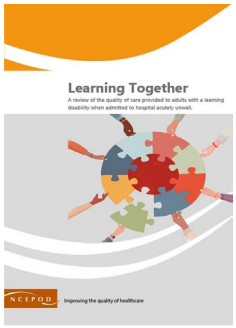
Commissioner's Guide to the NCEPOD Report 'Learning Together'

INTRODUCTION



This review highlighted some areas of good practice in the **acute care of patients with a learning disability**, but there was much room for improvement.

Diagnosis of a learning disability was not always recorded on a register/list or patient record systems/in clinical notes - only 53% of patients had alerts flagging a learning disability on the electronic patient record. This meant that people arriving in hospital did not receive any proactive adjustments being made and had to start afresh. Furthermore, patients and their carers were often not asked about reasonable adjustments or consistently involved in care decisions during the hospital admission. Carers were not always involved as appropriate.

The review found inconsistency in how mental capacity assessments and best interest decisions were made, 40% of healthcare professionals felt unconfident in assessing the mental capacity of patients with a learning disability.

Acute hospital learning disability services did not always exist and when then did, it was often just one person. This did not allow for a 24/7 service needed to care for patients admitted as an emergency. Input from the community learning disability team, who are likely to have known the person and supported them for many years, would be invaluable. Upskilling of all staff would also be beneficial.

Please use this report to guide your commissioning of services, with emphasis on the areas highlighted here.

THE REPORT CAN BE ACCESSED HERE

KEY AREAS WHEN COMMISSIONING SERVICES

Diagnosis of a learning disability was not always recorded on a register/list or patient record systems/in clinical notes. In addition, patients were commonly recorded as having a learning difficulty or the terms used interchangeably.

Recommendation: Accurately record a person's identified learning disability in the electronic patient record/clinical notes and in learning disability registers/lists.

- 119/366 (32.5%) patients were described as having a learning difficulty rather than a learning disability and the two terms were often used interchangeably.
- 175/196 (89.7%) organisations reported using alerts or flags on electronic patient records. However, only 310/583 (53.2%) patients had such alerts.

Patients and their carers were often not asked about the reasonable adjustments they needed during their hospital admission.

Recommendation: Assess and implement reasonable adjustments for patients with a learning disability. This should be undertaken:

- **Proactively if the reasonable adjustments have been flagged, and in place when the patient arrives in hospital**
- **As soon as practicable after arrival/admission to hospital and be reassessed throughout the admission.**

- Only 292/666 (43.8%) patients and/or their carer were asked if any reasonable adjustments were needed during the admission.

A person with a learning disability should not be presumed to lack mental capacity to make health related decisions. There was inconsistency in how mental capacity assessments and best interest decisions were made for the patients in this study.

Recommendation: Use decision support tools to aid healthcare professionals when assessing mental capacity in patients with a learning disability.

- 121/229 (52.8%) patients who did not have a formal assessment should have received one.
- Only 169/277 (61.0%) healthcare professionals reported being confident in undertaking mental capacity assessments in patients with a learning disability.

The report found that people with a learning disability were inconsistently involved in decisions regarding their care. Similarly, carers were not always involved as appropriate.

Recommendation: Consistently and continuously involve people with a learning disability in their care during a hospital admission. This should be from the point of arrival through to discharge. Include:

- **Support from carers as appropriate.**
- **Reasonable adjustments at all stages, e.g., using communication tools to support conversations.**

- 200/366 (54.6%) patients were involved in decisions regarding their care in the acute setting and in 148/353 (41.9%) cases there was no involvement of the patient or the patient's carer at discharge.

This study highlighted that acute hospital learning disability services did not always exist and when then did, it was often just one person. This did not allow for a 24/7 service needed to care for patients admitted as an emergency.

Recommendation: Commission local learning disability support services to enable equitable access to care for patients with a learning disability who attend or who are admitted to hospital. Consider:

- **Using multidisciplinary community learning disability services to provide an in-reach service.**
- **Upskilling all healthcare professionals to care for people with a learning disability.**
- **Locally assessing how many patients are seen annually to determine the size of the service needed. This would be aided by improved recognition and recording of patients with a learning disability (see recommendation 1).**

- Only 35/186 (18.8%) learning disability services were multidisciplinary, 69/186 (37.1%) were a single profession and 82/186 (44.1%) a single individual.

SUPPORTING NATIONAL GUIDANCE AND REPORTS

- Leeds and York Partnership NHS Foundation Trust - Learning Disability Register Inclusion Tool
- The British Psychological Society. Guidance on the assessment and diagnosis of intellectual disabilities in adulthood. 2015
- NHS England. Improving identification of people with a learning disability: guidance for general practice. 2019
- Mencap - Learning disability or learning difficulty?
- Public Health England. Learning disabilities observatory. People with learning disabilities in England. 2015
- Learning from Lives and Deaths: People with a Learning Disability and Autistic People. Annual report 2023. 2026
- NHS Race & Health Observatory. We deserve better: Ethnic minorities with a learning disability and access to healthcare - a review of policy and data. 2023
- NHS England. Health and care of people with learning disabilities, experimental statis22 to 2023. 2023
- Public Health England. Prescribing of psychotropic medication for people with learning disabilities and autism. 2015
- Government UK. Equality Act 2010: guidance.
- National Institute for Health and Care Excellence. Quality standard QS187: Learning disability: care and support of people growing older. 2019
- Office for Health Improvement & Disparities. Learning disability - applying All our health. 2025
- Royal College of Nursing. Connect for Change: An update on learning disability services in England. 2016
- Care Quality Commission. Experiences of being in hospital for people with a learning disability and autistic people. 2022
- Health Services Safety Investigations Body. Caring for adults with a learning disability in acute hospitals. 2023
- National Institute for Health and Care Excellence. NG96: Care and support of people growing older with learning disabilities. 2018
- NHS England. Clinical guide for front line staff to support the management of patients with a learning disability and autistic people – relevant to all clinical specialties. 2023
- NHS England. Reasonable adjustment flag
- Royal College of Physicians. Acute care toolkit 16: Acute medical care for people with a learning disability. 2022
- NHS England. Accessible Information Standard. 2025
- National Institute for Health and Care Excellence. NG150. Supporting adult carers. 2020
- NHS England. Guidance to support implementation of the Mental Capacity Act in acute trusts for adults with a learning disability. 2025
- British Medical Association. Mental capacity in Northern Ireland. 2025
- NHS England. Checklist for preparing to assess the mental capacity of someone with a learning disability