



Governance of Adult Safeguarding and Homelessness

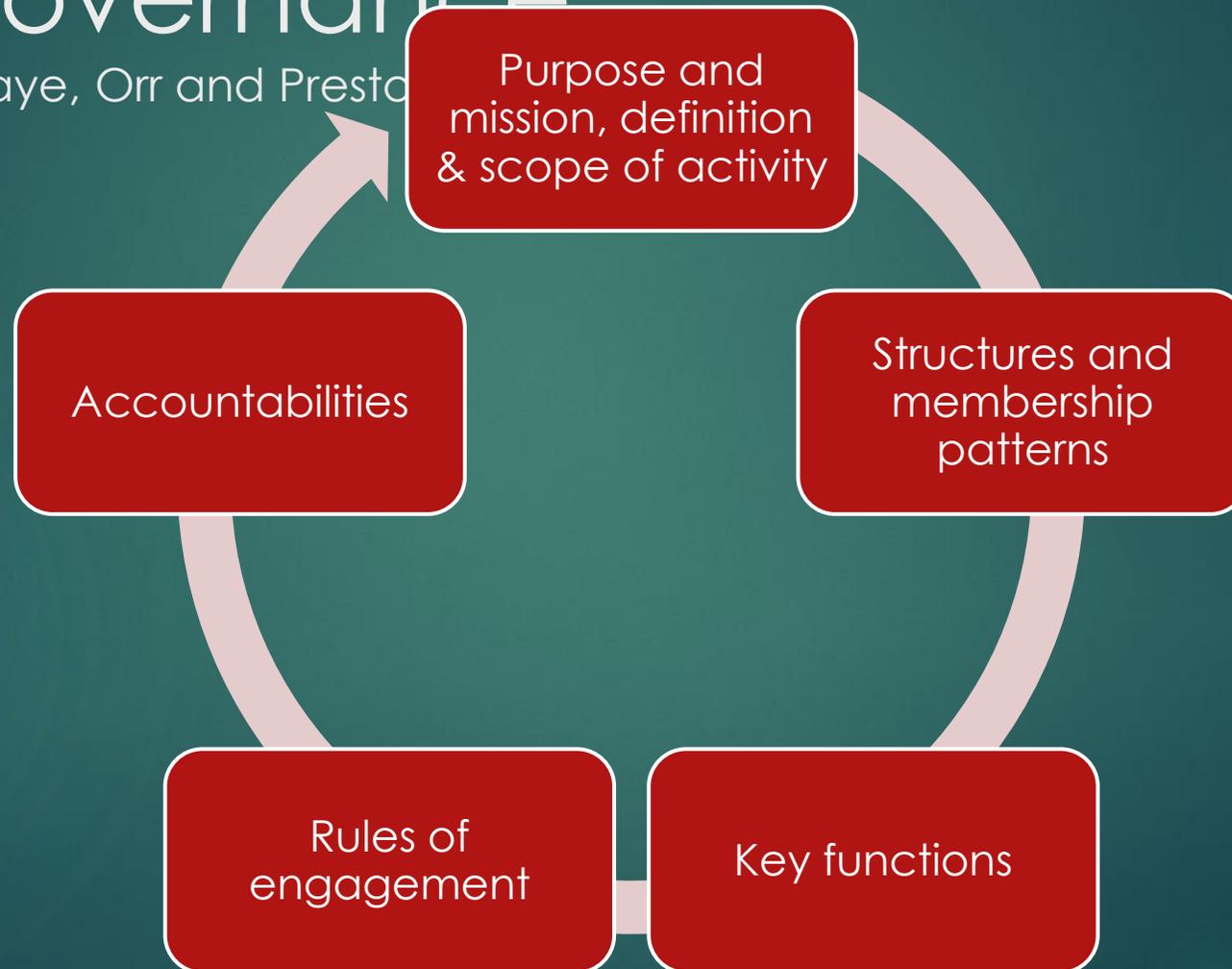
LEARNING FROM SAFEGUARDING ADULT REVIEWS, RESEARCH AND
PRACTICE

Voices of Experts by Experience

- ▶ When asked what he needed, Terence replied: “Some love, man. Family environment. Support.” He wanted to be part of something real, part of real society and not just “the system”. (reported in a thematic review on people who sleep rough, Worcestershire SAB (2020)).
- ▶ From the Leeds Thematic Review (2020):
 - ▶ “I lost everything all at once: my job, my family, my hope.”
 - ▶ “Without [this help in Leeds], I’d already be dead. I’ve no doubts about that. If the elements hadn’t got me, I would have got me. Sometimes I have rolled up to this van in a real mess and they have offered help and support and got my head straight.”
- ▶ Ms I’s partner commented (Tower Hamlets SAB (2020) Thematic Review):
 - ▶ At times “she could not help herself” because of the feelings that were resurfacing; access to non-judgemental services was vital and helpful, and that support is especially important when individuals are striving to

Key domains of good governance

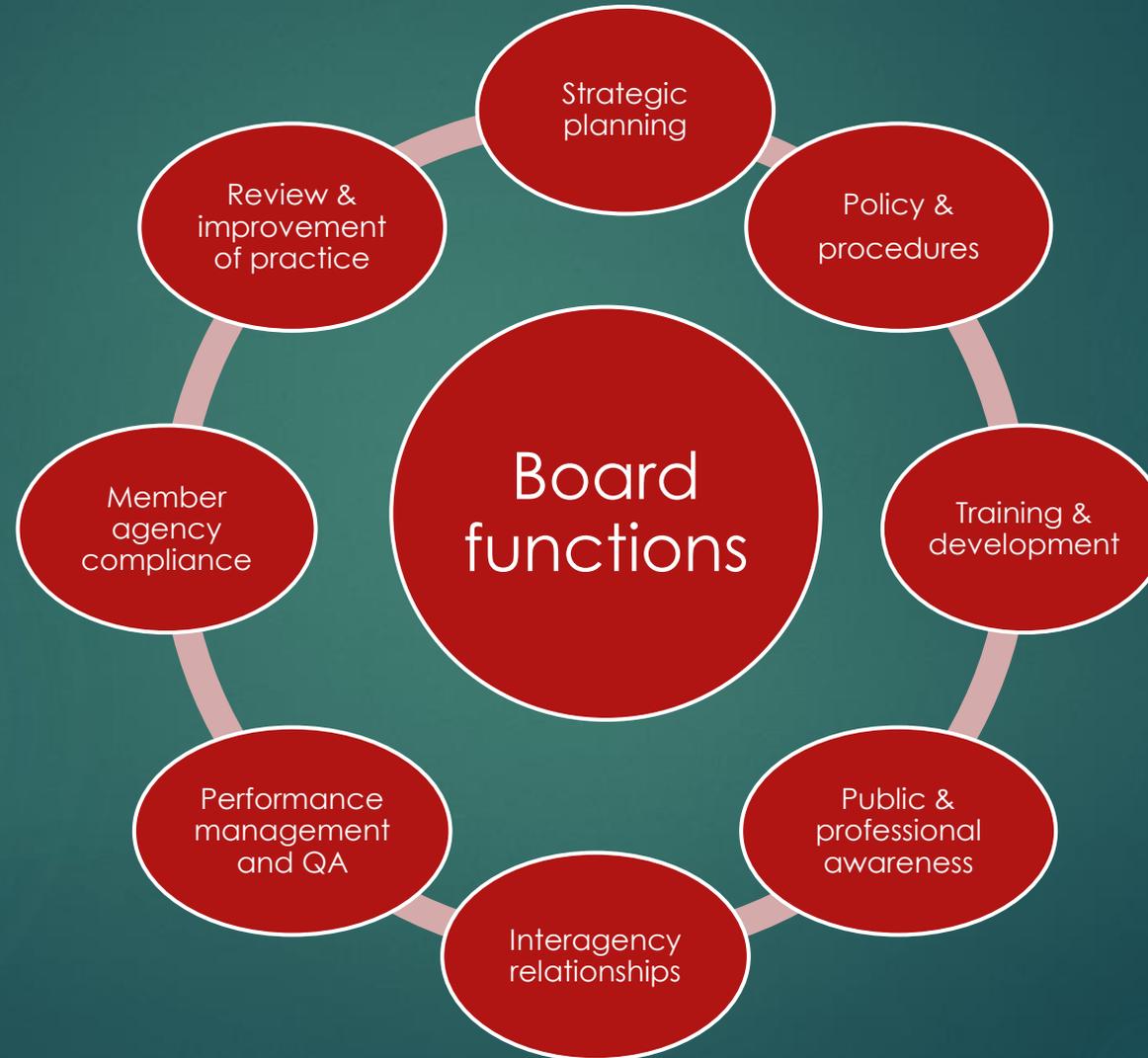
(Braye, Orr and Presto)



Modelling the scope



Good governance: Functions



Structural links with external stakeholders



Examples of specific issues in the 231 cases in the National SAR Analysis

- 57 cases involve alcohol-dependence issues (25%)
- 25 reviews involving homelessness (11%)
- 35 cases involving skin integrity (15%)
- 34 cases involving diabetes (15%)
- 161 cases involving mental health (70%)
- Advocacy referred to in 64 SARs (28%)

A selection of available reviews

- ▶ Doncaster SAB (2018) 'Adult G'
- ▶ Isle of Wight SAB (2018) Howard
- ▶ Essex SAB (2018) Frank
- ▶ Bexley SAB (2019) 'AB'
- ▶ Wiltshire SAB (2018) 'Adult D'
- ▶ Tower Hamlets SAB (2019) 'Ms C'
- ▶ Redbridge SAB (only available in an annual report 18/19)
- ▶ Brighton and Hove SAB (2017) "X"
- ▶ Southampton SAB (2019) Adult P
- ▶ Newham SAB (and others) (2019) Mr YI
- ▶ Solihull SAB (2019) Rachel

Recent reviews

- ▶ Thematic review – Leeds SAB (street homeless deaths) (2020)
- ▶ Thematic review – Manchester SAB (seven street homeless deaths involving self-neglect, substance misuse, homelessness, imprisonment, mental and physical ill-health) (2020)
- ▶ Thematic review – Oldham SAB (four cases involving self-neglect, substance misuse and housing/homelessness issues) (2020)
- ▶ Thematic review – Oxfordshire SAB (nine cases involving self-neglect, domestic abuse, no recourse to public funds, substance misuse and housing/homelessness issues) (2020)
- ▶ Thematic review – Ms H and Ms I Tower Hamlets SAB (two cases involving self-neglect, substance misuse and homelessness issues) (2020)
- ▶ A SAR – “Jack” Cornwall and Isles of Scilly SAB (a homeless person now in nursing care following a Court of Protection ruling) (2020)
- ▶ Milton Keynes SAB (2019) ‘Adult B’ – former care leaver
- ▶ Worcestershire SAB (2020) Thematic Review. People Who Sleep Rough.

Findings on multiple exclusion homelessness

- 14 references to good practice
 - Rapport building, expression of humanity, provision of care and support and emergency accommodation, health services outreach, colocation of practitioners, clear referrals
- 42 references to practice shortfalls
 - Delayed or missing risk, mental health and mental capacity assessments, unclear referral pathways, discharges to no fixed abode, lack of use of available legal rules, absence of consideration of vulnerability
- 18 recommendations
 - Wrap-around support (health and care and support as well as housing), coordination of response, legal literacy, commissioning for health and social care as well as housing, governance oversight

Direct practice – best practice

Person-centred,
relationship-
based practice

Professional
curiosity
(history)

Assessment of
care & support,
and mental
health

Transitions –
opportunities
not cliff edges

Assessment &
review of risk
and capacity

Family
involvement
(think family)

Outreach and
in-reach

Legal literacy

Balancing
autonomy with
a duty of care

Inter-organisational environment – best practice

Guidance on balancing autonomy with a duty of care

Information-sharing & communication

Working together on complex, stuck and stalled cases

Use of multi-agency meetings and safeguarding enquiries

Access to specialist (legal) advice

Clear roles and responsibilities (lead agencies and key workers)

Shared record-keeping

Co-location

Clear pathways for prevention, intervention and recovery

Organisational environment – best practice

Development,
dissemination &
review of
guidance

Clarifying
management
responsibilities
and oversight

Staffing,
supervision,
support &
training

Recording
standards

(Joint)
commissioning
& contract
monitoring

Culture of
openness,
challenge and
escalation

SAB governance – best practice

Audit & quality assurance of what good looks like

Multi-agency training

Engagement with other Boards

Workplace as well as workforce development

Continual review of outcome of recommendations

Use of SARs to inform policy development, practice audits and training

Recommendations from SARs on governance

- ▶ Involve people with lived experience in the development of policies, procedures and protocols
- ▶ Agree the main location for strategic leadership and oversight (two tier authorities)
- ▶ Ensure strategies on homelessness contain overt references to (pathways into) adult safeguarding
- ▶ Review range of procedures (people living street-based lives; high risk cases where individuals have capacity; risk assessment; frequent flyers; self-discharge)
- ▶ Reach out to national services (Royal Mail, utility companies, DWP)
- ▶ Clarify pathways for case reviews
- ▶ Review impact of previous SARs

Recommendations from SARs on enhancement of practice and management of practice

- ▶ Ensure guidance is embedded in practice (training, case and supervision audits)
- ▶ Promote recognition of interface between homelessness and self-neglect
- ▶ Audit adult safeguarding decision-making (section 42(1) and 42(2))
- ▶ Review pathways (mental health; services for women)
- ▶ Review commissioner-provider relationships, including gaps in provision
- ▶ Promote trauma-informed practice
- ▶ Promote shared databases to build a shared case narrative

Leeds Thematic Review (2020)

Prevention

Strong governance and system-wide leadership, involving care and support, criminal justice and community safety

Multi-agency strategies that cover different routes into homelessness and street-based lives (transient, frequent and embedded)

Hub and spoke model (core team linking with statutory and community services, groups and resources)

Intervention

Joint commissioning

Co-location

Multi-disciplinary working

Trauma-informed practice

Persistence, assertiveness, support to manage disengagement and, sometimes, enforcement

Recovery

Not just housing

Not just time-limited

Wrap-around support that sees the person, their strengths and their needs

High support and high challenge; people and place

Applying the Six Principles

- ▶ Empowerment – look beyond the presenting problem to the backstory; make every adult matter; listen, hear and acknowledge
- ▶ Prevention – commissioning to avoid revolving doors and to provide integrated wrap-around support; transitions as opportunities
- ▶ Protection – address risks of premature mortality
- ▶ Partnership – no wrong door; make every contact count
- ▶ Proportionality – minimise risk; judge the level of intervention required
- ▶ Accountability – get the governance right

Thinking about change – a whole system conversation with SAB as the guiding presence



Aim - the
change
sought

Inputs to
achieve
the desired
change

Outputs -
expected
products

Outcomes
- benefits
expected

Partner reactions

- Views of their experience of working with the SAB and in adult safeguarding

Changing attitudes

- Perceptions of partnerships in adult safeguarding are modified

Knowledge and skill acquisition

- Developing understanding and application in practice of procedures regarding assessment, intervention, purchaser/provider roles in adult safeguarding

Changes in practice

- Implementing new learning about adult safeguarding by the workforce

Changes in organisational behaviour

- Implementing new learning in organisational culture and procedures

Benefit to service users and carers

- Improvements in wellbeing

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