

**Safeguarding Adult Review of ‘Anne’**

**NYSAB Report - September 2021**

1. **Introduction**
   1. The purpose of this report is to present to the North Yorkshire Safeguarding Adults Board, an update on the actions in relation to the Safeguarding Adult Review of ‘Anne’.
2. **Background**
   1. **‘**Anne’ was a 34-year-old mother of three. She became a resident in supported housing accommodation in February 2015. Following assessment it was identified that she needed support with anti-social behaviour, recovery from substance misuse, physical and mental health needs and support to maintain a tenancy.
   2. Anne had a history of mental health problems and was supported by mental health services as well as the on-site staff where she lived. Following a referral in March 2015 into the Drug and Alcohol Recovery service by the supported housing provider, Anne disclosed substance misuse issues in relation to alcohol, diazepam and mephedrone.
   3. Anne initially engaged well with the Drug and Alcohol Recovery Service, abstaining from alcohol and, in May 2016 following assessment it was reported that she was making exceptional progress in relation to addressing her substance misuse issues.
   4. Anne was discharged from the Drug and Alcohol Recovery Service in September 2017 owing to the positive progress they felt she had made.
   5. In the days leading up to her death, Anne was appearing unwell and under the influence of substances. She was found dead in her flat on 4th January 2018 and the cause of death was subsequently given as drug toxicity.
3. **Overview**
   1. In February 2021, the North Yorkshire Safeguarding Adults Board (NYSAB) published a Safeguarding Adult Review which looks at the actions of the agencies involved in supporting ‘Anne’. We thank Anne’s family for their help with this review during this difficult time for them.
   2. The report made ten recommendations to the individual agencies involved and the SAB as a whole, all of which are accepted by the SAB in full. Since the report was published, the agencies involved in this review have been undertaking the work required as a result of the recommendations to ensure that lessons are learned from the sad death of Anne and that practice and process and the 10 recommendations it made. The Learning and Review sub-group met on 26th February 2021 to discuss how we could ensure the recommendations have the greatest positive impact upon practice, and what steps were required to achieve them. An action plan was composed which was subsequently agreed at a further Learning and Review sub-group meeting on 1st April 2021. This report highlights the progress made by partner agencies against the Action Plan, and identifies the next actions required to progress them further and ultimately sign the action plan off as complete.
4. **Current position on each recommendation**

**Recommendation 1:**

**NYSAB should commission an independent review of the supported housing accommodation arrangements, to identify risks and opportunities, with a view to influence changes to policy at a regional and national level.**

An author is currently being procured to undertake the independent review of the supported housing arrangements.

North Yorkshire County Council (NYCC) Health and Adult Services and Scarborough Borough Council met earlier in the year to discuss the theme of the review, and it was suggested ***‘what does good look like in supported housing***’ would be an effective approach.

Recommendations have been requested in relation to questions such as:

* ***‘What an effective an integrated supported housing would look like in a newly single tier local authority context’*** and;
* ***‘How a single housing pathway for all age groups could be developed from existing arrangements’.***

To ensure a thorough and robust review is carried out, timescales for this review will be confirmed when a reviewer has been appointed.

**Recommendations 2, 3, 6 and 10:**

For recommendations 2, 3, 6 and 10 from the SAR report, an internal audit of the six supported housing providers commissioned by NYCC was completed.

This was undertaken by the NYCC Service Development Team. The methodology of this audit included the following stages

• An initial conversation with the provider, explaining the context and learning within the ‘Anne’ SAR;

• Service providers submitted up to date Quality Assurance Framework (QAF) self-assessments, policies and procedures relating to safeguarding adults and children and welfare checks and staff training matrixes and;

• Desktop reviews of these documents were undertaken by the Service Development Team. Where sufficient evidence was not produced to demonstrate compliance with the QAF and recommendation of the SAR, an action plan was created with the provider. Outstanding actions from the action plans will now be monitored through the regular scheduled contract management meetings until completion.

**Recommendation 2:**

**NYCC and Scarborough Borough Council drawing upon learning from this case should ensure staff employed at the accommodation have relevant training with accreditation to help equip them to safeguard residents at the premises.**

All providers had policies and procedures in relation to safeguarding adults and children, and these had been reviewed within the last 3 years. The most recent of these referenced the multi-agency safeguarding policy and procedure, and North Yorkshire pathway for raising safeguarding concerns.

Where this is not clear it was made an action plan requirement.

Accessing NYCC safeguarding adults and children’s training will be embedded into on-going service specifications as a mandatory requirement for staff to undertake at a level relevant to their role.

**Recommendation 3:**

**NYCC and Scarborough Borough Council as commissioners of the accommodation drawing upon the learning from this review should ensure the guidance and support provided to staff as to the circumstances in which they should enter a resident’s flat is sufficiently robust and explicit so as to safeguard the individual concerned.**

Most providers had appropriate welfare checks policies and procedures in place, which give staff clear direction on when it is appropriate to enter a person’s room or flat and what to do if there were any concerns for the person’s welfare.

Where these were not evidenced or required some development, an action plan was created. It was acknowledged that these needed to be appropriate and proportionate depending on the type of service. This was due to now only two providers having on-site support 24/7 (Provider A and Provider B).

Provider A has written a new Welfare Policy which is due for sign off September 2021 by their own internal management.

**Recommendation 6:**

**NYCC and Scarborough Borough Council should ensure that a collaborative plan is drawn up between the provider, resident, and agencies prior to a move to independent living that addresses the individual’s care and support needs.**

Through their QAF self-assessment, all service providers gave good detailed responses to all the assessment and support planning criteria. Service providers gave examples, which provides assurance that their approach to assessing needs, risk and support planning ensuring clients views are at the centre of this and involves other professionals and / or carers as appropriate. Templates of the needs and risk assessment documentation that are used were provided, which further evidenced their approach.

**Recommendation 10:**

**People living in supported housing environments should be supported through the development of an outcome focused support and risk management plan, informed by all agencies providing care and support to the resident that is subject to regular review and monitoring to ensure it remains current.**

Through their QAF self-assessment, all service providers gave good detailed responses to the support planning criteria. Service providers also gave examples, which provides assurance that all people in receipt of the service have individual outcome-focussed support and risk management plans that address the needs and risks identified by the assessment process and that these are reviewed within appropriate timescales.

This also indicated there is a multi-agency approach to support planning which takes account of the wider needs of the person. This includes attendance at a variety of multi-agency meetings e.g. multi-agency risk assessment conference (MARAC), multi-agency public protection arrangements (MAPPA), local practitioners meetings, Community Mental Health Team (CMHT), and meetings regarding substance misuse etc.

The outstanding action for this recommendation relates to providers sharing copies of their training matrixes.

Progress is being monitored through quarterly contract meetings with the Commissioning Team at NYCC, where this is a standing agenda item.

**Recommendation 4:**

**NYSAB are required to raise awareness across the Safeguarding Partnership of the requirement of when to raise a safeguarding concern as detailed within the Joint Safeguarding Adults Multi Agency Policies and Procedures, West, North Yorkshire, and York.**

A 7-minute brief has been developed to raise awareness across the safeguarding partnership as to when a safeguarding concern should be raised.

The brief also includes learning captured within the SAR, including the need for effective support planning and information sharing. The brief will be published on the NYSAB website and shared with partner organisations. This action will be complete once assurances have been received from agencies that the brief has been shared throughout their organisations.

The 7 minute brief can be found here - <https://safeguardingadults.co.uk/wp-content/uploads/2021/09/Anne-SAR-7-minute-briefing.pdf>

**Recommendation 5:**

**NYSAB should commission an external review of the Drug and Alcohol Recovery Service discharge process where existing concerns of substance misuse are present in-service users.**

An independent reviewer has been identified to undertake an external review of the drug and alcohol recovery service’s discharge policy.

In order to maintain the Board’s integrity and accountability, the review is currently going through the procurement process.

The review will include stakeholder engagement, analysis against current national best practice, and a review of the service against the context of this SAR. It is anticipated that the review will take 6 weeks to complete.

In the interim, the supported housing provider completed their own internal audit of the service. The review includes a summary of ‘Anne’s’ involvement with the drug and alcohol recovery service and identifies learning to be considered. This includes communication with other agencies and staff awareness of mental capacity. The report makes a number of recommendations including:

* Reviewing the training available to staff;
* Developing a specific discharge policy and;
* Developing a ‘complex needs / multiple disadvantages’ model to improve management of risk with the most complex clients.

**Recommendation 7:**

**NYSAB should seek assurance from TEWV as to how the lessons learnt and improvement actions identified by the TEWV serious incident review including the use of the Care Programme approach to promote multi-agency working, have been shared with practitioners and the improvement activity embedded in current practice.**

TEWV completed a serious incident review in June 2018, which included 5 lessons to be learnt. These included the need to provide carer assessments on a regular basis and that staff should record all depot injections administered in patients Electronic Care Records (ECR).

TEWV have provided an assurance statement that these changes have been made and since been audited and that they are now embedded within practice.

**Recommendation 8:**

**NYSAB drawing upon learning from this case should promote the existence of The City of York and North Yorkshire Multi Agency Practice Guidance for working with Adults whose concerning behaviour/ self-neglect is likely to result in significant harm or may result in their death to promote multi-agency working and information sharing.**

A task and finish group of partner agencies is currently meeting to understand what obstacles need to be overcome before the multi-agency self-neglect meeting (MASM) policy can become operational.

Agencies have been asked to consult with their own internal teams as to what training and resources are required for them to be able to participate in the implementation of the MASM policy. Consideration should also be given to the impact the MASM have on by their own internal recording systems.

A further meeting is planned before the next Policies, Practice Development and Legislation (PPDL) group meeting in October 2021. It is not possible to produce a timeframe for when it is expected the MASM policy will be operational, so it was agreed that the Board will receive updates and assurances on this recommendation via the PPDL group rather than the action plan.

**Recommendation 9:**

**NYSAB should raise awareness of the “One Minute” guide on information sharing to North Yorkshire Police and promote its existence to the wider North Yorkshire Safeguarding partnership.**

A “One Minute” guide on information sharing to North Yorkshire Police has been shared with partner agencies and assurances have been received that the guide has been disseminated to internal staff.

The One Minute Guide (OMG) is available here on the NYSAB website: <https://safeguardingadults.co.uk/working-with-adults/one-minute-guides-omg/information-sharing/>

1. **Summary**

The progress of the outstanding actions and recommendations will be monitored and reviewed by the Learning and Review group. Updates and assurances will be provided to the NYSAB on the progress and delivery of these actions.