability of suitable changing/ toilet facilities seemed to be a problem.

Attitudes:
The general feedback from the questionnaires was that staff were welcoming and gave individuals time and space to think about information and to become familiar with the environment. In some cases individuals were able to come and visit prior to the procedure, to gain familiarity. However, some of the feedback suggests that individuals did feel that staff were abrupt, impatient or did not have time to talk to them.

Waiting times:
Difficulties with waiting times were reported in general. In particular in the questionnaires filled out by individuals or carers of individuals with learning disabilities who found it difficult to wait. In one case an individual was allowed to wait in the car park until they were required for their appointment, however this option was not given to everyone.

Reasonable adjustments:
Being offered a side-room was of great comfort to some individuals who wished to have a quieter, more private area to wait, or became anxious in a large waiting room. In one instance staff were also allowed to carry out a procedure; "Carer did the videoscopy, this was agreed beforehand and worked well for Sheila". Through making these small adjustments it was felt that the individuals had much lower levels of anxiety regarding the procedures.

Planning:
Feedback from the questionnaires did suggest that the Hospital Assessment Form was of use in regards to planning the admission and knowing the needs of the individual.

7.3 Treatment

TREATMENT					
COMMUNICATION					
There was a lack of Easy Read Communication	There was an assumption that carer would speak on behalf of patient	Reported that specific dietary requirement not met	Carers felt that they had to take the lead in ensuring patient fully informed	Reported that staff spoke clearly and directly to patient and carer	
15.38%	5.12%	2.56%	5.12%	15.38%	
ENVIRONMENT					
Felt that there were no suitable toilet/changing facilities	Felt nurses to busy to accommodate their needs				
2.56%	15.38%				
WAITING TIMES					
Reported that told to arrive much earlier than surgery, longer waiting time than expected	Reported that staff very flexible with arrival time				
10.26%	5.52%				
ATTITUDES					
Felt that information not passed from doctors to carers or patients	Found staff friendly and approachable				
10.26%	20.51%				
CONSENT					
Problems with consent issues, i.e. doctors not willing to go against family wishes					
5.12%					
REASONABLE ADJUSTMENTS					
Poor/no provision for carer to be with patient	Good adequate provision made for carers	Allowed open visiting	Given a side room without request	Put first on theatre list to reduce waiting time	Reported special adjustment made to surgery process
10.26%	7.69%	7.69%	17.94%	10.26%	15.38%
PLANNING					
Carers reported that they found Hospital assessments Forms useful					
10.26%					

Communication:

It was felt that there was a lack of clear, accessible information provided. It was felt that some staff spoke clearly and directly to the patients, however, some questionnaires also reported that staff had made assumptions that carers would speak on behalf of the patient or that the patient did not communicate as they had a carer with them "no questions were asked about R's communication skills….R's carers had to take the lead in ensuring R was informed of what was happening". It was felt that often communication between paid carers of individuals that had been admitted and the ward staff was lacking. Carers from nursing/residential homes in cases where individuals remained in the hospital for a period of time felt that they were not supported sufficiently. For example some made comments such as they "had to ask if they could go for a break" and "regularly had to ask several times" for support from ward staff to be able to meet the personal care needs of the patient and then "had to wait for long periods, before someone would eventually come". The SNAP team was looking at developing a protocol to improve communication between paid carers and ward staff.

Environment:
The issue regarding lack of suitable changing/toilet facilities seemed to be a common theme, in particular when an individual needed more than one carer to accompany them to the toilet or that there might be a risk of absconding if an individual accessed the toilet alone. It was felt that toilets/changing areas were too small to accommodate more than one individual. It was also felt that on some busy wards staff were too busy to accommodate needs "carer felt that the hospital staff didn't have time to talk with the carer about their knowledge of the client".

Waiting Times
Waiting times seemed to be a common problem, with individuals reporting to have been called in three and a half hours prior to the appointment "we were told to arrive at 11am, but Robert was not taken for his operation until 1.30pm, he found waiting time difficult and had to go outside and walk around".

Attitudes:
Positive feedback included that some individuals found staff friendly and approachable; however there was a mixed response in general, with comments of lack of communication with individuals and carers. Feedback from one questionnaire reported that "The doctor did consult me about my feelings of using a drug that may have caused minor side effects compared to the benefits". Another individual felt that "staff are often too busy with paperwork, etc, to spend as much time as they would like with patients".

Consent issues:
In some cases carers reported staff relying on them to inform the decision making. When patients were unable to communicate verbally this caused problems with consent to treatment, lack of accessible information to support decision making. In one instance a patient making a decision felt to be unwise by staff had their capacity queried.

Reasonable adjustments:
Reasonable adjustments were reported; "Staff were invited into the recovery room when R woke up, this really worked well for R to have a familiar face".

There was also reports of side-rooms being offered for individuals who may become anxious to wait in. However, this was not occurring in all cases, as one carer fed back that “Nobody had checked previously if J’s carers were allowed to be with J during her treatment, so J ended up with no one familiar to her, if this had been checked with carers previously, maybe it could have been arranged better”. Feedback also suggested a lack of provisions for carers of patients “Care staff were not asked about support, we had to ask for someone to sit with J if we wanted to take a break as J could not be left”.

Planning:
The feedback in general was that the Hospital Assessment Form was useful at treatment stage. It was reported that planning did benefit some individuals, however in other cases it was lacking “We were told to arrive at 11am, but Robert was not taken for his operation until 1.30pm, he found waiting difficult and had to go outside and walk around”.

7.4 Discharge

DISCHARGE					
COMMUNICATION					
There was a lack of Easy Read Communication	Reported that carers were involved in decisions at this state	Reported staff checked that patient would have adequate support after discharge			
23.08%	7.69%	17.95%			
ATTITUDES					
Felt that assumptions were made about the level of care available to the patient.	Felt discharge was rushed.	Reported that they felt comfortable and able to ask questions			
23.08%	12.82%	20.51%			
AFTERCARE ADVICE					
Reported no discharge plan in place	Reported that carers had to arrange follow up appointment or referral	Felt not give clear information about aftercare	Felt given good clear aftercare advice		
23.08%	5.12%	17.85/5	20.51%		
WAITING TIMES					
Reported delays in waiting for ambulance transport home					
5.12%					
REASONABLE ADJUSTMENTS					
Reported discharged early to reduce stress	Allowed to return home with some treatment still ongoing				
7.69%	2.56%				
PLANNING					
Existing care plans not checked or used in discharge process					
24%					

Communication:
A general theme that has arisen from the questionnaires it that individuals did not feel that they were given enough information regarding discharge, as one individual said “when I first went to A & E I was looked after well, then transferred to a ward. I was left with no explanation on anything then felt just rushed home”. Another individual reported that there were “some wards where I felt we were

sent home because of a bed shortage". In general the lack of information regarding discharge caused the most anxiety.

Attitudes:
In regards to discharge some carers of individuals with complex needs reported that assumptions regarding the level of care available to individuals on returning to the care home were made, which may have resulted in unsafe discharge. It was sometimes felt that discharge was rushed, and information/ assessments were not thorough.

Aftercare advice:
There was a mixture of responses in regards to aftercare advice, as some individuals felt that good, clear aftercare advice was given, whereas others felt that there was a lack of discharge plan/ co-ordination of professionals. It was also felt that there was sometimes a lack of involvement of paid carers in the discharge, and as a result aftercare advice was not communicated to the home.

Reasonable adjustments:
The day surgery were able to make reasonable adjustments in that in a few cases individuals were discharged as early as possible to avoid stress.
Waiting times:
Waiting times were reported to be problem in regards to waiting for ambulance transport home.

Planning:
'My current care plan should have been used as part of the planning; they should have looked at it'.

8. Incidental findings, functions and outcomes for the SNAP team

8.1 Enteral Feeding

Dysphagia and the associated needs with managing dietary intake and reducing the risk of aspiration for people with learning disabilities is a complex and well documented issue. During the 6 month project the SNAP team has been involved with 4 cases where by the liaison and support provided by the team has led to a reduced length of stay, improved communication and improved outcomes/quality of life for individuals.

One of the issues identified by SNAP which impacted on the patients length of stay and timely intervention was a reluctance by clinicians to go against family wishes and apply the principles within the Mental Capacity Act regarding 'best interests when patients lacked capacity.

Another issue was too many professionals being involved and a lack of co-ordination where capacity to consent was unclear. This led to delays in treatment, ineffective decision making and discharge planning.

Following involvement in these cases the team noted that UHNS policy was being reviewed and needed to reflect the good practice available to ensure holistic approaches to meet individual needs. Deputy Director of Nursing organised and chaired a meeting with the lead consultant and other professionals involved in reviewing the hospital Enteral feeding policy. It was agreed that the reasonable adjustments that might be needed in relation to people with learning disability should be incorporated into UHNS policy. SNAP and representatives from UHNS Dietetics and Speech and Language Therapy services have made recommendations for inclusion into the reviewed UHNS Enteral Feeding Policy. The recommendations are based on The British Dietetics Association Nutritional Care of Adults with a Learning Disability in Care Settings consensus statement (BDA, 2008) and Home Enteral Tube Feeding for Adults with a Learning Disability good practice guide (BDA, 2008) which are currently being circulated for comments.

8.2 POVA training

The project team were asked to review UHNS training in relation to vulnerable adults. This was done and the training now reflects case studies for staff to consider. It was also noted that although UHNS was working with the Interagency Stoke and Staffordshire Safeguarding policy consistency re referral to the safeguarding teams was sometimes a problem therefore a meeting was held with the Stoke and Staffordshire Vulnerable Adult Leads, UHNS Deputy Director of Nursing SNAP project Lead and actions agreed.

8.3 Contribution to complaint response

During the project the project lead was asked to make a response in relation to a complaint that related specifically to a patient with learning disability and raised queries generally as to the trust's support of people with learning disability.

8.4 Emergency Nurse Conference

As meeting the needs of Vulnerable people in hospital is a national focus currently it was discussed at the Learning Disability Steering Group and agreed that an abstract submission should be made for the RCN Emergency Nurse Conference taking place on October 16th and 17th 2009. The abstract was submitted in May and has now been accepted. Deputy Director of Nursing and SNAP project lead will present a 25 minute paper about meeting the needs of vulnerable people when in hospital- making reasonable adjustments.

8.5 Contribution to national project and NHS Confederation Briefing

In February of this year the Department of Health issued 'Valuing People Now: from progress to transformation-a consultation on the next three years of learning disability policy (DH, 2009). Within this document and the accompanying delivery plan it was announced that the NHS Confederation would carry out a two year project to review access to acute health services for people with learning disabilities. The lead for this project from the NHS Confederation visited UHNS when she came to the launch of the hospital toolkit 'My next patient has a learning disability: A Toolkit for Supporting People with Learning Disabilities; Helping me to care for you, and involving others'. She was impressed with the approach taken to meet the needs of vulnerable people within the SNAP and has since decided that the UHNS will be featured in a briefing from the NHS Confederation along with Norfolk and Norwich University Hospitals NHS Foundation Trust. In addition the SNAP project lead has been asked to join the steering group set up by the confederation to contribute to this national two year project and also a vulnerable adults group ran by the NHS Confederation.

9. Recommendations and future options

9.1 Recommendations

1. Development of Psychiatric liaison service

Currently the Psychiatric Liaison Service is only able to provide self harm clinics Monday to Friday and as identified in the report there is a clear need for a service that identifies and works with patients who regularly attend the Emergency Department. With little investment see option 1 and 2, the needs of this group of patients could be addressed as part of the vulnerable adults service.

NHS Confederation viewpoint on Liaison services: 'A liaison service is an example of a quality improvement with a strong business case as long as the service is well-designed and based on good data about the numbers of patients that could benefit. The system will also be supported by current policy, such as the dementia and learning disability strategies or the personalisation agenda, which insists on a holistic approach to care. Many of the streams in Lord Darzi's report 'High quality care for all', also mention the importance of providing services that treat both mental and physical health' (NHS Confederation Briefing Healthy Mind, Healthy Body, 2009).

2. Repeat attendees

There are significant numbers of repeat attendees to the Emergency Department. In order to support these individuals to have fair and equal access to a wide range of services to meet their health and social needs specific targets to identify and then work with these patients both within the UHNS and back into the community have been incorporated into option 1a,b and 2.

3. Vulnerable Adults Admission care pathway

Through implementation of the tracking/flagging system potential vulnerable adults would be identified and their needs visible throughout the UHNS. The aim of this care pathway would be to assess each person's needs and identify clear interventions to support a positive and effective hospital stay. Incorporating the traffic light assessment and risk, dependency and support assessment the admission care pathway would ensure a collaborative and person centred approach to individual care. Areas of potential risk for the patient would be identified and interventions and support planned and implemented to reduce these. Referral to and involvement from the SNAP team within the admission and discharge process would lead to reduced likelihood to re-attend, reduced length of stay and increased appropriate use of primary care services.

4. Vulnerable Adults Discharge care pathway

The potential additional needs that an individual with a pre-existing condition may have needs to be considered very early on in the admission process as these may impact on the discharge plan and require co-ordinated and collaborative working. The current hospital discharge policy reminds staff to consider the persons additional needs such as learning disability but as indicated from the findings requires clarity as to who takes responsibility to co-ordinate this. The SNAP team linking back into community could provide this necessary co-ordination.

5. Training

The need for ongoing training for existing and new staff has been clearly identified from the SNAP pilot. In order to change culture and attitudes and support staff at the UHNS to take responsibility for ensuring that additional needs associated with the persons learning disability or mental health need are not only recognised but also addressed a comprehensive rolling programme of teaching for all levels of staff is required. As identified earlier the SNAP team noted an increase in staff referrals following training and also the SNAP teams visibility in the UHNS. Staff felt able to raise queries and importantly make suggestions to support individuals. Training should be mandatory not just as part of induction but ongoing. In addition there needs to be training about the UHNS, care pathways and the vulnerable adults or SNAP service. There also needs to be training delivered to patients and carers and staff working with these vulnerable groups of patients in the community.

6. Consent and Mental Capacity

There needs to be more in depth and focused training relating to consent and mental capacity. As highlighted in the report some clinicians are not following the principles as set out in the Mental Capacity Act (2007). It is suggested that mandatory training about the Mental Capacity Act is reviewed and joint training delivered. A leaflet informing patients and carers of the procedure re consent and capacity needs to be developed to ensure increased understanding and to support informed input into the process.

7. POVA

As discussed earlier the SNAP team updated the Vulnerable Adults training for the UHNS it is recommended that this training is delivered by mental health, learning disability professionals and service users (as in option 1, 2 and 3).

8. Enteral Feeding Policy

The UHNS accepts and implements the recommendations from the SNAP team in relation to enteral feeding.

9. Traffic light assessment

The benefits of using the traffic light risk assessment are wide ranging and it is suggested that the use of this assessment for all patients who receive care from nursing or residential homes would ensure improved communication and reduce risks associated with patient care needs. The training developed by the SNAP team if delivered as suggested would ensure that all UHNS staff understand and use the assessment.

It is recommended that the commissioners introduce the use of the traffic light assessment for all nursing and residential homes as part of their contract agreement.

10. Risk, Dependency and Support Assessment

This assessment ensures that any areas of risk and vulnerability are identified and support needs planned and agreed to. Implementing this assessment would irradiate the financial battles that often occur when a patient has additional support needs. To support the effective implementation of this assessment the UHNS would need to agree and implement a protocol regarding the payment of additional staff where indicated, for specialist learning disability or mental health staff a service level agreement would need to be in place.

11. Accessible information
The development of more accessible information is required throughout the UHNS. Information given to patients in the Emergency Department and letters sent to invite patients for appointments and/or investigations should be the priority.

12. Pocket size information
Information about reasonable adjustments, the Mental Capacity Act, POVA flow chart and the Emergency Department Protocol to be added to this existing resource.

13. Mystery shopper approach to reviewing care
People with learning disability, mental health needs and family carer's to be invited to regularly involved in audits and reviews of services at the UHNS. Their findings/feedback should be presented to the Board and used to improve services.

14. Signage
A review of bedside information is currently taking place at the UHNS as part of the productive ward programme. The SNAP team have been asked to contribute to this regarding accessible information. It is recommended that this continues. The signage within the new build needs to be accessible to all, the steering group can support with this.

15. Changing places toilet
The UHNS needs to ensure that appropriate changing facilities are in place within the new build.

16. Emergency Department protocol
The Emergency Department Protocol needs to be formally agreed through the UHNS governance processes and should continue to be part of the regular teaching to ensure that it is implemented consistently.

17. Steering group
It is recommended that the Terms of Reference of the UHNS learning disability steering group are reviewed in light of the Option implemented as a result of this report.

18. Disability Equality Scheme
Work with people with learning disability and family carers to review Disability Equality Scheme to ensure that it includes and reflects the reasonable adjustments required by people with learning disability.

9.2 Future service provision-Options 1-4

Options
In option 1 and 2 where WTE are referred to it would be expected that the hours of operation would be Monday-Friday 8.30-4.30 or 9-5 or 10-6. The findings from the SNAP pilot indicate that service provision needs to focus on the learning

disability patient group due to existing or planned services being in place for people with mental health needs therefore this is reflected in the options.

Option 1
Vulnerable Adult Liaison Service
a)1 WTE Band 8a Strategic Vulnerable Adult lead
b)0.5WTE Band 8a Strategic Vulnerable Adult Lead
a)1 WTE Band 6 Liaison Nurse
b)2WTE Band 6 Liaison Nurse
2 WTE Band 3 Liaison Support Worker
0.5 WTE Liaison team worker (Person with learning disability)
Sessional employment of service user (Mental Health)
Sessional employment of carer X2 (I carer of person with LD, 1 carer of person with mental health need)
Link nurses from each department and ward (already employed at UHNS)
Dedicated 2 days input from liaison psychiatry from Band 6 or 7

The Strategic Vulnerable Adult Lead would take the lead role within the UHNS for the development of strategies, care pathways, protocols, monitoring, and delivery of training.

- Implement a tracking system that identifies and flags potential vulnerable adults including patients with learning disabilities (discussed in section 3.6)
- Develop a range of accessible information i.e. information that is readily available and comprehensible. This will include treatment options (including health promotion), complaints procedures and appointments.
- Provide support for family carers including the provision of information regarding learning disabilities, relevant legislation and carer's rights.
- Provide a comprehensive rolling programme of training for ALL staff looking at learning disability awareness, relevant legislation, human rights, communication techniques, person centred approaches, the protocols and care pathways, resources to support provision of high quality care for all vulnerable people, values and attitudes (see appendix 6, this is an example of one session only).
- Work with the UHNS engagement department to ensure that people with learning disability and their family carers are involved in the planning and development of services and in decisions affecting the operation of services.
- Work with lead at the UHNS for implementation of 'Proud to care' to incorporate benchmark re 'reasonable adjustments', Traffic Light Assessment
- To implement a system to audit practices within the UHNS and demonstrate the findings to the UHNS Trust Board. Ensure that this information is part of the published UHNS annual report
- Take over the provision of Vulnerable adults Training, suggest that some of these sessions are joint with mental health and learning disability services
- Review and make recommendations about the physical and cognitive access to all wards/departments in the area
- Implement Admission care pathway for **all** vulnerable adult admissions including using the Traffic Light assessment (appendix 7) and Risk, dependency assessment (appendix 8)

- Develop individual plan of care with individual, people that know the person well following completion of the Traffic Light Assessment
- Train UHNS staff to use the Admission Care pathway, including how to complete the Traffic Light Assessment (appendix 7) and Risk, Dependency Assessment Tool (appendix 8)
- Through training ensure that all individuals within wards and departments are aware of and act on their responsibility to make 'reasonable adjustments' in the services that they deliver
- The team would work with the UHNS Emergency department lead to identify repeat attendees and co-ordinate in put and support through application of care co-ordination principles i.e. identify range of professionals involved with individual, provide 1:1 support and if appropriate teaching to allow the individual to recognise own health needs, ensure appropriate primary care support making referrals as necessary, act as key worker if no other more appropriate professional from primary or specialist services identified and contribute to the development and implementation of management plans as and when indicated.
- Work with and into the community to reduce inappropriate and frequent attendances
- Reduce length of stay and ensure effective planning around discharge to ensure that all discharges are safe (consider additional needs and implications for going home)
- Provide thorough planning and preparation to reduce likelihood of refusal to attend and/or comply with treatment/intervention
- Carry out patient and carer satisfaction surveys to inform the UHNS planning
- Carryout 'mystery shopper' reviews of services to monitor implementation of care pathways, reasonable adjustments and protocols
- Provide advice and support including 'institu' training as required to ensure that an individuals care is of the highest quality
- Expediate discharge when appropriate through liaison with family carer and/or care providers involved, linking to existing services e.g. Re-ablement team
- Strategic Vulnerable adult lead to represent the UHNS as the Safeguarding Adult Board, provide quarterly reports re safeguarding to UHNS Trust Board and the Learning Disability Partnership Board
- Strategic Vulnerable Adult Lead to represent the UHNS on the Learning Disability Partnership Board
- Strategic Vulnerable Adult Lead to review the terms of reference for the Learning Disability Steering Group to ensure that reflects the needs of all vulnerable people
- Monitor and review the UHNS' action plan re Healthcare for all, Six lives and Steven Hoskins
- Improve communication within the UHNS and between the UHNS and community services
- Promote the use of the toolkit 'My next patient has a learning disability' developed with Keele university (Toolkit can be viewed at www.keele.ac.uk/depts/ns/toolkitpeopleld)

Option 2
UHNS Modern Matron to lead the Specific Needs Access Service (SNAS)
2WTE Band 7
1WTE Band 3
Link Nurses within each ward and department (already employed at UHNS)
Dedicated 2 days input from Liaison Psychiatry Band 7
Sessional employment (minimum of 2X1 hr monthly) of person with learning disability
Sessional employment (minimum of 2X1 hr monthly) of service user (Mental Health)
Sessional employment (minimum of 2X1 hr monthly) of carer X2 (I carer of person with LD, 1 carer of person with mental health need)

This service would provide the following:

- Implement a tracking system that identifies and flags potential vulnerable adults including patients with learning disabilities (discussed in section 3.6)
- Develop some accessible information i.e. information that is readily available and comprehensible. Information given to patients in the Emergency department and appointment/investigations.
- Provide a rolling programme of training looking at the protocols and care pathways and resources to support provision of high quality care for all vulnerable people; learning disability awareness (see appendix 6, this is an example of one session only).
- Work with the UHNS engagement department to ensure that people with learning disability and their family carers are involved in the planning and development of services and in decisions affecting the operation of services.
- Review and make recommendations about the physical and cognitive access to all wards/departments
- Implement Admission care pathway for **all** vulnerable adult admissions including using the Traffic Light assessment (appendix 7) and Risk, dependency assessment (appendix 8)
- Train UHNS staff to use the Admission Care pathway, including how to complete the Traffic Light Assessment (appendix 7) and Risk, Dependency Assessment Tool (appendix 8)
- Develop individual plan of care with individual, people that know the person well following completion of the Traffic Light Assessment)
- Through training ensure that all individuals within wards and departments are aware of and act on their responsibility to make 'reasonable adjustments' in the services that they deliver
- Work with and into the community to reduce inappropriate and frequent attendances
- Reduce length of stay and ensure effective planning around discharge to ensure that all discharges are safe (consider additional needs and implications for going home)
- Provide thorough planning and preparation to reduce likelihood of refusal to attend and/or comply with treatment/intervention
- Provide advice and support including 'insitu' training as required to ensure that an individuals care is of the highest quality

- Expediate discharge when appropriate through liaison with family carer and/or care providers involved, linking to existing services e.g. Re-ablement team
- Promote the use of the toolkit 'My next patient has a learning disability' developed with Keele university (Toolkit can be viewed at www.keele.ac.uk/depts/ns/toolkitpeopleld)

Option 3
Service Level Agreement in place re delivery of training for all UHNS staff.
Would require 48hrs paid time of a Band 6 Registered Learning Disability Nurse and 48hrs paid time of a person with learning disability and family carer. Training would include basic information about the Traffic Light Risk assessment
Primary Health Facilitators provide support and advice to patients for elective admission and to ensure that information from the GP was appropriate and up to date

- Delivery of 1hr sessions X 2 monthly for all staff as part of the UHNS induction
- Delivery of mandatory 1hr sessions for all staff on a yearly basis-to achieve this sessions would need to be delivered minimum X2 monthly
- Completion of Traffic Light Assessment for elective/planned admissions

NB The Primary Health care facilitators would not have the capacity to come and work in the hospital setting, follow up and reduce repeat attendances or to carry out the teaching/training with hospital staff.

Option 4
Do nothing and anticipate further deaths by indifference and expect failure to meet required performance indicators/targets as described under 9.3

9.3 Care Quality Commission Performance assessment 2009/10 and risk analysis
The Care Quality Commission has recently issued an amended indicator for all trusts re 'access to healthcare for people with learning disability' This indicator will not be included in the scored assessment for 2009/10. However, trusts will be expected to collect the requisite information and report on it separately and the CQC will publish this along side the results of the review to ensure visibility.

Option 1 would ensure full compliance with the CQC performance indicator giving a score of 24/24 from the set criteria.
Risk analysis indicates green low risk

Option 2 would give a score of 15/24
Risk analysis indicates yellow moderate risk

Option 3 would give a score of 8/24
Risk analysis indicates amber significant risk

Option 4 would give a score of 6/24
Risk analysis indicates amber significant risk
Please see Appendix 2 for the full breakdown of scores and risk analysis

10. References

- Department of Health (2009) Valuing People Now: A three year strategy for people with learning disabilities. The Stationary Office, London
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- Michael J (2008) Healthcare for All: Report of the independent inquiry into Access to Healthcare for People with Learning Disabilities. Stationary Office, London
- NHS Confederation (April 2009) 'Healthy mind, Healthy body'. Breifing issue 179
- Parliamentary and Health Service Ombudsman (2009) Six Lives: The provision of Public Services to People with Learning Disabilities. The Stationary office, London
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- The Academy of Medical Royal Colleges (2009) 'No health without mental health' draft report. www.rpcysch.ac.uk/nohealth
- The Academy of Medical Royal Colleges (2008) 'Managing Urgent mental health needs in the Acute Trust'.
- Toolkit (2008) www.keele.ac.uk/depts/ns/toolkitpeopleld

Care Quality Commission Last updated: 19th June 2009
Performance assessment 2009/10

Access to healthcare for people with a learning disability

Rationale

Equality in access to healthcare is central to the delivery of healthcare. The Independent Inquiry into Access to Healthcare for People with learning Disabilities, led by Sir Jonathan Michael, published its findings 'Healthcare for all' on 29th July 2008.

The inquiry was ordered following Mencap's 'Death by indifference' report, which told the stories of six people with a learning disability who died while in NHS care. The Inquiry sought to identify the action needed to ensure adults and children with learning disabilities receive appropriate treatment in acute and primary healthcare in England.

Central to the development of these performance indicators is adherence to the Human Rights Act 1998 and the Disability Discrimination Act 1995, to ensure equality of access and equity for all people with learning disabilities and that a human rights approach is adopted by the NHS and that 'reasonable adjustments' are made in the delivery of services to reduce health inequalities.

This indicator will seek to respond to the recommendations made in the Inquiry report for providers, specifically around the collection of data and information necessary to allow people with a leaning disability to be identified and the arrangements trusts have in place to ensure the views and interests of people with learning disabilities and their carers are included in the planning and development of services.

Indicator

NOTE

This indicator will not be included in the scored assessment for 2009/10. However, trusts will be expected to collect the requisite information and report on it separately and we will publish this along side the results of the review to ensure visibility.

Trusts will be assessed on their responses to the following six questions, based on the recommendations set out in 'Healthcare for all' (2008) – the Independent Inquiry into Access to Healthcare for People with learning Disabilities. For each question, a response of 1 to 4 is required depending upon the extent to which plans and protocols are in place and are fully implemented for all aspects of each question.

The scoring guide for all questions (except question 2) is as follows:

(1) = Protocols/mechanisms are not in place.
(2) = Protocols/mechanisms are in place but have not yet been implemented.
(3) = Protocols/mechanisms are in place but are only partially implemented.
(4) = Protocols/mechanisms are in place and are fully implemented.

1. Does the trust have a mechanism in place to identify and flag patients with learning disabilities* and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? (1-4)

2. In accordance with the Disability Equality Duty of the Disability Discrimination Act (2005), does the trust provide readily available and comprehensible information**

(jointly designed and agreed with people with learning disabilities, representative local bodies and/or local advocacy organisations) to patients with learning disabilities about the following criteria:
• treatment options (including health promotion)
• complaints procedures, and
• appointments
Scoring:
1. Accessible information not provided
2. Accessible information provided for one of the criteria
3. Accessible information provided for two of the criteria
4. Accessible information provided for all three of the criteria.
3. Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities, including the provision of information regarding learning disabilities, relevant legislation*** and carers' rights? (1-4)
4. Does the trust have protocols in place to routinely include training on learning disability awareness, relevant legislation***, human rights, communication techniques for working with people with learning disabilities and person centred approaches in their staff development and/or induction programmes for all staff? (1-4)
5. Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups and other relevant forums, which seek to incorporate their views and interests in the planning and development of health services? (1-4)
6. Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? (1-4)
* Learning disabilities (Valuing People, 2001) include the presence of:
1. A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
2. A reduced ability to cope independently (impaired social functioning);
3. which started before adulthood, with a lasting effect on development.
**As described in the Mental Capacity Act (2007), organisations should take 'all practicable steps' to present information in a way that is appropriate to the person's circumstances.
***To include the Mental Capacity Act (2007), the Disability Discrimination Act (1995) and the Carers Act (1995)
Data source and period
Care Quality Commission special data collection (as at 31st March 2010)

Appendix 2

Options measured against Care Quality Commission indicators Risk Analysis of Options

Performance Indicators	Option 1	Option 2	Option 3	Option 4
The Trust has a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are reasonably adjusted to meet the health needs of these patients.	4	3	1	1
In accordance with the Disability Equality Duty of the Disability Discrimination Act (2005), the Trust provides readily available and comprehensible information.	4	2	1	1
The Trust has protocols in place to provide suitable support for family carers who support patients with learning disabilities, including the provision of information regarding learning disabilities, relevant legislation and carers' rights.	4	2	1	1
The Trust has protocols in place to routinely include training on learning disability awareness, relevant legislation, human rights, communication techniques for working with people with learning disabilities and person centred approaches in their staff development, and/or induction programmes for all staff.	4	3	3	1
The Trust has protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups and other relevant forums, which seek to incorporate their views and interests in the planning and development of health services.	4	2	1	1
The Trust has protocols in place re regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports.	4	3	1	1
Scores:	24/24	15/24	8/24	6/24

Risk Analysis

Risk Identified; potential for the death of a patient, similar to those cases identified in Death by Indifference.

	Option 1	Option 2	Option 3	Option 4
Likelihood Score	rare = 2	unlikely = 2	moderate = 4	moderate = 4
Consequence Score	minimum = 2	significant = 3	severe = 4	severe = 4
Total	4 = green, low risk	9 = yellow, moderate risk	16 = amber, significant risk	16 = amber, significant risk

Appendix 3

COSTINGS

OPTION 1 A Vulnerable Adult Liaison Service

BAND	*POINT SCALE*	*ONCOSTS*	*TOTAL*	*WTE*	*COST PER HOUR*	*FYE TOTAL*
8A Strategic Vulnerable Adult Lead	£40,853.00	23%	£50,249.19	1		£50,249.19
6 Liaison Nurse	£28,816.00	23%	£35,443.60	1		£35,443.68
6 Liaison Psychiatry Nurse	£28,816.00	23%	£35,443.60	2DAYS		£14,177.49
3 Liaison Support Worker	£16,698.00	21%	£20,204.58	2		£40,409.16
1 Liaison Team Worker (person with a learning disability)	£13,588.00	21%	£16,441.00	0.5		£8,220.05
1 Sessional employment (person with a mental health need)	£13,588.00	21%	£16,441.00	1 HOUR	£8.40	
1 Sessional employment of a carer x2 (learning disability/mental health)	£13,588.00	21%	£16,441.00	2 HOURS	£16.81	
Link nurses from each dept/ward (already employed by UHNS						

OPTION 1 B Vulnerable Adult Liaison Service

BAND	*POINT SCALE*	*ONCOSTS*		*WTE*		*FYE TOTAL*
8A Strategic Vulnerable Adult Lead	£40,853.00	23%	£50,249.19	0.5		£25,124.59
6 Liaison Nurse	£28,816.00	23%	£35,443.60	2		£70,887.36
6 Liaison Psychiatry Nurse	£28,816.00	23%	£35,443.60	2DAYS		£14,177.49
3 Liaison Support Worker	£16,698.00	21%	£20,204.58	2		£40,409.16
1 Liaison Team Worker (person with a learning disability)	£13,588.00	21%	£16,441.00	0.5		£8,220.05
1 Sessional employment (person with a mental health need)	£13,588.00	21%	£16,441.00	1 HOUR	£8.40	
1 Sessional employment of a carer x2 (learning disability/mental health)	£13,588.00	21%	£16,441.00	2 HOURS	£16.81	
Link nurses from each dept/ward (already employed by UHNS						

OPTION 2 Specific Needs Access Service

BAND	*POINT SCALE*	*ONCOSTS*		*WTE*		*FYE TOTAL*
Modern Matron (already employed by UHNS)						
7 Liaison Nurse	£34,410.00	23%	£34,410.00	2		£83,960.40
3 Liaison Nurse	£16,698.00	23%	£20,204.58	1		£20,204.58
7 Liaison Psychiatry Nurse	£34,410.00	23%	£34,410.00	2DAYS		£16,792.08
1 Sessional employment (person with a mental health need)	£13,588.00	21%	£16,441.00	1 HOUR	£8.40	
1 Sessional employment (person with a learning disability)	£13,588.00	21%	£16,441.00	1 HOUR	£8.40	
1 Sessional employment of a carer x2 (learning disability/mental health)	£13,588.00	21%	£16,441.00	2 HOURS	£16.81	