

# Learning Together from Safeguarding Audits

This short briefing summarises the findings of a recent **multi-agency audit** of safeguarding responses to homeless adults in Brighton & Hove.

It is important for everyone to embrace the learning from this audit to ensure that Brighton & Hove becomes a safer place for adults who are at risk of neglect and abuse.

**Background:** Brighton & Hove Safeguarding Adults Board (SAB) undertook a Safeguarding Adults Review (SAR) following the death in December 2014 of 'X', a homeless individual in Brighton & Hove. You can read the full report and a learning briefing in relation to that review here:

[brightonandhovelscb.org.uk/safeguarding-adults-board/safeguarding-adults-reviews](http://brightonandhovelscb.org.uk/safeguarding-adults-board/safeguarding-adults-reviews)

Following the SAR and a 2015/16 review of homelessness deaths, the SAB brought together professionals from agencies across the city to look closely at the services and interventions provided to people currently experiencing homelessness. This multi-agency audit identified examples of existing good practice and explored the challenges and difficulties faced by agencies when supporting homeless individuals.

**The audit:** The audit assessed whether the needs of vulnerable people who self-neglect, misuse substances, have come to the recent attention of Police, have poor mental health and/or have had a recent health crisis, are being appropriately addressed.

Four actively homeless clients were selected, put forward by Sussex Partnership NHS Foundation Trust Mental Health Homeless Team and the Brighton Housing Trust First Base Day Centre. The sample included both women and men of various ages and ethnicities.

The audit considered:

- 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 audit group produced a report and made recommendations which have been considered by the SAB Quality & Assurance (QA) Sub-Group. An action plan is in place to monitor the implementation of the recommended improvements.

If you work with homeless adults in Brighton & Hove, there may also be specific actions & recommendations for your agency and your role. Please ask your manager, or contact your representative on the SAB.

If you would like to read the full report please contact us at [SAB@brighton-hove.gov.uk](mailto:SAB@brighton-hove.gov.uk)



## Key findings:

- The audit found that agencies are not consistently utilising safeguarding as a mechanism to hold multi-agency, 'strategy' or professionals meetings to bring staff together to improve outcomes for homeless adults with complex needs.
- Multi-agency working would benefit from improved coordination of care to ensure that clients who need support are not overlooked.
- Liaison between A&E and the Pathways Homeless Team could be improved.
- Support/ safety plans and risk assessments are not consistently shared across the partnership, again resulting in missed opportunities for co-ordinated approaches.
- There are not always effective arrangements in place to ensure that responsibility is transferred to another named individual when the client is discharged from a service.
- 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.
- Learning disability identification and support was lacking in one case.

## Recommendations included:

- A review of Brighton & Hove multi agency forums for discussing complex cases.
- For homeless clients there should be a robust person-centred risk management plan, developed by a lead agency (in collaboration with other agencies involved with the client) which is agreed with the client and shared with relevant services.
- The Sussex Safeguarding Adults Procedure for working with people who self-neglect should be reviewed to include working with clients who are hard to engage. Brighton & Hove City Council Adult Social Care should ensure compliance with the refreshed procedure.
- There should be management plans in place within A&E for homeless patients who frequently attend. This should include action plans and who to contact or refer to.
- 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 staff in hostels about the actions that should be taken if they have concerns about the deteriorating health of any client.

## Key findings relating to multi-agency working and information sharing

### Multi-agency working & information sharing

- On the whole the audit found good evidence of agencies working well together in Brighton & Hove. For some clients all of the agencies working with them were aware of their vulnerability and the impact of their homelessness on their wellbeing.
- Whilst in some cases there were good examples of agencies working effectively together, in other cases there was a lack of communication and sharing of important information between key agencies.
- In some cases there was an absence of formal multi-agency strategy meetings being held.
- Support and safety plans and risk assessments were not shared across the partnership. As a result not all agencies were aware of current arrangements in place.
- In another case there was a missed opportunity by one agency to share information with mental health and GP services despite concerns that one client had returned to rough-sleeping and was using new substances.
- One agency recorded a diagnosis of bipolar disorder for a client but this diagnosis did not appear to be known by any other agency.
- In one case although there was a clear safeguarding plan for the client under the self-neglect procedures, not all agencies were aware of it.
- In another case BSUH had not been informed that a client was the subject of a S42 safeguarding enquiry.

## Key points for learning and reflection:

Are you familiar with the arrangements for sharing information with the other organisations you regularly work with?

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

Do you meet regularly with the other organisations involved in supporting your clients?

Do the current arrangements work?

How could they be improved?

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



## Awareness and use of safeguarding and self-neglect procedures

### Safeguarding & Self-neglect procedures

- Although there was evidence of safeguarding concerns being raised in relation to some of the clients, there were several occasions where opportunities to raise concerns were missed.
- For one client, a safeguarding referral could have been made by Housing when he made a homeless application, but this did not happen.
- In another case, opportunities were missed by all agencies supporting the client to discuss the safeguarding implications of his homeless status and his increasing vulnerability despite all agencies involved sharing serious concerns for his wellbeing.
- A safeguarding concern raised for one client by a homeless service was rejected by Adult Social Care without further discussion with the referring case worker or the client. Doing so may have provided an opportunity for a more appropriate intervention.
- In common with the recent Safeguarding Adult Review for Adult X, there was a missed opportunity to implement the self-neglect safeguarding procedure for more than one client in the audit. In one case the initial safeguarding concern was rejected with insufficient consideration of the client's self-neglecting behaviours e.g. in relation to medication to control diabetes. Initiating the self-neglect procedure would have triggered a multi-agency safeguarding response and safety plan.
- In another case, First Base advised that a client was known, or suspected to be suffering from self-neglect. The self-neglect procedure was not initiated for this client.

## Key points for learning and reflection:

Do you know who to report to or seek advice from if you have a safeguarding concern about an adult you are working with or supporting?

Do you know how to spot the signs of self-neglect in the clients you support?

Do you know what a Section 42 enquiry is?

Do you know who you could speak to if you felt a safeguarding concern was not being taken seriously?  
Do you know how to escalate a concern?

Are you aware of the Self-neglect procedures?

Do you know where you can access these?



## Working with clients who have multiple and complex support needs



- The audit team agreed that persistent encouragement, creativity, flexibility, making safeguarding personal and offering support is key to homeless individuals with complex needs committing to meaningful change. The group discussed the merits of employing an assertive outreach model and felt rigid interventionist approaches, that dictated the speed of engagement rather than responding to the individual's own pace, were not appropriate for people with complex needs.
- There was not always a clearly identified Care Co-ordinator for each client; on discharge from a service the Care Co-ordinating role appeared to not always be transferred to another named individual.
- There was good evidence of agencies demonstrating flexible working to try new approaches with clients e.g. the referral of one client to SOS when he started engaging with Richmond House demonstrated good practice and an understanding of the complexities of the case.
- The audit group found good evidence that agencies provide effective support when clients are at crisis points. However, when the crisis abates services often fall away resulting in the client requiring support again.
- Despite a good intervention and reasonable engagement one client had in effect moved from one high risk situation to another. Although receiving appropriate support for a mental illness, the client had moved into a peer environment that was not conducive to addressing substance misuse issues.
- When another client was placed in temporary accommodation some of their support services fell away, which was likely to have led to increased risks.
- Agencies could improve on reviewing their approaches and service offer/s when there is no change or the client's health and wellbeing is deteriorating.
- In one case there were indications that the client had a learning disability but this was not followed up.

### Key points for learning and reflection:

**Does your organisation have an agreed approach to supporting clients who are difficult to engage?**

**Is this applied consistently?**

**What do you understand by 'Making Safeguarding Personal'?**

**Does your organisation have an agreed process/procedure for when clients leave your service?**

**Do you know who you should inform?**

**Does this always happen?**

**Is there anything you could do differently to reach out to clients who are not engaging with your service?**

**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?**



**Learning Briefing Event:** We are holding a staff briefing in partnership with BHT to inform partner agencies of the key learning points from this audit; to allow agencies to review their own practice and consider how practice might be changed or improved.

- [Thursday 30 November 2017, 3pm - 4.30pm at The Great Hall, Moulsecoomb Hub North, Hodshrove Lane, Moulsecoomb](#)

You can find out more and book your place on this and other safeguarding training events at: [learning.brighton-hove.gov.uk](http://learning.brighton-hove.gov.uk)

## If you have any concerns about an adult with care or support needs contact Access Point



**Phone: 01273 295555**

**Email address: [accesspoint@brighton-hove.gov.uk](mailto:accesspoint@brighton-hove.gov.uk)**

**Minicom: 01273 296205**

## 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](#) is a national charity supporting organisations who work directly with people who are homeless.
- [Shelter](#) is another good source of information and research in relation to homelessness.
- [SCIE](#) (Social Care Institute for Excellence) is a good source of information and research in relation to self-neglect and safeguarding generally.
- [SCIE](#) guidance on sharing information in relation to safeguarding
- [BHT Training](#) provides training courses to staff in the voluntary sector, working with homeless people.



Brighton & Hove  
**SAB**  
Safeguarding  
Adults Board

**Feedback:** As staff and frontline managers you will know about the quality and impact of your own services, and those of the partner agencies you work with. It is important that the SAB receives continual feedback from staff and managers about what is or is not working. We also 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 on findings presented to you in this briefing and any feedback on the style of the briefing itself. Please e-mail [SAB@brighton-hove.gov.uk](mailto:SAB@brighton-hove.gov.uk) with any feedback.