Priority Area	Aim/Final Position	12 month outcome (to end Mar 2021)	deliverables	Who - organisations/Forums/ CCG	Measures
Annual Health Checks	Every person over 14 years with a Learning Disability will have a comprehensive and Annual Health Check, which identifies their needs and produces a Health Action Plan which outlines how these needs will be met. Both the Health Check and the Action Plan will be in a format which is understandable to them and shared with all involved in their care.	Everyone on ELDP case load/RAG rated as priority has a pre course questionnaire (or known to be done by someone else) and has had an AHC.	the LD primary care registers are validated and expanded	LD HE Team & EQUIP	50% take up of AHC
	All young people aged 14yrs who meet the criteria for a learning disability healthcheck are idenitifed and are offered the choice to be added to the GP LD register. Parents carers and young people are informed and understand the AHC process and are actively involved in the decision making process.	Increase in Practice LD register sizes and increase in AHC uptake within the 14yr + cohort.Increased understanding by parents, carers and young people and schools of the AHC offer . Increased understanding of local servcies available to Young people with a learning Disabilty.	The LD primary care registers are validated and expanded Learning Disability awareness campaign is promoted amoungst local populations and within the LD community support	Thurrock, Basildon and Brentwood CCG local area SEND systems	
			Profile of AHCs to be raised in special schools and at transition planning	Southend & CPR, Thurrock CCGs BBCCG, ECC	

			ELDP RAG rating of caseload used to identify those a) at risk and in need of priority Health Check and b) those who can be seen remotely/need face to face appointment.	ELDP	Improved experience of AHCs for people with LD and their families
			ELDP support primary care in booking AHCs for priority patients	ELDP	
			ECC media channel to promote benefits of AHCs	Michelle Brown	
			Social care providers support to people to prepare for/attend/set up remote appointment	LA Commissioners/Contracts. ECC MLM Aging Well project	

			training is delivered to help people (adults, carers, families) to understand and prepare for the AHC	ELDP	
	LD HE Team & EQUIP, Raise profile in specialist schools and day centres, Birthday Card/health check reminder. Regular comms in the GP/Primary Care bulletin and education forums. Early planning through the transission to adult services.raise profile through weekly comms on LD themes and with social care. LD Community engagement model		ELDP work with social care providers to help prepare the pre-course questionnaire and attend/set up remote appointments	ELDP/ Family Organisations/SC provider link?	
			promotion of flu vaccine	CCGs Public Health ELDP	50% uptake of flu vaccine
			Training/support for primary care to understand the Easy Read questionnaire, expectations of check and how to complete an Easy Read Health Action Plan – videos.	ELDP	
			LAs ensure social care providers support target number of checks	ECC Michelle Brown/MLM	

			CCGs promote AHCs, the use of Easy Read resources and new model of joint working with ELDP and ASC with primary care (bulletin, education forums, comms)	CCG Primary Care Leads and Clinical Leads	
			Community and user groups (such as Project 49 in Southend & Summit in Essex) will promote AHCs and support people not open to ELDP or social care to prepare and access remote appointments	Comms Leads (Amanda Shears Southend &CPR)	
			Primary Care (PCN Directors) agree delivery model and support new ways of working including GP LD Champions	PCN Directors/CCG Primary Care Leads Southend & CPR Imelda Callowhill	
			Engagement with people with LD & Families around experience of AHCs - baseline and re-measure	Healthwatch	

			GPs produce Easy Read Health Action Plans for each AHC		
			HAPS are shared with family, ELDP and Social Care where appropriate	GPs (Southend&CPR Taz Syed through the GP and AHP forums) CCG Primary Care Leads to support	

Priority Area	Aim/Final Position	12 month outcome (to end Mar 2021)	deliverables	Who	Measures
Frailty	Early frailty in people with Learning Disability will be understood, prevented where possible and mitigated to ensure optimum health and quality of life where it cannot be prevented.	Frailty in people with Learning Disability will be understood as part of the dynamic risk register function	Assessment of current understanding of frailty in ELDP and social care staff	ELDP Leads Gemma Robertson & Mary Seaman	Reduction in conveyance to hospital for frailty related conditions
			Tool/ process of assessing frailty in LD population	ELDP with CCG Frailty Leads and DoNs	
			Application to people open to ELDP as part of dynamic risk register	ELDP - GR & MS	
			whole system approach identified including mainstream frailty model, training for care homes, primary care, National directives such as care home DES)	CCG Frailty Leads Care Home Hubs Mid South Task and Finish Group	
			Aging Well Approach to include frailty approach in social care provision	ECC MLM programme	
			A shared understanding of inpatient lists, reasons and frequency of admission.	Frailty Leads West Frailty Oversight Group	

			training delivered to residential and supported living provision on identification and management of frailty	PROSPER, Mid&South Task & Finish	
Priority Area	**Aim/Final Position**	**12 month outcome (to end Mar 2021)**	**deliverables**	**Who**	**Measures**
Dynamic Support Register	There is a single, multi-agency owned, dynamic support register and process in place across the whole of SET. Anyone with a learning disability (initially aged 18 +) within the area is eligible for inclusion. Services are aligned and primed to respond to the needs presented. The tools/materials used to support the process are well known and understood; services look for them when someone presents to them.	The register is in place for those people open to ELDP	• An identified lead responsible of overseeing and co-ordinating all aspects of delivery; and for holding people/the service to account for the agreed actions.	ELDP Leads Jenna Braddick & Owen Fry	A reduction in premature deaths.
			• A clear protocol and process for identifying those considered at risk from a variety of acute and/or chronic health conditions.	ELDP/Acute Liaison Nurses/PCNs	A reduction in ambulatory care hospital admissions.
			• The register - a dynamic/live list of those at risk – held electronically with the ability to analyse the data both at individual and at a system level. [potentially linked to/one and the same as the TC DSR]	ELDP - JB & OF	A reduction in HEF Risk scores(!)

Priority Area	Aim/Final Position	12 month outcome (to end Mar 2021)	deliverables	Who	Measures
Case management	There is multi-agency agreement for and resourcing of the required capacity to ensure that all people with learning disabilities (initially 18+), in SET, with significant risks resulting from physical health issues are case managed. Case management, as a role/function, is understood and supported across the whole health and cares system. There are sufficient case managers with the required skills to undertake the role as needed. Individuals and their families report better co-ordinated health responses.	A pilot to be run in an agreed CCG or PCN area with an agreed cohort: • Those at RED • Those at AMBER • Those at GREEN	• An agreed risk stratification process, that includes: o Clear definitions re the different levels of risk and how this applies to the variety of conditions and situations that may apply o Clear expectations about the actions to be taken at each level of risk o Mechanisms for recording and monitoring agreed actions, and for escalating when necessary	ELDP Leads Joanne Ayris & Katy Heery	
			• An agreed list of items/actions considered good/best practice and where/how they will be implemented as part of the dynamic risk levels.	?	• A reduction in ambulatory care hospital admissions.
			A shared understanding of inpatient lists, reasons and frequency of admission.	LD hospital Liasion Nurses	

			• Data that demonstrates the type and volume of health issues known to (this part of) the system	PCNs/EQUIP/Hospital Liaison Nurses/ELDP	
			• The identification of issues within the system that need addressing/escalation outside the remit of managing the register itself.	?	
Additional	**Aim/Final Position**	**12 month outcome (to end Mar 2021)**	**deliverables**	**Who**	**Measures**
Condition Specific LeDeR Recommendations	Specialisms such as Cardiac, cancer, respiratory and Dental will understand the issues relevant to people with LD, will identify their LD caseload, work in collaboration with specialist LD nurses make reasonable adjustments to ensure access and good outcomes	A lead will be identified for cardiac services to develop an action plan	CCG clinical leads will circulate condition specific recommendations to the relevant department leads for action	CCG clinical leads	