Multiple Exclusion Homelessness: Safeguarding Adults Reviews

‘Phil’ and ‘Colin’

The BSAB plan of action

In mid-2022 Barnet’s Safeguarding Adults Board [BSAB] received two referrals for a Safeguarding Adults Review [SAR]. Two men, with care and support needs had died while sleeping rough in the borough, each in very different circumstances. Both men were of white ethnicities.

Phil went missing from his residential care home in January 2022. In April 2022, his body was found in a rough sleeping site in woodlands near to the North Circular. He was 64 when he died. The Coroner’s Inquest was unable to establish a specific cause of death as it is likely he had died months before he was found. The police investigation ruled out any third-party involvement.

In May 2022 Colin died from a sustained violent attack while he was sleeping rough in North Finchley. He died on his 55th birthday. The perpetrator of the attack pleaded guilty to manslaughter on the grounds of diminished responsibility. The perpetrator was sentenced with a hospital order. There is nothing to suggest that Colin and the perpetrator knew each other before these tragic events.

From what was known of Phil and Colin’s lives they had some of the characteristics of what is termed *Multiple Exclusion Homelessness*. That is, that in addition to a history of housing need, they had experienced:

- Physical and mental ill health
- Drug and/or alcohol misuse
- Experiences of institutional care and/or in criminal justice settings

In response to the circumstances of these two tragic deaths, both involving men with a history of sleeping rough, the BSAB commissioned a thematic SAR, focusing on the circumstances of their care and support in the months before their deaths.

Once the reviewer had gathered the information about the two individuals, it became clearer that while their experience had some common features, each story also some unique characteristics. To fully reflect on their experiences and address the different recommendations resulting from each case, in discussion with the SAR reviewer, the Board decided to provide individual reports rather than a single report integrating both accounts.

In July 2023 BSAB members received the reports, accepted the findings and agreed to action the recommendations. In September 2023 relevant partners came together to explore what actions each agency had already taken or would take to progress the actions and implement change. A summary of this is detailed below. In addition, in September 2023 Barnet’s Health and Wellbeing Board completed a deep dive into local responses to homelessness, reporting how the work to improve responses to multiple exclusion homelessness was being taken forward in Barnet and how the impact of actions taken would be monitored both locally and by the Pan- London Health, Homelessness and Safeguarding Practice Development Group.

Summary of BSAB and partners' actions to date

Whilst this review was underway Barnet Council completed a homelessness strategic needs assessment and reported this to the Health and Wellbeing Board. BSAB is well represented on that forum and can also take forward the learning from this review to the local Community Safety Partnership, the Violence against Women and Girls Forum and the Combatting Drugs Partnership. In addition, we will work with safeguarding leads at a regional and national basis to report any good practice and escalate issues for national policy change if required.

In Barnet, the Council's public health department currently chairs a Homeless Health Steering Group to progress recommendations from the homelessness strategic needs assessment and has incorporated learning from this review. For example, the steering group (in collaboration with NLMHP and the Council's Housing team), are reviewing the referral pathways for people with co-occurring mental health and alcohol and drug use to ensure that dual diagnosis services are made available to those who need them and that individuals who pose a risk of violence to others connected with these needs are prioritise for access to services. In addition, locally 'Blue Light' operational multi-agency meetings are taking place and exploring how to adopt a Making Every Adult Matter[1] approach in targeted interventions. Barnet Council's public health will retain oversight over this practice, but report on the success (or any barriers to successful implementation) to BSAB on a regular basis. BSAB have a continued commitment to respond where reports suggest poor practice requires strategic policy, training or further case auditing is required.

The Council's Homelessness and Rough Sleeping Strategy 2023 – 2028 outlines the council's strategy for dealing with rough sleeping in the borough. Barnet Homes deliver the Rough Sleeping service on behalf of the council and work with Community Safety, the police and other agencies such as Change Grow Live to identify rough sleepers and to ensure that they are referred to the Outreach Team. The service also works closely with other boroughs where we know there are rough sleeping 'hubs' that cross borders. The annual rough sleeper count involves work undertaken in advance with all agencies to identify all potential sites in the borough, and the count is based on intelligence from all partners.

Within Barnet there is already an established frailty pathway led by CLCH, with a dedicated multi-disciplinary team to provide support to patients who run bi-weekly meetings to support GPs and Primary Care Networks to identify adults who would benefit from individualised care plans to reduce harm and unplanned admissions to hospital. Whilst currently the team's focus is on those over 65, as the model develops, primary care and the team will work together to work towards proactive identification, prevention approaches, and consideration of any areas of inequalities to ensure that the service provides care to all who need it. Assurance has been given, including to the Health and Wellbeing Board, that a flexible approach will be adopted to the age criteria for those who are moderately/ severely frail due to co-occurring conditions often associated with multiple exclusion homelessness. To maximise the benefit of this existing service, the ICB (working with the GP network and public health) will provide a 'MECC' briefing to GPs and raise awareness of the learning from these reviews at NCL's GP safeguarding conference. BSAB has also committed to providing bespoke training for GPs through our monthly lunch and learn sessions on the role of primary care in supporting good housing outcomes, including how to assess and report on an adult at risk's executive function in the context of Mental Capacity Act 2005 obligations and when/how to escalate if a patient is known to be street homeless or at risk of street homelessness.

[1] http://meam.org.uk/

The Council's Adult Social Care [ASC] department confirmed they reviewed the support offered Francesca (Colin's former partner) to ensure her wellbeing was protected in line with the making safeguarding personal principles. They have also reviewed their Deprivation of Liberty Safeguards [DoLS] tri-age process to ensure that adults with care and support needs who are deprived of their liberty necessarily to provide suitable, protective care have their rights balanced carefully and access to Court to challenge any restrictions if they wish. The Council report quarterly to the BSAB on quantitative DoLS data to demonstrate compliance with these legal safeguards. In addition, the Council now also audit DoLS case files on a bi-annual basis to ensure all social care staff are meeting these legal duties. The Council's ASC department have also written to all social care staff, providing guidance on safeguarding functions and clarifying that cases should not transition to a review team if there are safeguarding or other high risks that require urgent action.

To ensure this approach is applied across all partner agencies, BSAB are developing a decision support tool to assist practitioners (including those working in primary care and the voluntary sector) raise effective safeguarding concerns and actively support enquiries for adults at risk in Barnet. This will incorporate guidance on how to refer to local risk management processes that run alongside safeguarding duties for adults experiencing multiple exclusion homelessness, provide links to relevant existing policies (e.g. self-neglect) and use learning from these reviews to inform policy implementation of the 'Right Care; Right Person' approach adopted by the Metropolitan Police in November 2023.

Since completion of the thematic review, the Multi-agency safeguarding hub and voluntary sector agencies now meet quarterly to review operational safeguarding practice issues. This group now form part of the BSAB so that they have a direct reporting line and can therefore influence the SAB's strategic priorities.

In response to this review (and learning from other regional safeguarding reviews) NCL ICB has devised a hospital discharge protocol. This should be read alongside government guidance issued in January 2024[2]. The guidance details specific risks to adult experiencing multi-exclusion homelessness and sets out expectations of all practitioners across hospital and community-based services to work together to reduce risk and address the underlying health inequalities felt most acutely by adults within this cohort. This includes a reminder to refer for both homelessness support and assessments under the Care Act 2014 where the adult has an appearance of need for care and support.

North London Mental Health Partnership [the 'Trust'] have already introduced three safeguarding drop-in surgeries for safe to discuss cases of concern. They are advertising this support across their operational teams, with a particular focus on supporting staff to manage risks associated with domestic abuse or harmful practices in a 'think family' way. They have appointed a safeguarding named doctor to further support frontline staff and their Domestic Abuse coordinator has run workshops. In response to the findings of this review, the Trust are conducting a review of their current practice and intend to report on steps taken to address the recommendations (alongside all our health partners operating in Barnet) as part of our annual self-assessment and bi-annual challenge events. In addition to reporting on the steps they have taken to ensure frontline practitioners are applying this new protocol, they will report on compliance (assessed through case audits) within their operational teams with reporting

[2] 'Discharging people at risk of or experiencing homelessness' available at: https://www.gov.uk/government/publications/discharging-people-at-risk-of-or-experiencing-homelessness/discharging-people-at-risk-of-or-experiencing-homelessness

standards, compliance with their ‘duty to refer’[3] and multi-agency risk mitigation pathways, including under s42 Care Act and for those at risk but awaiting allocation to an assessment or community support team. The Trust report much improved direct working with GP (with named mental health practitioners attached to each GP surgery) and with Barnet Housing staff, which includes a member of the Council’s housing team attending ward rounds and community team meetings to address housing issues. A housing checklist also now forms part of the initial assessment process for all Trust service users. The Trust have introduced an obligation for staff to contact anyone discharged from hospital or support within 72 hours to check on their wellbeing, providing an opportunity to identify gaps in care and facilitate early intervention if needed. Crucially, given the learning in respect of Francesca in these reviews, the Trust has introduced access to mental health advice for partners of service users to assist families to manage challenges associated with providing informal care to people with mental health conditions. The Trust’s Board will continue to monitor concerns and complaints regarding failed discharges and report to BSAB any organisational concerns. Finally, the recommendations arising from these SARs have been considered as part of a planned review of the Trust’s Information Sharing policy,

In respect of the procedural issues that arose and caused delay in the completion of this review, the BSAB have reviewed and agreed revisions to our Safeguarding Adults Review guidance. This was signed off by BSAB partners in July 2023. We have also inducted new members into the Board, including a strategic housing lead and set up a rolling programme to ensure board members have opportunities to meet with the Chair and SAB manager to evaluate contributions and ensure our work plan remains on-track and relevant to individual organisations’ and our shared priorities. In symmetry, the ICB are working with health partners to introduce the new Patient Safety Incident Reporting Framework in line with NHSE’s expectations for full implemation by 2024. The ICB and North London Mental Health Partnership have committed to provide confirmation at BSAB’s next challenge and progress event of how they are managing to meet demand for specialist safeguarding oversight into SAR or SI processes and how they have socialised the new expectations across their operational services.

[3] In line with obligations under the Homelessness Reduction Act 2017, more details available at: https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer