

Alternative Action Plan – Clinicians Actions
Draft Actions from the November 2022 CB-NSG Meeting

Action: What is needed	How it will be done	Who will do it	When it will be done
Early psychological support and intervention to provide support before reaching a crisis point	Specialist CAMHS provision for supporting people with a learning disability who require psychological support	CAMHS/NHS – learning disability specialism should be embedded in all CAMHS services	
<p>Greater understanding of environmental and sensory issues, and actions to tackle these</p> <p><i>See 'Housing' actions for further details on similar subject</i></p>	<p>Sensory assessments should be mandatory and regularly taken, and then acted upon; if they are not acted upon, it should be possible to legally challenge this (whether under Equalities Act/different legislation or through a specific body/route)</p> <p>Providers and inpatient units should be required to undertake specific sensory assessments when designing housing and should make the necessary adaptations to meet the sensory needs of the person Disabled Facilities Grant (or a similar specific fund) could be used to meet these needs</p>		
Sectioning process needs to change	<p>Requirement that, when the possibility that a person may need to be sectioned is raised the person's family members are meaningfully involved, and an advocate and/or legal representative for the person and/or their family is involved – new guidance, with statutory force, should be produced and distributed</p> <p>Clinicians that are involved in the sectioning process should be required to get a full picture of the person, their needs, and to get to know the person and their family</p> <p>Should require looking into what factors have led to a person being in crisis and whether these can be changed within the community as a standard part of the process</p> <p>Clear route to challenging sectioning process for families if they do not believe that it is the right decision and/or necessary</p>	<p>DHSC/government – produce statutory guidance</p> <p>Clinicians – act; DHSC – produce legislation/guidance</p>	

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Comprehensive and multidisciplinary community team, with adequate funding to enable them to provide support		
Better engagement with families	<p>Training and guidance on how to work with families to support the individual (training should be co-produced with families)</p> <p>Providing clear information to families proactively (e.g., when their child is first diagnosed, provide them proactively with details of their rights, what they are entitled to, and support services that, if needed, they will be able to access)</p>	
Provision of respite care for both individual and family	<p>When conducting JSNAs, local authorities/ICSs should be required to identify a) how many people with a learning disability there are, and b) how many family members of people with a learning disability there are – they should then be required to commission and fund respite care to meet these needs, including providing respite care that meets sensory and environmental needs etc</p>	Local authorities and ICSs – statutory guidance should also be produced
Tackle staff recruitment and retainment issue	<p>Increase salary of social care workers to improve retainment and reduce reliance on agency staff</p> <p><i>Will require funding, but savings in long-term should theoretically make up for this</i></p>	
Improve training for clinicians and social care workers who work with people with learning disabilities whose behaviour challenges	<p>Training around supporting people with learning disabilities and people with learning disabilities whose behaviour challenges should be embedded in education and training programmes (core, undergraduate curriculum – should NOT be an optional part of curriculum)</p> <p>Training should be co-produced with families and should emphasise the importance of listening to and maintaining active and collaborative relationships with family members</p>	
Regular community IC(E)TRs with chair who is a) independent, b) knowledgeable of the different strands that come together to provide support for a person with learning disabilities, and c) able to coordinate these different strands within the review and	<p>Needs to be training and guidance for IC(E)TR chairs, particularly around the needs of people with learning disabilities whose behaviour challenges, the lack of therapeutic benefits of ATUs to this cohort, etc</p> <p>Should be accountability and sanctions if recommendations are not followed</p> <p><i>how would this work in e.g., Wales, where it is CTPs not C(E)TRs?</i></p>	

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when considering community support			
Learning Disability Liaison Nurses role should be expanded	<p>Funded by NHS but with additional role within community learning disability teams</p> <p>When conducting JSNAs, should identify (based on number of people with learning disabilities within local area) how many are required – there should be a minimum number of Learning Disability Liaison Nurses per x number of people with learning disabilities (?)</p> <p style="text-align: center;">Further work required to identify precisely how this should be done</p>	Joint responsibility between NHS and local authorities/ICSs (making use of pooled budgets)	
Staff rotation between community settings and inpatient settings to prevent institutionalisation of staff and to increase knowledge of the corresponding setting	<p>Part of mandatory training (would therefore not require additional funding)</p> <p><i>Logistical issue would be how this would impact the people being worked with, e.g., to ensure that there is still continuity of care – would need to make sure this does not lead to distress for people who are being supported, it may be needed that very small independent teams will need an exemption from this.</i></p> <p>‘clinical placements’?</p>		
Trauma-informed support for people with learning disabilities and their families	<p>Expansion of existing trauma training (CBF provide trauma-informed training, Sarah Broadhurst/Autism Education Trust provide trauma-informed training, etc)</p> <p>Trauma-informed approaches should be embedded in education and training programmes</p> <p><i>Additional work needed to identify what roles specifically need to be targeted for receiving this training</i></p>		
Discharge planning to begin at/prior to the point of admittance to an inpatient unit	<p>Should include an assessment of what will be needed for the person to be successfully discharged back into the community, and a clear action plan of what will be done to ensure that this is put in place</p> <p>e.g., identify a person’s specific housing needs, and either identify a suitable existing placement, or commission a placement that can be tailored to meet that person’s needs, so that it will be ready for them to be discharged</p>		

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	Discharge planning to be reviewed frequently		
Research should be conducted into the cost-savings of properly funded community support and the actions in this plan, compared to the status quo/funding inpatient units (to help make case for action plan)	Address similar issues to funding flows report , but will need adequate access to financial data etc	Could this be done by the research network? Would it require specific funding? If so, where could this funding come from?	
Families need to be able to input into commissioning decisions			
Ensure all methods that are used have clear clinical and therapeutic benefits	See <i>'Evidence-based practice' workshop actions</i>		
Require commissioners to be acting in line with NICE guidance, with sanctions if this does not occur		DHSC/other government departments – should produce legislation/statutory guidance	
Additional assessment of support needs and a requirement to implement them for all people placed on dynamic risk register		ICs?	
CQC to speak to family members of voluntary inpatients as well as those formally detained under the MHA <i>Link with 'Safeguarding and Regulation' actions</i>		CQC	