



## LeDeR Programme Quarterly Report Q1 2019-20

### 1.0 INTRODUCTION

1.1 This report provides an update of the LeDeR Programme within Dorset for Q1 2019-20.

### 2.0 PROGRAMME UPDATE

#### Reviewer recruitment progress

2.1 There are now 19 trained reviewers; however only ten are 'active' and currently allocated reviews. The remaining individuals (some of whom have previously undertaken a LeDeR review) are currently stating work pressures as the reason to be unable to undertake a LeDeR review at this time.

2.2 The breakdown by organisation is as follows:

Organisation	No of trained reviewers	No of reviewers who have commenced one or more reviews	No identified and awaiting reviewer training and/or line manager authorisation	Total number of trained and potential reviewers per organisation	Total number of reviewers currently allocated a case
CCG (including primary care)	4	4	4	8	4
DHC	11	7	2	13	5
PHFT	0	0	1	1	0
RBCH	3	1	1	4	1
DCHFT	1	1	0	1	0
Bournemouth, Christchurch and Poole Council	0	0	0	0	0
Dorset Council	0	0	0	0	0
Local LD Charities - Liveability - Dimensions - Diverse Abilities - Stable Family Home Trust	0	0	5	5	0
SWASFT	0	0	0	0	0
<b>Total</b>	<b>19</b>	<b>13</b>	<b>13</b>	<b>32</b>	<b>10</b>

2.3 For details on how to become a reviewer, contact Helen Corlett on 01305 213599.

### Programme status and activity

2.4 The following table summarises the activity of the Dorset programme, at the end of Q1 2019-20. All data is cumulative.

	2017-18			2018-19				2019-20
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Total notifications	41	49	56	73	75	81	83	95
Notifications awaiting allocation to a reviewer	31	32	15	17	14	13	9	15
Completed reviews	5	7	9	15	16	23	36	49*
Reviews awaiting sign off by Assurance panel	2	0	0	0	0	0	3	2**

\*This includes those reviews undertaken by NHS England as part of the initial 'backlog' ('Backlog 1')

\*\*These reviews were submitted to the LAC in late June and had not yet been presented to the assurance panel by 30.06.2019; these were signed off as completed in early July 2019.

2.5 In July 2019, discussions are taking place at a national level regarding the month by month increase in the number of deaths reported nationally, which exceeds the proportion of reviews completed each month. This is leading to an increasing backlog of cases ('Backlog 2').

## 3.0 SHARING LEARNING

3.1 The objective of this report is to be primarily about identification, sharing and implementation of learning from LeDeR reviews within Dorset.

### National learning and resources

3.2 The national team, based in Bristol, have produced five 'Action into Learning' newsletters since July 2018, sharing the national learning associated with:

[Aspiration pneumonia](#)

[Sepsis](#)

[Recognising deterioration](#)

[Constipation](#)

[Mental Capacity Act](#)

3.3 There have been no new newsletters since the last quarterly report.



### Local learning

- 3.4 Seven of the 13 reviews closed during Q1 2019-20 were the final cohort of reviews overseen by NHS England as part of the first accumulated backlog ('Backlog 1').
- 3.5 Not all reviews have generated learning, with a significant number of reviews demonstrating good care throughout the life, and end of life, of the individual. To date, 14 reviews have generated no learning at all.
- 3.6 To 30.06.2019, 10.2% of reviews have indicated that care fell short of expected good practice (scored 4, 5 or 6).
- 3.7 One closed review during Q1 2019-20 was subject to a Domestic Homicide Review (DHR) so the DHR process took precedence over the LeDeR process. This review was therefore not 'scored'.
- 3.8 The 49 reviews completed (to 30.06.2019) are scored as follows:

Score	Score description	To 31.03.19	Q1 2019-20	Total	% of cases
1.	This was excellent care and met current best practice	8	1	9	18.4%
2.	This was good care, which fell short of current best practice in only one minor area.	20	8	28	57.1%
3.	This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the person's wellbeing).	2	2	4	8.2%
4.	Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death.	1	1	2	4.1%
5.	Care fell short of current best practice in one or more significant areas, although this is not considered to have had the potential for adverse impact on the person some learning could result from a fuller review of the death.	3	0	3	6.1%
6.	Care fell far short of expected good practice and this contributed to the cause of death.	0	0	0	0%
7.	This review was done prior to 1-6 care scoring; deemed unavoidable	2	0	2	4.1%
8.	This review was conducted via an external process and has therefore not been scored (e.g. CDOP, DHR)	0	1	1	2.0%
<b>Total</b>		<b>36</b>	<b>13</b>	<b>49</b>	<b>100.0%</b>

3.9 The appendices of this report are:

<b>Appendix 1</b>	Synopses of learning from three reviews scored '3' or '4' (none scored 5 or 6 in Q1 2019-20). This appendix also includes observations from a review which was scored '2'.
<b>Appendix 2</b>	A summary of additional learning from closed reviews.

3.10 At the end of Appendix 1 and [via this hyperlink](#) is a survey monkey. Readers of this report are encouraged to provide feedback by answering the survey. This will not only provide the report author with feedback regarding how the learning can affect change, but will demonstrate how the learning from LeDeR is being disseminated across Dorset. There was a very limited response to the survey within the Quarter 4 2018-19 report, so the LeDeR team would be grateful for anyone reading this report to please take a little time to complete it.

#### 4.0 AFFECTING CHANGE

4.1 Embedding and monitoring LeDeR learning continues to be a challenging proposal due to the breadth of recommendations which impact service delivery including primary care, acute provision, local authorities and social care provision.

4.2 Work is currently taking place to clearly document the governance arrangements within learning disabilities health and social care commissioning, and formalise the mechanism for both sharing the learning and monitoring change.

4.3 A Dorset LeDeR conference in early 2020 was discussed widely amongst the LeDeR team, LeDeR reviewers and the CCG leading disabilities commissioning colleagues. It was agreed, however, that at this stage in the evolution of the LeDeR programme that most impact could be achieved, to the most people and organisations, by improving on-line learning resources. The LeDeR team within the CCG are in discussions with the CCG Communications and Engagement team regarding how this could be developed.

#### 5.0 DORSET LEDER FRAMEWORK

5.1 A Framework document, detailing how the LeDeR programme is managed within Dorset was approved by the CCG Directors on Tuesday 16<sup>th</sup> July 2019. The Framework can be viewed [via this link](#).

#### 6.0 CONCLUSION

6.1 The Dorset Local Area Contact would be grateful if readers of this report could complete the survey monkey ([via this link](#)) giving feedback on the learning to date.

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**Date:** 17 July 2019



Appendices		
Appendix 1	Q1 2019-20 case studies	See below
Appendix 2	Themes	See below

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To routinely receive the quarterly report directly from the Local Area Contact (by being added to the distribution list), please contact [suzie.hawkins@dorsetccg.nhs.uk](mailto:suzie.hawkins@dorsetccg.nhs.uk), stating your contact details, your job title and the meeting at which the paper will be presented.

**NOTIFY A DEATH:** Anyone can notify the LeDeR team including people with learning disabilities themselves, family members, friends and paid staff.

[Click here to notify of a death online](#) or call **0300 777 4774**

A poster about how to notify a death is available [here](#). If you would like any printed copies, please contact the LeDeR team on [leder-team@bristol.ac.uk](mailto:leder-team@bristol.ac.uk) or call 0117 331 0686



## ENSURE THESE LEDER REVIEWS MAKE A DIFFERENCE

### LeDeR Learning: ID: 19262226

**LeDeR Score: 4:** Care fell short of current best practice in one or more significant areas, but this is not considered to have had the potential for adverse impact on the person and no significant learning would result from a fuller review of the death.

**INTRODUCTION** Tom was a 66-year-old man with moderate learning disabilities, who had lived in the family home until he moved to a residential home (which later changed to supported living). He had a close relationship with his brother who he saw often. He enjoyed holidays, gardening and attending a day centre. He had good verbal communication and was able to communicate his needs. He was very chatty and able to say if he didn't feel well or didn't want to go somewhere. He had good mobility.

Two weeks prior to his death he went to the GP with his carer with increased confusion and urinary incontinence. A UTI was diagnosed and appropriate 'safety netting' advice was given. Four days later, he was admitted to hospital (via his GP) with abdominal pain, reduced appetite and being generally unwell. His past medical history included a myocardial infarction in 2000, atrial fibrillation, obsessive compulsive disorder and hypomania.

Tom was diagnosed with cholecystitis and acute kidney injury, was admitted under the medics but refused a chest x-ray. Tom did not have a carer with him at the hospital as he did not have a 1:1 care package but his supported living manager said she was available to contact 24/7.

During the next 3-4 days, Tom was regularly reviewed by the ward doctors. The working diagnosis changed from cholecystitis to acute hepatitis. Whilst stable, his EWS score started to decrease two days before his death and on the day of his death it was thought to be acute hepatitis: ciprofloxacin? infection? Other?

Tom suddenly became unresponsive. A cardiac arrest call was made; he was initially bradycardic but then there was loss of output. Resuscitation continued for 30 minutes.

**LEARNING** The following learning was identified during the LeDeR review:

- The hospital records report that Tom was non-verbal due to his learning disability but this was not the case. Staff should liaise with someone who knows the patient well to establish a baseline of what's 'normal' for them. Tom did have a 'This is me' document with him so this information was available.
- Tom's care package didn't include 1:1 support when he was in hospital. This means he was potentially not well supported or advocated for when in hospital. The records suggest he wasn't supported to provide a good history and the hospital staff appear (at times) to have been working from a wrongly assumed inaccurate baseline.
- Tom's risk assessment and reasonable adjustment form was not fully completed, with many sections incomplete, including the mental capacity assessment.
- Tom refused to have a chest x-ray. Nothing was recorded regarding his capacity to make this decision. The records give the impression that it was assumed Tom didn't have capacity and therefore wasn't involved in discussions regarding his prognosis or treatment.
- During one ward round, Tom's abdomen wasn't fully assessed as he was sat out in a chair and required help transferring back to bed. Accepting that staff are very busy, Tom should have been transferred back to bed to undergo an assessment, especially as he was presenting with abdominal pain.
- It was recorded that Apixaban (an anticoagulant) was to be stopped, but it wasn't for two days.
- The working diagnosis changed from cholecystitis to acute hepatitis but it appears his medication wasn't reviewed. There was a query regarding the administration of Ciprofloxacin (an antibiotic) twice in the days before his death and it is noted that there is a risk of acute hepatitis with the use of this drug.
- It isn't evident that there was one person co-ordinating his care. He was seen by a lot of healthcare professionals during this inpatient stay.



## LeDeR Learning: ID: 25148325

**LeDeR Score: 3:** This was satisfactory care, falling short of current best practice in two or more minor areas, but no significant learning would result from a fuller review of the death.

**INTRODUCTION** Donald was a 73-year-old man with mild learning disabilities. Following a difficult childhood, he moved into supported living in 1993 where he remained for the rest of his life. He had four siblings but only spoke to one of them occasionally. There were no family members at this funeral.

Donald lived in supported living with five other residents. They had day support only with an on-call function overnight. He was described as a 'real character with a big personality and a great sense of humour'. He got on well with everyone. He enjoyed 1:1 trips out, rather than group trips. He was prone to bad language and had to be reminded to have socially acceptable behaviour in the community.

In the month prior to his death he was taken to an Emergency Department with sepsis? following a tooth extraction two days prior. His medical history included chronic kidney disease (stage 4), morbid obesity and a peptic ulcer. He had been found on the floor by his carers. In the ED department, a learning disability risk assessment and a reasonable adjustment record were completed. His carers were asked to bring in his 'This is me' documentation/passport. He was admitted to HDU with a plan to manage with antibiotics, considering inotropes and non-invasive ventilation if required. ITU were made aware of him and outreach were involved. A DNAR decision was made (end stage renal failure, multiple co-morbidities). His sepsis was managed well. Following his stay on HDU, he was transferred to a ward and discharged home eight days later.

The day after discharge he contacted SWASFT overnight 'anxious and panicky' and 'wanting to go back to hospital to get better'. His care provider and GP were contacted. SWASFT were unable to re-admit Donald to the ward, so they conveyed him to ED as he was not safe to leave at home. The ED team contacted the ward he had been discharged from to gain an insight to his presenting behaviour and informed it was normal for him and no different to discharge. Plan: symptomatic treatment (as patient will allow), and OT/Social Services referral.

Donald remained in hospital for the next four weeks, when he died of renal failure. Initially he was an inpatient as he was unable to return to his supported living environment however he then clinically deteriorated. Throughout the admission Donald was evidently very anxious and distressed at times. He was also non-compliant with care, shouted and was disruptive; however, he was more settled when he was

**LEARNING** The following learning was identified during the LeDeR review:

- Donald died alone. Although his next of kin were contacted, he didn't have a close relationship with them. It was unclear whether anyone from his home was contacted and given the opportunity to be with him.
- There was no evidence of MCA or best interest decision making documented. There is no evidence an IMCA was involved in the decision making, despite having no close family or friends.
- It wasn't clear how much the carer's who knew Donald well were involved, or given the chance to be involved. Although hospital staff were evidently trying their best to encourage compliance with treatment and keeping his legs elevated, they didn't have much luck. People who knew him may have been beneficial in helping him accept the care he needed.
- It is not clear from the records whether a Tissue Viability Nurse was involved in his care (pressure ulcers and cellulitis), although a referral was mentioned.
- The records indicate that he was presenting with anxiety but there is no evidence this was assessed or that he was prescribed any anti-anxiety medication.
- The DNAR documentation wasn't fully completed, but it was appropriate and it was followed.
- The Care Manager involved in the review commented that he wasn't coping well with his placement and his re-admission appeared to have come from a place of anxiety and fear of not coping. It isn't clear from the records reviewed whether anyone escalated the concern that he wasn't coping, and whether there were plans to re-assess his suitability for supported living.



## LeDeR Learning: ID: 25168905

**LeDeR Score: 3:** This was satisfactory care, falling short of current best practice in two or more minor areas, but no significant learning would result from a fuller review of the death.

**INTRODUCTION** Zara was a 36-year-old woman with moderate learning disabilities and an extensive medical history. She had a primary diagnosis of Down's Syndrome and complex learning disabilities. She also had a clinical diagnosis of Eisenmengers Complex for which she was under the care of the cardiologists at the regional cardiac centre. Eisenmengers is a condition that affects blood flow from the heart to the lungs due to a structural heart defect. Zara also experienced recurrent haemoptysis (coughing up blood or blood stained mucus) due to a pulmonary artery embolism which was being treated conservatively.

Zara lived in the family home with her parents. She enjoyed arts and crafts, gardening, cooking and helping around the home. She was able to read and write and had an excellent memory. She was supported by her family to manage her health needs, who also supervised her taking her medication. She understood what her medication was for, for example one might help her feel "less puffed out" and the other would "help her with her worries".

In the 18 months prior to her death her episodes of haemoptysis became more frequent. The tertiary centre provided support and advice but she was no longer a surgical candidate. A request for a 'priority response' was sent to SWASFT due to the possibility of further life threatening events at home. A referral was also made to the community palliative care team.

10 months prior to her death, during a hospital admission, a DNACPR form was completed. A recommendation was made that, although not for further active treatment, that the family should call 999 as an emergency should it happen again. Later the same month, the hospital records state following a discussion with the GP, her parents and the community nurse she would be for resuscitation at this stage. Six months later, Zara had three episodes of haemoptysis in a six-week period. During the last of these three admissions "*it was discussed that this patient was not for resuscitation but for end of life care*".

Zara's family immediately expressed "*frustration, hurt and anger*" that this had been changed with an apparent lack of transparency. Zara's GP spoke to the hospital Consultant about this most recent admission. The GP noted that they felt that the acute care services were following an appropriate care pathway for Zara, but that due to the emotional stress and anxiety at the time that the family had difficulty processing all this information regarding treatment options. This may have been compounded by a junior doctor changing Zara's hospital passport to reflect the changes in DNAR status which family may not have been expecting if they were unclear this had been agreed. It was felt that terminology could have been different to provide clarity – e.g. '*not for CPR but for all other treatments until the heart stops beating*.'

A letter from the tertiary centre the same week confirmed "*the team expressed sadness and sympathy for the family and would advocate all supportive therapy but not active cardiopulmonary resuscitation should event's progress to her heart stopping beating during an episode of bleeding*".

The following month a complaint was received by the Trust stating the family "*were unclear which version of the DNAR form was in place and what this form references as approved life saving measures*".

Zara had four more episodes which required an ED attendance. She died from a pulmonary bleed at home. Her parents called an ambulance but were unable to save her.

**LEARNING:** The following learning was identified during the LeDeR review:

- Healthcare professionals need to be careful regarding their choice of language in relation to DNACPRs and ensure that family's/carers are involved at each stage, if the individual themselves lacks capacity;
- There was limited anticipatory care planning for Zara's parents. Ideally this should have been developed in conjunction with her family and how/when to escalate symptoms when she was at home – especially when in a palliative situation and the onset of symptoms can be sudden and/or traumatic. In this case, this care planning could have been improved.



## LeDeR Learning: ID: 18805320

LeDeR Score: 2: This was good care, which fell short of current best practice in only minor area.

**INTRODUCTION** Jack was a 51-year-old man with a mild learning disability. He lived alone in a ground floor flat managed by a Housing Company. He had a dog, he was a smoker and the flat was very dirty. He was at risk of self-neglect; he said he would do things, but then didn't.

He spent most of his time playing computer games. He was a 'big chap' and wasn't very mobile. This caused concerns about the dog as she wasn't being exercised and was desperate to get out.

He was reluctant to engage with services and had been known to the Social Services learning disability team on and off since 2008. He had been referred, assessed as ineligible and then closed to the team. The issues consistently presented were around him maintaining his home and self-neglect of personal care. An IQ test in 2009 was inconclusive and Jack used a number of excuses throughout the test as to why he couldn't complete the test tasks.

At a care assessment review in 2015, Jack stated he'd like a cleaner and would like the garden sorted. Following this review, he was assessed as ineligible for support. He stated he was unable to afford a private cleaner. The risks identified at this review were self-neglect and deterioration in physical health. No safeguarding concerns were identified and it was felt he could advocate for himself.

His neighbours upstairs expressed concerns about him and would keep an eye on him. A safeguarding referral was made following an attempt by Jack to cook chips in the microwave on a metal plate, resulting in a fire. Jack knew where the social services office was and would drop by and visit if he needed to. The Housing Officers would also pop in on Jack from time to time. He didn't want to attend any groups or services.

Since 2013, Jack had had two entries in his GP records. He'd received an accidental burn to his hand and right thigh, caused by caustic soda. In 2015, he was invited for a health check but did not attend.

In 2014 the police issued a harassment order against his nephew for financial abuse.

The Housing Association called Social Services to make them aware of their intention to enter Jack's flat with the help of the police as Jack hadn't been seen for a week. The Housing Association team had left a card stating they'd called, and it was untouched when they checked two days later. There were no records

### LEARNING/OBSERVATIONS:

- As Jack was reluctant to engage with services it was difficult to find detailed records about him.
- The Social Care Assessment in 2016 stated that he could advocate for himself, however no formal mental capacity assessment was documented.
- Jack was not eligible for support from the Local Authority and was also reluctant to engage with services. It is difficult to predict whether if there had been more support on offer, whether Jack would have accepted it. However, it does appear that there is potentially a cohort of individuals who don't meet eligibility criteria, but would benefit from assistance or support.
- Jack didn't regularly attend his GP practice, even when invited for an annual health review. It isn't clear from the notes reviewed whether or not he was on the Learning Disabilities register. Also without access to more detailed GP records it wasn't clear whether the practice has tried to engage with Jack. Recommendation - Primary Care to have clear processes in place to try and improve contact and engagement with 'difficult to engage' patients.
- There was a concern around self-neglect in this case. It was unfortunate that he requested help and assistance in some areas, but was deemed not to meet criteria for support.
- Was a referral about the welfare of the dog considered? This is unknown.



There are lessons to be learned for anyone who reads this. Please take some time to think about the learning points and provide feedback by answering this survey:

<https://www.surveymonkey.co.uk/r/ML96K5K>



## APPENDIX 2 – Q1 2019-20 LeDeR QUARTERLY REPORT

### ENSURE LEDER REVIEWS MAKE A DIFFERENCE

The following learning is a summary of additional learning from all cases closed to date where there are recurrent themes, irrespective of their 'score'. It is clearly marked when:

- there has been new learning from the last quarterly report - 'new';
- previous learning has been repeated in this cohort of reviews - 'recurrent'.

Additional contextual information is available on request.

**CAUSE OF DEATH:** In three cases the cause of death was "congenital cerebral palsy". It may be a contributing factor, but it is not the cause of death.

#### NOT KNOWN TO SERVICES:

- **NEW:** Processes for recording those with a learning disability has evolved. There are individuals who live with their elderly parents who are not known to services. GP practices should ensure that patients with a learning disability are on the GP register and a referral is made to the Community Learning Disability team, if required.
- **NEW:** For those individuals who become known, having previously been unknown for a significant period of time, it is imperative that any referrals that are made (e.g. to social services) are followed up to ensure that the referral was received and actioned.

#### SIGNPOSTING:

- **RECURRENT:** There is a need to raise awareness of the role of the Community Learning Disability team.
- **RECURRENT:** The signposting for families could be improved, detailing the services which are available to them.
- Primary Care are often unaware that there is a Speech and Language Therapy (SALT) team specifically for those with a learning disability. Referrals are often made to the wrong team, which then take time to be forwarded on and can cause delays to assessment and treatment.
- Primary Care can be unsure which services to refer to, due to the large and differing number of services available.
- Hospital based learning disabilities facilitators can provide support and care to families, even if the individual is unconscious. If the patient has a learning disability and is an inpatient, contact the hospital learning disability facilitator.

**TRAINING:** A large number of reviews indicated a need for specific learning disability training, within both acute hospitals and the community setting. Highlights were:

- Staff need to understand that a change in behaviour and mood can be a sign of an underlying medical condition.
- Staff need to listen to the voice of the family and/or carers when they are acting as an advocate.
- Medical and nursing staff can struggle with assessment and communication, especially with non-verbal patients. Training regarding the clinical assessment of non-verbal patients would be invaluable.
- Staff should be reminded of the different criteria for learning difficulty and learning disability.



#### MENTAL CAPACITY AND BEST INTEREST DECISIONS:

- **NEW:** If medications are to be administered covertly in someone's best interest, there needs to be evidence of the appropriate documentation to support this decision.
- **RECURRENT:** Ensure all conversations and decisions around mental capacity and best interests are clearly documented.
- **RECURRENT:** Ensure that decisions made in the best interests of the individual are backed up by demonstrable processes, meetings and documented outcomes.
- **RECURRENT:** Decisions that individuals are not going to participate in screening programmes should be backed up with the appropriate documentation. Each screening programme should be considered separately as they involve different approaches
- Health and social care professionals need to be considerate of families and carers if they disagree with the decisions made in relation to mental capacity and best interests. Do not make them feel "brushed off".
- Ensure a robust assessment for individuals with a mild learning disability who may give the impression that they are 'coping'.
- Ensure individuals are informed honestly about their health and procedures, unless a best interest meeting decides otherwise.

#### END OF LIFE CARE AND PLANNING:

- **NEW:** A learning disability is not a reason for not attempting resuscitation (*NB/ This was from a death in 2016*)
- Whilst appropriate and involving those who needed to be involved, there were many examples of poorly completed DNACPR documentation.
- There were examples of individuals who were identified as requiring end of life care but there was no evidence that a referral was ever made.
- Families reported that, whilst they knew the individual was at the end of their life, they felt unprepared and didn't know what to expect. Although every death is different, a leaflet or a conversation with families about what to expect might be helpful.
- Reviews evidenced a need for care home staff to have end of life training and guidance in how to provide the planned care, and in what circumstances to seek help from other professionals.

#### ADDITIONAL LEARNING:

- **NEW:** General Practice should offer flu vaccinations to all eligible individuals
- **NEW:** Ensure there is a process in place to support those with a learning disability (and their next of kin/guardians if appropriate) to access their finances and understand how much they have.
- **NEW:** Consider how individuals with capacity can plan where their money should go following their death, and the options available to them in terms of making a will.
- **RECURRENT:** Ensure the individuals are on the Learning Disability Register at the GP practice and have annual health checks.
- Be mindful of ensuring continuity of professionals, wherever possible, over short periods of time.
- Should referrals made to the learning disability community team be acknowledged, especially in circumstances when they are not going to be acted on immediately?
- There is still uncertainty over who is on the Learning Disability Register as who is on these registers is not known to the acute providers.

#### PLEASE GIVE US YOUR FEEDBACK

There are lessons to be learned for anyone who reads this. Please take some time to think about the learning points and provide feedback by answering this survey:

<https://www.surveymonkey.co.uk/r/ML96K5K>