OSAB Summary Briefing on a thematic Safeguarding Adults Review regarding the deaths of homeless people in Oxfordshire

i. This briefing[1] aims to provide an accessible overview of a Safeguarding Adults Review (SAR) report completed in October 2020, drawing out key concerns and opportunities for improving practice. A SAR is a multi-agency process which seeks to look at what relevant agencies and individuals could have done differently that might have prevented serious harm or death. The primary goal of this briefing is to spread learning from the SAR as widely as possible. It is not intended as a substitute for reading the full report[2].

ii. The SAR was commissioned following the deaths of nine homeless people in Oxford between November 2018 and June 2019. The ages of the people ranged from 26 to 57. The decision to undertake this discretionary review reflected the concern of OSAB members about the loss of lives of these individuals who all died in very difficult circumstances and at far too young an age, and a commitment to implement any safeguarding lessons across the health and social care system in Oxfordshire.

iii. The review aimed for a "whole system understanding". It produced 15 recommendations across 4 domains: direct work with homeless individuals; the team around the homeless person; the organisations around the team; and governance (which primarily covers lessons for the OSAB).

iv. A wide range of agencies who had directly served these individuals were involved in the review. Chronologies were compiled of what happened to each person who died, and discussion sessions held with appropriate staff. The reviewers also took note of a previous report into homelessness services in Oxfordshire from 2013 and of similar inquiries in other parts of the UK, and central government policies which they recognised would impact on what Safeguarding Boards can accomplish locally. Families of those that died were approached and several chose to add their perspectives to the review.

v. The full report provides brief descriptions of each person's circumstances and history, while protecting anonymity. The level of detail available to the reviewers varied considerably; some individuals appeared to be hardly known to services in Oxfordshire. The reviewers concluded that the term "multiple exclusion homeless" was relevant to all nine people, referring to extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care. Their needs were complex and long-standing.

[1] prepared by the Lay Member and the Chair of the Oxfordshire Adults Safeguarding Board.

[2] https://www.osab.co.uk/wp-content/uploads/2020/11/Review-of-Homeless-Deaths-Full-Report.pdf

vi. Alongside the full SAR report, OSAB partners and specialist homelessness agencies are encouraged to read a very accessible briefing on positive practice for adult safeguarding and homelessness, written by one of the report's authors[3].

1) Direct work with homeless individuals - summary

Research and other SARs on multiple exclusion homelessness and substance misuse suggest 16 key elements of best practice for an effective, person-centred approach to supporting people with these difficulties into safer lives. The SAR report considers whether the service provided by keyworkers to these individuals fell short of this best practice.

The review identified a lack of understanding of the needs of people who self-neglect, with practitioners not recognising or not understanding **repeated patterns of behaviour** - for example, *why* people might frequently visit Emergency Departments or repeatedly fail to attend appointments. There were occasional examples of outreach and support to attend appointments but more often, examples of offering 'more of the same', i.e. another fixed appointment and then cases closed for non-attendance. There was concern about whether sufficient recognition was given to the impact of trauma and adverse childhood experiences and how these might be affecting current behaviour. The reviewers also wondered to what extent drug and/or alcohol abuse was being seen as an issue of lifestyle choice and unwise decision-making, with insufficient consideration given to mental capacity and possible mental health needs.

Case records revealed very few **mental capacity** assessments, despite their relevance to heavy users of drugs or alcohol as well as to other diagnoses held by some of these individuals (e.g. global cerebral atrophy). The reviewers also questioned the level of understanding shown by agencies into "executive capacity" (the ability to carry out decisions and intentions) which is often an issue for people who are seen as neglecting themselves.

The review found limited evidence of **risk assessment and mitigation** plans, especially multi-agency ones, for example, when someone was evicted from their hostel accommodation. Other transition points were also noted as requiring more careful multi-agency risk assessment and planning, such as leaving hospital or prison. In addition to some basic errors and omissions (such as not notifying a person's GP of their hospital discharge), the reviewers highlight the need for services to consider more deeply the individual's skills, resilience and capability to manage such change, even a seemingly positive one such as into supported accommodation. They note "the need to consider what wrap-around support was necessary in order to support those who were trying to recover from the impact of trauma and adverse experiences and trying to manage their emotional responses".

The review identifies that many of the individuals potentially had eligible care and support needs (under the Care Act 2014), yet most had not been referred for an **Adult Social Care**

[3] https://www.local.gov.uk/adult-safeguarding-and-homelessness-briefing-positive-practice

assessment. Possible barriers to referral for Adult Social Care, if only in the perception of potential referrers, need consideration.

Some of the individuals were known to have suffered **domestic abuse** and some were also perpetrators. It was not clear whether the usual channels for supporting victims of domestic abuse and managing perpetrators were available to them as homeless people, and the reviewers ask: "when domestic abuse happens on the street, rather than in a home, when is this considered a safeguarding concern?"

2) The team around the person - summary

The 'team' comprises workers from specialist homelessness organisations and staff from organisations that provide services to the wider population that includes homeless people, such as the County Council, the Police or the different parts of the NHS. The care and support received by these homeless individuals was analysed with reference to the 8 key elements of best practice for the team.

Collaboration

The reviewers found examples where agencies worked together well, but also examples of **poor collaboration and fragmentation of services**, with a perception that too much responsibility was placed on accommodation providers to engage with other services and to coordinate their involvement. The clearest example of where improved multi-agency collaboration was needed was in relation to hospital discharge.

The report also refers to "**referral bouncing**", with a perceived reluctance to be "part of the solution". This sometimes resulted in the least formally qualified and experienced workers being left to deal with the most challenging and complex individuals. In one case, mental health services are reported to have stated that they would only accept a referral if the individual would engage; a best practice response would have been more flexible, offering 'wrap-around', mental health support.

Risk-assessment

There was no agreed format for convening or conducting **multi-agency meetings** nor a standardised approach to **risk assessment and management** plans. There were examples of plans developed without all relevant agencies involved, of plans formulated but not followed, and plans that were not reviewed or reformulated when events disrupted what had been agreed. In none of the nine cases did there appear to have been a nominated lead agency and/or keyworker to coordinate the multi-agency input for these complex individuals.

Safeguarding Referrals

The review highlighted front-line staff were not recognising when a **safeguarding referral** was warranted. These clients had a range of physical and mental health problems that potentially translated into eligible 'care and support needs' (under the Care Act 2014) and, despite the services provided, these individuals remained in high risk and unsafe situations. Yet none of

the nine people had been subject to a safeguarding enquiry. Alongside this, concern was expressed by operational staff of 'not being heard' when they did attempt safeguarding referrals.

Legal Literacy

The report recommends improving staff confidence in applying the **Homelessness Reduction Act 2017** and notes the absence of assessment under the **Human Rights Act 1998** for at least one individual with no recourse to public funds, who might then have been eligible for some support. With some staff appearing nervous to share information, scope for improving understanding of the new data protection law (2018) was also noted, and OSAB were strongly advised to review other situations involving multiple risks and repetitive complex needs to ensure that information is being shared appropriately.

3) Organisations around the team - summary

This section of the report considers best practice at the organisational level, everything from the work environment that enables staff to support this complex group of people effectively (skills, tools, cultures etc) to how services are commissioned. The review outlined 3 key areas needing to be addressed.

a) The review found a **lack of strategic agreement** between housing, adult social care and health agencies across Oxfordshire about priorities, and a lack of 'ownership' of homelessness as a shared responsibility of these agencies. The evidence reviewers found of the strategic approach being followed, often referred to locally as "the homeless pathway", was considered to be too crisis focussed and lacking support for recovery of the person. It appeared there was across Oxfordshire a "history of fragmentation and retrenchment" between agencies serving the homeless, particularly following the reductions in funding from the national Supporting People fund (as had happened in other areas too).

b) There were difficulties with commissioning of services for people experiencing homelessness which affected their access to mental health services in general, and especially to **services for 'dual diagnosis'** (substance misuse and mental health). At the heart of this difficulty was the lack of any clear agreement about which agency was responsible for commissioning such services to achieve and maintain recovery. The report references commissioning approaches in other areas that deliver integrated provision, and calls for a greater number of specialist multidisciplinary services offering more flexible and proactive support, some of which needs to be available out of standard office hours.

c) The review called for work-force and work-place development opportunities for staff working at the front line with people experiencing multiple exclusion homelessness, especially in the non-statutory services. They identify a need for support staff to receive further training in undertaking capacity assessments, in assessing and managing risk, and improving understanding of how to access statutory support and trigger statutory duties (such as safeguarding). They also note how raising staff confidence and status could help them advocate more successfully for their clients with statutory services. The emotional

impact on staff of the work with such complex and sometimes challenging individuals is also recognised.

4) Governance - summary

The review described a number of concerns around governance, advising as follows:

a) The OSAB should use its statutory mandate to hold the District, City and County Councils to account for the safeguarding of adults experiencing multiple exclusion homelessness and host a "governance conversation" to determine agreement. It is vital that there is one clear partnership or organisation in Oxfordshire that takes responsibility for homelessness in terms of governance and strategic oversight.

b) The OSAB should seek to influence statutory partners to adopt a "no wrong door" approach, to end the experience of service users being seemingly passed around the system.

c) The OSAB should revise its approach to reviews of all cases of people experiencing multiple homelessness especially those who initially may appear unlikely to fall into the existing criteria for a mandatory review under Section 44. The reviewers call for a local and national approach which enables the circumstances of everyone who dies whilst sleeping rough or in emergency accommodation to be examined to ensure lessons are learnt and improvements are made to support the needs of such individuals.

d) The OSAB should review its policies on Safeguarding in respect of self-neglect to ensure people who experience multiple exclusion homelessness are included and procedural advice is clear and widely understood.

The '**Connecting Learning'** section of the review reports clear parallels between the findings of this thematic review and learning available from SARs completed by other Safeguarding Adults Boards around the country. The reviewers drew on this wider learning to develop their recommendations on what should happen next in Oxfordshire.

5) SAR Recommendations – reproduced here in full (Section 12 of the SAR report)

Arising from the analysis undertaken within this review, the independent reviewers recommend that the Oxfordshire Safeguarding Adults Board:

1. Engages with the Health and Wellbeing Board, countywide Community Safety Partnership group, Countywide Homelessness Steering Group and local partnership arrangements for the safeguarding of children, to agree roles and responsibilities with respect to services for people experiencing multiple exclusion homelessness – undertakes to hold the 'governance conversation'.
2. Reviews its policy and procedure on self-neglect, with reference to people who experience multiple exclusion homelessness, and subsequently ensures that all agencies disseminate the requirements and expectations to all staff so that they are consistently followed across Oxfordshire.

3. Engages with partner agencies on developing policy and procedures for work with people experiencing multiple exclusion homelessness, to include arrangements for accessing the adult homelessness pathway.
4. Engages with the Health and Wellbeing Board, countywide Community Safety Partnership group, and partner agencies to consider the local process to be adopted for future reviews of cases involving the deaths of people experiencing multiple exclusion homelessness.
5. Maps current service provision for adults who self-neglect and/or have complex needs/or misuse substances and/or are homeless or threatened with homelessness and, at a summit with commissioners and providers, considers what refinements, resources and further developments are advisable in light of learning from this SAR in order to deliver an integrated and collaborative system for meeting people's complex needs (section 8.4). This summit should also review progress on the recommendations made in Oxfordshire's own health needs assessment of people experiencing street homelessness[4].
6. Maps current service provision for women who experience multiple exclusion homelessness, which includes domestic abuse, and reviews how children's services and adult services respond individually and work together in cases where child protection concerns are engaged alongside adult care and support needs and adult safeguarding.
7. Reviews multi-agency procedures for working with people who self-neglect to ensure that they include clear pathways for convening multi-agency panel meetings and for escalation of concerns, and arrangements for agreeing on lead agency and key worker to coordinate practice.
8. Produces guidance and tools for assessing risk in respect of adults who self-neglect and/or experience multiple exclusion homelessness.
9. Monitor the outcomes of referrals for Safeguarding enquiries for those experiencing multiple-exclusion homelessness.
10. Promotes with partner agencies the development of trauma-informed practice and the assessment of mental capacity, with specific reference to executive decision-making.
11. Seeks reassurance that discharge arrangements/transitions from prison or hospital settings conform to best practice guidance.
12. Seeks reassurance that people experiencing multiple exclusion homelessness are benefiting from an integrated approach to meeting their care and support, mental health, physical health, substance misuse and accommodation needs.
13. Ensures the availability of procedures for responding to self-discharge and to patients/service users who do not engage or attend appointments in situations where risks are significant.
14. Promotes through the network of SAB independent chairs a "whole system" conversation, including with central government departments, about the learning from this thematic review and other SARs that have considered cases of people experiencing multiple exclusion homelessness.
15. Audits progress on learning from this SAR after one year from publication, using the evidence-base in section 5 to identify and tackle where barriers and obstacles to effective practice and policy or management for practice remain.

[4] Ghinai, I. (2019) *A Health Needs Assessment of the Adult Street Homeless Population in Oxfordshire*. Oxfordshire County Council.

Conclusion

The Safeguarding Adults Review on the theme of homelessness was commissioned by Oxfordshire's Safeguarding Adults Board (OSAB) to help agencies working across Oxfordshire to learn lessons from the circumstances surrounding the tragic deaths of 9 individuals who had all experienced "multiple exclusion homelessness" leading up to, and at the time of, their deaths in 2018/19. While areas of good practice were identified during learning events carried out for the review, the review report naturally focusses on where improvements could be made to reduce the chances of further such tragedies. The SAR yielded fifteen important recommendations, to be interpreted for the Oxfordshire context and turned into a multi-agency action plan.

The reviewers and all members of Oxfordshire's Safeguarding Adults Board are grateful to those individuals' family members who felt able to contribute to the review and who gave their views about what might have helped their loved ones. To all of them, and to all those affected by the tragedies of these individuals, the Board extends its condolences and its sincere determination and commitment that this review, and the work that follows it, will improve the way services work in future with such vulnerable people.