1 – Introduction

North Lincolnshire Safeguarding Adults Board hold a range of scrutiny and assurance events across different themes as part of our Scrutiny and Assurance Framework.

As part of the event, key partners were requested to complete and submit a single agency audit in relation to the case for consideration by the panel. The panel is made up of subgroup members representing the SAB Executive Leads who come together to agree key lines of enquiry prior to a discussion with multi-agency practitioners.

The focus of the learning event is to reflect on the person's journey and to identify any opportunities for improved collaboration between agencies and to share good practice. It was also an opportunity for Safeguarding Adults Board representatives to seek assurance as to the quality and effectiveness of multi-agency practice and how partner agencies are working to fulfil their safeguarding responsibilities.

*A pseudonym has been used to protect the person's identity.

2 – Background

Kate* is a young woman in her 30s who moved to supported living accommodation in North Lincolnshire and was being supported and funded by another council**.

Kate has a diagnosis of autism and a learning disability and a history of contact with mental health services including inpatient treatment. During her 6 months residing in North Lincolnshire, the supported living provider struggled to manage her behaviours. Multiple incidents were reported to partners with the final incident leading to the placement breaking down and Kate being arrested and taken into custody.

Whilst in North Lincolnshire, Kate had contact with multiple partners including North Lincolnshire Council (safeguarding, single point of access and an Approved Mental Health Professional (AMHP)), Rotherham, Doncaster and South Humber NHS Foundation Trust mental health crisis team, Humberside Police, and Humberside Fire and Rescue Service.

** the name of the council has been anonymised

3 – Strengths and good practice

- There were good relationships between the out of area council and the residential care provider
- Where urgent issues required addressing, MDT meetings were held proactively
- The police used person centred approaches positively including 'right care, right person'. This ensured that Kate received the appropriate service and support, rather than defaulting to arrest. Good practice was also noted when Kate was taken into custody, in that they made sure she was under observation, they engaged with liaison and diversion, and they ensured plans were in place prior to her release. She was also provided with a stress ball to support her during interview and her father was supported to be her appropriate adult
- The residential care provider was flexible and creative in their approach to supporting Kate. An example of this was amending staff rotas to ensure that there was always a manager present, which worked well in providing her with a sense of stability and support
- In terms of the Mental Health Act Assessment undertaken by the AMHP, it was highlighted as good practice that the AMHP maintained their independence and were confident in their rationale despite pressure from other professionals
- The multi-agency working towards the end of Kate's placement, particularly during times of distress, was seen as a positive. Multi-agency staff came together to resolve any issues and support her effectively

4 – Key learning

- The need for strengthened contingency planning in relation to crisis situations was highlighted, especially given that previous placements have previously broken down as a result. There were instances where services were not aware of Kate's needs, and it was often difficult to get the necessary information and support during times of her distress.
- The oversight and monitoring of out-of-area placements was identified as an area for strengthening. It was noted that more enhanced planning and oversight prior to the placement starting would have been beneficial. Additionally, there were challenges in ensuring robust monitoring and support during the placement. Care providers may also benefit from ensuring contingency plans are in place prior to accepting complex or high risk out of area placements
- There was a lack of understanding regarding whose role it was to coordinate services and lead the support for Kate. There appeared to be occasions where organisations were working in silo and were making assumptions about what other agencies were doing. There also did not appear to be any one person who had a good understanding of Kate's life experiences or who had a significant relationship with her which may have been improved by having a lead professional coordinating support for Kate.
- There were some gaps around the use of legal frameworks and escalation processes and how they could be used to effectively support Kate. Practitioners shared that MDT meetings did not always have appropriate representation and there was evidence that some agencies did not utilise all frameworks to leverage and escalate appropriately.
- Practitioners' understanding of the Mental Capacity Act 2005 could be strengthened particularly in relation to mental capacity and executive functioning.
- There was some misunderstanding amongst some partners about what the Dynamic Support Register was and how it should be used.
- It was highlighted as a national challenge around supporting people with dual diagnoses, such as mental health issues and learning disabilities. The lack of clear pathways for support and the reluctance of services to take responsibility for such cases were highlighted as an ongoing issue.
- Learning around ensuring that the outcomes of referrals are shared in a timely manner so as not to delay future plans being put into place was identified.

7 – Next steps

An overview of the event is presented to the SAB Protection & Accountability Group for consideration. Actions from the event will be monitored and reviewed as part of the SAB scrutiny and assurance action plan.

Some of the actions agreed for North Lincolnshire include:

- Disseminate information around the Dynamic Support Register including its purpose and how to refer.
- Strengthen resources on the SAB website around contingency planning.
- Consider the development of escalation guidance.
- Continue to strengthen multi-agency understanding of legal frameworks
- Share the learning with providers, specifically around planning for out of area placements

The learning will also be shared with the out of area council and their respective Safeguarding Adults Board for them to consider and reflect on what local action may be required.

NORTH LINCOLNSHIRE SAFEGUARDING ADULTS BOARD – Keep Safe

7 Minute Briefing

5 – Reflect on the learning

To inform your practice you can

- Discuss this area of work with your supervisor in the context of collaborative working across agencies when supporting people who have moved into North Lincolnshire from another area
- Reflect upon your understanding of legal frameworks and your understanding of escalation processes
- Take a look at the resources on the SAB website around mental capacity assessments and executive functioning
- Book onto our Legal Literacy training which will increase your understanding of the legal frameworks that can be used to support people that you work with

6 – Further information and resources

- SAB Website – Legal Literacy and executive functioning resources
- Easy read – Dynamic Support Register leaflet
- Humber and North Yorkshire ICB website – Dynamic Support Register
- Learning hub – Supporting people with executive dysfunction