South East London Integrated Care System

NHS South East London

# Adults Learning Disabilities and Autism

## Protected Learning Time Event
## 18th January 2023

South East London Integrated Care System

# Agenda

**13:00 – 13:25:** Introduction

**13:25 – 13:45:** Social Prescribing for people with Learning Disabilities and Autism

**13:45 – 14:05:** Community Learning Disability Team service overview

**14:05 – 14:30:** Social Care support for people with learning disabilities

**14:30 – 14:45:** Learning Disabilities and Autism Specialist Prescribing Advisors and how they can support primary care

**14:45 – 15:00:** Q&A

**15:00:** Close

# Aims

- To better understand learning disabilities and autism
- To learn about the services available for adults with learning disabilities and autistic adults in Southwark
- To receive information about challenges for people with learning disabilities and autism accessing services
- Have a greater awareness of national and local priorities for people with learning disabilities and autism

# Introduction to Adults Learning Disabilities and Autism

Dr Nancy Küchemann: GP and Co-Chair Partnership Southwark
Jordan Oliver: Learning Disabilities and Autism Lead Southwark ICB

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Join at menti.com | use code 2234 4571

# Definitions Reminder

**Learning Disability** (also known as intellectual disability): significantly reduced ability to understand new or complex information, to learn new skills, with reduced ability to cope independently which started before adulthood, with a lasting effect on development. A Learning Disability usually has a significant impact on a person's life. Learning disabilities are diagnosed with a cognitive assessment and categorised based on severity.

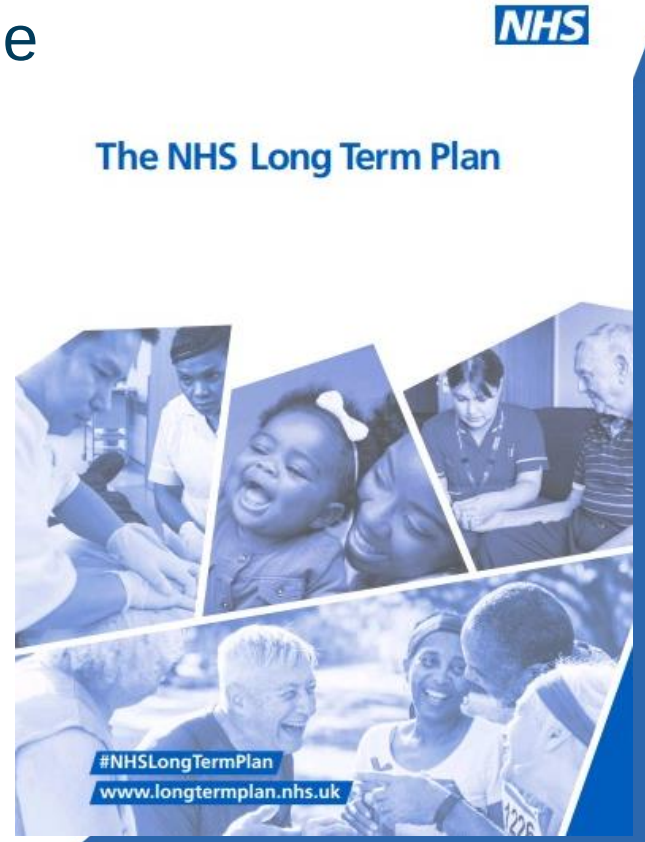
**Autism**: "persistent difficulties with social communication and social interaction" and "restricted and repetitive patterns of behaviours, activities or interests" (this includes sensory behaviour), present since early childhood, to the extent that these "limit and impair everyday functioning".

**Learning Difficulty**: a persistent difficulty learning and using academic skills related to reading, spelling, writing and maths e.g. dyslexia. People find it harder to learn

**ADHD**: an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.

# National Priorities: NHS Long-Term plan

- Whole NHS will improve understanding of the needs of people with learning disabilities and autism, and work together to improve their health and wellbeing
- Reduce waiting times for specialist services
- ‘Homes not hospitals’
- Investment in intensive, crisis and forensic support
- Improving the quality of inpatient care across the NHS and independent sector
- Action to tackle morbidity of autistic people and people with learning disabilities



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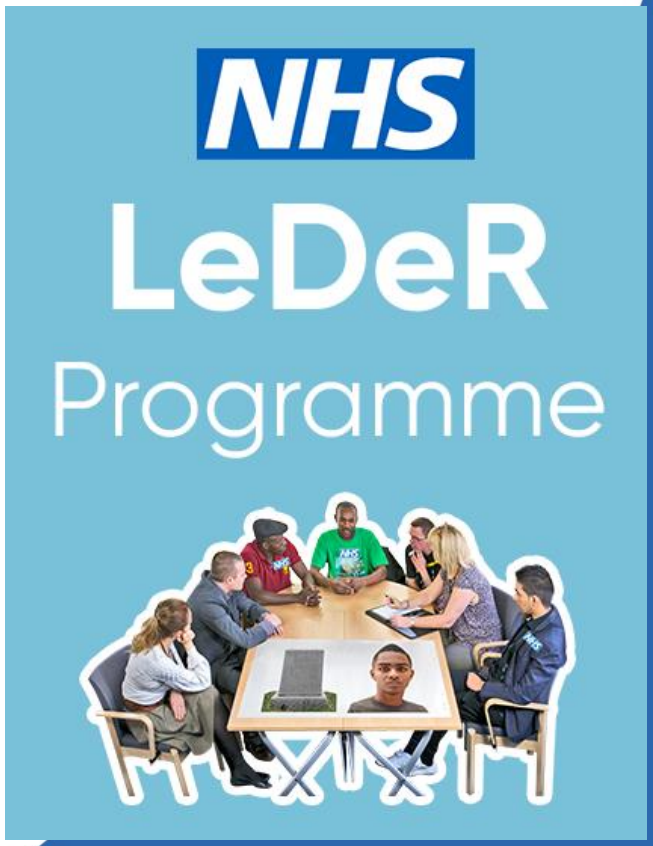
# LeDeR

LeDeR is an NHS **service improvement** programme which aims to **improve care, reduce health inequalities and prevent premature mortality of people with a learning disability (LD) and autistic people** by reviewing information about the health and social care people received

Findings indicate that **more than three times the number of people with learning disabilities in England die each year** than would be expected from general population mortality rates after allowing for their age and gender profile: on average men die 23 years earlier and women die 27 years earlier



# LeDeR Case Study

A was an Afro-Caribbean Male Aged 60. He was autistic and had a mild learning disability. A had epilepsy which was managed by medication, and asthma

A was said to be independent and private. He had no living relatives at the time of his death.

A was reportedly able to communicate well but struggled when asked to repeat information he had already told people

A enjoyed writing stories, art, playing the guitar, watching films and children's TV, walking, going to the pub and socialising with friends

A was not on LD register and was not flagged as having a learning disability during hospital appointments; no reasonable adjustments or support were in place in primary or secondary care, no evidence of him being invited for annual health check and he didn't have a health action plan

# LeDeR Case Study

Epilepsy - no information found about when epilepsy was diagnosed or what A's seizures looked like despite hospital admission follow two tonic clonic seizures. He was invited to epilepsy clinic the following month but did not attend – there was no information regarding follow up

Asthma – asthma plan in place – reports that he had poor technique and needed support with this. A was invited for reviews from GP however he reportedly did not engage with GP appointments. Evidence of asthma monitoring over the phone. A suffered frequent asthma attacks which required hospitalization; he had previously spent time in ITU incubated due to asthma

A lived alone. He received one hour of support a week; he asked for support with finances and reading letters with this support. His care plan said A would book his own appointments but would need support understanding and reminding him of appointments

He had close friends at a local chip shop who were said to keep his carers up to date with his hospital admissions and his health. A's neighbour informed support workers that he had passed away. He passed away at home; cause of death was said to be pneumonia and asthma

# LeDeR Case Study – System Learning

- No hospital passport. This could have been completed by support staff
  - Local authority and LD teams to promote use of hospital passports
- A requested support from care team on the phone rather than face to face because of preference meaning he was not receiving the support funded
  - Providers to inform local authority if they are not able to provide support funded
- Care providers should have systems and processes when healthcare appointments are due to support can be provided
  - Local authority to ensure care package and care act assessments are reviewed regularly for suitability

# LeDeR Case Study – GP Learning

- A was not on practice LD register meaning he was not receiving reasonable adjustments needed
  - Learning: GPs to check every time the refer to learning disability that the person in on the LD register and not assume they are
  - GP practice to ensure LD register is up to date
  - Health and Care providers to have a mechanism to record person-centred needs so reasonable adjustments can be made whilst accessing outpatient appointments
  - Consider use of e.g. easy read documents
- A was not flagged as having a learning disability meaning he was not reviewed by an acute LD nurse during admission and support workers were not contacted to support. No evidence of any LD support post discharge to promote him attending future appointments
- LD flags to be applied to records of people with LD to ensure reasonable adjustments can be made
- Health checks completed by GP over the phone
  - GPs should do not more than two telephone consultations over the phone for people with learning disabilities and/or Autistic people before seeing face to face to allow for appropriate physical examination
- GP practices must provide clear evidence of annual health check invitation. Outcomes should be shared with community LD teams so care and support can be provided
- Primary care team/support workers to consider referral to social prescribers to support when there is disengagement
- Inconsistency in diagnoses: Learning Disabilities noted in GP notes, Autism in social care documentation

# Local LeDeR learning

1. Improvement in knowledge and application of existing systems of support
   - Oliver McGowan Training: **SELWDH · Oliver McGowan Campaign**.
2. Review of clinical practices including diagnostic overshadowing
3. Annual Health Checks (AHC) and Health Action Planning
4. Person centred care and engagement
5. Effective sharing of information to provide effective care:
6. Facilitating effective care can be complex for people moving into SEL
7. Reasonable Adjustments and equity in access to services

# Reasonable Adjustments

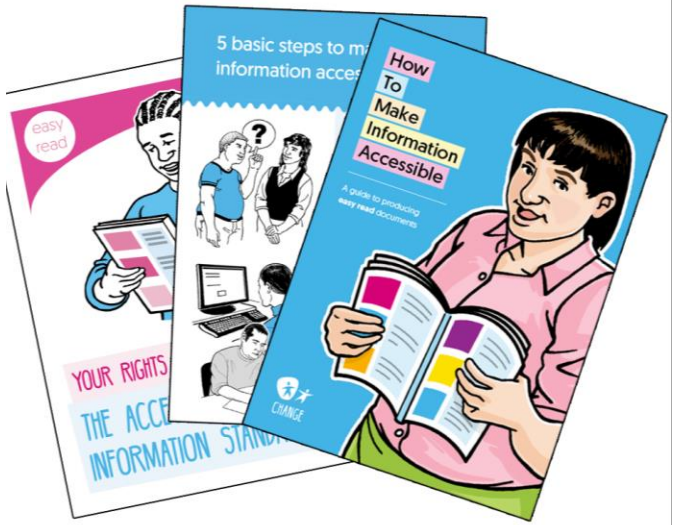
- Under the Equality Act 2010 there is a duty to provide reasonable adjustments to ensure that services are accessible to disabled people as well as everybody else.
- Reasonable adjustments can take many forms and most are/should be specific to an individual.
- The Accessible Information Standard sets out a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. This includes autistic people and people with a learning disability.

NHS Digital have rolled out Reasonable Adjustments Flag that will show on electronic patient records to help alert health professionals of reasonable adjustments needed

# Reasonable Adjustments

Reasonable adjustments can include things like:

- making sure there is wheelchair access
- providing easy read appointment letters
- giving someone a priority appointment if they find it difficult waiting in their GP surgery or hospital
- longer appointments if someone needs more time with a doctor or nurse to make sure they understand the information they are given




Primary care liaison nurses can support identifying what reasonable adjustments a person may need

Easy Health – library of accessible health information in easy read:
Easy Health | Home

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# Questions?

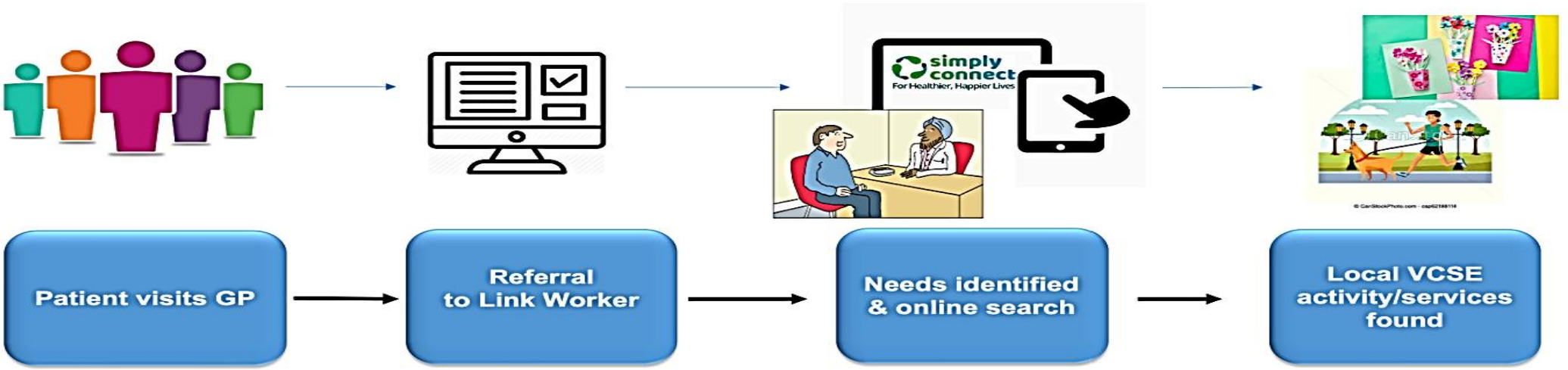
# Southwark's Social Prescribing Services

Gay Palmer Social Prescribing Team Lead
Mary Olushoto Social Prescribing Team Lead

# Social Prescribing is…

….a key component of Universal Personalised Care. It is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing. (NHS England)

## Traditional Social Prescribing Pathway



# Social Prescriber Link Workers will:

Give patients time and space to discuss and identify key issues.

- Explore what is important to patients and what they want to achieve.
- Provide options for suitable support .
- Support patients to access and engage with services.

**In order to provide tailored support for patients**

# Southwark Social Prescribing

### *South SP Team – IHL*

- 13 SPLWs (13 FTE) & 2 Team Leads, inclusive of 1 housing & 2 CYP SPLWs. 4 Wellbeing Coaches
- Only accept referrals from practice staff via Elemental
- Provide support for up to 12 weeks.
- Various appointment options.

### *North SP Team - QHS*

- 12 SPLWs (13 FTE) & 2 Team Leads.
- SPLW with a focus on LD support services.
- Only accept referrals from practice staff via EMIS.
- Patients referred need to be 18 years or older (parent/guardian to be referred for support of <18s).
- Provide support for up to 12 weeks.
- Various appointment options

# Southwark Social Prescribing

**What happens after referrals are received:**

- A SPLW will pick up the referral and triage appropriateness.
- If appropriate patient will be contacted and support provided. If referral is inappropriate the practice/referrer will be sent an email to state why referral has not been accepted.
- Updates on the support being provided will be added to EMIS patient record. Requests may also be sent to practice/referrer, if medical professional input is needed for accessing services i.e. medical supporting evidence.
- When referrals are closed patients EMIS record will be updated.

***The SP offer available to your patients depends on the PCN your practice is a part of. Further information regarding how to make referrals can be obtained by contacting your SP team***

# Social Prescribing for LD Cohort

**What we cannot do:**

- Resolve housing/accommodation issues.
- Provide specialist LD advice.
- Hold patients whilst they are awaiting LD assessments.
- Provide admin support for practice staff i.e. complete referrals which practice staff can do.

**What we can do:**

- Refer/link patients to local and national LD VCS and statutory organisations.
- One off accompanying to services.
- Support LD patients to communicate with services.
- Support carers to access services, via separate referrals.

**Reasonable Adjustments**

- SPLWs teams have easy read SP leaflets designed for patients with LD.
- Flexibility with appointment types i.e. face to face, community setting, home visits etc.
- Patients are offered increased face to face and appointment time, in line with their needs. Carers, family members or support workers can also attend appointments (with consent).
- SPLWs are happy to liaise with carers, family members etc. to ensure communication and support is suitable for patients.
- Written summary of agreed support plan.
- Appointment reminders.
- Facilitate communication with services i.e. liaise with services on patient behalf.

# Social Prescribing for LD Cohort

Although we aim to support all cohorts effectively, there are still outgoing needs which have been noted for the LD cohort. This is due to limited services for this cohort in the borough. However, our teams are raising this with partners and stakeholders. With a view to working towards how this can be addressed, so far this has resulted in:

- SP support with the dissemination of LD inclusion training opportunities to SSPN (VCS).
- PS inequalities funding opportunity for VCS, with LD cohort prioritised & LD VCS services granted funding.
- SP team lead working with LD and weight management teams to support increased provision for LD cohort.
- Co-production work, such as today's PLT

**Key points:**

- There are high instances of patients and their carers not knowing what to do after receiving diagnoses i.e. no follow up, no information on support services.
- Elderly parents who are carers of adults with LD, expressing concerns with regards to what will happen to their child if they pass away.
- Team members attend the Southwark wide LDA monthly forum.
- Both teams attend the Southwark Inclusive Sport & Physical Activity Network (SISPAN) steering group meetings and use this as a means to raise awareness of the importance of exercise/activities for LD cohort. In addition to promoting schemes, activities and exercise groups in the Borough.
- **The more information added on referrals to our service, the better! Such information could include reasons for referral i.e. social isolation, exercise, financial advice etc. or if carer needs to be contacted. This helps to support with ensuring that needs and preferences are taken in account when contact is made.**

# Case Study

**SP Support –** 66 yr old lady with a moderate learning disability was referred to due to social isolation.

- Initial telephone contact, with the support of patient's sibling, highlighted a preference for a face to face appointment with siblings. SPLW accommodated this with a practice based appointment, at patient's practice, and patient attended with her 2 siblings.
- It was established patient would like to regularly attend a social club for socialisation. Siblings advised that patient previously attended a local LD centre (Bede House). SPLW advised that this service was still running social clubs and offered to refer patient to Bede House and patient consented to this.
- Patient was referred to Bede House and SPLW arranged an appointment for patient to attend. Patient's current needs/preferences were also included in the referral form.
- Patient was offered a number of follow up SP appointments to ensure she accessed the service and was finding it beneficial.

**Outcome –** The patient attend Bede House, where she was supported to attend social clubs and offered a volunteering opportunity, which she agreed to give it go. Unfortunately, she struggled to support others, as she was keen to take part in the activities herself. At the time of closing patient's SP referral, she was attending Bede House social club and their lunch club once a week. A colleague recently attended the Bede House Summer fare and reported this individual was volunteering at one of the stalls.

# LD Resources

Bede Learning Disabilities - Bede House

Southwark LD Local Offer

Southwark SLAM Mental Health & Learning Disability Service

Toucan Employment - Inclusion of disability in the workplace

Social Prescribing easy read leaflet


Microsoft Edge
PDF Document


# Q&A

**Email queries can be sent to:**

qhs.socialprescribing@nhs.net

ih.socialprescribers@nhs.net

# Learning Disability Health Team

Southwark, Lambeth and Lewisham Community Learning Disability Health Team


Petrea Woolard: Lead Speech and Language Therapist GSTT CLDT

# Who are the learning disability health team?

We are a specialist health team based in Southwark, Lambeth and Lewisham. In the team we have:

- Community Learning Disability Nurses
- Occupational Therapists
- Physiotherapists
- Speech and Language Therapists
- Audiologist (ear doctor)

We are employed by Guys and St Thomas' NHS Foundation Trust, and we work very closely with our psychology, psychiatry, CPN and behavioural specialist colleagues (employed by) SLAM and our social care colleagues (employed by the council)

# Why is there a specialist team for adults with learning disabilities?

Risks & Physical Health

- Visual and hearing problems – up to 60%
- Cerebral palsy/other motor impairments – 20-30%
- Epilepsy – 35% (at least 20 times higher than for the general population).
- Respiratory diseases – 46-52%
- Communication problems – 90%
- Dysphagia – 1 in 3 individuals with LD
- Gastro-Oesophageal Reflux Disease – 50%
- Constipation – up to 50

# How we can help

- We talk to adults with a learning disability and their carers to find out what help is needed.
- Some of the things we can help with are:
- Advice on how to stay healthy ( LD Nurses)
- Advice on seeing your GP and other health services ( LD Nurses)
- Help with hearing problems and communication (Audiology and SLT)
- Help to live as independently as possible ( Occupational Therapy)
- Help with eating and drinking problems ( Speech and Language Therapy)
- Help to sit and lie down comfortably ( Physiotherapy)
- We see people at home, work, day centre or in the community.

# How to refer to our service

You can complete a referral form or write to us:
121 Townley Rd
East Dulwich, SE22 8SW

You can call us:
020 30497518


You can email us:
Gst-tr.AWLDHealthTeam@nhs.net

If you prefer, you can ask a friend, carer or health professional to call for you.

# Referral Process

- Referral Received
  - gst-tr.AWLDhealthteam@nhs.net
- Is client known?
  - If not known to team follows eligibility process which may require a visit by two team members
- Eligibility agreed
  - Passed to individual professions to process
- Eligibility not agreed
  - Referral rejected, referrer is contacted and signposted if applicable

# Who does the Team Support

1. The service is available to adults (over 18) who also meet the following criterion: Have a learning disability as defined by a global impairment of intellect and skills arising in childhood, which has resulted in a significant impairment of adaptive and social functioning. This is generally supported by an IQ of less than 70

2. In broad terms this includes the presence of: • A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with; - A reduced ability to cope independently (impaired social functioning); - That started before adulthood, with a lasting effect on development.

3. In addition, those eligible for the service will: • Have complex physical health or communication needs additional to those which would be met by generic health care services and which require the assessment or an intervention from a learning disability specialist provider. • Be requiring/needing services from the learning disabilities team • Be a resident of a borough in which the service is commissioned OR be placed out of Borough but there are definite plans to return to the borough in the near future. Have a GP in borough.

Learning disability community health - referrals | Guy's and St Thomas' NHS Foundation Trust (guysandstthomas.nhs.uk)

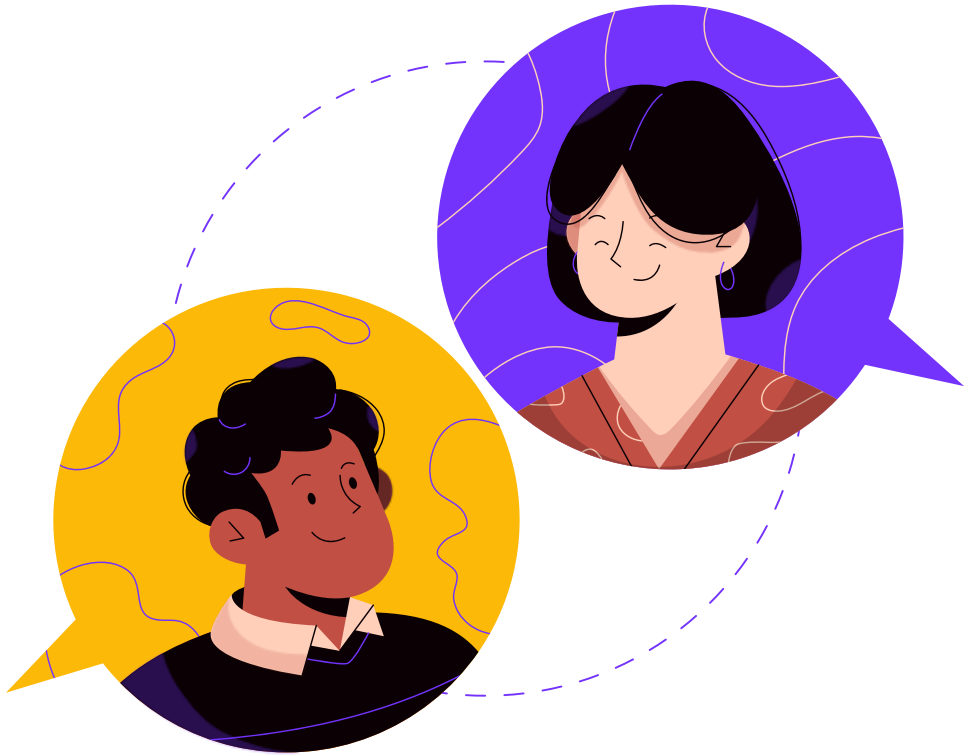
# Thank you for listening

Any Questions?

# Community Learning Disabilities Service

Social Services

Hannah Taylor-Rowe – Team Manager



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# The Service is Divided into 2 Teams

## All Age Disabilities

The All Age Disabilities Team works with children and young people with learning and/or physical disabilities, from birth to age 24. The team was created to ensure a smooth transition from Children's to Adult Services in the context of different legislative frameworks for provision of services once people reach 18 (or 16 in some cases). Young adults approaching age 24 will be transferred to either the Learning Disabilities 25+ Team or other services depending on needs e.g. OPPD for people with physical disabilities or sensory impairments.

## Learning Disabilities 25+ Team

The Learning Disabilities 25+ team works with people whose primary needs relate to their global learning disabilities but may also have physical disabilities, sensory impairment, mental health issues, autism etc.

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# LD Team

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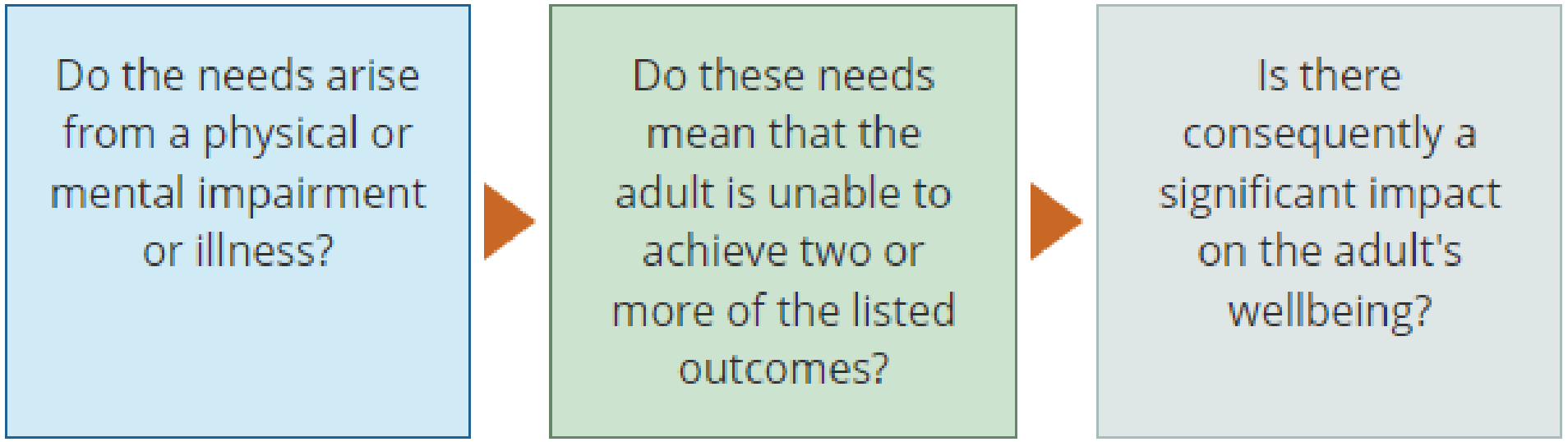
# Information that may help to determine whether a person has Global Learning Disabilities are:

- Evidence if available of delays in reaching developmental milestones
- Evidence that the person was assessed as having special educational needs might be a copy of the original Statement of Special Educational Needs or better still an educational psychologist's report.
- Evidence that the person has significant impairment in his/her intellectual functioning. This could be a report such as a psychometric assessment.
- Evidence that the person has significant impairment with adaptive functioning (everyday living skills),
- If available, information about the person's developmental history (e.g. were there significant delays in reaching developmental milestones?).
- If the person has worked, information about the person's work history (what exactly was the person required to do as part of their work?).
- Information about what support (if any) the person is currently receiving.

# Care Act Eligibility




Outcomes:

- Manage and maintain nutrition
- Maintain personal hygiene
- Manage toilet needs
- Be appropriately clothed
- Be able to make use of their home safely
- Maintain a habitable home environment
- Develop and maintain family and or other personal relationships
- Access and engage in work, training, education and volunteering
- Make use of necessary facilities or services in the local community, including public transport and recreational facilities or services
- Carry out any caring responsibility the adult has for a child

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# What is the person's primary need?

When referring to the LD social care consider what is the person's primary need for support.

- 75 year old with a diagnosis of a learning disability has lived independently in the community without services, they visit their GP and it is noted that they may require support to meet 2 or more of their Care Act outcomes due to declining physical health – LD is not the Primary need – refer to OPPD

- 27 year old with autism living with parents, care has been provided by parents who are advising they are unable to continue with current level of support. Does the individual have a diagnosis of LD alongside their autism? Do they currently have input from LD health colleagues? If yes referral to LD team – if no consider whether they have a mental health need or physical disability need and refer to the appropriate team. If it's unclear send referral with as much information as possible to LD, MH and OPPD and request that all teams consider who is appropriate to allocate the case.

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# Carers assessments

Carers of adults with a learning disability can also be referred to the team for a carers assessment. A carer is eligible for an assessment if they are over the age of 18 and provide unpaid care to someone over 18 living in Southwark.  It is important to ensure that the Carer has consented to the referral and is aware that someone from the team will be in contact with them.

The carers assessment is similar to the assessment for the cared for and will consider the impact the caring role has on the carers ability to achieve certain outcomes and the impact on their wellbeing.

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# Services to meet Care Act eligible needs

The Care Act 2014 highlights prevention as one of seven key responsibilities for local authorities, with an inextricable link to the fundamental principle of promoting wellbeing. This should be the first step before commissioning services, if appropriate. This usually involves looking at local resources, community assets, assistive technology, family and friends.

If needs cannot be met by through preventative interventions and resources then social care will consider appropriate commissioned services to the meet the identified needs.

## Referrals

Referrals can be made through the Duty desk and should include as much information as possible from the list on the previous slides

Duty contact details:

Email: LearningDisabilitiesDuty@southwark.gov.uk

Telephone: 0207 5252333

Southwark ASC referral

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southwark.gov.uk

**Safeguarding is everyone's responsibility**

Vulnerable or 'at risk' adults: The Care Act 2014 defines this as anyone over the age of 18 who:

a) Has needs for care or support (whether or not the authority is meeting any of those needs.

b) Is experiencing, or is at risk of, abuse or neglect, and

c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it

**Raising a Safeguarding concern:**

- Where possible seek consent from the individual before raising a SG concern. Best practice is to inform the individual that you will need to make a referral due to SG concerns.
- The law does not prevent the sharing of sensitive, personal information **within** organisations or between organisations. If there is a Safeguarding concern or public interest, and there is a safeguarding concern, sharing it may be justified.
- Information can be shared lawfully within the parameters of the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

**Responsibilities:**

- Care Act Section 42 SG enquiries are led by social workers
- Requests may be made to colleagues for information or evidence gathering, to be involved attend SG meetings and contribute to safety plans.

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# Mental Capacity Assessments

You may need to assess capacity where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness of disability. Lack of capacity may not be a permanent condition. Assessments of capacity should be time- and decision-specific. You cannot decide that someone lacks capacity based upon age, appearance, condition or behaviour alone.

Every effort should be made to promote the person's ability to make the decision themselves particularly if the decision can be delayed. This can be done in a number of ways, through providing information and education, or through finding and trialling alternative ways of communicating with the individual.

**Who should assess capacity?**

The professional who has most knowledge on the decision required, or the professional who will be ultimately responsible for the decision if the person lacks capacity, would be the person best placed for completing the MCA. For example, if the decision relates to a medical condition or decision or treatment, then a health professional would be best to lead on the assessment.

However, they do not need to complete this assessment in isolation and can seek involvement from other professionals involved in the individuals care.

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# Community DOL applications

Local authorities are required to make applications to the court of protection for clients who are living in the community and lack capacity to make decisions about their support and accommodation and where the acid test has been met. ( person is not free to leave, and is subject to continuous supervision and control)

As part of the application to the COP we require a letter from GP's confirming the client has an impairment or disturbance in the functioning of his/her mind or brain.

COP DOL GP letter template

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# Case study – working with GP

- Case of male who was reported to have a LD diagnosis, autism and physical health issues
- Friend was client's advocate
- Client refused to meet with social care to complete care act assessment
- Concerns about coercion and abuse by advocate
- Difficult to get an understanding of the clients needs

Joint working with the GP in this case was instrumental in achieving a good outcome.

- He attended safeguarding meetings
- He supported social care to meet with the client at his surgery
- He supported to address concerns regarding the clients medication

Any questions?

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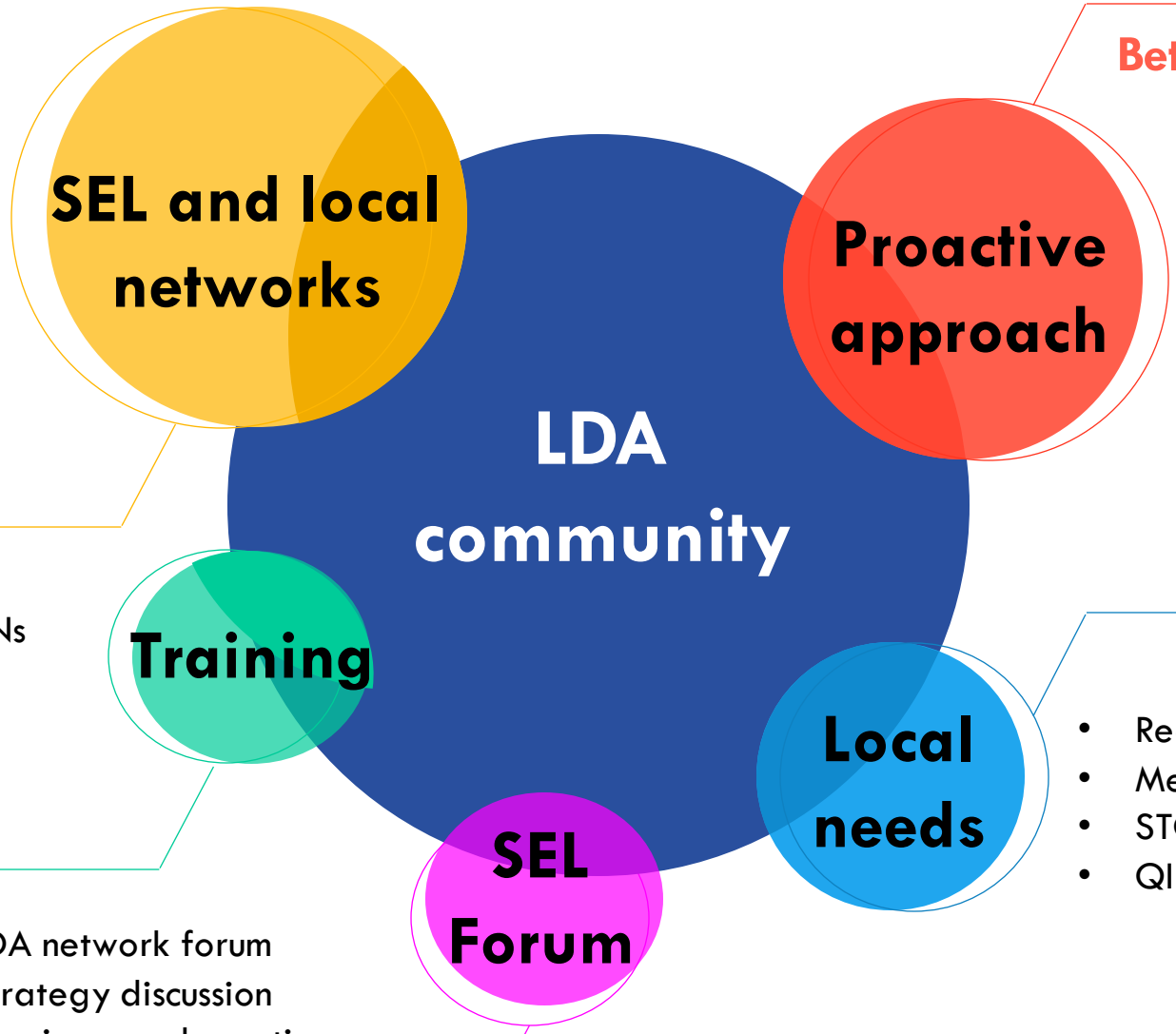
# SEL Learning Disability & Autism Specialist Prescribing Advisors

Ashika Patel
Learning Disability and Autism Specialist Prescribing Advisor
and Clinical Pharmacist

# Our Aim




## Improve clinical outcome

- Improving prevalence
- Patient safety
- Medication administration
- Upskilling and training
- AHC and QoF

## Better Healthcare access and reduce health inequality

- Point of Contact
- Stakeholders/patients engagement
- MDT Joined up care
- Family and carer support
- Referrals and signposting

- Borough wide and PCNs
- Shared learning
- Webinars
- Mentorship
- Care home training

## Improve quality of life

- Reduce unnecessary hospital admission
- Medicine Optimisation
- STOMP/STAMP
- QI Projects

- LDA network forum
- Strategy discussion
- Sharing good practices
- Challenge and Barriers

# Register Validation

| Does person have difficulty with: | | |
|---|---|---|
| Communicating needs | yes | no |
| Writing | yes | no |
| Self-Care | yes | no |
| Living independently | yes | no |
| Interpreting social cues | yes | no |
| Controlling their behaviour | yes | no |
| Co-ordinating movement | yes | no |
| Learning new skills | yes | no |
| Understanding new or complex information | yes | no |
| Do they have a sensory impairment? | yes | no |
| Is English their first language? | yes | no |
| **Several 'yes' answers could indicate the presence of a Learning Disability*** | | |

| Factors which MAY indicate No learning disability | Factors that MAY indicate a learning disability |
|---|---|
| • Normal development until other factors impact (before 18)<br>• Diagnosis of ADHD, dyslexia, dyspraxia or Asperger's<br>• Successfully attended a mainstream education facility without support<br>• Gained qualifications (GCSE and/or A 'Levels)<br>• Able to function socially without support<br>• Independently manage their financial commitments<br>• Able to drive a car | • Record of delayed development/difficulties with social functioning & daily living before the age of 18.<br>• Requires significant assistance to undertake activities of daily living (eating & drinking, attending to personal hygiene, wears appropriate clothing) and/or with social/community adaptation (e.g. social problem solving/reasoning).<br>• NB need for assistance may be subtle. |

**Aim:** Assessing patient's **social functioning skills** and establish if AHC could prevent potential unnecessary hospital admission in future, due to ability to express / complex needs.

## Key words to be searched for – in GP consultation

| Carer | Drive | University | Non verbal |
|---|---|---|---|
| Family | Occupation | College | Communicate |
| Live with | Work as | School | Education |
| GCSE | Job | Class | mainstream |

## Key clinical letters to screen : in documents, particular for CYP

| Community Paediatrician letter |
|---|
| Community LD teams , MH/LD team |
| Specialist children services |

Improving identification of people with a learning disability: guidance for general practice

# LD Register Validation: Southwark

Estimated prevalence : 2.2% (NHSe)

National prevalence : 0.55%

Lambeth : 0.38%
Southwark : 0.36%
Lewisham : 0.54%
Bexley : 0.48%
Bromley : 0.36%
Greenwich : 0.53%

SEL Prevalence : 0.44%

## 6 practices , 223 patients reviewed

- Patients with diagnosis that will indicate a LD
- Patients with diagnosis that may indicate a LD
- Patients coded as LD and learning difficulty

## 17 recommended to go on register (7.6%)

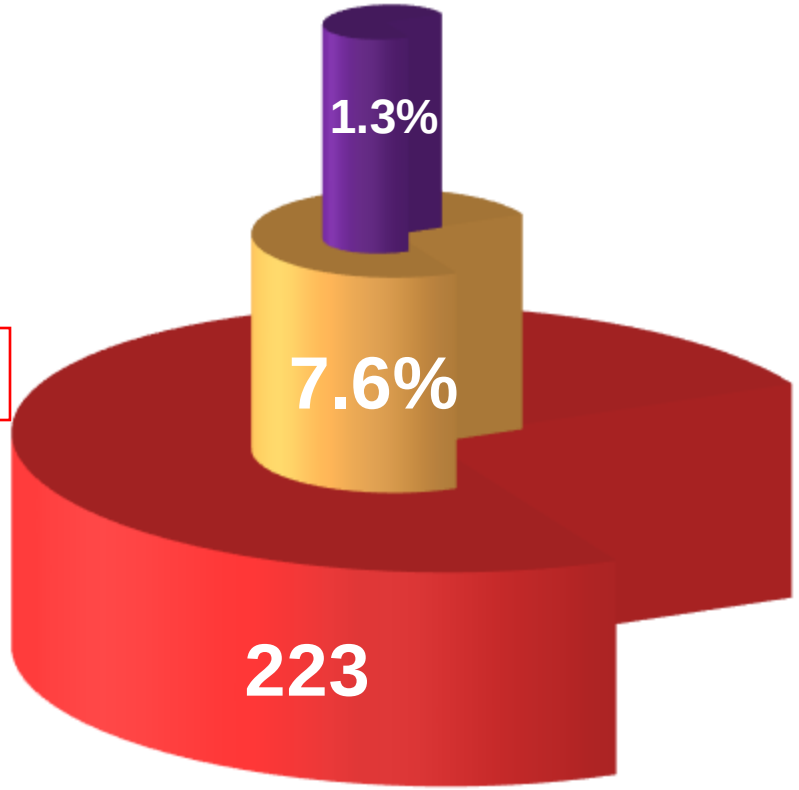
## Out of 17, 2 were Age 14 or under (from 2 practices)

- AHC and STOMP can now be offered
- Referral to the community LD services can be made

£140

## 3 recommended to be removed from register (1.3%)

- Increase GPs capacity for more complex patients
- Addressing incorrect codes



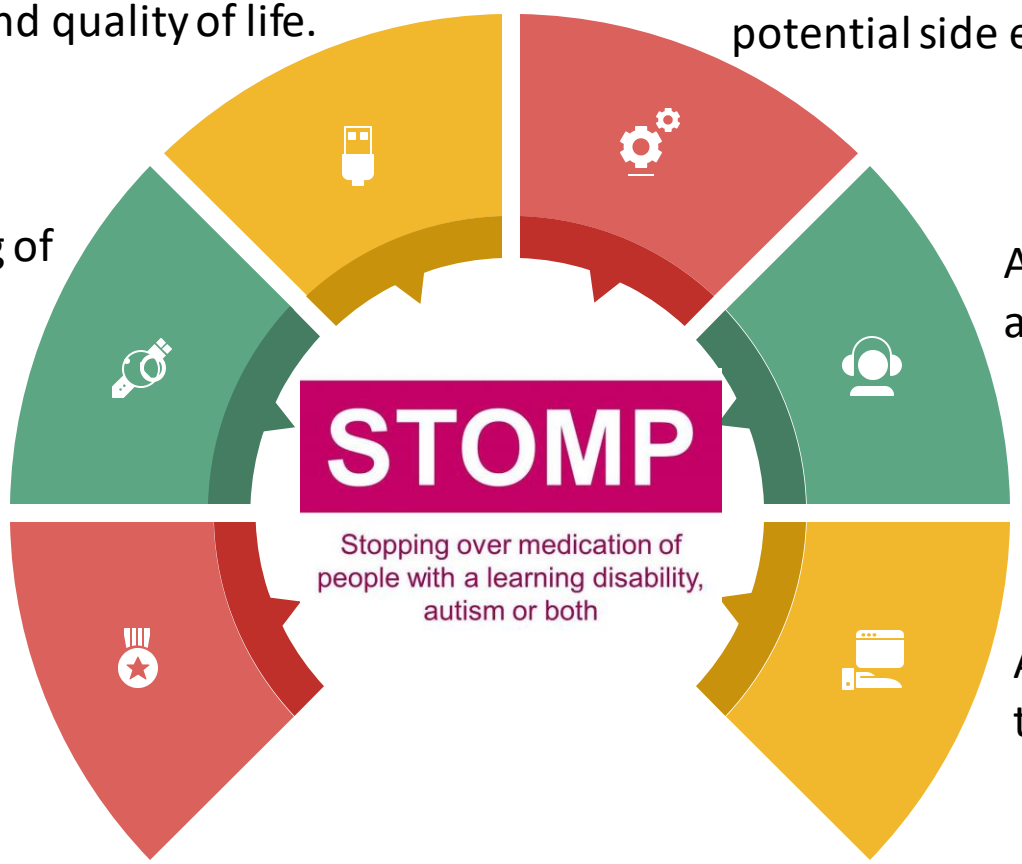

- 11% of patients already on the LD register needed parent coding

# What does STOMP aim to achieve?

Promoting wellbeing and quality of life.

Understanding of psychotropic medication, including why it is being used and its potential side effects

Ensuring monitoring and reviewing of psychotropic medication is in line with local and national guidance




Ability to recognise areas of concerns around inappropriate medication

Empowering patients on their medication and involving them in decisions about their care

Actively exploring alternatives to medication

# Structured Medication Reviews (SMRs)

***Aim***_- What matters to the patient?

***Need*** - Identify essential medicines

***Need*** - Is the patient taking unnecessary medication?

***Effectiveness*** - Are therapeutic objectives being achieved?

***Safety*** - Is the patient at risk of ADRs or suffers actual ADRs?

***Efficiency*** - Is drug therapy cost-effective?

***Patient-Centred*** - Is the patient willing and able to take the medication as intended?

**Where does Psychotropic Deprescribing fit in?**

**What is the definition of "inappropriate" or "over prescribing" in the context of learning disability and autism?**

# How can our team help?

South East London Integrated Care System

## STOMP CLINIC

1. Recruitment of Team
2. Right capability and skill mix for the clinic
3. Identification of STOMP eligible service users
4. Referral Pathway

## SUPPORT AVAILABLE

## SEL LDA PHARMACIST SUPPORT

1. LDA Query Support
2. LD Register Validation
3. Integration and MDT working
4. Training & Webinars

## QUALITY IMPROVEMENT

Work with practices across SEL to support and carry out LDA Quality Improvement projects


Ldaprescribingteam@selondonics.nhs.uk

# Questions?

## Resources

- Flowchart of services – in development
- Daniel's story: A Whole New World: Daniel's Story
- Oliver McGowan: The Oliver McGowan Mandatory Training on Learning Disability and Autism
- LeDeR
- LeDeR Report 2022
- What is a health action plan?.pdf (mencap.org.uk)
- Annual health check toolkit
- Everything you need to know about the learning disability register | Mencap
- Easy Health
- My Autism Information Booklet
- Preparing for Adulthood: All Tools & Resources – NDTi
- Bede Learning Disabilities - Bede House
- Southwark LD Local Offer
- Southwark SLAM Mental Health & Learning Disability Service
- Toucan Employment - Inclusion of disability in the workplace
- Home | SeeAbility
- NHS England » Universal Personalised Care: Implementing the Comprehensive Model
- NHS Long Term Plan » Learning disability and autism
- Transforming Care Autism Team – SLAM
- NHS Long Term Plan » Learning disability and autism
- What is autism – National Autistic Society
- Easy Health | Home – easy read resources
- NHS England » Dynamic support register and Care (Education) and Treatment Review policy and guide
- STOMP: https://youtu.be/2WhA9x31Nns
- Hospital Passport Template example from South West London Access to Acute Group.doc (live.com)
- Flu vaccination: easy-read flu vaccination resources - GOV.UK (www.gov.uk)
- Treat me well top 10 reasonable adjustments.pdf (mencap.org.uk)
- NHS England » Reasonable adjustments
- NHS England » Accessible Information Standard
- Reasonable adjustments for people with a learning disability - GOV.UK (www.gov.uk)
- Annual health checks and people with learning disabilities - GOV.UK (www.gov.uk)
- Annual Health Checks and people with learning disabilities (publishing.service.gov.uk)
- What is a health action plan?.pdf (mencap.org.uk)