Safeguarding Adults Review

Lilian SAR

Multi Agency Action Plan

Newham Safeguarding Adults Board - Version 1 | 09-04-2024

Note regarding presentation of recommendations

This multi agency action plan is the substance of Newham Safeguarding Adult Board's work to keep with our commitment to strengthen partnership working which we will continue after publication of this plan.

The multi agency action plan will be monitored by the Performance & Quality Assurance subcommittee of Newham Safeguarding Adults Board.

Recommendation 1	**Understanding and connection with protected characteristics and intersectionality:** The report uses the concept of intersectionality to demonstrate how the combined impact of her protected characteristics reduced her ability to access services. For example, there was evidence to suggest that her experience of society would have made her less trusting of services and less likely to engage. Further, there were occasions when a better understanding of her cultural background would have improved professional's understanding of her belief system and potentially reduced barriers to engagement with services The report also notes that a diverse team worked with Lillian but this alone this was not enough to reduce barriers to accessing service. The report suggests that the concept of psychological safety can be used to enable services to reap the benefits of the diverse teams which already exist			
NSAB Strategic Response: What difference do we expect to see?	Reduced barriers to engagement with services will be achieved by the following: • Improved awareness and understanding of the barriers to engagement which arise form protected characteristics • A toolkit for professionals to enable them to address the barriers to engagement • Improved awareness of trauma informed approaches throughout the organisation • Increased support to service users from vulnerable groups • To reap the benefits of diverse teams			
Owner	**Action: What are we expecting to see**	**Timescale**	**Progress/Evidence/Impact**	**Completed**
London Borough of Newham-Adult Social Care	1.1 ASC to develop a vulnerability assessment tool which will flag cases where there are increased barriers to engagement	6 months	This should prompt professional curiosity about the issue, enable preventative actions and reduce risks related to non-engagement Evidence through case file review	September 2024
	1.2 ASC to produce practice guidance to support the use of the vulnerability assessment tool and to encourage professional curiosity	6 months	Enhance workforce skills and knowledge This should prompt professional curiosity about the issue, enable preventative actions and reduce risk related to non-engagement Evidence through case file review	September 2024
	1.3 ASC's current training offer will be developed in response to the EDI issues which are	2 months	Mentorship schemes are already in place - further work is required to develop our response to this action	August 2024

	highlighted in this report. Specifically, there will be developments in relation to trauma informed approaches and our mentorship schemes		To develop our professional development offer related to protected characteristics and intersectionality - further work is required to develop our response to this action	
	1.4 ASC to consider enhancing their advocacy service to ensure appropriate support is in place for residents	9 months	This service could enable people to overcome barriers to accessing service	December 2024
	1.5 LBN will work with London SAB and SCIE with the objective of developing a more diverse pool of professionals who are able to complete SAR reviews	9 months	Increased number of professionals from diverse backgrounds who are able to complete SAR's	December 2024
	1.6 A Quality Improvement project is underway seeking to understand and tackle the issues resulting in safeguarding concerns not reflecting our diverse population	Ongoing	Safeguarding concerns reflect the demographics of the Borough	September 2024
Community Mental Health Team for Older People East London NHS Foundation Trust	1.7 Commission equality and diversity training for CMHTOP staff.	January and February 2023	CMHTOP staff have completed three levels of commissioned LGBTQ+ and People over 50, facilitated by LGBT Opening Doors. It was intended to provide the Team with the skills and knowledge to provide the best possible care to the service user group. ELFT provide care and interventions for service users within the Framework of Dialog+, the core principle of which is based on 'What matters to me' (the service user). The Framework is intended to make routine service user-	12.01.2023 L1 26.01.2023 L2 09.02.2023 L3

			professionals encounters therapeutically effective.	
	1.8 Deliver staff training on cultural competence and competence around conscious and unconscious bias.	By July 2024	The next steps are being reviewed in the directorate Inequalities Group, which continues the focus on the Let's Talk themes. Such training will link in with the Patient Carer Race Equality Framework (PCREF) as another helpful resource	Community Mental Health Team for Older People, East London NHS Foundation Trust,

Recommendation 2	**Safe Management of Patients who Struggle to Engage in Care:** The report indicated that Lilian had a long history of non-adherence with treatment and disengagement with services. The impact of Lillian's mental health diagnoses on her understanding of the care and support needs may have resulted in non-engagement. Moreover, the trauma informed approach provides a framework for understanding non engagement because the model suggests that those in most need of services are least likely to engage effectively. Considering intersectionality is an important aspect of the approach, the model has particular relevance for Lilian's experience There was also evidence to suggest that information sharing between agencies and between departments in LBN was suboptimal. This could be addressed by enabling suitably qualified and senior members of LBN departments to access the different databases. For example, allowing designated members of ASC to access Northgate and giving designated Housing workers access to Azeus.			
NSAB Strategic Response: What difference do we expect to see?	• Increase awareness, understanding and application of trauma informed approaches throughout LBN • Increased staff awareness about safe discharge of service users from the service or down grading from Care programme Approach (CPA) to non-CPA as a result of staff in-depth knowledge in CPA Policy. • LBN to develop a toolkit for practitioners which will enable them to implement a trauma informed approach • Improved recoding and information sharing • Reduction in incidents/SIs due to timely enhanced risk assessment and management. • Prevention of potential and actual neglect of service users and maintenance of safeguarding strategy. • Compliance with Trust Care Programme Approach, Admission, Transfer & Discharge and other Trust Policies. • Embed service users' right to quality care.			
Owner	**Action: What are we expecting to see**	**Timescale**	**Progress/Evidence/Impact**	**Completed**
London Borough of Newham-Adult Social Care	2.1 Audit of cases closed without support being offered. This was complete in June 2023 but another audit will take place	4 months	Review of thresholds for closing cases and review of the quality of case records LBN ASC has Difficult or Non-Engagers guidance in place	July 2024
	2.2 Practice framework related to positive risk taking to be finalised	2 months	Casework Practice Supervision launched (June 2023) and Supervision Policy launched (Nov 2023)	June 2024

			Principal social worker developing positive risk taking framework	
	2.3 Case recording standards guidance to be reviewed	Complete	2 x thematic case file reviews on case recording complete Ongoing work which is addressed by audits and case recording framework Importance of recording to be discussed in reflective sessions and peer support groups	Complete
	2.4 Reflective session on trauma informed practice	3 months	Improved practice in complex/high risk cases	June 2024
	2.5 Development of a practice framework for trauma informed practice	6 months	To commence	October 2024
London Borough of Newham-Adult Social Care & Housing Directorate	2.6 ASC and Housing to develop information sharing protocols which would enable senior members of each organisation to access both databases	9 months	Improved information sharing leading to higher quality risk assessments	January 2024
Community Mental Health Team for Older People. East London NHS Foundation Trust	2.7 Deliver a lessons learnt seminar on the topic of “Safe Management of Patients who we struggle to engage in care”.	December 2022	The Team continue to make reference to the findings of the SAR and final SI review report in MDT, Business and Huddles where similar cases arise.	The recommended refresher training on the Trust’s CPA took place on 06/05/2022. This was followed by

				Team discussion on 26/06/2022.
	2.8 Review the CMHTOP process for managing service users who fail to attend routine appointments.	April 2022	The Team's weekly MDT Review Meeting and the Team three weekly Huddles are now key review and decision making spaces. Discussion takes place after service user's non-attendance at regular appointments or failed to engage successfully.	8.2 Review the CMHTOP process for managing service users who fail to attend routine appointments.

Recommendation 3	**Mental Capacity:** The report states that the presumption of capacity applied to all decisions which were made by Lilian. This is not consistent with the evidence of long term self-neglect which indicated that executive capacity was an issue. There was no evidence to suggest that her executive capacity was considered when professionals made decisions about Lilian's mental capacity. For example, professionals appeared to assume that Lilian was making an informed choice to remain in her living conditions			
NSAB Strategic Response: What difference do we expect to see?	Improved practice relating to carrying out mental capacity assessments. Specifically, this will involve the need for decision specific assessments, the importance of executive capacity and fluctuating capacity. • Improved mental capacity assessments leading to a better balance between autonomy and risk management • Improved awareness of the concept of executive capacity in LBN and across the safeguarding partnership • Improved access to best interest decisions for residents who lack capacity			
Owner	**Action: What are we expecting to see**	**Timescale**	**Progress/Evidence/Impact**	**Completed**
London Borough of Newham-Adult Social Care	3.1 Amend Azeus (database) to provide practitioners with reminders about mental capacity assessments. This will also enable LBN to produce more detailed reports about mental capacity assessments in safeguarding enquiries Request an Azeus system change for the below a. Mental Capacity Assessment forms can no longer be voided. b. Add into the Mental Capacity Assessment form within Azeus a question asking "Is this MCA in relation to a safeguarding enquiry" c. Amend recording fields within Azeus to better reflect safeguarding enquiry outcomes and conclusions. d. Add into the Azeus Safeguarding Concern Form additional outcomes which reflect actions which may be taken without the person's consent.	Complete	Current data for ASC indicates around 24% of people involved in enquires lack capacity to make relevant decisions	Complete

	e. Add into the Safeguarding Enquiry Form a reminder to trigger a Mental Capacity Assessment when required			
	3.2 Complete audit and learning and practice development shared.	Complete	Audit is complete and learning has been shared. Training is ongoing. The DoLS Team manager also delivered a follow up session in August 2023	Complete
	3.3 Feedback areas to be addressed in future MCA forum workshops to feedback practice	Complete	Forums which addressed these issues were held in May 2022 and August 2023	Complete
	3.4 LBN will chair an MCA and DoLS sub-group to improve practice regarding MCA (2005) and DoLS.	Ongoing	The sub-group will continue and will embed the developments and learning from this review into practice	Ongoing
	3.5 ASC will improve awareness of executive capacity by reviewing training programs and holding a reflective session on executive capacity	Ongoing	Improved awareness of executive capacity in LBN and across the partnership	Due October 2024
Community Mental Health Team for Older People. East London NHS Foundation Trust	3.6 The Newham Directorate Safeguarding Adults and Children Leads co-facilitated training for the CMHTOP staff in Mental Capacity, with special emphasis on the principles of executive capacity and recording capacity assessments.	May 2023	Service users' capacity in relation to care provision are now routine discussions in the Team MDT Meetings and Huddles. Where required, staff do undertake formal capacity assessment and document.	Complete

Recommendation 4	**Safeguarding and Self-Neglect:** The reports provide clear evidence of self-neglect and hoarding but there was no evidence of a safeguarding intervention. There is some evidence to suggest that the self-neglect was caused by the negative symptoms of psychosis but a safeguarding intervention would have been appropriate in these circumstances. A successful intervention through a multi-agency safeguarding process would have improved her well-being and may have improved her ability to engage with services. Additionally, the multi-agency approach would have improved the partnerships awareness of her issues and may have led to an effective contingency plan following discharge			
NSAB Strategic Response: What difference do we expect to see?	• Improved awareness and understanding of self-neglect and hoarding throughout NSAB agencies • A more effective multi-agency response to self-neglect and hoarding • Improved risk assessment and risk management plans relating to fire risk • Increased staff awareness so that each professional play their part in preventing, identifying and responding to abuse and neglect. • Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs. • Safeguard adults with informed/executive capacity in a way that supports them in making choices and having control about how they want to live; • Improved communication among the different stakeholders through safeguarding processes.			
Owner	**Action: What are we expecting to see**	**Timescale**	**Progress/Evidence/Impact**	**Completed**
NSAB Self-neglect sub-group	4.1 Develop a multi-agency self-neglect policy grounded in liaison with residents and staff, focused on meaningful action to reduce self neglect. The policy should explain how to manage and escalate risks. The policy should also provide guidance on contingency plans when cases are closed.	September 2024	NSAB has established a self-neglect sub-group that will develop a multi-agency self-neglect and hoarding policy that adopts a wider multi-agency approach with delivery overseen by NSAB.	
London Borough of Newham-Adult Social Care	4.2 ASC has a self-neglect/hoarding policy available on the LBN website	Complete	Improved understanding of self-neglect in LBN	Complete
	4.3 Carry out multi agency self-neglect audit	Complete	Peer supervision in ASC has focused on hoarding and self-neglect and hoarding	Complete

	4.4 ASC will continue to be the lead agency for the multi-agency fire safety group	Ongoing	Improved risk assessments and risk management plans and improved access to relevant equipment	September 2024
Newham Council – Housing Directorate	4.5 Develop a joint working protocol for Housing and ASC with respect to cases of hoarding and/or self-neglect. To include a process for reopening cases that have been previously closed if concerns persist. Joint working with ASC on cases of concern to prevent escalation particularly where there is risk to the sustainability of tenancies.	September 2024		
	4.6 Arrange for designated Housing officers to be granted access to the ASC Azeus system and the development of information sharing protocols to facilitate improved case management.	December 2024		
Community Mental Health Team for Older People, East London NHS Foundation Trust	4.7 The Newham Directorate Safeguarding Adults Lead to facilitate awareness raising training for the Team/MHCOP in self-neglect and hoarding, including assessment and intervention processes and guidelines on involving other agencies for multi-agency approach.	December 2023	The Directorate Safeguarding Lead facilitates monthly Safeguarding Supervision for CMHTOP staff, where staff bring potential and actual safeguarding issues for discussions and sharing ideas. This has empowered staff to bring for discussion and sharing learning on various safeguarding issues.	Completed on 07/12/2023

Recommendation 5	**Support vulnerable housing tenants:** produce housing policies and procedures that set out how Housing staff should support and work with vulnerable tenants.			
NSAB Strategic Response: What difference do we expect to see?	• Improved working between council teams on cases of hoarding and self-neglect • Consistent response to Housing cases impacted by tenant vulnerability			
Owner	**Action: What are we expecting to see**	**Timescale**	**Progress/Evidence/Impact**	**Completed**
Newham Council – Housing Directorate	5.1 Develop of a Vulnerable Tenants Policy and Procedure. This policy will set out the Housing response to vulnerable tenants, and guide the possible service accommodations required. The policy will build on service adaptations already in place for elderly tenants for the delivery of day-to-day and planned (i.e. Project Irene) repairs, and garden maintenance to council tenants.	November 2024 – draft for consultation September 2025 – final report		
	5.2 Develop a Housing Hoarding Policy and Procedure. Policy to reference ASC's approach to incidences of hoarding and will set out Housing's response/contribution to a multi-agency response to hoarding cases, whilst explaining the Council's approach to apparent breaches of tenancy in this area, and the management of any related building safety or fire risk.	November 2024 – draft for consultation September 2025 – final report		

	5.3 Housing officers who have frequent contact with vulnerable residents to receive training on trauma informed practice.	September 2024	Not applicable	Not applicable

Recommendation 6	**Housing Directorate information sharing:** Improve information-sharing and record-keeping by officers in the same and different teams within the Housing Directorate			
NSAB Strategic Response: What difference do we expect to see?	• Improved case management of tenants' concerns and/or concerns about tenants			
Owner	**Action: What are we expecting to see**	**Timescale**	**Progress/Evidence/Impact**	**Completed**
Newham Council – Housing Directorate	6.1 Improve the quality of handovers for Housing Patch officers to ensure that tenant issues are effectively communicated to officers to achieve continuity of the management of tenancies.	April 2023	This change was introduced after the original incident and remains in operation.	Completed
	6.2 Maintain and improve information sharing between Housing teams via the main housing IT system (NEC Housing)	April 2023	Housing teams share information on tenancies at risk due to suspected or actual breaches of tenancy (e.g. rent arrears). The contact details of ASC staff involved in cases is also recorded.	Completed
	6.3 Develop a resource plan to extend the Independent Living team service to Temporary Accommodation tenants in Housing Revenue Account stock.	September 2024		

Recommendation 7	**GP Practices:** all GP practices in Newham to ensure that administrative staff are aware of the vulnerable patients on the practice list and understand the process for escalation to the GP.			
NSAB Strategic Response: What difference do we expect to see?	• Vulnerable adults will be recognised by GP practice administrative staff • Novel ways of making contact with vulnerable adults will be considered at an earlier stage • Vulnerable adults who miss appointments will be appropriately escalated to the safeguarding lead after contact has been attempted by at least 2 different routes			
Owner	**Action: What are we expecting to see**	**Timescale**	**Progress/Evidence/Impact**	**Completed**
NEL ICB Primary Care	7.1 Administrative staff will feel more confident in identifying and escalating missed appointments in vulnerable adults.	12 months (March 2025)	We are producing new guidance for administrative teams in primary care which is targeted and user friendly. Increasing the visibility of new guidance will occur via a number of modalities – namely the GP Safeguarding leads meeting, Newham level 3 training for GPs, the production and distribution of an easy read policy, the distribution of the 7 min briefings produced by NSAB.	

Recommendation 8	It was recommended that: a. The Trust explore an alternative system to ensure that 48-hour report is commissioned for all unexpected deaths of existing and former service users, irrespective of when the service user last accessed services of ELFT. b. The Trust Risk & Governance Team to amend the protocol for daily incident reviewers to include an instruction to refer such incidents to twice weekly Incident Grading Panel meetings for a decision to be made on investigation or closure, if another agency raises a concern. c. To review and amend the Trust's Incident Policy to ensure that it highlights the need to report cases as incidents where a local authority has decided to undertake a Safeguarding Adults Review (SAR) involving an ELFT service user. d. To review and amend the Trust's Incident Policy to ensure that it references the need for staff to raise as incident if made aware of Missing Person's inquiries regarding ELFT service users. The ELFT Patient Safety Serious Incident Review (SIR) identified that CMHTOP and the Trust Risk & Governance staff followed Trust Incident Reporting Procedures in reporting Lilian's death. However due to shortcomings in the Trust's Incident Reporting Process, the need for further investigation into Lilian's death was not identified and a comprehensive review of her care started by the time of the Inquest hearing on 11.07.22.			
NSAB Strategic Response: What difference do we expect to see?	• Incidents are managed effectively and immediate action/learning takes place • Staff follow the correct procedures when an incident occurs • Investigations are conducted in a timely manner and are of high quality • The Trust learns from incidents to improve the safety and quality of services • Staff, service users, their carers and families and members of the public are provided with appropriate support throughout the process.			
Owner	**Action: What are we expecting to see**	**Timescale**	**Progress/Evidence/Impact**	**Completed**
Community Mental Health Team for Older People, East London NHS Foundation Trust	8.1 Review the Trust Incident Policy and incorporate the recommendations. Key areas: • Section 11.0 of the Policy specifically outlines guidance on 'responding to deaths' and Point 4 of Section 11.1 - the Incident reporting and investigation process of the Policy, clearly states that	Policy was reviewed in June 2022, after the incident. Final review completing 30 April 2024	The Trust commissions 72 - hour reports, depending on the circumstance, for all unexpected death of service users, under the care of ELFT services. The Reports are then referred to a decision making Panel Meeting with Directors where	

	'Where a patient is not under the care of the Trust at the time of death but another agency raises concern, this will be discussed at the weekly grading meeting and a decision made on investigation or closure'		decisions are made regarding the incident to decide which learning response will produce the best learning outcomes following discussion and review. Trust's Legal Department views are considered at this meeting and the meeting is also open to representatives from various ELFT Service Teams, including CMHTOP and other third parties and agencies to bring any issues of concern relating to safety incidents for discussion.	

Recommendation 9	**Issues for national attention (SAB Chairs group)** When a person goes missing, banks will inform relevant police forces that an account is either active or inactive. The terminology 'active' can be misleading when related to missing people, especially given that many transactions are conducted automatically in the modern era. In Lilian's case, the active label led to the wrong assumptions being made. The recommendation is that the issue is addressed at national level.			
NSAB Strategic Response: What difference do we expect to see?	• SAB Chair to use leadership position to seek advocacy for policy change and/or banking sector awareness			
Owner	**Action: What are we expecting to see**	**Timescale**	**Progress/Evidence/Impact**	**Completed**
Newham SAB Chair	9.1 SAB Chair to raise issue with National, pan- London and NEL independent SAB Chairs groups to seek support to draw attention of the impact to the banking sector. 9.2 SAB chair to work with the local Met Police to examine approaches to missing person to strengthen current guidance in respect of the intelligence gained and/or interpretation given to missing persons and in active bank accounts	July 2024 July 2024	SAB Chair raised issue with SAB Chairs of the pan-London, NEL and National Groups SAB Chair planned meeting 9th April 2024 includes raising issue with Metropolitan Police SAB Partner	
	9.3 SAB chair working with partners to develop a safeguarding equity and quality intelligence improvement plan that builds equity as an underpinning part of the work of the SAB and supports the SAB;- • Deliver against its responsibilities set out in the Care Act 2014 tailored to the needs of Newham residents. This will draw from and collate existing safeguarding data and intelligence sources;	2024/2025	SAB Chair engaged with LBN Public Health and data insight team to explore gaps in existing safeguarding data.	

	including self-neglect providing insights into the care and support needs of the diverse groups in Newham.			

Initialisms used in this plan:

GPs	General Practitioners
NSAB	Newham Safeguarding Adults Board
CMHTOP	Community Mental Health Team for Older People
LBN	Newham Council
ASC	Newham Council Adult Social Care
ELFT	East London Foundation Trust
SI	Serious Incident
DoLS	Deprivation of Liberty Safeguards
Azeus	LBN Adult Social Care IT system
MDT	Multi Disciplinary Team
Datix	A system used by NHS staff to report incidents and risks
MCA	Mental Capacity Act (MCA) 2005
HRA	Housing Revenue Stock