Developing a Homelessness Fatality Review Procedure

LGA Workshop

January 14th 2020

- describe the legislation and policy as it relates to homeless deaths and reviews
- explore the approach adopted by London Borough of Haringey
- discuss the early findings and lessons learnt to date from Haringey's approach
- share tools and further reading

Introductions

- What is your connection with homelessness i.e. lived experience, frontline practitioner, senior manager, commissioner, SAB Member etc.

- **Why** do you do your job?
- **What** do you do in your job?

Homelessness in the UK

Around 13,000 households make an application of homelessness in London every quarter, 141 every day.

The most common reasons for homelessness is loss of Assured Shorthold Tenancies

83,700 households are living in Temporary Accommodation, a 74% rise since 2010.

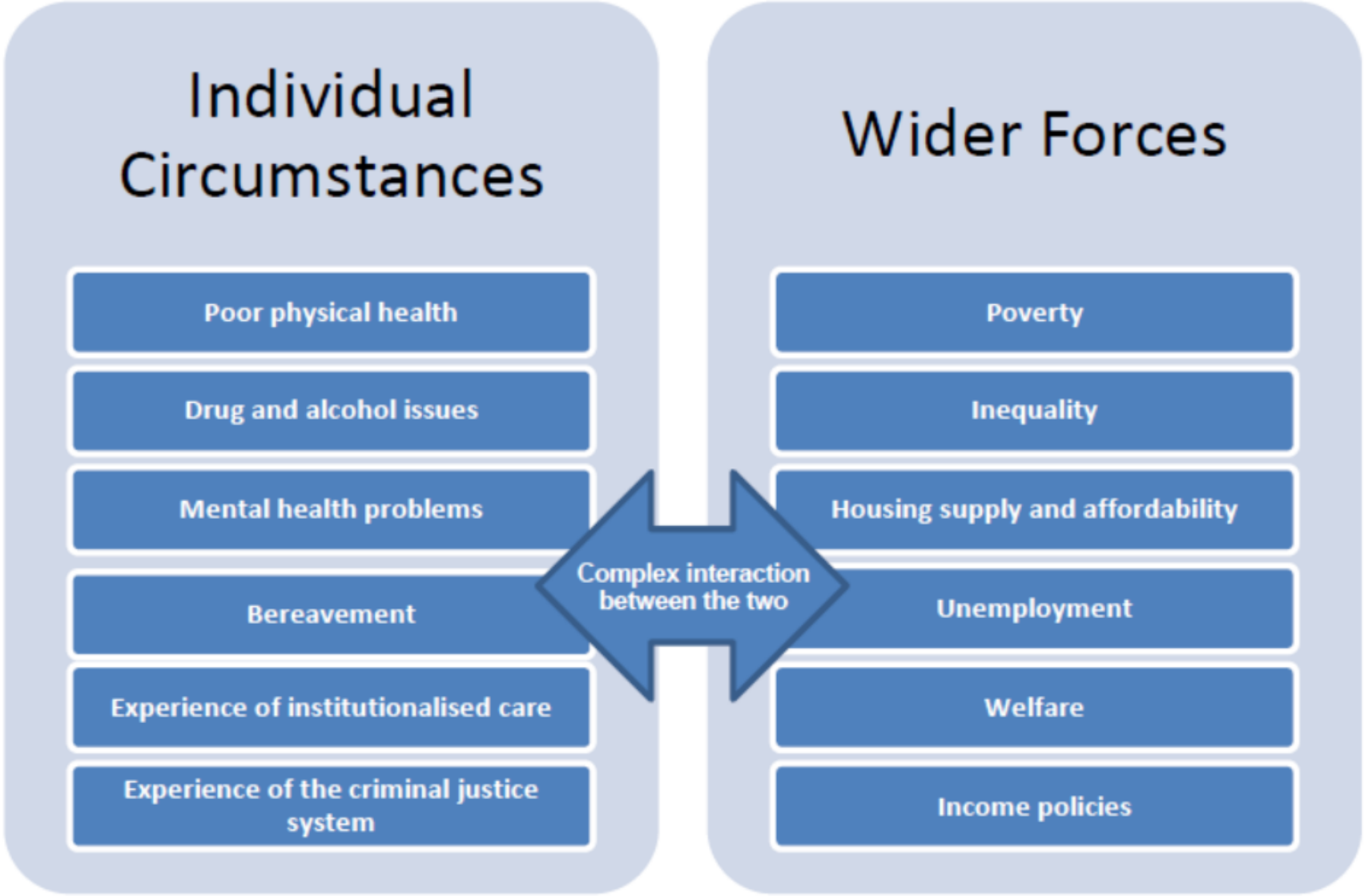
120,000 children are currently living in temporary accommodation in the UK

4,677 people sleep rough in the UK on a given night, 1283 of them are in London.

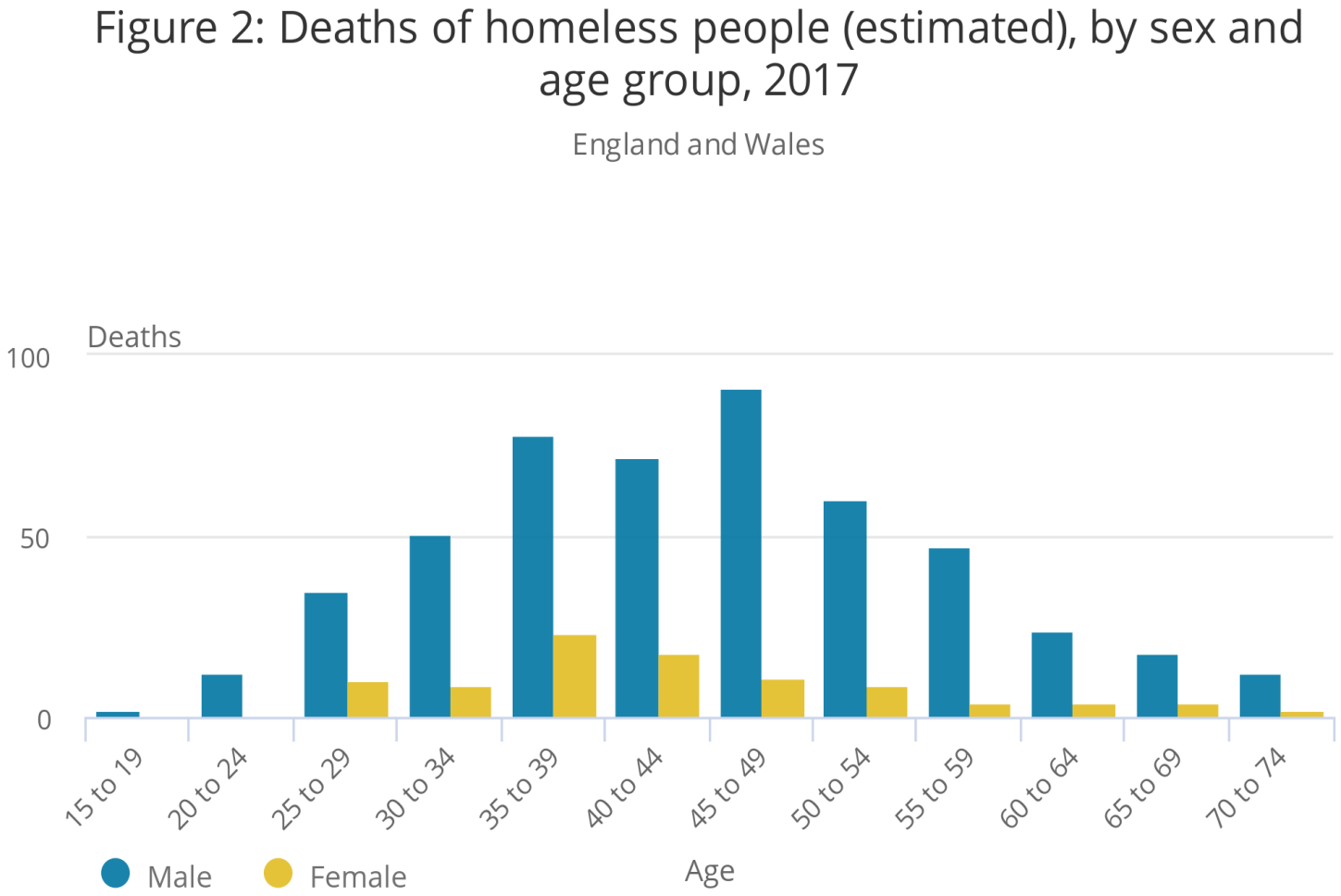
25% of homeless young people are LGBTQ+

It is estimated that homelessness costs £1.5bn per year in public spending, illness, lost work days etc

Factors that Influence Homelessness



Why are we here?



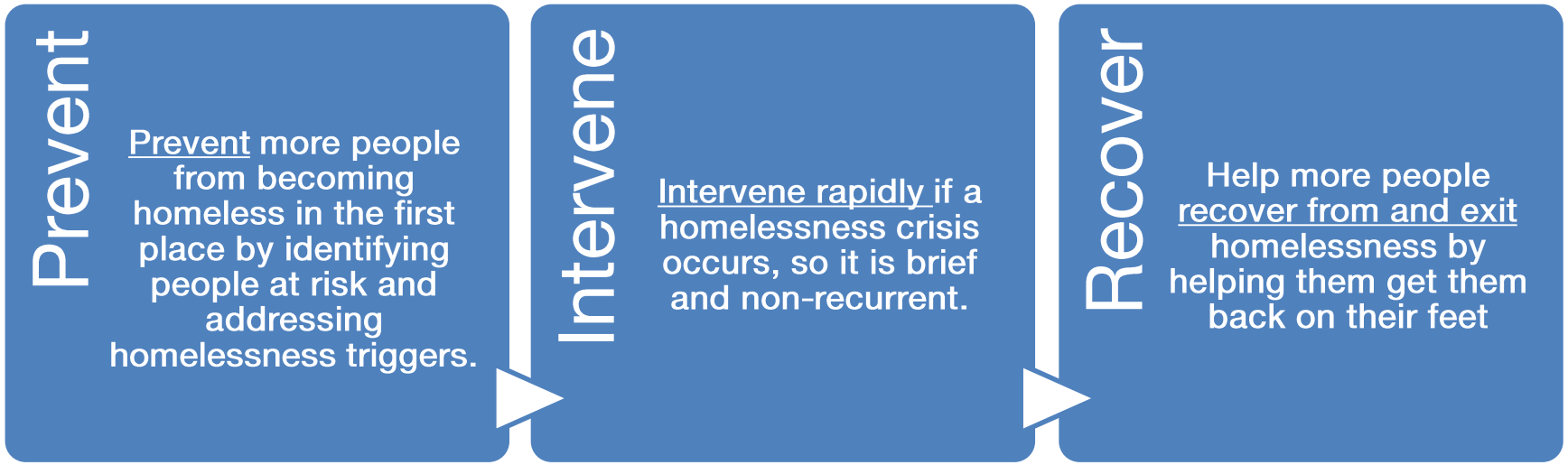
Source: Deaths of homeless people in England and Wales: 2013 to 2017 (ONS)

- There were 726 deaths of homeless people in England and Wales in 2018, an increase of 22% since last year.
- Homeless men make up 84% of the total number of people who died
- The mean age of death for men was 44 years and the women's mean age of death was 42 years.
- In comparison, the mean age at death for the housed population was 76 years for men and 81 years for women.
- Most people who die homeless pass away in hostels or hospitals, there are relatively few deaths actually on the streets

Relevant Legislation & Policy

Homelessness Reduction Act

- Most significant change to housing legislation in 40 years
- Draws on the work of an independent panel of experts established by Crisis - based on the Housing (Wales) Act 2014
- Sits within a range of national measures and commitments to address homelessness and rough sleeping
- Increased focus on partnership working and addressing the underlying causes of homelessness
- Extends the councils duties to people who are at risk of homelessness within 56 days
- Brought in the 'Duty to Refer', an obligation for statutory agencies to alert Councils to people who are homeless or at risk of homelessness
- **Importantly it's an opportunity to do things differently and in partnership**



MHCLG Rough Sleeping Strategy (2018)

The aims of the strategy are to provide a national framework through which local areas can prevent, intervene and assure recovery from rough sleeping

The strategy commits to ending rough sleeping by 2027

Improving oversight: ensuring that the deaths of people who sleep rough are recorded and rigorously investigated.

Recommends a more consistent use of SAR's when a person rough sleeping dies

Review processes should inform learning, reflection and change at local level

There is an emphasis on sharing knowledge and best practice between local areas

The Care Act (2014)

The Care Act 2014 is by far the most wide-ranging legislation affecting adult social care and related partners. It consolidated existing legislation and provides a more systematic focus on the “wellbeing” of all adults.

It extends safeguarding and care beyond the responsibility of Adult Social Services and all areas of the council now have a role to play in:

- Promoting individual well-being
- Preventing needs for care and support
- Promoting integration of care and support with health services etc.
- Providing information and advice
- Promoting diversity and quality in provision of services
- Co-operating with relevant partners

The Act signifies a shift from providing particular services, to the concept of ‘meeting needs

The Care Act (2014) cont.

Under Section 44 of the 2014 Care Act, Safeguarding Adults Boards (SABs) are required to consider undertaking a Safeguarding Adults Review (SAR) when an adult in its area has suffered death or significant harm as a result of abuse and/or neglect, and there is a concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a SAR is to:

- **Learn** from the way local agencies, staff and volunteers worked together to safeguard adults at risk; what did and what did not work well; and what might have been done differently;
- Provide an **analysis** of what happened and what action could prevent recurrence;
- Agree how this learning will be acted on, and what is expected to **change** as a result; and
- Include findings and actions in the **SAB Annual Report**, which is available to the public.

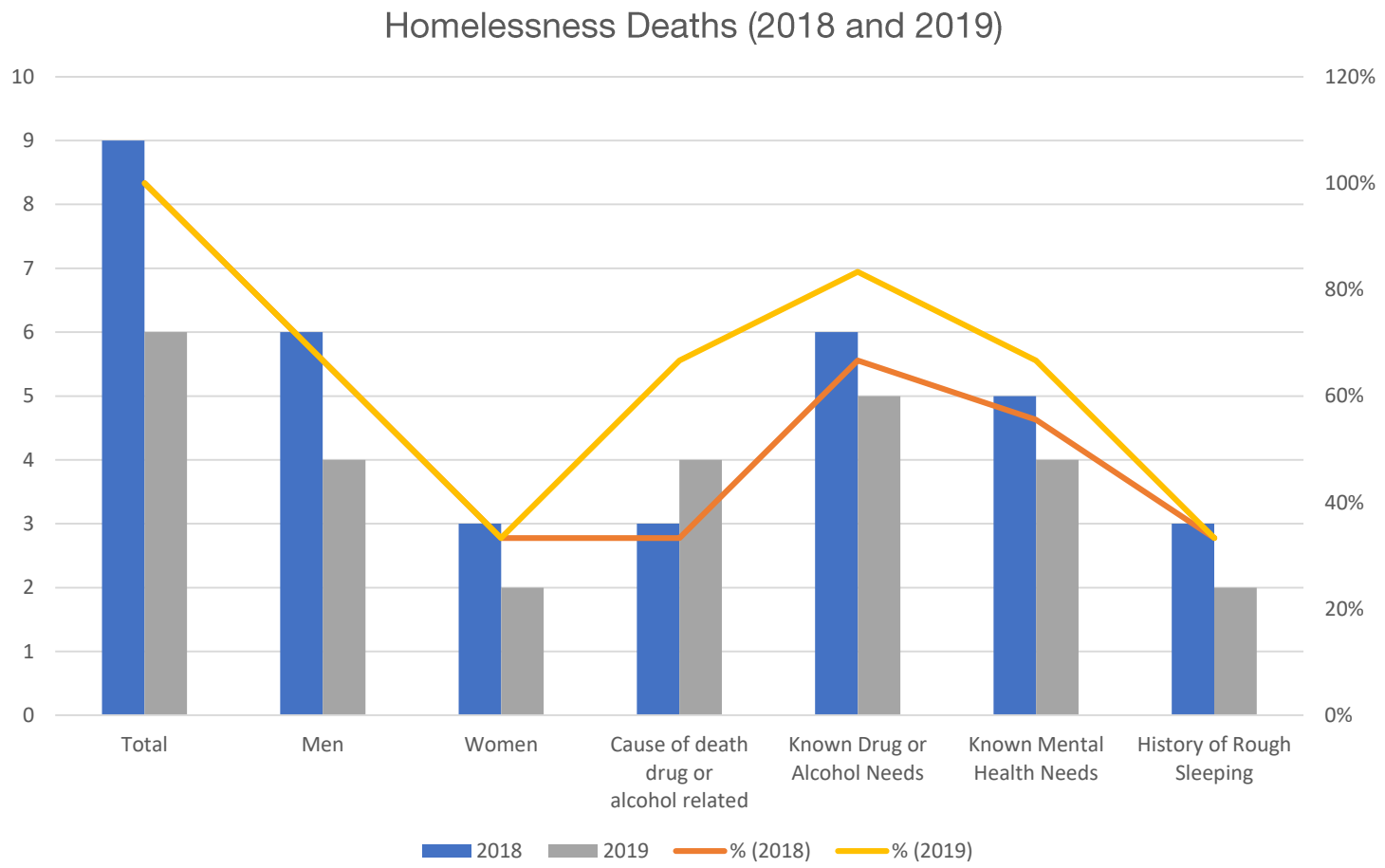
A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Healthy London Partnership

1	People experiencing homelessness receive high quality healthcare
2	People with a lived experience of homelessness are pro-actively included in patient and public engagement activities, and supported to join the future healthcare workforce
3	Healthcare ‘reaches out’ to people experiencing homelessness through inclusive and flexible service delivery models
4	Data recording and sharing is improved to facilitate outcome-based commissioning for the homeless population of London
5	Multi-agency partnership working is strengthened to deliver better health outcomes for people experiencing homelessness
6	People experiencing homelessness are never denied access to Primary Care
7	Mental Health Care Pathways, including Crisis Care, offer timely assessment, treatment and continuity of care for people experiencing homelessness
8	Wherever possible people experiencing homelessness are never discharged from hospital to the street or to unsuitable accommodation
9	Homeless Health advice and signposting is available within all Urgent and Emergency Care Pathways and Settings
10	People experiencing homelessness receive high quality, timely and compassionate end of life care

Developing the Approach in Haringey

Homeless Deaths in Haringey



Source: Haringey Homelessness Fatality Review Procedure (internal data source)

- There are an average of 10 deaths of homeless people each year in Haringey.
- Homeless women made up 33% of the people who died, more than the national average.
- The average age at death for homeless people in Haringey is 41 years old, younger than the national average

- In 2018, 66% of those who died had an identified drug or alcohol need, to date in 2019 this has increased to 87% of the people who died.
- In 2018, 37% of deaths were drug or alcohol related, in 2019 this has risen to 67%
- Potential suicide or documented suicidal thoughts were identified in around 30% of cases

Local Context

- A sharp increase in the deaths of homeless people in 2018
- Recurrent themes about information sharing, recognising risk and vulnerability
- Strategic and political move to recognise homelessness as more than a housing issue
- Becoming a Making Every Adult Matter (MEAM) approach area in 2018
- Renewed commitment to psychologically-informed working at frontline, inter-agency and commissioning levels
- Feedback from staff and service users, reflective practice and case reviews

Approach to Design

- Multi-disciplinary design meetings including frontline and strategic staff
- 1:1 conversations with people with lived experience of homelessness
- Based on LeDER reviews, SAR's and existing incident reporting procedures
- Drew on and built in existing mechanisms such as incident reporting, professionals meetings and lead professionals
- An iterative approach, will and should change over time

Primary Aim: to prevent the premature deaths of homeless people.

Secondary Aims:

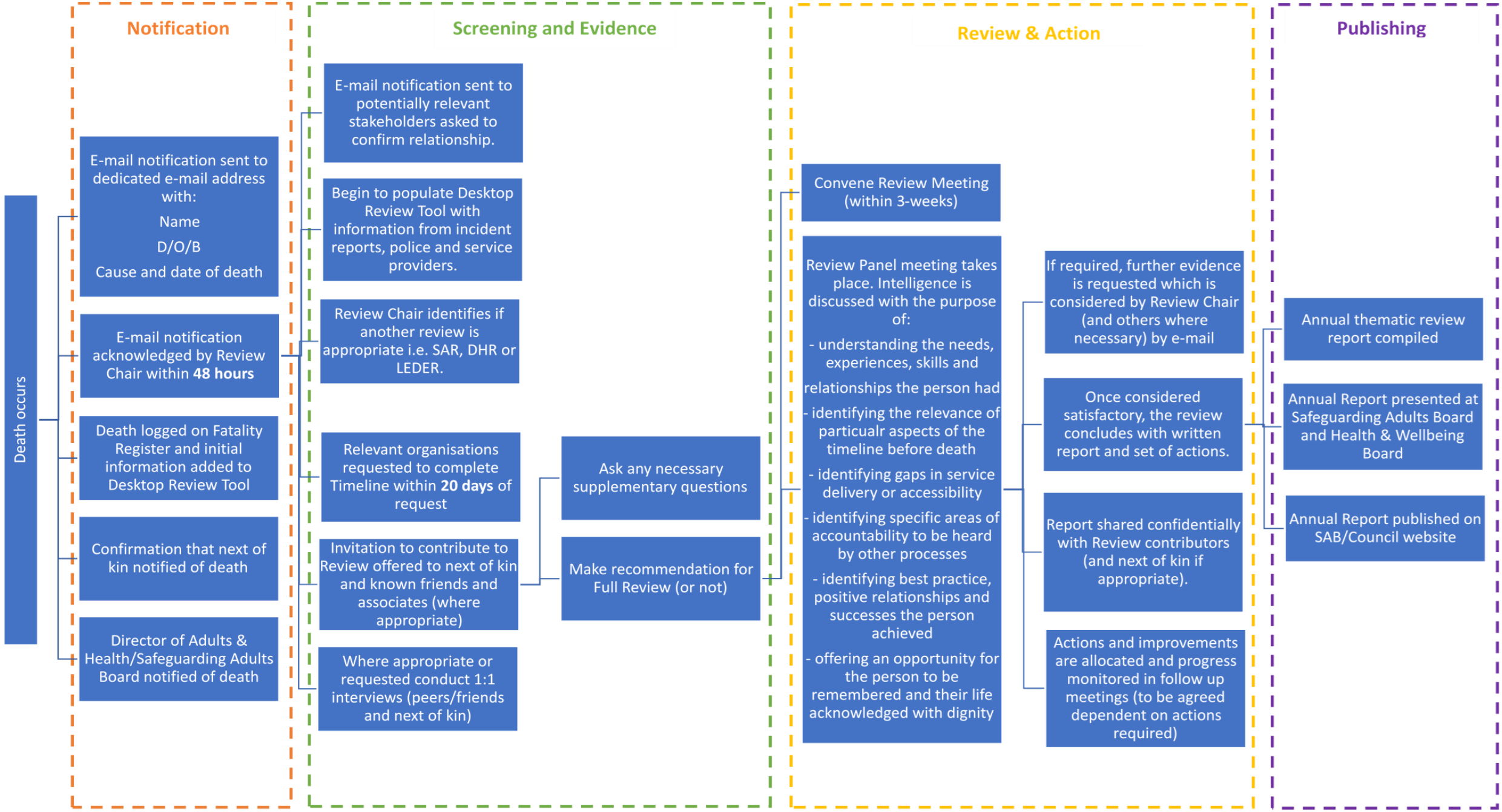
1. To improve multi-disciplinary partnership practice which is central to reducing the inequality affecting homeless people
2. To recognise the particular vulnerabilities affecting homeless people as they relate to safety and safeguarding
3. To create a human portrait of some of our most invisible residents, that resists framing people solely by their needs and risks

Formally implemented in February 2019

Doesn't supersede other statutory review processes

Faster than a SAR, actions and recommendations are implemented in 'real-time'

Submits an annual thematic review to the SAB

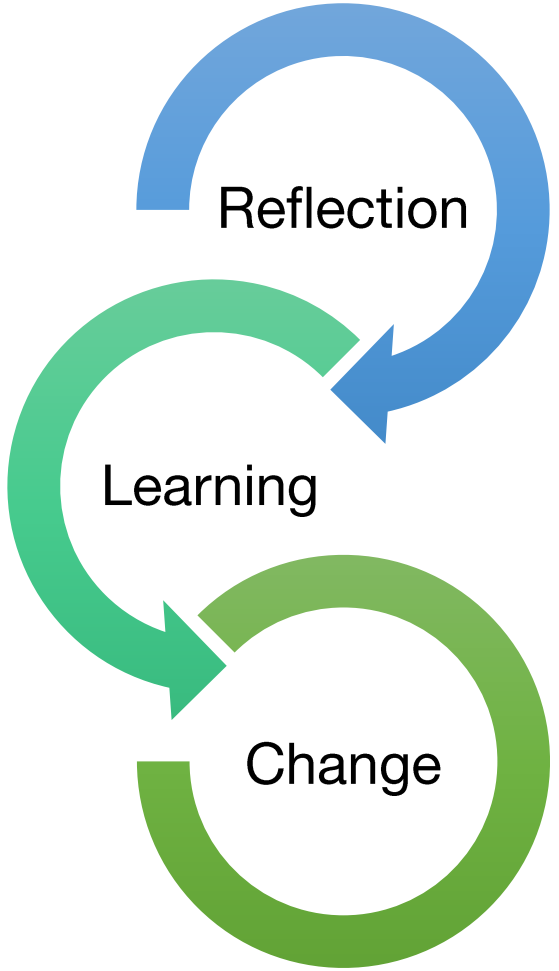

Notification
Screening and Evidence
Review & Action
Publishing
Death occurs
E-mail notification sent to dedicated e-mail address with:
Name
D/O/B
Cause and date of death
E-mail notification acknowledged by Review Chair within 48 hours
Death logged on Fatality Register and initial information added to Desktop Review Tool
Confirmation that next of kin notified of death
Director of Adults & Health/Safeguarding Adults Board notified of death
E-mail notification sent to potentially relevant stakeholders asked to confirm relationship.
Begin to populate Desktop Review Tool with information from incident reports, police and service providers.
Review Chair identifies if another review is appropriate i.e. SAR, DHR or LEDER.
Relevant organisations requested to complete Timeline within 20 days of request
Invitation to contribute to Review offered to next of kin and known friends and associates (where appropriate)
Where appropriate or requested conduct 1:1 interviews (peers/friends and next of kin)
Ask any necessary supplementary questions
Make recommendation for Full Review (or not)
Convene Review Meeting (within 3-weeks)
Review Panel meeting takes place. Intelligence is discussed with the purpose of:
- understanding the needs, experiences, skills and relationships the person had
- identifying the relevance of particualr aspects of the timeline before death
- identifying gaps in service delivery or accessibility
- identifying specific areas of accountability to be heard by other processes
- identifying best practice, positive relationships and successes the person achieved
- offering an opportunity for the person to be remembered and their life acknowledged with dignity
If required, further evidence is requested which is considered by Review Chair (and others where necessary) by e-mail
Once considered satisfactory, the review concludes with written report and set of actions.
Report shared confidentially with Review contributors (and next of kin if appropriate).
Actions and improvements are allocated and progress monitored in follow up meetings (to be agreed dependent on actions required)
Annual thematic review report compiled
Annual Report presented at Safeguarding Adults Board and Health & Wellbeing Board
Annual Report published on SAB/Council website


Break

Culture

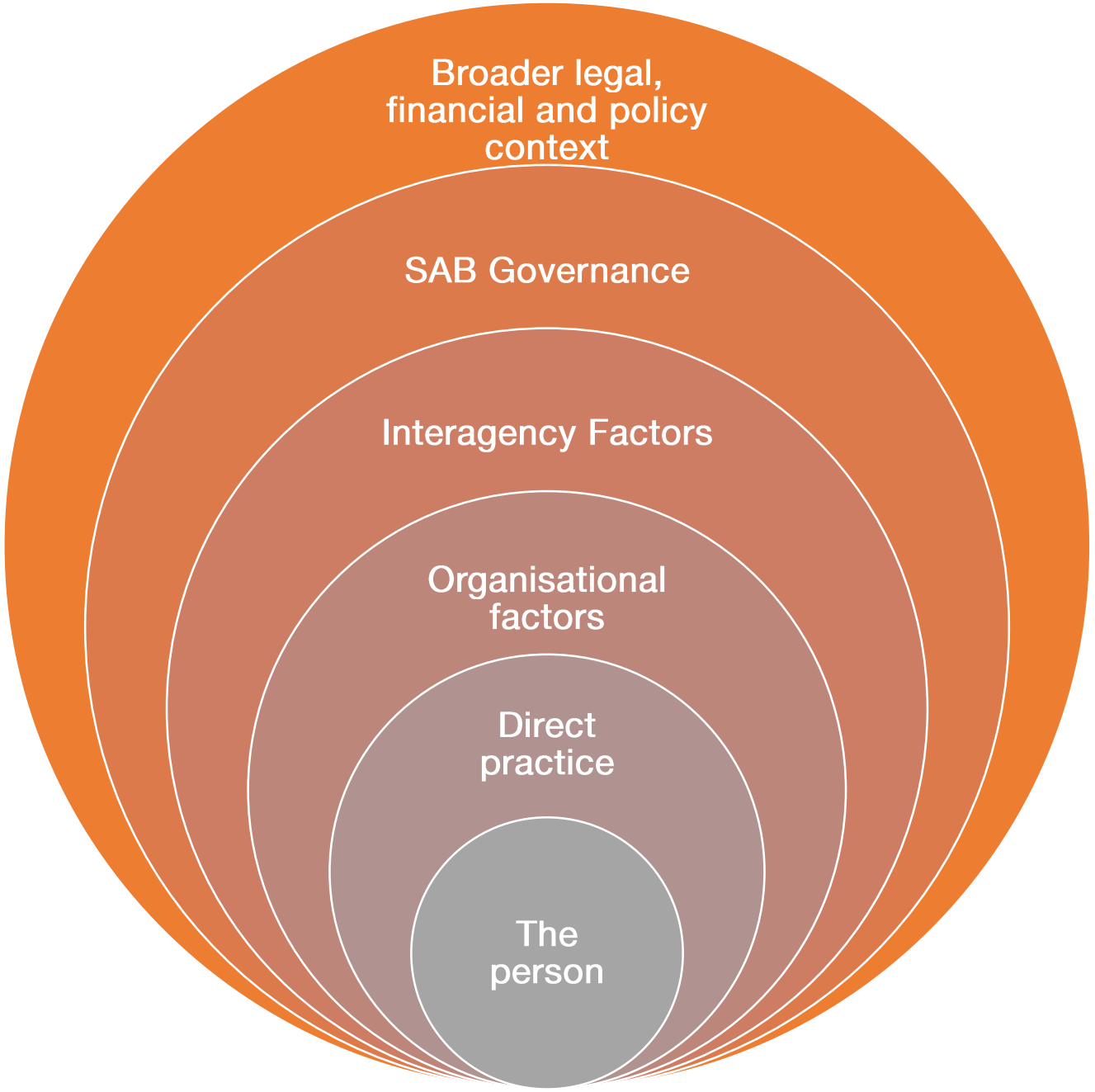
'An ungrievable life is one that cannot be mourned because it has never lived, that is, it has never counted as a life at all' – Judith Butler, 2016

- Why would you conduct a review of the death of a homeless person?
- How visible is homelessness in your area?
- Where is it visible?
- Who has a sense of ownership over the issue?
- Where is responsibility for homelessness located in your organisation?
- How are people with lived experience involved in the work to address homelessness in your area?



Systems Approach

- What is the ‘system’ surrounding homelessness in our area?
- How can a fatality review procedure help us better understand that system?
- What do we want the fatality review procedure to be able to influence?
- How open are people, services and organisations to change in our local area?
- What is the process of influencing relevant policy and strategy in our area?



Governance

- Governed by Haringey SAB, using the Care Act (Section 44(4)) powers, making it a statutory review function.
- Annual thematic report to SAB capturing a thematic reflection from completed reviews and change initiated as well as other relevant information about homelessness
- Deaths and reviews are reported to Director of Adults & Health
- Fatality Reviews are chaired by the Head of Service for homelessness and rough sleeping commissioning

- Where is homelessness located in your organisation?
- Where does appropriate monitoring take place that could consider the deaths of homeless people?
- How can homeless people and their family members and peers be involved in this?

Information Sharing

The Data Protection Act 2018/GDPR provides a lawful basis for processing information:

Article 6(e) - information can be shared where processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller.

Article 9(h) - information can be shared where processing is necessary for the purposes of preventive or occupational medicine…medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services.

- Are there existing ISP's around homelessness and safeguarding?
- Where can you foresee potential challenges?
- How will you ensure that information sharing is relevant and respectful?
- How could you involve peers and family members appropriately?
- How will you seek to respect the persons wishes around what is shared and with who?

Documents & Tools

We developed the following documents for the purpose of delivering the Homelessness Fatality Review Procedure:

- Procedure
- Fatality Register
- Information Sharing Protocol
- Desktop Review Tool
- Outcome Report
- Confidentiality Statement
- Next of Kin Letter/Consent

- How will you record deaths?
- What would you want to produce as evidence of a review?
- How would you record action taken?

Early Findings

Factors Influencing Deaths	Professional Practice
Social Isolation	Creating a reflective culture
Relationships	Grievability
Disproportionate effect on BAME people	Highlights good practice
Benefits of psychologically-informed practice	Platforms tensions, limitations and conflicting practices
‘Cliff edges’	Generates evidence of known issues and gaps
Timely & flexible access to services	Buy-in
Personal achievements	Capacity and time
‘Missing’ periods	Raised the profile of safeguarding & prevention

Useful Resources & Further Reading

Homeless Link	https://www.homeless.org.uk/our-work/resources/guidance-on-safeguarding-vulnerable-adults
National Health Service	https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
Association for Directors Adults Social Services (ADASS)	http://londonadass.org.uk/wp-content/uploads/2018/01/Appendix-Seven-Safeguarding-adults-who-sleep-rough-in-London-draft-chapter-2.pdf https://www.adass.org.uk/AdassMedia/stories/Mental_Health/Bull_Docs08/HousingLIN.pdf http://londonadass.org.uk/wp-content/uploads/2019/01/Adult-safeguarding-and-homelessness.pdf
SCIE	https://www.scie.org.uk/self-neglect/at-a-glance
Healthy London Partnership	https://www.healthylondon.org/wp-content/uploads/2018/01/April-2019-Revised-Commissioning-Guidance.pdf https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health
MHCLG Rough Sleeping Strategy	https://www.gov.uk/government/publications/the-rough-sleeping-strategy https://www.gov.uk/government/publications/rough-sleeping-strategy-delivery-plan
Voices of Stoke	http://www.voicesofstoke.org.uk/2019/03/04/case-study-mental-health-safeguarding/ http://www.voicesofstoke.org.uk/care-act-toolkit/

Homeless SARs

- Kings College (2019) - Thematic review of 14 cases
- North Yorkshire SAB (2012) 'Robert'
- Walsall SAB (Learning Review summarised in Annual Report 2016/17)
- Doncaster SAB (2018) 'Adult G'
- Bexley SAB (2019) 'AB'
- Wiltshire SAB (2018) 'Adult D'
- Milton Keynes SAB (2019) 'Adult B'
- Brighton and Hove (2017) - X