Safeguarding Adults Review –
Adult with Learning Disability Thematic Review

What is a Safeguarding Adults Review? A Safeguarding Adult Board, as part of its Care Act 2014 statutory duty, is required to commission SARs under the following circumstances:

***(1)** A SAB **must** arrange for there to be 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)** condition 1 **or** 2 is met (see below)*
(2) Condition 1 is met if: -
(a)** the adult has died, **and
***(b)** the SAB knows or suspects that the death resulted from abuse or neglect (whether or not It knew about or suspected the abuse or neglect before the adult died)*
(3) Condition 2 is met if: -
(a)** the adult is still alive, **and
***(b)** the SAB knows or suspects that the adult has experienced serious abuse or neglect*

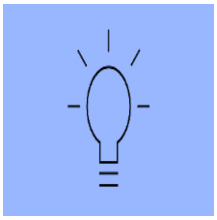
SABs can decide to undertake a SAR in any other situations involving an adult in its area with needs for care and support.

About this briefing – A Safeguarding Adults Review (SAR) has been undertaken by the Bexley Safeguarding Adults Board (BSAB) in respect of several adults which were conducted under the Thematic Review methodology. This briefing aims to summarise key thematic learning points from the review, to facilitate the learning being shared with SAB members, partner agencies and frontline practitioners.

Please take time to reflect on the findings and consider how you can learn, develop and work together to improve outcomes for, and prevent harm occurring towards, adults with needs for care and support.

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.

This SAR will highlight the 6 cases of adults with a learning disability that met the SAR Criteria.



About the review process – BSAB is resolved to consider how reviews can be more effective in terms of balancing the time that agencies are involved in such reviews, timeliness of reviews and learning. outcomes that can improve the service provided as partners. The methodology used was analysis of how agencies worked with individuals well as with each other. The way the BSAB captured this information was through a Thematic Review process with supporting information and surveys from the Bexley partnership. The agencies worked together with the Bexley SAB Local Reviewer, Elizabeth Deeves, who led and agreed the final report, which can be found here.

21 Findings with 49 Recommendations: -

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.
Recommendations: -
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.
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.
Recommendations: -
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.
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.
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.
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.
Recommendations: -
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).
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.
Recommendations: -
D1 – The Local Authority must ensure that reporting and recording systems for concerns are up to date and shared.
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).
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.
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.
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.
Recommendations: -
E1– 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.
Recommendations: -
F1 – 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.
Recommendations: -
G1 – 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.
G2 - Agencies should be encouraging 'carers' to register as 'carers' where appropriate.
G3 – Agencies should be sharing information about 'carers' rights and support available.
G4 – 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.

Recommendations: -
H1 – 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.
H2 – Agencies must ensure they use accessible formats for individuals with disabilities.
H3 - 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).
Recommendations: -
I1 – 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.
I2 – Making sure that the ALD is invited in the way they can communicate and engage in their own treatment.
I3 - 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.
Recommendations: -
J1 – Bexley Public Health to consider supporting the work to collate the ALD data sets (registers) and ensure the coding of the individuals is accurate.
J2 – 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.

12. Agencies are not consistently raising concerns for support when someone has a dual-diagnosis – this is known as Diagnostic Overshadowing.
Recommendations: -
K1 – BSAB to support agencies to understand what Diagnostic Overshadowing through training and awareness.
K2 – Agencies to consider attending the Oliver McGowan Training being rolled out nationally.
K3 – 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.
K4 - 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: -
L1 – 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: -
M1 – 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.
Recommendations: -
N1 – BSAB to relaunch the Easy Read version of DA awareness and how to access support.
N2 - Domestic Abuse Services to consider offering training services on DA with ALD services in Bexley.
N3 - Adult Social Care staff must complete the mandatory training for Domestic Abuse then apply what they've learned.
N4 - 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.
Recommendations: -
O1– Oliver McGowan training is now mandatory for all health & social care.
O2 – 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.
Recommendations: -
P1 – BSAB to consider auditing this as it is not unique to this review.
P2 – 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.
Recommendations: -
Q1 – ICB to consider Access to Health project which is time-limited should be considered rolling out wider or something similar to be considered.
Q2 - Fire Safety - GPs to consider fire safety, and would they want a welfare visit or how would this work to share concerns when usure.
Q3 - GPs mostly reach out to specialist services for support; all GPs will have SA and LD Leads.
Q4 - GPs to consider using Daniel Stratton's methodology and Diagnostic Toolkit.
Q5 - GPs to consider asking the BSAB Quality Checkers to give feedback on GP visits.
Q6 - 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: -
R1 – 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.
Recommendations: -
S1– Agencies to consider using the local network 'champion' approach especially where multi-agency concerns are raised.
S2 – 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.

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.

Bexley Safeguarding Adults Board website – http://www.safeguardingadultsinbexley.com

- The website holds an annual SAR Themed Learning & Development Programme
- Tools and Resources for all Bexley Organisations
- Other SAR published reports
- 7-Minute Briefings
- Other Resources and Links
- Email Bexley SAB at bsab@bexley.gov.uk for any support on embedding this learning