Bexley Safeguarding Adults Board

Commissioned by: Bexley Safeguarding Adult Board

Local Reviewer:
Elizabeth Deeves, LB of Bexley, Head of Integrated Commissioning for Adults with Learning and Physical Disabilities

Independent Scrutineer:
Andy Rabey, BSAB Independent Chair

SAR Thematic Review:
Adult Learning Disabilities Systems Review

December 2023

SAR – Learning Disability Systems Review

1. Introduction

1.1 The BSAB in 2022-23 had several SAR Notifications with adults with learning disabilities and agreed to commission a Thematic SAR to look at the LD Systems in Bexley.

1.2 This SAR is written and aimed for any Senior/Executive agency/organisation that has commissioning, care and support duties/responsibilities for Adults with Learning Disabilities and their family/carers.

1.3 The review has been led by Elizabeth Deeves, LB of Bexley, Head of Integrated Commissioning for Adults with Learning and Physical Disabilities. With the following agencies invited to participate in the SAR Panel:

1. London Borough of Bexley Adult Social Care
2. Integrated Care Board, Bexley
3. Oxleas NHS Foundation Trust
4. Carer's Partnership Bexley
5. Mencap
6. Advocacy for All
7. Lewisham and Greenwich NHS Trust
8. Dartford and Gravesham Trust

1.4 There were six cases that met the SAR Criteria and agreed to be used in this report. The cases are all anonymised to protect their identity and will be referred to as:

- Individual A (IA)
- Individual B (IB)
- Individual C (IC)
- Individual D (ID)
- Individual E (IE)
- Individual F (IF)

1.5 This review used thematic headings where 21 emerging system-wide findings with 49 recommendations found by the SAR Panel (see Appendix 1 for more information on Systems Reviews).

2. Safeguarding Adult Reviews

2.1 Section 44 of the Care Act 2014 places a statutory requirement on the Bexley Safeguarding Adults Board (BSAB) to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Bexley Safeguarding Adults Board the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether the local authority has been meeting any of those needs).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) identifying the lessons to be learnt from the adult's case, and

b) applying those lessons to future cases.

2.2 The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures

2.3 SARs are about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR took a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.4 This SAR has been discussed at SAR Subgroup in June and July 2022 and due to complexities and matters arising of cases specifically concerned with persons with learning disabilities, the BSAB SAR Subgroup recommended a LD Systems Review be called and led by the commissioner of the LD services. There are 6 individual cases that have met the Care Act 2014 SAR Criteria that has triggered this SAR.

2.5 The BSAB's Safeguarding Adults Board Independent Chair, Andy Rabey, agreed that the criteria under s44 of the Care Act had been met and that circumstances leading to all 6 cases should be reviewed and has independently scrutinised this report.

3. Analysis and Evidence Summary – This section provides a brief factual and contextual summary of Panel members involvement with adult(s) at risk under the six-principles of safeguarding as identified in the Care Act 2014 (see Appendix 2 more details).

3.1 The Panel identified that the following pieces of legislation govern agency's practice –

- Care Act 2014
- Mental Capacity Act 2015
- Human Rights Act
- Mental Health Act

3.2 The Panel identified that Safeguarding Adult cases must include looking at the person's history not just the current concerns coming in the 'front door', previous histories would contribute to decision making.

For example, when a safeguarding concern comes in, there was a culture identified where it was not raised as a 'new' concern if there was already an open s.42 on the adult. To resolve this, there should be a new concern raised and a review of 'repeated concerns', frequency and taking in the whole picture, including Think Family.

3.3 The Panel identified that some agencies have an existing basic LD training on communication.

For example, there are mandatory Autism training courses for Bexley Adult Social Care; and health partners identified that awareness will be mandatory for all safeguarding adult level 3 training across NHS.

3.4 The Panel identified that although there is training for ASC there is still a gap in learning across the BSAB partnership.

3.5 The Panel identified that there are ongoing concerns with Primary Care, particularly, with GPs as there is not currently an Annual Health Check for those with Autism nor is there an updated LD Register.

The Panel found evidence that this is not just a concern primary care but is a system wide issue. There is a plan to introduce an annual health check for people with autism, but this is not mandated currently. The LD register maintained by GPs relies on appropriate information sharing. However, this is a system wide issue that acknowledges that agencies are not recording the numbers expected using population data. There is also a problem with information sharing across the system which allows the LD register to be maintained.

3.6 There were additional concerns discussed around how each GP will have their own set of safeguarding adults policies and procedures even though there is Southeast London (SEL) Guidance, they are independent contractors, so they have their own and what the overall impact is on the patient waiting for support.

For example, CQC requires a safeguarding adults policies/procedures and training and are supposed to evidence this with them directly.

3.7 SEL will still (as for now) provide the same oversight and compliance checks, but no management jurisdiction.

For example, if there are concerns, then those get raised with NHS England (NHSE); also, as GPs are independent contractors however, they have a professional body in the GMC and also advice from the RCGP. They have to comply with this and the CQC who mandate the safeguarding policies that are in place. SEL also mandates that safeguarding adults policies are in place. Quality issues around care can be raised with the Bexley primary care team and subsequently NHSE if needed. All practices have been sent a guidance policy around a “was not brought” policy. They can choose whether to adopt this or not, which is a different matter. A reasonable adjustments flag is due to be added by NHS Digital in 2024 which should also alert GPs that this may be considered.

3.8 The Panel highlighted risk to individuals falling through diagnostics or support referral pathways due to lack of consistency especially where someone has an undiagnosed or hidden disability, such as illiteracy or communication difficulties.

3.10 The Panel members reported that the Adult LD Register has less people on it than currently known to ALD persons in Bexley (and wider) and are they missed, coded incorrectly, reluctance to make the diagnostics across primary care, or whatever the reason should be explored; including whether this is a NHSE responsibility not Bexley alone to resolve.

For example, Acute partners noted that there is a reluctance to share those people who are known to have an LD/ autism within Bexley with us and therefore we may not have those people appropriately flagged on our system.

3.11 The Panel agreed that this was particularly salient to those especially going through Transitions pathways as currently, Bexley does not have a clinical/care professional lead for LD/Autism.

Two cases presented confirmed – 1) there was an Adult that did not have a diagnosis and slipped through the net; and 2) where they had a diagnosis in place and wasn’t getting the support they needed.

In both Cases there was no identified support in place for the 'carers.'

3.12 The Panel agreed the diagnosis pathway is confusing and misleading to the family, carer(s), and other professionals, as the language used professionally is identical for Learning Disability and Learning Difficulty –

Examples –
1) Learning Disability (where a confirmed diagnosis is on file) is called LD; as well as a person with Learning Difficulties (where there is not a confirmed diagnosis on file) is also called LD.

2) diagnostic language is confusing between LD, Autism and Mental Health as it is not always clear when recorded.

3.13 The Panel was informed that in order to access 'specialist services' like the LD Team there would be eligibility criteria to access this service. There will be a proportion of people not getting these services if not diagnosed or the diagnosis is in the mild range. Oxleas reported there is a LD Screening Tool, but currently there is not a diagnostic service or tool in Bexley.

For example, to receive LD Team MH support services, a diagnosis is required and this is excluded a large number of individuals.

3.14 Panel members from Lewisham and Greenwich NHS Trust (LGT) reported that they have a Clinical Specialist, LD Nurse based at Queen Elizabeth Hospital, operating at an NHS Band 8 that supports most training and gives support to practitioners.

In addition to the Clinical Nurse Specialist, LGT has LD Champions (LDC) on Wards. The LD Champions supports where a patient comes in, the LDC can support the nurses to work effectively with the patients.

For example, assisting with Communication Tools, applying the Mental Capacity Act, apply for DoLS and refer on to Community support teams and there is a Therapeutic Plan in place to assist staff with 'restraints.'

3.15 The Panel was overall impressed by work of the LDC and would really welcome this in the Emergency Departments (ED) as there is a lack of safeguarding adult training amongst ED staff.

For example, there will be referrals by ED for someone to go on a Ward, but the Wards will pick up safeguarding concerns particularly with adults with Autism where ED staff had missed the concerns.

Additionally, the Wards are picking up concerns from placements and should be considering if it is safe to discharge.

3.16 The Panel heard that some ED's are updating their processes particularly around 'unsafe discharges' when unexplained injuries and concerns are identified.

3.17 The Panel heard from Dartford Gravesham Trust that their ED has 'frequent attenders meeting' called High Intensity Users Meeting, which the LD Nurse attends. The information gets shared with LA's under information sharing protocol. The definition of FA equates to someone attending several times in a short time; what are the reasons for attending; and what is the risk route.

For example, other agencies like the London Fire Brigade can also have the information shared with them so that they can take action on any fire risks identified.

4. Pen Pictures and Summaries of involvement for Individuals A-F

The panel considered how decisions made, and the actions taken or not and where judgments were made, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. At the end of this section, the Panel was asked to consider the six-safeguarding principles (see Appendix 2) and how these were applied in practice.
First, we looked at the Pen Pictures of all the individuals considered for this review, two cases had already had a LeDeR completed, some are awaiting a LeDeR to commence, and some are not linked to LeDeR. Where LeDeR has completed and concerns with actions made, the BSAB has agreed to include those in this report, (see Resources for more information on LeDeR).

Pen Picture of Individual A (IA) -

IA was 50 years of age when he died. He lived at home with his elderly parents in an adapted property, including a house lift, specialised bed, accessible shower, and 3 ceiling tract hoists throughout the property.

IA required support throughout the day since he was non-weight bearing. The social worker has reported that IA also did not have speech and had severe learning disabilities in addition to his physical support needs. There was a safeguarding concern raised that the parents were unable to cope with IA's needs.

It was identified that all of IA's home care support, including, all transfers, washing, dressing, feeding and toileting was completed by his parents, even though, IA was assessed for Homecare services to give the parents a break and to assist with IA's care and support needs, but the parents declined this service. IA was then assessed to and was allocated 5 days at a day centre, this is above the usual amount allocated to individuals' with similar care and support needs which also included transport services being provided.

IA's wider family included 2 younger brothers who did not live at the family home. It was reported that IA's parents being elderly, and their health needs increasing, made caring for IA very difficult. The parents reportedly had very little support and they were in the process of referring to Bexley Carer's Support.

There was a 2nd safeguarding raised by the day centre around concerns with how the family were struggling working with IA. When IA had an epileptic seizure at the day centre, the family did not want IA to receive oxygen at the scene.

The concerns raised to BSAB by the Bexley Integrated Care Board were as follows:

- It has been identified that prior to this gentleman's unexpected death there had been an increase in IA's seizures and that he had been unwell since Christmas.
- IA's GP was unaware of any increasing health concerns.
- On 24/02/2022 he attended his regular day centre where he had a seizure and a call to LAS was made.
- Both the day centre and LAS state there had been reports of increased seizures.
- Parents requested LAS to remove oxygen at the scene - this was not done and he was taken to Queen Elizabeth Hospital.
- There was evidence that he vomited at the scene and possibly inhaled this to cause an aspiration pneumonia.

He was treated in Queen Elizabeth Hospital and he died 11 days later

IA's recorded Cause of Death:

1a Aspiration pneumonia, candidal pneumonia
1b Epilepsy

The Local Authority reported that IA passed away before they could commence the s.42 enquiry and in reflection has reported,

'(this case has) Raised future learning what should be considered and reflected upon when working with those from a different ethnic background.

There should be acknowledgement and understanding of how language, cultural identity and belief systems impact on the children and adults within the family. If language remains a concern the professional to ensure information is shared in the language of choice and interpreter used when necessary.

Consideration should be given if an advocate is required for the family to understand government process.'

Pen Picture of Individual B (IB) –

IB was 48 years old at the time of her death and lived at, a CQC registered care home in Bexley.
IB had the following health diagnoses -

- Asthma
- Anxiety
- Paranoia
- Bi-polar Effective Disorder
- Emotionally Unstable Personality Disorder (EUPD)
- Mild Learning Difficulties

The BSAB became aware of the unexpected death by the Local Authority, their concerns were:

- Prior to IB's hospital admission at Princess Royal University Hospital there were various concerns around her hygiene, her general well-being and concern for her mental well-being.

Examples of IB's behavioural difficulties were:

At the bank, she was quite a difficult customer to deal with including:

- IB would not adhere to covid 19 restrictions in place including social distancing.
- IB would also shout at bank staff and the bank became concerned about IB's agitation and would not leave their branch and is making it difficult for staff and other customers.
- IB had altercations with customers including children, she did not appear to be able to look after herself and she appeared to be at risk to herself.

IB was investigated for causes of cognitive decline since 2019, but no cause found.
IB stabilised for a few weeks prior to discharge and her mood could be variable but generally she is bright and enjoys spending time with others and members of staff.
IB also had numerous Merlin reports from the police.

- IB was admitted into PRUH under S.2 MHA.
- IB was initially allocated a main Ward where she exhibited ongoing requests to go to the shop and when this was refused, she would lie down on the floor.
- IB would not answer questions about what lead her to admission.
- IB had a family history of early onset dementia.
- IB's speech is limited to short sentences but had perseverance to repeat herself until understood.
- IB was discharged to a care home under the care of Intensive Case Management in Psychosis (ICMP) Service on the 15th November 2021. ICMP helps all adults suffering from psychosis who require secondary community mental health treatment and support. This includes individuals diagnosed with bipolar affective disorder as well as other psychotic conditions.
- IB was experiencing significant unexplained weight loss, frequent unexplained falls, which were both witnessed and unwitnessed by professionals.
- IB's GP was contacted to support with these concerns, and IB was placed on a 1:1, but continued to have falls.
- IB was admitted into Prince's Royal University Hospital (PRUH) following a fall.

IB's family history notes that her parents separated when she was approximately 2 years old and according to records her biological father physically abused her as a child. IB's mother later re-married a known paedophile by whom she was sexually abused. There was no record of any support offered to IB during her childhood to work through this trauma. IB has 2 surviving children, but they were taken when young, into care and then later adopted.

There is no evidence that there was any support to IB to keep her children by moving out of the house where IB's abuser, her stepfather, was living or seek any police intervention regarding crimes against IB.

IB was initially referred to mental health services in February 1991 following an episode of post-natal mental health problems (Puerperal Psychosis). IB was given a diagnosis of Bi-polar Effective Disorder, Emotionally Unstable Personality Disorder (EUPD) and Mild Learning Difficulties. It was reported that IB

also had Asthma. IB subsequently had several inpatient admissions to psychiatric hospital but was not known to mental health services in Bexley from 2012-2019.

From 2019, IB's mental health appears to have deteriorated after a long period, 7 years of known stability and was inpatient with Oxleas NHS Foundation Trust based at Queen Mary's Hospital (QMH), Sidcup. IB was admitted on 26/11/2019 following relapse in her mental health. IB had reportedly been exhibiting signs of self-neglect, anxiety and paranoia and not been taking her medication.

Prior to IB going into QMH, IB had fallen out with 2 close friends who used to offer support and had not been leaving in her flat and was socially isolated.

By 2021, IB was re-admitted into hospital under s.2 MHA and was later discharged into the Care Home and had been under s.117 MHA.

At the time of her assessment, IB was unable to express her wishes but there is no mention or evidence for this review that a mental capacity assessment was completed, and her case was assigned to complete her care review and also to complete safeguarding enquiry following frequent un-witnessed falls despite having a 1:1 care provision in place.

Whilst IB was at the home, towards the end Dec 2021, IB began declining meals, which led to a significant weight loss, weakness, frailty, she became non-verbal, and she was experiencing frequent un-witnessed falls.

IB passed away on 13/05/2022 at Queen Elizabeth Hospital after a prolonged illness.

The London Authority has reported the following: -
'IB was seen by SW in her home on 9th March 2022 for the purpose of reviewing her care and support plan.

Unfortunately, she was admitted to hospital on 14th March 2022, but the safeguarding was raised with the local authority on 16th March 2023. Due to her admission. IB views around making safeguarding personal was not achieved at the time.

An advocate was considered but a referral was not completed. Information has still been gathered from the care provider.

SW identified that IB was not in the appropriate care setting and SW was working to find alternative placement and get the medical/mental health support she needed. IB case was presented to the mental health panel for discussion and to seek support on how to meet and manage IB care and support needs.

IB was in hospital and the plan was for IB to move into a more suitable placement with mental health support.'

IB's Cause of Death –
1a Pneumonia
2 Covid-19

Pen Picture of Individual C (IC) -

IC's information was submitted by LBB from their Care Act Assessment completed 07/03/2022:

"IC said she was born in London, and she has 2 sisters and 2 brothers but has no contact with any of them. She said she currently has no family supporting her.

She stated she was previously married, but her husband was stabbed to death, she has a daughter, who does not maintain any contact with her either.

IC said she worked briefly in a charity shop but is now in receipt of her benefits made up of Income Support, Housing Benefit, Disability Living Allowance and Universal Credit.

IC has a diagnosis of Schizophrenia, Learning Disability, Anxiety, Bowel Cancer, and Leukaemia.

She said she enjoys watching TV, listening to the radio, crossword puzzles and reading women's magazines.

IC is known to the palliative team and Greenwich Mental Health Team. She used to live in Plumstead and moved to Bexley on May 2021 and she used to have friends in the neighbourhood where she was living in Plumstead.

IC mentioned to that she does not like living in Bexley and she wants to move back to Plumstead or Woolwich.

Alternatively, IC wants to move to a care home or sheltered accommodation. However, staff from Greenwich Mental Health Team said it won't make a difference due to her mental health issue and she is approaching the end of her life.

IC has a support worker who is supporting her with shopping and visits her once a week and takes her to shop for an hour. She also helps IC to manage her finance such as bills".

The Local Authority reported that ***no safeguarding*** was formally raised only the following alerts –

'08.11.22 – Social Worker received an email from support worker from Greenwich CMHT – 'her care needs are higher - maybe needs a nursing home?'

22.11.22 – Concerns from Queen Elizabeth Hospital Triage Hub Referral Outcome: 'Safeguarding concern received regarding self-neglect and neglect by the care agency' after IC spent the night on the floor. Concerns were also raised regarding the home environment and amount of medication.

IC was allocated to social worker and the concern has been passed to them for follow up and to raise a s.42 if required.

07.12.22 – Concern from Queen Elizabeth hospital raised when LAS arrived, found lady on the floor with duvet and pillow, alleged carers had found her on the floor & gave her the duvet and pillow ...environment unkempt, out of date food, flies etc.....IC appears to be a hoarder, bed can't be slept in.....medication laying around, some out of date....QEH reported multiple pressure ulcers, one ungradable pressure ulcer.

Themes: Neglect....unkempt environment.....medication.....out of date food.....pressure ulcers
No formal section 42 safeguarding was raised.
Community work continue to resolve the concerns raised.'

Pen Picture of Individual D (ID) – There is a parallel LeDeR being completed on this case, however, it was not completed in time for this SAR.

ID was born on 25/05/1964 and sadly passed away on the 15/12/2021 at the age of 57 years old. This review has identified, there is no record of Adult Social Care or GP information to contribute towards the learning.

The BSAB was made aware of the unexpected death of ID from partners from the Bexley Integrated Care Board on the 18/05/2022 for the following reasons:

1. *Inpatient at Oxleas (anxiety and auditory hallucinations and ID had not been compliant with medication and in particular, clozapine.*
2. *ID also had a learning disability and was living at Shrewsbury House in Bexley showing signs of increasing physical health concerns.*
3. *ID was transferred back and forth from Shrewsbury Ward to QEH 20 times within 3 months, as listed below –*

- *10 September 2021 - admitted to Shrewsbury Ward under Section 2 of the Mental Health Act 1983 (MHA amended 2007).*
- *16 September 2021 - Clozapine re-titration commenced.*
- *16 October 2021 - unwitnessed fall on the Ward but sustained no injuries.*
- *18 October 2021 - reviewed by the Ward doctor as he looked frail. He was transferred to A&E and admitted to the medical Ward at QEH with an infection.*
- *22 October 2021 – QEH diagnosed with 'acute constipation; sepsis'. Discharged back to Shrewsbury Ward.*
- *25 October 2021 - had a head CT scan which showed no organic causes to his mental health presentation.*
- *1 November 2021 - observed to be disorientated and drowsy. He was transferred to A&E. Blood results on Shrewsbury Ward indicated an infection. QEH discharged with a diagnosis of constipation, and he returned to Shrewsbury Ward.*
- *November 2021 - Shrewsbury Ward doctor escalated her concerns to the A&E registrar that he had been discharged from QEH without the infection having been treated. He was transferred back to QEH.*
- *November 2021 - discharged from QEH with a diagnosis of 'psychotic disorder' and was prescribed antibiotics for an unconfirmed UTI.*
- *November 2021 - escorted by Shrewsbury Ward nursing staff to have a PCR test ahead of a colonoscopy on 7 November 2021.*
- *6 November 2021 - had Moviprep as prescribed in preparation for the colonoscopy.*
- *7 November 2021 - escorted to QEH to have a colonoscopy. The colonoscopy consultant would not complete the capacity assessment and he returned to Shrewsbury Ward without having had the procedure.*
- *21 November 2012 - complained of pain and was reviewed by the duty doctor. He had some superficial injuries on his shoulder which was attributed to repeatedly moving his mattress and sleeping on the floor and swelling to his right leg.*
- *28 November 2021 - reviewed by the duty doctor as his left foot and leg were swollen. He was transferred to A&E. At A&E, routine blood results showed an increase of inflammatory markers, indicating an infection. He was diagnosed with cellulitis, DVT and pitting oedema and discharged back to Shrewsbury Ward with antibiotics.*

- *29 November 2021 - escorted to the Ambulatory Care Unit at QEH. He was diagnosed with folliculitis. He was also seen by the orthopaedic team who advised that if the cellulitis worsened he could return to A&E for intravenous antibiotics.*
- *30 November 2021 - reviewed by the Ward doctor who was concerned the cellulitis had worsened. She sought advice from the on-call microbiologist who advised that he required intravenous antibiotics. He was transferred to QEH. He was discharged back to Shrewsbury Ward with a diagnosis of cellulitis and antibiotics.*
- *December 2021- antibiotics were increased by the Ward doctor as the dose prescribed by QEH was not considered high enough to treat the worsening cellulitis.*
- *December 2021 - was observed vomiting in his room. He was assessed by the duty doctor and a physical examination was carried out. There were no concerns except the swelling in the leg.*
- *14 December 2021 - escorted to QEH for an MRI scan. It was postponed until he was well enough to remain still for a longer period*
- *15 December 2021 - found unresponsive in his bedroom at around 1300 hours. CPR was commenced and the paramedics were called. The paramedics pronounced life extinct at around 1407 hours. Oxleas medical team have escalated concerns to the ED registrar that discharge despite abnormal bloods and low blood pressure. History of constipation.*

Lack of colonoscopy due to conflicting views on who should complete the MCA.

Several attempts at rebooking the procedure but not successful.

ID's reported Cause of Death:
1a. Peritonitis
1b. Small bowel perforation
2. Urinary Tract Infection (UTI)
The Local Authority reported that Individual ID was not known to Adult Social Care and therefore no s.42 enquiry could be completed. LeDeR in parallel not completed.

Pen Picture of Individual E (IE) – There was a LeDeR completed in advance of this SAR, it has been agreed to use these findings and incorporate the learning and actions into this SAR.

'In the absence of discussions with someone who knew IE well there are challenges in building up a picture of his life - his background, relationships, personality, preferences, and feelings. IE's sister declined to take part in this review although an email from her daughter suggests that she was distressed by the circumstances of her brother's death. There is no information about IE's life before his admission to a care home.

As it stands the diagnosis of Learning Disability is ambiguous and there is no explanation about how his disability presented or was managed. Community ALD services declined a referral due to a lack of corroboration and the diagnosis of dementia.

Similarly, there is no documentation around the dementia diagnosis or how this affected him. Terminology such as "mild learning disability" "moderate learning disability" and "learning difficulty" are scattered throughout IE's medical and social care notes but - like "dementia" - without classification or clarification they appear to be only labels.

There is limited indication that any consideration had been given to any reasonable adjustments that IE may have required. It can be interpreted that the 'label' of learning disability removed any agency that IE may have had and given the rationalisation for others to make decisions on his behalf.

There is no evidence in the QMH notes that a that a Mental Capacity Assessment was undertaken, attempted, or even considered. Family were, however, involved in the decision-making process, and it seems that the least restrictive options were followed.

He was not seen by the Learning Disability Liaison nurse during his last two hospital admissions. From the available information we are left with the impression of an elderly and increasingly frail man who appears to have been largely passive in health and social care interactions and, generally, accepting of any interventions.

There is little information about IE's day to day life - his likes and dislikes, his choices, and inclinations. The Care Act Assessment largely excluded these, and the care home have been unable to produce copies of his care plan and risk assessment despite repeated requests.
The GP appears to have been proactive in treating, monitoring and making specialist referrals for IE's low mood but in none of the health and social care records is there any indication that professionals sought to understand its cause or address his emotional responses.

Both the community and hospital Speech and Language therapy appear to have been active in regularly assessing IE swallow and making relevant recommendations to the care home and treating teams.

The care home appears to have been proactive in alerting the GP and district nursing team to IE's pressure sore, applicable treatment and management given and the appropriate equipment provided. The care home was alert in managing IE's risk of falls by installing assistive technology in his room. It is open to conjecture whether the treatment and management plan during IE's penultimate admission at QMH was sufficient given that he remained bedbound on discharge, continued to deteriorate, and was readmitted 2 weeks later. The deterioration and late identification of the pressure sore from grade 2 to ungradable is a concern and indicates the need for more a robust process for assessment and diagnosis.

The protracted period of the review into this may delay any local actions from the learning.

LeDeR theme A - Lack of clarity in diagnosis of Learning Disability
1. Oxleas ALD team, declined referral as IE's primary need was dementia. There was, however, no evidence provided of a thorough investigation. Dementia care within the context of learning disability may have been beneficial for IE, his family and paid carers. Oxleas ALD service has a Memory clinic and provides support for people with dual diagnosis.
2. IE was on the GP LD register, but the basis for this is unclear, another pathway may have been more suitable if there was evidence of LD. If evidence of LD was available this should have been shared with the ALD team.
3. Lack of clarity regarding learning disability, dementia, and cognitive functioning may have contributed to reasonable adjustments not being made within the acute setting.
4. Bexley Social Care records did not include a clear history of support needs or learning disability. Bexley Social care was the responsible commissioner and should have ensured documented clarity of need and history in order that client and carer needs were met most effectively.
Positive Practices identified:
IE's placement was in his home borough, and so within travelling distance of his family.
***Positive practice action** - There are a limited number of placements who accept people with learning disability, and it can be a challenge to find local placements. The details of this placement as a potential provider to people with LD and dementia should be shared with LD networks in SE London.*
LeDeR Theme B - Late identification of unstageable pressure sore and protracted process of investigation through the Pressure Sore Panel, noting that 5 months after his death there is still no outcome. This time lapse could reduce availability of information available and in turn reduce learning opportunities. It also leaves potential risks unaddressed and other vulnerable people open to similar risks.
Actions –
1. Request that the LD Teams' referral response consider a person's full history to improve clarity of diagnosis and response to referrals.
2. Liaison with Medicines Management Team and PCN with queries regarding GP LD register accuracy, within the context of the ongoing improvement work to ensure GP LD register accuracy.
3. QEH to consider a more robust system for considering the reasonable adjustments for people who are flagged up as having a learning disability and to demonstrate that assessment of mental capacity has been considered and undertaken.
4. Raise awareness with Social Care about how the lack of history in Community Care Assessments can impact upon access to other services in short and longer term.
5. QEH to review their processes for assessment and diagnosis of pressure ulcers.
6.QEH to consider the timescales in which investigations are undertaken to ensure that learning is implemented in a timely manner.

Pen Picture of Individual F (IF) - There was a LeDeR completed in advance of this SAR, it has been agreed to use these findings and incorporate the learning and actions into this SAR.

'IF was a 67-year-old man with a Moderate to Severe Learning Disability and Cerebral Palsy who died unexpectedly from Acute Heart Failure.

Despite his disabilities, IF's general health was good, and he showed no signs or symptoms of illness prior to his death. The GP practice undertook annual health checks and completed health action plans. There had been no acute health events or necessity for hospital admission over the previous past two years. Medication was routinely reviewed, and the only repeat prescriptions required were for his secretions and thickeners for fluids. There was regular communication between the GP and care home and any anomalies in test results - i.e., deranged bloods during the last few months of his life - were investigated, reviewed, and treated.

IF lived in a specialist care home for people with learning disabilities. His placement was funded by Bexley Social Services. Wheelchair dependent, he was reliant on others for all activities of daily living but was encouraged to participate in care tasks and his preferences sought. Risks around moving and handling were evaluated by the care home. Requisite specialist equipment was used, and referrals made to appropriate services for assessment when there were changes in IF's functionable abilities.

IF had a history of chest infections and was at risk of choking. Dangers around eating and drinking were considered, specialist input and advice was sought from Speech and Language Therapy and guidelines adhered to which ameliorated risks in this area. Prior to moving into residential care IF was supported at home by a small but committed informal support network of family and the move was necessitated by parental illness.

IF's next of kin, his cousin, continued to maintain frequent contact. IF's next of kin and the care home have presented IF as being a gentle natured and sensitive individual who displayed humour and a sense of fun and whose requirements from life were uncomplicated. He enjoyed his food and the company of others. He was inquisitive and interested in what was happening in his immediate environment. IF appears to have been orientated to person and place. Although largely non-verbal he was able to express his feelings and make his preferences known by sounds, and gestures.

Staff at the care home using aids to assist with communication and maximise his choice and control. The care home has a well-established staff team, who appear to have developed a good rapport with IF, were attuned to his needs and ensured that he felt safe and secure.
IF's next of kin visited him very regularly and involved him in wider community activities. This relationship was encouraged and supported by the care home. The care home involved the next of kin in any decision making and were proactive in updating him on any changes in need.

The care home has continued to connect with the next of kin after IF's death.

LeDeR Positive Theme A – Mountview Care Home's provision of a person centred, caring and supportive environment which was sensitive and respectful to IF's needs and preferences and allowed him to feel safe and secure.

Positive practice action: - Feedback to the Care Home via the Local Lead and Bexley Adult Social Care of the positive practice identified in the review and commendations by the family.'

5. Family and Carer Involvement –

The SAR process should where appropriately inform and engage with the individual(s), their family, and carers. However, as is a thematic review, the BSAB did not write to inform families and/or carers

for the individuals that have died. This is a key learning point for the Bexley SAB for future thematic reviews to consider how best to engage in order to capture the 'voice of the individual.'

The Reviewer has found as part of this review that the rationale behind not approaching the family/carers as not appropriate for the following reasons –

1. The Family / Carers were the perpetrators linked to the case;
2. There were no family / carers to meet with;
3. Some of the cases were LeDeR and anonymous; and
4. There were identified individuals in the adult's life prior to their deaths that would have 'known' them to give their voice for the review.

Therefore, the Bexley SAB engaged and worked with the agencies that do work with families and carers to capture the wider-knowledge and feedback for this thematic review.

The Reviewer has recommended the following in relation to this –

- Where these cases have identified family/carers we would seek to involve them during the IMR/Fact-finding stage of the review process.

  This may be done through the ASC allocated worker, or any other professional that is known to the individual, family/carers concerned.

6. Evidence Questions and Submissions

Evidence Questions: - Agencies were asked 29 questions to seek a system-wide response to working with ALD communities and their family/carers (see Appendix 3 for more details details on what questions were asked).

Evidence submitted by agencies/organisations is below: -

The Panel heard from Dartford and Gravesham Trust who flags individuals only when consent is given to share the information. The Panel agreed that this would be very difficult in practice to replicate and maintain, particularly since agencies do not always seek consent from the individuals nor do the agencies share information, thus the information may not always be accurate. The Panel agreed that one consequence of this is that it leaves a database of individuals 'known' but not informed. Like all systems, only good as information that is sent in and up to date.

The Panel also heard that Lewisham and Greenwich NHS Trust have both mental health and learning disability nurses allocated to the hospital wards and this will also be flagged as a need. However, other Acute Trusts noted that they use flagging for adults with learning disabilities ALD is done on all individuals; and another Acute Trust flags ALD only not LD in general. The Panel agreed this part of the system is very confusing and not always helpful, nor does the information follow the patient when attending one acute trust to another.

The Panel heard from one Acute Trust that for all elected surgeries (planned) the LD Nurse will support, using Information Systems at the hospital by various reports that are flagged, however cannot pick up on coding it has to be the flag and local teams are asked to share the information which includes: social, spiritual, cultural background is captured and added to the hospital passport, but not necessarily political.

The Panel heard from Oxleas NHS Foundation Trust, a community-based Trust, has a Community Liaison Team role seen as vital here, as they will hold a lot of the information via the Nurse in the Community. Often, they will ring ahead to Acute Trust to alert them on an attendee, joint work, visiting patient when at hospital.

The link with the Ward staff does regularly update at the passports and can be seen on the system as needed.

Oxleas NHS Foundation Trust also reported that they have a Core Assessment, which is a large e-assessment, that covers everything but not political. Noting that there are some challenges here, for example, if getting Physical Therapy only – the service won't complete on that for 1 hour a week session and each discipline will have their own way of recording. The Panel felt that an individual's political views wouldn't be asked on each individual on each occasion but would ask the questions salient to the need of the visit or service.

The Panel heard from SLaM that they have an electronic clinical system which has the capacity to capture Accessible Information/details and prompts practitioners to ask questions in relation to communication preferences. SLaM also reported that there is a comprehensive assessment tool which gathers a range of information relating to the individual, however, political is not covered. This system is shared within the Trust and core information is shared on the London Care Record which is available to health and social care providers in London. This links to the individuals hospital passport and communication passports are encouraged and are routinely used for those received care and treatment within our specialist LD services.

Extract from SLaM Learning Disability web page: demonstrates resources available to all staff: -

> *Easy read and accessible information form an important component of improving communication between health staff and people with a learning disability. They are often written in simple English using one key concept per sentence and have a picture, symbol or photo that accompanies it to augment understanding. Information produced in other formats such as film and audio can also be used.*
>
> *External websites also provide specific content for people with a learning disability that can be freely downloaded.*

SLaM also reported that Carer's Assessments are offered within the service and in some boroughs, they sign post to organisations who may perform this service on behalf of the local authority – they have a dedicated third party section on our records to ensure that carers views are documented. The Trust has a proactive carer support group.

Oxleas reported that they use the CPA approach, which is a review process and plan that covers: Risk assessments, crisis plans and care plans are updated based on reviews. Involving the individual, PCP/MSP, making sure they have a way to share their experience. Communication profile, how to be effective. Communication Needs Assessment.

Dartford Gravesham Trust reported that they complete monthly audits on all enquiries done internally and are recorded, the outcomes get registered – i.e. NFA or referred on Wards. All learning (all types of reviews) audited along with good practice; action needed – monthly.

SLaM reported that safeguarding adult training employs the Signs of Safety model to encourage a person centred and strengths-based approach to exploring risk and outcomes. SLaM has included their models in the appendices of this review.

Dartford Gravesham Trust reported that a staff member with LD background, i.e. LD Liaison Nurse should be capturing the individual's information. The Panel agreed that this role could identify what do they want, can they make decision, consequences, reasonable adjustments been made to support them? If no, then, look at support from family/carers, advocate.

Oxleas reported that they keep baseline records, particularly where non-verbal, ie. Refused to get off bus/transport – need to evidence patterns of behaviour, presentation, changes, and support needed.

The Panel agreed that it is vital to the individuals wellbeing to have someone who knows how to communicate and offer behavioural support and other LD work.

SLaM- has a LD Consultant Nurse who holds weekly surgeries for advice and support.

The Panel heard from Dartford Gravesham Trust around risk assessments and reiterated their use of risk assessments, as well as their High Intensity User Panel which meets monthly. These panel meetings are attended by Multi-Disciplinary Teams across the hospital/community; including Mental Health Teams, and Police; then, a referral onwards to GPs for community support. It was reported that some GPs are more engaged than others. The GP involvement allows greater access to information and active communications on matters. It was also reported that some individuals in this risk group, are not admitted, and at times cannot prevent calling 999, this has repeated attendance to hospital implications, as Ambulance Services must convey to hospital. Additional MARAC referrals, Hospital IDVA's, referrals to vulnerability panels based in community and lots of liaison with ASC, as well as capacity assessments are decision specific and are completed very regularly within the trust.

Oxleas reported there can be times where a decision-maker could not be found. The Panel agreed that MCA is still not applied consistently nor accurately across the system; including, not knowing what to do, where to go and 'can't do it.' The Panel agreed that there is a lack of confidence is still out there on professionals, sometimes guidance is not clear or too technical when deciding if there is MCA or not and where to go when support is needed.

The Panel identified the following as barriers to supporting someone with an adult with learning disability: -

- Communication methods and skills training is a gap/barrier.
- Legal Literacy with various pieces of Legislation and confidence to embed and use; including discrepancies in 'guidance' vs practice.
- Lack of appropriate resources – both time and financial
- Family/Carers being overly involved and at times causing difficulties
- Lack of Advocacy availability especially in a timely manner

SLaM reported that there is cultural recognition when working with an adult with LD however this may impact on engagement with family. The Panel agreed that this can be labour intensive in terms of slowly building up trust with family and provision of psycho education provision to family members.

Mencap suggested there's a lack of awareness of wider sources of support e.g. local voluntary sector offers, some people with LD/autism do not want to have a label or diagnosis so will say they don't need support – how are practitioners trained and empowered to recognise those and find ways to engage.

Also, that some barriers to substance misuse/MH/DA services – are commissioned services required to have an accessible Pathway to their services. There is a big gap locally in MH services who are able to support people with LD – not aware of any prevention services accessible for LD MH in Bexley (we haven't had to use DA services so can't comment).

Dartford Gravesham Trust reported that they make direct referrals at A&E is sent to Hospital IDVA.

SLaM reported they have a Lead Nurse on Dual Diagnosis who has developed a policy for all teams to adapt their service-to-service users who may use substances. The policy makes reference to the need not to "infantilize" people with an LD – but to routinely enquire about alcohol and / or drug use.

Additionally, there are dual diagnosis champions within a variety of services and a forum for staff to seek support and advice. Use of social stories and pictorial aids are used. An issue is that most interventions involve some cognitive behavioural techniques - including motivational interviewing – which requires an element of abstract thinking . This can sometimes be difficult as some people will function and feel safer with concrete thinking. However, there are some useful resources to highlight how to adapt the Motivational interviewing techniques see link - Modification of motivational

interviewing for use with people with mild intellectual disability and challenging behaviour - Social Care Online (scie-socialcareonline.org.uk)

The Panel referred to Bexley SAR Elvis published in 2020 and another SAR regarding adults with learning disabilities and domestic abuse particularly where co-dependency is identified between partners.

Mencap suggested where co-dependency is identified that earlier conversations around planning for the future could prevent people with LD suddenly experiencing loss of a loved one and having to leave their home at this difficult time. Increased risk to both carer and cared for as the carer gets older and is less able to manage their caring role. Having supportive conversations about the future much earlier could help to prepare people and make decisions earlier.

Dartford Gravesham Trust report they have in depth training on this particular area to be proportionate. For example, when cases come through, family can be linked on the internal systems, including safeguarding adult concerns can be explored and share new concerns and worked with LA to seek individuals views independently. As soon as they raise to the Safeguarding Adult Team, an escalation happens immediately; including LA, GP, others as needed.

The Local Authority reported where the individual was 'known' they used Community Care Plans, Social Workers escalated cases to the mental health panel for discussion. The LA reported that in the case of IA, they opened a s.42 safeguarding enquiry following the notification of their death. It was considered at the time that his parents did not fully understand or acknowledge the medical response required. However, upon further exploration, it was considered that his parents have a different medical view on what should have occurred. Outcome of the s.42 is unclear as s.42's are not typically opened on deceased individuals.

In the case of IB, The social worker liaised with Bexley brokerage team regarding accommodation and raised concerns around IB's significant weight loss as she was declining food whilst in hospital and to ensure she was not discharge back to the community until she was back to her baseline.
The Local Authority reported mixed and inconsistent responses in regard to oversight and support particularly where the adult was known to a social worker. However, there were reports that discussions around the case were held at supervision level with senior social worker where guidance was provided on how to support IB whilst she was in hospital and in preparation for her discharge.
And with the case of IA, the following reflective practice was identified – Case was discussed during safeguarding reflective meeting and the below advice was given:

- Find out the parent's fist language and get an interpreter to support during the meeting.
- Email GP for IA's medical records.
- Find out LD community nurse involving with the late client,
- Find out if he was being seen/supported by other professionals.
- Safeguarding Coordinator will support in obtaining any useful information on RIO and clarity given to GPs on all safeguarding concerns raised and actions (if any) Bexley are taking.

For example, in the case of IB, the Local Authority reported,

> ***'It appears the safeguarding concerns from Nov 2022 had not been shared with senior complex care team and the individual was on Complex waiting list for financial support.***
>
> ***The allocated worker in complex care on the 18.11.22 subsequently closed on the 03.01.23 and the allocated worker had not made any contact.'***

Also, as in the case of IA, the Local Authority reported,

‘

IA’s support worker (day centre), Oxleas SaLT, LBB Social Work Assistant and LBB OT were all involved.

IA was known to different teams in Oxleas Adult Learning Disability (since 2009) and had regular contact and visits from Oxleas professionals and Erith Health centre District nurses (also under Oxleas NHS Trust). IA’s parents are in their 70s (mum has mobility issues), they appeared to have no support or respite in place, according to some case notes (not sure if this was by choice).

…review the info on Rio first and speak to Oxleas professionals before we consider visiting the family. …Oxleas will be able to advise you regarding his needs, his family and if they had any concerns re the client or any other family members (which I would have expected to have been looked into at that time given the intensive support he had).’

7.Findings and Recommendations

This section focuses on the 21 Findings with 49 Recommendations for Agencies to consider: -

1. **The system used in the community is not the same system used in hospital, nor for GPs. The use of Connect Care is not accessible to all partners. This was found to be a NHSE issue for escalation wider than Bexley.**

   Recommendation A1 – NHSE to consider why NHS records are not all linked for access of information. Question to ASC regarding this area as we know 1 case in this SAR was not seen but parents views taken.

   Recommendation A2 – Consider having LD specialism co-located with the integrated hospital teams.

2. **The role of the Carer needs to be explored further where the ‘adult’ is treated like a ‘child’ although they are legally an adult.**

   Recommendation B1 – Agencies to understand that legal responsibilities change at age 18 and where the normal parental rights end and starts for the adult with LD.

   Recommendation B2 – Agencies may wish to consider how they ensure parents/carers with Court of Protection are allocated deputyship understand their duties as ‘best interests’ and safeguarding the adult at risk.

   Recommendation B3 - Agencies may wish to review and consider how they prepare parent/carers to be more legally literate and therefore prepare for ‘adulthood’ starting as early as 14 years.

   Recommendation B4 – Agencies should support ‘carers’ planning for emergency support/crisis prevention?

3. **The role of the ‘older’ Carers needs to be explored further where the aging parent/carers needs/decline/death impacts on adults care and support needs especially with LD.**

Recommendation C1 – Professionals need to consider the risks to the individual(s), including parent/carers and how they can execute their duties as a parent/carer(s).

Recommendation C2 – When professionals are challenged with parent/carer(s) not agreeing to the care and support plan decisions, the professionals must consider the risks to this and the parent/carer(s) competency to manage and/or provide direct care themselves.

4. **Not all safeguarding concerns were reported or recorded as safeguarding and the Local Authority 'front door' for oversight was not used, including concerns flagged to allocated social workers, instead of a s.42 being raised.**

   Recommendation D1 – The Local Authority must ensure that reporting and recording systems for concerns are up to date and shared.

   Recommendation D2 - Agencies should understand there is not a need for 'consent' to safeguard an adult at risk and/or within their own organisation (i.e. NHS to NHS – CSC to ASC).

   Recommendation D3 – The LA to have a more effective way of engaging and working with partners/agencies when safeguarding concerns arise and evidence that they are proactively engaging with the 'notifier' of the concern as per the Care Act responsibilities.

   Recommendation D4 – The LA to consider: How well do 'notifiers' know their rights, responsibilities and escalation measures that can be taken when a s.42 is not opened, closed or risk remains.

   Recommendation D5 - Safeguarding Duties and Mental Capacity – How to explore 'unwise' decisions.

   Early identified action – The LA has commissioned training with a focus on LD with MCA for frontline practitioners.

5. **When agencies raise a safeguarding concern to LA, there is a generic email response, no engagement with the Provider/Professional who has raised the concern often leading to the risk escalating for the other professionals and the individual.**

   Recommendation EA– The LA should consider reviewing their automated response systems to have assurances that Provider/Professional(s) are being communicated with effectively and efficiently.

6. **Carers should not be used as translators the adult still retains their own right to contribute towards their care and support.**

   Recommendation FA – Professionals must consider the use of translator and advocacy services in lieu of parent/carer(s) regardless of mental capacity.

7. **National SAR theme as Carer's Assessments is not regularly offered; in Bexley the Panel has found that Carers Needs are often declined when offered at the same time of the 'adult' and when Carers Assessments do give DP as an option, they are often not enough allocated to make it worth the effort.**

   Recommendation GA – Agencies to understand the Bexley Joint Think Family Protocol and identify the carer role and how to support the 'carer' to access support in their own right to verify the information given is accurate.

Recommendation GB – Agencies should be encouraging 'carers' to register as 'carers' where appropriate.

Recommendation GC – Agencies should be sharing information about 'carers' rights and support available.

Recommendation GD – Agencies must consider the impact of culture, religion, ethnic background, and other factors when assessing adults at risk, including carers.

8. **The individual must be communicated with in a way that is meaningful to them to ensure the wellbeing of the individual is paramount.**

   Recommendation HA – The Local Authority should consider using social workers or professionals with LD background and fundamental skills and where that is not reasonable joint visits/ training? with those services.

   Recommendation HB – Agencies must ensure they use accessible formats for individuals with disabilities.

   Recommendation HC - Agencies should have strengths-based approach or person-centred training. Agencies should be more creative/innovative with how people are supported to live their lives or do people have to fit into commissioned services.

9. **Many professionals have a policy in place that they will ring up to 3 times, writing to individuals that are illiterate or other non-accessible ways to invite to an appointment; there are concerns that ALD particularly those with co-morbidities not then turning up for appointment(s).**

   Recommendation IA – Making sure that services in Bexley have a 'was not brought' instead of 'failed to attend' model similar to what is implemented in Children's Services as the ALD may be dependent on others to bring them to their appointments.

   Recommendation IB – Making sure that the ALD is invited in the way they can communicate and engage in their own treatment.

   Recommendation IC - LA/ICB should consider commissioning/identifying an Easy Read or Accessibility Officer to ensure all adults have the right information to keep them safe.

10. **Unable to capture the full data as not all ALD are formally diagnosed, on a register, as well not all Bexley GPs participate (as optional); however, those that are known are having 76% attendance for Annual Health Checks. National target is 75% - this is a good practice where GPs are engaged**.

    Recommendation JA – Bexley Public Health to consider supporting the work to collate the ALD data sets (registers) and ensure the coding of the individuals is accurate.

    Recommendation JB – BSAB to work more closely with Primary Care Services to ensure they understand their duties under the Care Act 2014 to embed and action learning from statutory reviews.

11. **There was a difficulty with an ALD when requiring emergency medical attention due to parent/carer(s) challenges on what medical treatment they wanted. However, medical attention by LAS was given promptly but day service staff felt the parent/carer(s) were negatively impacting the actions required. This is a sign of good practice.**

12. **Agencies are not consistently raising concerns for support when someone has a dual-diagnosis – this is known as Diagnostic Overshadowing.**

    Recommendation KA – BSAB to support agencies to understand what Diagnostic Overshadowing through training and awareness.

    Recommendation KB – Agencies to consider attending the Oliver McGowan Training being rolled out nationally.

    Recommendation KC – Agencies should consider whether or not this is a national finding re: Dx and coding and consider how SEL plays a role in embedding learning.

    Recommendation KD - Agencies should be more joined up especially across Health & Social Care to share up-to-date information in a timely manner.

13. **Where agencies do escalate, it is not in a timely manner and misunderstanding that adults at age 18 have their own rights**.

    Recommendation LA – Personalisation with the adult at the heart not the 'carer' must be applied across the system.

14. **Where an adult has dual-diagnosis, LD and MH, the approach is not clear.**

    Recommendation MA – Agencies working with adults with disabilities may wish to ensure they understand the diagnostic pathways and where to seek support if concerns arise.

15. **Where an ALD has a Domestic Abuse concern, this is not always identified, escalated, recorded, or assessed by appropriate services so that they can get the DA support needed.**

    Recommendation NA – BSAB to relaunch the Easy Read version of DA awareness and how to access support.

    Recommendation NB - Domestic Abuse Services to consider offering training services on DA with ALD services in Bexley.

    Recommendation NC - Adult Social Care staff must complete the mandatory training for Domestic Abuse then apply what they've learned.

    Recommendation ND - Each agency must consider having a Domestic Abuses Champion.

16. **Consideration for developing ALD awareness and understanding training and ongoing support should be rolled out across the system. This should include Regularly updated LD Awareness training which covers communication, accessible information which is vital. At least one course (perhaps induction) delivered by people with learning disabilities would be more impactful than e-learning if possible**.

Recommendation OA– Oliver McGowan training is now mandatory for all health & social care.

Recommendation OB – Professionals should know where to go to get support for 'communication tools' such as: PECS, Makaton, other ways to communicate.

17. **Consideration for auditing Carers Assessments as many organisations may offer these but are they offered separately from a meeting with cared for person and at a time when the carer isn't in crisis or struggling. Carers are more likely to decline if they are trying to resolve things for their cared for people so it could become a tick box exercise rather than a meaningful offer.**

    Recommendation PA – BSAB to consider auditing this as it is not unique to this review.

    Recommendation PB – LA should remind and brief staff that this is a statutory offer that all Carers must be given information regarding and what assistance is available.

18. **GPs – What other things would help them support patients with LD? It maybe we can assist with some resources through our Access to Health project which can be shared across the borough to be universally used.**

    Recommendation QA – ICB to consider Access to Health project which is time-limited should be considered rolling out wider or something similar to be considered.

    Recommendation QB - Fire Safety - GPs to consider fire safety, and would they want a welfare visit or how would this work to share concerns when usure.

    Recommendation QC - GPs mostly reach out to specialist services for support; all GPs will have SA and LD Leads.

    Recommendation QD - GPs to consider using Daniel Stratton's methodology and Diagnostic Toolkit.

    Recommendation QE - GPs to consider asking the BSAB Quality Checkers to give feedback on GP visits.

    Recommendation QF - Where some individuals are 'scared' to answer the Health Check questions – lifetime disability assistance payment are providing funding for a fixed period to contact those who have disengaged from their GP practices.

19. **How do Housing Services determine priority when with people with LD? Do they have training in LD, understanding in how some people may present or respond to questions What's the escalation route if there are issues**

    Recommendation RA – BSAB to ensure the Learning offer is shared with ALD services.

20. **There is no care/clinical professional lead in Bexley.**

    Early identified action –SE London has drafted a JD/PS for this role.

21. **Specialist services (Mencap, Oxleas, Ambient) are not always being considered as 'experts' in the room when working with adults.**

    Recommendation SA– Agencies to consider using the local network 'champion' approach especially where multi-agency concerns are raised.

Recommendation SB – Agencies should consider whether Specialist services are needed at meetings so that the most appropriate support can be agreed.

Additional key areas for consideration –

1. Information sharing - Agencies should work with individuals using their communications techniques (like an interpreter for non-English speakers). This would include: illiterate and non-verbal clients / patients.

2. Information sharing – Agencies should evidence use of Accessible Information Standard – legal requirement for information to be provided in accessible language and how are agencies embedding this.

3. Fire Safety - LFB to visit Supported Living sites in Bexley to ensure the water temperatures are 'safe' alongside Bexley Quality Assurance Team Officers.

4. LA/ICB to check what is already in place to assure with commissioned Providers around Fire Safety and Risk Assessments – ie. What does the contract say, what does QA check against this for validation off Framework? Including OOB placements.

5. All - Agencies to consider whether or not a LD Champion would benefit their services including using a 'local care' approach with outside agencies for support.

Identified Good Practice

1. The panel found that where agencies had a specialist Adult with Learning Disabilities Champion showed greater positive outcomes for individuals and their families than those that do not have this role.
2. At Dartford Gravesham NHS Trust, when they have completed an audit and have found good practice, they share these with the clinical/non-clinical staff by uploading onto their online internal systems; including internal briefings, SAR and others are shared internally for learning and shared at various governance meetings.
3. NHS England's LeDeR reviews good practice and shares this with NHS and other colleagues through their LeDeR Pathway.
4. Local evidence of how LeDeR learning is connected to safeguarding adults is through the BSAB Practice Review & Learning Manager attends the LeDeR meetings led by local Safeguarding Lead within the Integrated Care Board for Bexley.
5. The BSAB Review Learning Delivery Plan includes actions from LeDeR where cases have also met the SAR criteria.
6. The BSAB maintains this local safeguarding oversight through the SAR Subgroup and reports annually on this through the BSAB Annual Report, which is published.
7. NHS England's NICE Guidelines are a well-recognised tool for benchmarking good practice and sharing this across NHS Forums.
8. SLaM has a Patient Safety Bulletin also known as a Blue Light Bulletin to highlight good practice and have an attached plan which indicates how the information should be disseminated to practitioners.
9. London Borough of Bexley Adult Social Care Safeguarding Team has Practice Forums where cases and learning can be shared.
10. Bexley GPs and London Fire Brigade have already started the learning and engagement.
11. Oxleas NHS Foundation Trust has shared that they have exceptional Accessible Information Standards in place to work with Adults with Learning Disabilities.

8.Appendices and Resources

Appendix 1 – The definition of a Systems Review according to BSAB SAR Methodologies is –

- **Systems Review -** The 'systems' model has been identified by Sheila Fish, Eileen Munro and Sue Bairstow as a means of identifying which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely.

- This approach has been widely adopted in Children's Safeguarding following Dr Munro's review of children's safeguarding arrangements and has been used in some authorities in adult safeguarding reviews. However, this is an evolving area of practice. It is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

- **A systems approach to conducting a Safeguarding Adults Review involves:**
  - Scoping of review / terms of reference: identification of key agencies/personnel; roles; timeframes:(completion, span of person's history); specific areas of focus/exploration
  - Appointment of facilitator and overview report author
  - Production/review of relevant evidence, the presiding procedural guidance, via chronology, summary of events and key issues from designated agencies
  - Material circulated to attendees of learning event; anticipated attendees to include: members from the BSAB; frontline staff / line managers; agency report authors; other co-opted experts (where identified); facilitator and / or overview report author
    - Learning event(s) to consider what happened and why, areas of good practice, areas for improvement and lessons learnt
    - Consolidation into an overview report, with analysis of key issues, lessons learned and recommendations
    - Event to consider first draft of the overview report and action plan
    - Final overview report presented to BSAB, agree dissemination of learning and monitoring of implementation
    - Follow up event to consider action plan recommendations
    - On-going monitoring via the BSAB.
    - (Do we want to put in here) re event with LDPB to consider action plan and learning?

All agencies were asked to provide information under the following headings –

- **Factual/Contextual Summary -** Provide a brief factual and contextual summary of your Agency's involvement with adult(s) at risk under the theme being reviewed.

- **Analysis of Involvement –** The panel should consider how decisions made, and the actions taken or not. Where judgments were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. A template was provided, with instructions that if one section did not apply to the agency then identify that this is the case in the appropriate box. Otherwise, to respond to the questions as fully as possible, clarifying the evidence for views where applicable.

- **Empowerment –**
  - How do agencies gather information regarding a person's social, political, technical, economic, cultural, spiritual, and medical history
  - How do agencies gather information regarding a person's carer / family members social, political, technical, economic, cultural, spiritual, and medical history

- How do agencies gather information regarding a person, showing evidence of 'Making Safeguarding Personal' in the everyday practice of practitioners within the agency in relation to the person and carers. Considering the following:
    - Identifying all capacity assessments that were completed, and the narrative of the person or carers / family members recorded within these capacity assessments that led to the determination of capacity/lack of capacity and identify who carried out the capacity assessment and the date that the assessment was recorded.
    - Identify how the person / family was helped to understand actions, agencies involved, responses.
    - Describe communication methodologies tried (Did you know how literate the person was, what forms of communication might have empowered the person/family and what was used, what forms of communication were used, were they effective and what might have improved communication and accessibility of services to the person and family).
    - Identifying how safeguarding was described to the person and what outcomes the person wanted to achieve.
    - Identifying how the agencies applied preventative measure and ensured that the mental and physical wellbeing of the person and their family members was maintained.
    - Good practice is evidence based and considers the legislation, policies, procedures, models, methods, theories, research case law etc applied, triangulated with what the person did or said that made you think that this was the right course of action and why the response was proportionate to the risks presented. Identify evidence led practice, that is not risk averse and empowered the person / family through 'Strength Based' approaches.
    - What supportive or therapeutic interventions were put in place to aid engagement and to preserve the wellbeing of the person and carers / family?
    - How do agencies identify all aspects of your agencies practice that you consider to be good practice
    - How do agencies gather information regarding a person's choices and decisions, that led the practitioner to believe or the consequences of that statement / action. In the absence of verbal statements, describe what the practitioner saw / observed that led them to take a particular course of action (Describe in context).

- **Prevention -**
    - How do agencies prevent the deterioration of the persons physical and mental wellbeing and to prevent the risk of abuse, neglect, self-neglect or self-harm
    - How were capacity assessments coordinated and what legislation was considered and were there any conflicts in legislative directives, how were these resolved? Identify if we had considered x then y might have been a better outcome

- Describe any barriers or responses that exacerbated or failed to alleviate the stress, distress of the family. For example, any gaps in service, communication methods, service boundaries, policies and procedures or culture within an organisation.

- **Proportionate -**
  - How do agencies gather information regarding a person's -consider any barriers in accessing preventative mental health and substance misuse services or barriers in recognising domestic abuse and the impact on the whole family (if applicable).

  - How do agencies describe the response to the needs of the whole family as identified within the Care Act and the equal responsibility to assess and determine carer support needs. Consider any co-caring responsibilities and how escalation may have been prevented by understanding any co-dependency issues applicable within this review.

- **Protection –**
  - What was the safeguarding intervention? How did you improve prevention from abuse neglect harm / self-harm and protection from the same? What was the intention / direction outcomes expected from the safeguarding process and how were these determined?

  - Describe what informed decision making, who the decision makers were and what the rationale was for the person being the appropriate person to be the decision maker. Consider the Mental Capacity Act and who had lawful jurisdiction to be the decision maker and the evidence to support this.

- **Accountability –**
  - Reflective Practice
  - Action taken or not to be taken

Appendix 2 - SLaM Resources shared for the learning


Process for Completing Risk Asse


Signs of safety.docx


Blue Light bulletin WEB122081.docx

Guidance and training on the use of communication passports have been utilised within SLAM and we are implementing Oliver McGowen – mandatory training within this year. We have advertised for a trainer with lived experienced of LD to co design and deliver some of this training The Oliver McGowan Mandatory Training on Learning Disability and Autism | Health Education England (hee.nhs.uk)

Accessible health information leaflets and appointment letters free to download and use at:

- *Mental Health Act: www.nhs.uk*
- *Medicines » Printable leaflets (choiceandmedication.org) (chose VERA leaflets)*
- *Physical health appointments, autism and money/finances https://www.nhs.uk/conditions/autism/easy-read-and-videos/*
- *Hospital Passports and Health guides https://www.mencap.org.uk/advice-and-support/health-coronavirus/health-guides*
- *COVID-19 and vaccine programmes https://www.gov.uk/government/publications/covid-19-vaccination-easy-read-resources*
- *C(E)TRs https://www.england.nhs.uk/learning-disabilities/care/ctr/my-ctr/*
- *www.easyhealth.org.uk*
- *Find out about the Accessible Information Standard*
- *For further examples of easy read and other forms of accessible information visit NHS England*

Appendix 3 – Specific Evidence Questions

1. Describe evidence of 'Making Safeguarding Personal' in the everyday practice of practitioners within your agency in relation to the person and carers. This includes all assessments, communication tools used and how you know as a professional that they understood.

2. How do agencies gather information regarding a person's show evidence of 'Making Safeguarding Personal' in the everyday practice of practitioners within your agency in relation to the person and carers.

3. How do agencies gather information regarding a person's choices and decisions what that led the practitioner to believe or the consequences of that statement/action. In the absence of verbal statements, describe what the practitioner saw/observed that led them to take a particular course of action (Describe in context).

4. Identify all capacity assessments that were completed, and the narrative of the person or carers/family members recorded within these capacity assessments that led to the determination of capacity/lack of capacity and identify who carried out the capacity assessment and the date that the assessment was recorded.

5. Identify how the person/family was helped to understand actions, agencies involved, responses.

6. Describe communication methodologies tried (Did you know how literate the person was, what forms of communication might have empowered the person / family and what was used, what forms of communication were used, were they effective and what might have improved communication and accessibility of services to the person and family).

7. Identify how safeguarding was described to the person and what outcomes the person wanted to achieve.

8. Identify how your agencies applied preventative measure and ensured that the mental and physical wellbeing of the person and their family members was maintained.

9. Good practice is evidence based and considers the legislation, policies, procedures, models, methods, theories, research case law etc applied triangulated with what the person did or said that made you think that this was the right course of action and why the response was proportionate to the risks presented. Identify evidence led practice, that is not risk averse and empowered the person/family through 'Strength Based' approaches.

10. What supportive or therapeutic interventions were put in place to aid engagement and to preserve the wellbeing of the person and carers/family.

11. How do agencies prevent the deterioration of the persons physical and mental wellbeing and to prevent the risk of abuse, neglect, self-neglect, or self-harm?

12. What and how do other agencies prevent this? What responsibility is there on the GPs to ensure individuals are seen outside A&E? How many ALD have presented at A&E vs GP? Healthwatch?

13. How were capacity assessments coordinated and what legislation was considered and were there any conflicts in legislative directives, how were these resolved? Identify if we had considered x then y might have been a better outcome).

14. Describe any barriers or responses that exacerbated or failed to alleviate the stress, distress of the family. For example, any gaps in service, communication methods, service boundaries, policies and procedures or culture within an organisation.

15. How do agencies gather information regarding a person, consider any barriers in accessing preventative mental health and substance misuse services or barriers in recognising domestic abuse and the impact on the whole family (skip if not applicable).

16. How do agencies describe the response to the needs of the whole family as identified within the Care Act and the equal responsibility to assess and determine carer support needs. Consider any co-caring responsibilities and how escalation may have been prevented by understanding any co-dependency issues applicable within this review.

17. What was your safeguarding intervention?

18. How did you improve prevention from abuse neglect harm/self-harm and protection from the same?

19. What was the intention/direction outcomes expected from the safeguarding process and how were these determined?

20. Describe what informed decision making, who the decision makers were and what the rationale was for the person being the appropriate person to be the decision maker.

21. Consider the Mental Capacity Act and who had lawful jurisdiction to be the decision maker and the evidence to support this.

22. Please describe any concerns or anxieties regarding the information presented and how you can be better supported to alleviate any concerns or anxieties throughout the review process.

23. Did any reflective practice take place?

24. Were concerns escalated to senior managers and what was the support response offered?

25. Did any reflective practice take place?

26. Were concerns escalated to senior managers and what was the support response offered?

27. Do you consider that your agency shared information in a manner that facilitated the multi-agency safeguarding process in relation to this person and their family?

28. Do you consider that your agency valued the contribution of the skills, knowledge and experiences of the person and their family as contributors to their wellbeing and safeguarding plan?

29. Do you consider that your agency engaged well and cooperated with other agencies in line with safeguarding duties within the Care Act?