Brighton & Hove SAB Safeguarding Adults Board

www.brightonandhovelscb/safeguarding-adults-board
@SAB_Brighton

Learning Together from Safeguarding Audits

Learning outcomes from a recent multi-agency audit of homelessness cases

Purpose of Briefing

To inform partner agencies of key learning points from the audit

To allow agencies to review their own practice

To consider how agencies can change or improve practice

Background

- Brighton & Hove Safeguarding Adults Board (SAB) undertook a Safeguarding Adults Review (SAR) following the death in December 2014 of 'X', a person who was street homeless in Brighton & Hove.
- **brightonandhovelscb.org.uk/safeguarding-adults-board/safeguarding-adults-reviews**
- 2015/16 review of homelessness deaths
- Multi-agency audit looking at services and interventions provided to four actively homeless clients.
- Identified examples of existing good practice
- Explored the challenges and difficulties faced by practitioners

The Audit

- Led by Candy Gallinagh, Designated Nurse for Safeguarding Adults, Brighton and Hove Clinical Commissioning Group, supported by Mia Brown, SAB Business Manager.
- Four clients who were homeless.
- Women and men of various ages and ethnicities.
- Focus:
  - Evidence of multi-agency partnership working
  - Quality of information sharing
  - Evidence of client involvement in decision making and care planning
  - Evidence of appropriate safeguarding actions taken – referrals, escalation and consistency
  - Adherence to self neglect procedures

The Clients

Client A	Client B	Client C	Client D
Self-neglecting	Self-neglecting	Self-neglecting	Self-neglecting
Dual diagnosis	Multiple and complex needs	High risk drug use and poor mental health	Misusing substances (alcohol)
At risk of being sexually, physically and financially abused by other members of the street homeless community.	Potential undiagnosed learning difficulty	Living in a high support hostel	Deteriorating memory
Had come to attention of Police			Deteriorating physical health

Learning and reflection

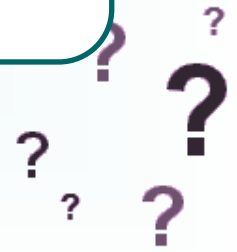
How confident are you now?

Think of examples where clients have fallen through the gaps between agencies. Do these gaps still exist and where are they?

Think of examples where it has been difficult to engage with a client because of their presentation. What was difficult?

What are the things that stop you engaging with clients in creative and flexible ways?

How do you feel when a client through action or inaction is harming themselves yet refusing to work with you?



Key findings

- Agencies not consistently utilising safeguarding as a mechanism to hold multi-agency or ‘strategy’ meetings to bring professionals together
- Missed opportunities for co-ordinated approaches
- Coordination of care lacking
- Liaison between A&E and the Pathways Homeless Team could be improved.
- Support/ safety plans and risk assessments not consistently shared across the partnership

Key findings

- Agencies respond well to clients in crisis but services fall away when the crisis is abated, which can result in the client needing crisis support again later on.

- Not always a clearly identified Care Co-ordinator or effective arrangements to ensure that responsibility is transferred to another named individual when the client is discharged from a service.

- Learning disability identification and support lacking

Key findings

Multi-agency working and information sharing

- On the whole –good evidence of agencies working well together in Brighton & Hove.
- In some cases there was a lack of communication and sharing of important information.
- An absence of formal multi-agency strategy meetings in cases where these might have been expected.
- Support/safety plans and risk assessments not shared between partners.

Recommendations

- A review of Brighton & Hove multi agency forums for discussing support for people with multiple and complex needs.
- The need for a robust person-centred risk management plan, agreed with the client and developed by a lead agency (in collaboration with other agencies involved with the client) shared with relevant services.
- Review the Sussex Safeguarding Adults Procedure for working with people who self-neglect so that it includes working with clients who are hard to engage. Brighton & Hove Adult Social Care to ensure compliance with the refreshed procedure.
- There should be management plans in place within A&E for homeless patients who attend frequently . This should include action plans and who to contact or refer to.

Learning and reflection

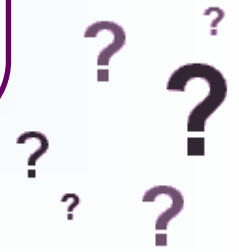
Multi-agency working & information sharing

What arrangements are in place for sharing information with the other organisations you regularly work with?
What gaps are there?

What arrangements are in place to ensure that you notify and are notified of any significant changes affecting your clients? What could improve?

How do you share support plans/safety plans/risk assessments with other agencies who are involved in supporting your clients?

What other organisations do you meet with regularly who are involved in supporting your clients? Do the current arrangements work? How could they be improved?



Key findings

Safeguarding and self-neglect procedures

- Good evidence of safeguarding concerns being raised in relation to some of the adults included in the audit. However:
- For one client, a safeguarding concern could have been raised when he made a homeless application
- In another case opportunities were missed by all agencies to pick up on a client's increasing vulnerability and the safeguarding implications of his homelessness.
- In common with the recent Safeguarding Adult Review for Adult X, there were missed opportunities to implement the self-neglect safeguarding procedure for more than one client in the audit.

Key findings

Supporting clients with complex support needs

What works well?

- Persistent encouragement, creativity and flexibility.
- Good evidence of agencies demonstrating flexible working to try new approaches with clients.
- Agencies provide effective support when clients are at crisis points.
- Making safeguarding personal – e.g. working at the client's pace.
- These are all key to supporting clients with complex needs to make positive changes.

What isn't so effective?

- There was not always a clearly identified Care co-ordinator for each client; the co-ordinating role was not always transferred effectively when clients moved from one service to another.
- When crises abate services often fall away resulting in the client requiring support again.
- Agencies could be more effective in monitoring deterioration of clients' health and wellbeing.
- Assertive outreach models and rigid interventionist approaches can be counter-productive.

Recommendations

- For one organisation it was recommended that arrangements for case work supervision for staff working with people with complex support needs should be improved.
- Improved awareness for hostel staff about the actions that should be taken if they have concerns about the deteriorating health of any client.
- Improved coordination of care to ensure that clients who have multiple and complex support needs are not overlooked.

Learning and reflection

Safeguarding & Self-neglect procedures

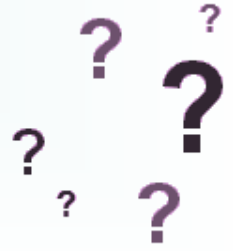
Where would you go to seek advice if you have a safeguarding concern about an adult you are working with or supporting? How would you involve the adult if they were self-neglecting?

How can you spot the signs of self-neglect in the clients you support? How do you prevent yourself from normalising self-neglect?

What would you do if you felt a safeguarding concern was not being taken seriously? How would you escalate a concern?

What do you do to engage with an adult who is refusing support?

How would you access the self-neglect procedures? How would you raise a concern about self-neglect?



Further Reading & Useful Links

- Sussex Safeguarding Adults Procedures
- Brighton & Hove Safeguarding Adults Board
- Self-neglect guidance and procedure can be found in the Sussex Safeguarding Procedures.
- Homeless Link - national charity supporting organisations who work with people who are homeless.
- Shelter is another good source of information and research in relation to homelessness.
- SCIE (Social Care Institute for Excellence)
- SCIE guidance on sharing information in relation to safeguarding
- BHT Training - training courses to staff in the voluntary sector, working with homeless people.

Learning and reflection

Working with clients with multiple and complex support needs

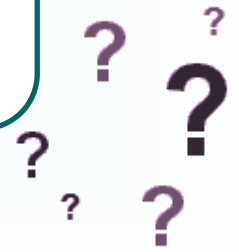
What do you understand by 'Making Safeguarding Personal'?

Does your organisation have an agreed approach to supporting clients who it is difficult to engage with? Is this applied consistently?

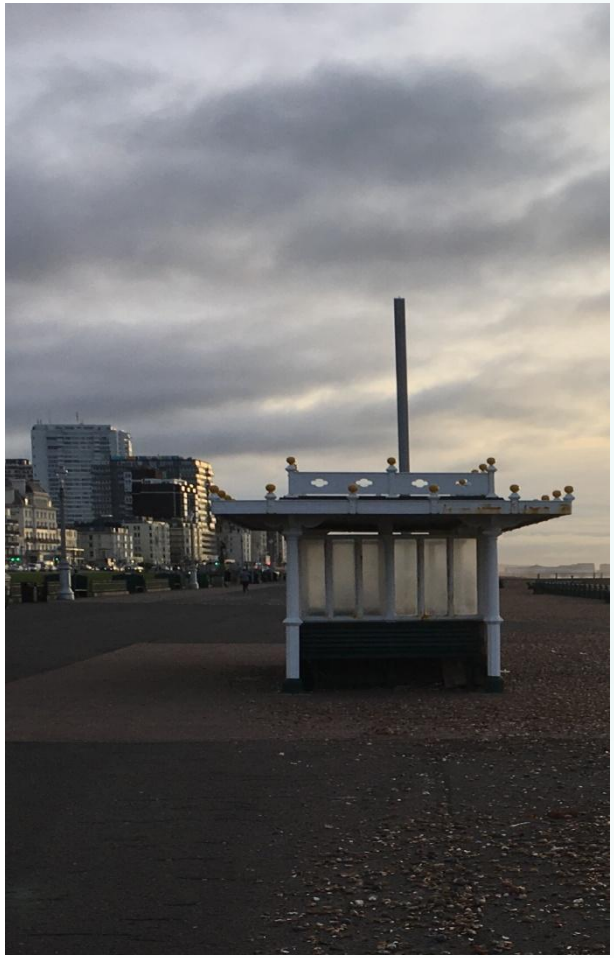
What are the safeguarding implications for clients with a learning disability? Do you know how you can access specialist support for clients with learning disabilities?

What could you do differently to reach out to clients who are not engaging with your service?

What processes and procedures are in place for when clients leave your service? Do you know who you should inform? Does this always happen?



Safeguarding is everyone's business



It is important that the SAB receives continual feedback from staff and managers about what is or is not working.

We want to hear your ideas for improvement so that changes can be made to improve safeguarding throughout the city.

We would like to hear your thoughts, feedback and comments. Please e-mail SAB@brighton-hove.gov.uk