SAR Malcolm

Improvement Briefing

Supporting people who have/are experiencing multiple exclusion homelessness, with worsening cognitive impairments that are impacting on their functional capacity and executive functioning

What we have learnt about ordinary work across partners in Westminster and the implications for creating more conducive practice conditions for timely and effective help

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Remembering Malcolm
The Man of Endless Smiles

By David Woodley
Westminster Homeless Health Care Navigator

Whenever I escorted him to appointments he would talk to everybody. […]

And what was lovely about it, was that it was his thing – it was who he was.

You can see his charm in the photo of him with a Santa hat. He always had a smile on his face, always.

Malcolm was Canadian and he came to London around 13-14 years ago. He would joke when people would say to him. Are you American? He would respond *"no, I'm from the cultured side. I'm from Canada".* Malcolm was always talking about his travels, he had some incredible stories about travelling the world, mainly working in bars. He joined the Royal Canadian Navy when he was relatively young employed as a Bomb disposal expert officer. After he left the Navy, he went to the Caribbean where he was a diving instructor for many years, he travelled all across the Caribbean, from there he went over to Asia. He stayed a long time in Thailand working in bars. He had four marriages. His last wife was Russian, he also lived in Russia for a time, and he had come to the UK together with his Russian wife. Their relationship ended here in the UK, and she went home to Russia in a new relationship which may be how he came to end up sleeping rough. He also lived in France for a time; he had literally travelled and lived the whole world. He would tell so many stories; he talked about wanting to set up a diving school when he was in Spain.

I found Malcolm extremely humorous; he always had a joke to tell but it became more difficult for him to establish boundaries when telling jokes as his dementia progressed. As a person he was always happy, always smiling, always quite jovial. Everyone loved spending time with him. I loved spending time with him. He was fascinating and his presence and his personality were infectious. It was a pleasure to have Malcolm scheduled into my day. It really was and he could be fun to the extremes at times. He was always talking about women and his past wives. He liked going out to tourist hotspots such as Leicester Square and Oxford Street where he would often meet tourists and he loved talking to them.

Here in the UK, he mentioned being a chef in one of Jamie Oliver's restaurants, he said he learnt to cook in the Navy. He said that when he was in Thailand he was employed mainly in bars where cooking was an element of his roles. When asked by clinicians at appointments if he would be allergic to anything, he would often say "marriage, because I've been married four times". So that was one of his repetitive jokes.

We attended a lot of appointments together and it became clear that his memory was becoming very poor, sometimes he could converse very well with professionals and then the next time that he couldn't remember anything. Sometimes I could see in his eyes that at times he couldn't remember me, so obviously this was very concerning.

Malcolm had no personal belongings, but he collected coins. He loved cooking as he spoke about that often. He used to paint maps on the floor in Leicester Square with chalk and he would get given money from tourists.

Whenever I escorted him to appointments, he would talk to everybody. It was his personality, sometimes it was it was a bit thwarting when you're in a rush to get to an appointment and he would want to talk to everybody but what was lovely about it, was that it was his thing it was who he was. You can see his charm in the photo of him with Santa hat shared. He always had a smile on his face, always.

Table of Contents

1 Introduction

1.1 MALCOLM'S LEGACY

1.1.1 This report opens with a tribute to Malcolm written by the care navigator who, together with a specialist support worker from The Passage[1], were the closest Malcolm had to family in the UK, in the last years of his life.

1.1.2 Malcolm died an untimely death, aged just 60, on 17 May 2023.

1.1.3 A small, highly dedicated group of individuals worked with tenacity, determination and love to try to secure timely and effective help for Malcolm in order to reduce the risks he faced. They had almost succeeded, making Malcolm's death additionally tragic; Malcolm died just days before he was due to move into a residential care home, with the redecoration of his room completed. But the barriers experienced in securing risk mitigation and support, including accommodation that Malcolm needed, meant that he had been at significant risk for a number of months and could have died at any time in the intervening period – as clinicians and practitioners working closely with him at the time, had shared. The toll on practitioners closely involved with him during this time was heavy and knowledge of his death has hurt many deeply.

1.1.4 This Safeguarding Adults Review (SAR) report and the improvements it is designed to support for others who find themselves in similar circumstances, is offered as Malcolm's legacy.

1.2 LEGAL MANDATE

1.2.1 The Safeguarding Adults Executive Board (SAEB) of Kensington and Chelsea and Westminster decided to use its powers under the Care Act 2014, to arrange for the conduct of a discretionary SAR.

1.2.2 A mandatory SAR was not indicated because Malcolm's death was not related to abuse or neglect including self-neglect. Malcolm died from head injuries sustained while he was in hospital.

1.2.3 However, there was agreement across partners that responses to the risk Malcolm faced had not been timely or effective, despite extraordinary efforts of many. The precise extent of his self-neglect and neurological deterioration only became evident after his death, when his flat was being cleared, underlying the validity of concerns there had been at the time. In this context, it was agreed that there were vital and valuable lessons to be learnt from a review of the multi-agency practice, and it was therefore appropriate to use the SAEB's discretionary powers to arrange for the conduct of a SAR.

[1] **The Passage**, founded in 1980, runs one of the largest Resource Centres for those experiencing or at risk of homelessness in London, offering a wide range of specialist homelessness services.

1.3 A SYSTEMS-BASED METHODOLOGY

1.3.1 Across multiple sectors, the evidence base suggests that a systems-based approach provides the most useful learning from practice, to drive improvements. This is reflected in the new Patient Safety Incident Response Framework (PSIRF) in the NHS.[2] It is also reflected in the work led by the reviewer for this SAR, Dr Sheila Fish, over nearly two decades at the Social Care Institute for Excellence (SCIE) to support multi-agency safeguarding reviews in both child and adult safeguarding.[3]

1.3.2 A systems-based approach assumes that multi-agency working takes place in a complex, adaptive system. In such complexity, reviews of practice provide an invaluable opportunity to better understand ordinary practice in contemporary contexts. By this means, a systems approach uses a single case to give a 'window on the system'[4] revealing how social and organisational factors, and complex systems dynamics influence what practitioners and clinicians do in direct work with citizens.

1.3.3 This approach uses the specifics of what happened and why in the index case under review, to explore what is typical and usual. It moves from the 'case findings' of what went well and where engagement and outcomes were not optimum in terms of appropriateness, timeliness or quality, to draw out wider, generalisable learning about strengths and vulnerabilities in single and multi-partners social and organisational set-ups and ways of working. This wider learning can be distinguished with the terminology of 'systems findings' that identify what is enabling good practice and what is getting in the way and making it harder to achieve.

1.3.4 Using this methodology involves:

- Meaningful engagement with family members or equivalent
- Enabling collaboration with practitioners and managers involved at the time (Case group)
- Close working with strategic leads of involved agencies and services (Review team)
- A concise, practical focus on learning relevant to improvement activity across partners and SAB assurance work.

1.4 METHODS, TIMELINES AND PARTICIPANTS

USING THE LEARNING TOGETHER SYSTEMS MODEL (FISH 2010)

1.4.1 This SAR has used the process and methods of the Learning Together model (Fish et al. 2010) The development of Learning Together pioneered the use of a systems-based approach to reviewing multi-agency safeguarding practice. It is the most tried and tested approach to-date.

1.4.2 Practically, this meant that background reading of case related documentation was conducted, allowing the timeline to be divided into Key Practice Episodes (KPEs), and

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[2] See: **NHS England » Patient Safety Incident Response Framework**

[3] See: **SCIE Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case reviews | The Learning Exchange (iriss.org.uk)**
SCIE SAR Quality Markers March 2022 (lbbd.gov.uk)

[4] Vincent, Charles **Systems analysis of clinical incidents: development of a new edition of the London Protocol | BMJ Quality & Safety**

an early analysis of practice to be progressed. Early analysis is supported with a table layout, distinguishing evaluation of practice minimising hindsight bias, from questions raised about the context, influencing contributory factors and how ordinary and usual responses seen in the case are more generally.

1.4.3 Individual conversations with key practitioners and clinicians involved in the various KPEs, enabled an appreciation of the 'view in the tunnel'[5] rationale and intended goals of professional decision making and activity, and a grasp of the pressures and dilemmas faced on the ground. A multi-agency workshop was then structured around the refined KPE analysis, allowing for those directly involved to check, challenge and amplify the detail.

1.4.4 From this evidence basis, draft systems findings were then drawn out and prioritised, discussed with the senior leads in the Review Team as well as in a regroup meeting with operational staff and managers.

1.4.5 A set of conversations with people in relevant roles were then scheduled to support further contextualisation and triangulation of the systems findings. An additional Review Team meeting was agreed, to enable those senior leads from commissioning services (rather than provider services) to engage with the process and findings, ahead of the report being finalised.

TIMELINES, TIMESPAN & CAPACITY

1.4.6 Table 1 below captures the process and delivery dates of the SAR process.

Table 1. SAR process and timescale

SAR process	Dates 2024
Commissioning and set up	Feb 2024
Intro meetings	22 March
Early analysis	8-9 April
Individual conversations	10-12, 15, 17, 18, 19, 25 April
Review Team – regroup pre-workshop	15 April
Case group workshop	16 April
Review Team– systems findings	18 April
Case group regroup	19 April
Additional conversations for triangulation	18-19 April
Review team - Rescheduled to bring in commissioners	04 June

[5] Dekker, S **Fieldguide to accident investigation**.

Finalise report and share	12 November
Final meeting to sign-off	10 December

1.4.7 The reviewer was commissioned for a maximum of 13 days work.

1.4.8 The timespan of practice reviewed covered just over one year and a half (16 Sept 2021 to 19 April 2023).

PARTICIPANTS

1.4.9 Case group and review team participants are detailed below.

Table 2. Participants

Review Team	Organisation	Case Group
• Interim Rough Sleeping Commissioner, Housing Needs, Support and Safety • Rough Sleeping Accommodation Coordinator & Project Manager – Changing Futures Blue Light & VAWG and Multiple Disadvantage Projects	Westminster City Council (WCC) Housing Needs	• Also Review team • Also Review team • Housing Solutions Service
• Head of Safeguarding, Quality Assurance and Engagement • Head of Care & Assessment	Bi Borough Councils Adult Social Care (ASC) WCC ASC	• Head of Service - Care & Assessment • Social worker • Safeguarding Adults Manager (SAM) • Social Work Team Manager WCC South Complex Team - Sensory Impairment, No Resource to Public Funds (NRPF), Homelessness and Rough Sleeping • Social Worker WCC South Complex Team • Head of Safeguarding, Quality Assurance and Engagement
• Specialist Homeless Health GP and Director of Homeless Health Community Interest Company (CIC	Great Chapel Street Medical Centre	• Also Review Team • Joint Clinical Lead GP • Westminster Homeless Heath Care Navigator • Homeless Health Clinical Nurse Specialist

• Director of Nursing	Chelsea and Westminster Hospital NHS Foundation Trust	• Consultant Neurologist • Consultant Neurologist
• Director of Quality • Older Adults Service Manager • Team Manager – Rapid Engagement and Support Team (REST); Statutory Team Enabling Pathways (STEP); Peripatetic Nursing Team • Team Manager, Kensington, Chelsea and Westminster (KCW) Dual Diagnosis Team	Central and North West London NHS Foundation Trust (CNWL)	• Senior Social Worker and Approved Mental Health Practitioner; West End Primary Care Network (PCN); South Westminster Hub • Senior Care Manager/Approved Mental Health Professional (AMHP), Westminster Community Mental Health Team (Older Adults)
• Senior Responsible Officer, Homeless Health (Westminster, Kensington and Chelsea, Hammersmith and Fulham)	NHS North West London	
• Service Manager	Care Grow Live (CGL)	
• Senior Delivery Manager Integrated Commissioning • Strategy Officer Integrated Commissioning	Bi-Borough Integrated Commissioning Team	
	The Passage	• Specialist Project Worker • Head of Housing and Progression and Safeguarding Lead

1.5 OUTLINE OF THIS REPORT

1.5.1 This report aims to be a concise, practical report to inform improvement activity across partners and SAEB assurance work.

1.5.2 Story telling about Malcolm and his experiences is actively kept to a minimum. The rationale for this is to reduce the chances of reflection and discussion being drawn back into the detail of Malcolm's single case, and to enable the focus to be on systems learning from Malcolm's case, that continues to influence work with other people in circumstances similar to Malcolm's.

1.5.3 In the event, we have one significant and multi-faceted systems finding. In the systems finding we focus on what we have learnt through an appreciative, determined curiosity about ordinary practice for practitioners and clinicians working with people in circumstances like Malcolm's and the systemic conditions that influence was is ordinary.

1.5.4 The finding ends with a starter for ten on how Board partners can best begin to grapple with the issue and start moving toward addressing it so as to provide more conducive conditions for practice.

2 Which areas of our multi-agency system have we tried to open windows on to through this SAR?

2.1 COGNITIVE IMPAIRMENT AND MULTIPLE EXCLUSION HOMELESSNESS

2.1.1 Westminster has the largest homeless population in London (36% of people are reported to be living in poverty. This is one of the highest rates in London (Trust for London, 2023), with 2.5 times the number of people sleeping rough in Westminster compared to the next highest borough at 1,698)[6]

2.1.2 There are well run, unique and well-established services for people experiencing multiple exclusion homelessness that already exist in the borough, both statutory and voluntary sector provisions, health, housing and social care.

2.1.3 People working in these areas have, in the last year or two, brought into focus the adequacy of services responses to cognitive impairments for people who have experienced homelessness. A number of networks and unique services and networks have been created bringing together practitioners and clinicians from across different professions and providers of services. See Table 3 below.

Table 3. Projects, networks and services concerned with cognitive impairment for people experiencing multiple-exclusion homelessness

Name	Coordinator/lead	Date established	Purpose
Westminster Blue Light Project - working as part of Changing Futures[7]	Rough Sleeping Accommodation Coordinator and Project Manager – Changing Futures, Blue Light and Violence Against Women and Girls (VAWG) and Multiple Disadvantage Projects, WCC	December 2021	In partnership with Alcohol Change UK to adopt their Blue Light Protocol initiative (The-Blue-Light-Manual.pdf) to develop alternative approaches and care pathways for the group of change resistant, alcohol dependent drinkers in Westminster.
Cognitive impairment and alcohol network (CIA) part of the Blue Light Changing Futures	Rough Sleeping Accommodation Coordinator & Project Manager – Changing Futures Blue Light &	April 2022	Each meeting we hear different viewpoints in the system and try and skim off quick wins , provide a space for anonymised

[6] Figures from Network for brain inury and homelessness in Westminster slides April 2024, Dr Lily Drause, Clinical Psychologist Homeless Neuropsychology Pathway, Psychology in Hostels Team, SLAM

[7] **Changing Futures | Westminster City Council**

Workstream	VAWG and Multiple Disadvantage Projects Westminster City Council		case discussion, better understand the nature of gaps and find opportunities for join up.
The Homeless Neuropsychology Pathway in the Psychology in Hostels Team South London and Maudsley NHS Foundation Trust (SLAM)	Operational Lead and Clinical Psychologist SLAM	February 2023	A service aimed at working with people experiencing homelessness with a diagnosed or suspected brain injury in Westminster. We are a team of clinical psychologists and a neurospecialist GPs.
Homelessness and Brain Injury Network in Westminster	Clinical Psychologist SLAM	April 2024	Rationale: to work better together and enhance/optimise the pathways for this client group. To think about ways in which we as health providers (rather than housing providers) can enhance the network to get the best outcomes.

2.1.4 Cognitive impairments can have different causes, including amongst others:

- Traumatic brain injury,
- Alcohol-related brain damage (ARBD)
- Neuro-degenerative conditions such as Alzheimer's, Parkinsons, Huntington's and Motor neuron disease (MND)
- Hypoxia and other toxic insults
- Vascular causes
- Schizophrenia, depression and / or other serious mental illnesses.

2.1.5 A person's cognitive impairments may stem from any number of the above at the same time.

2.1.6 As cognitive impairments increase, they can progressively impact on a person's executive functioning and functional capacity. This is typically evident in worsening:

- Memory problems
- Confusion / disorientation
- Falls
- Socially inappropriate behaviour
- Disinhibition including sexually inappropriate behaviours
- Self-neglect

- Inappropriate spending and management of money
- Changes in personality
- Difficulties concentrating and motivating oneself.

2.1.7 Consequently, as a person's cognitive impairments progress, they often face increased risks and can also pose increased risks to others.

2.2 WHAT RISKS LINKED TO COGNITIVE IMPAIRMENT LOOKED LIKE FOR MALCOLM

2.2.1 Below a selection of detail from the case notes on Malcolm are presented. These illustrate powerfully how risks presented for him, as captured by professionals at the time. They are presented chronologically which shows the heightening of risks over time.

2.2.2 The purpose of sharing these snapshots of moments in time in Malcolm's case is to provide tangible real-life illustrations of what the risks of cognitive impairment for someone in circumstances like Malcolm's can look like. They are not comprehensive. They are presented without analysis.

17/08/22

UPDATE FROM CARE NAVIGATOR

"Malcolm was by Tottenham Court road station. He was wearing Pyjama Bottoms and a T-shirt. He was soaked to the bone. He said he needed to get home to have a warm shower but didn't seem to be able to find his way. I walked him back to his accommodation."

17/10/22

SPECIALIST PROJECT WORKER FROM MALCOLM'S ACCOMODATION

Can you reopen the referral for Malcolm please?

He came to see me on Friday with a cut on his head and his hand. He had an A&E wrist band on and told me he had been seen at University College London Hospital on Thursday. He told me on Thursday someone attacked him while he was withdrawing cash on Oxford Street. He says it has been reported to the police, but I do not believe him (I will report it today).

He was still wearing the blood-stained clothes on Friday. He said he didn't have any concussion symptoms. I asked the staff at his supported accommodation to keep an eye on him over the weekend. […]

Unfortunately, this is exactly the kind of incident I was concerned about when I made my safeguarding referral; Malcolm is lucky it wasn't more serious. However, his dementia means he will continue to put himself at risk. His attitude is he will fight anyone who tries to take his money. I am concerned that next time he will suffer a serious injury.

19/10/22

SPECIALIST GP SURGERY NOTES

Meeting this morning - and we also have concerns about Malcolm's capacity to make decisions

around his safety and finances due to the impact of his dementia on his memory and insight into risks.

Although superficially he appears able to retain and process information, recent attendances at the GP practice have demonstrated significant issues with his memory e.g. returning on multiple occasions with the same symptoms and unable to recall the previous diagnosis or advice he has been given.

I know that his Care Navigator has also witnessed him withdrawing and carrying large amounts of cash in public, and then unable to recall what he has done with it minutes later.

I think it would be helpful to organise a Microsoft Teams meeting to discuss a formal capacity assessment and a future plan for his safeguarding

01/11/22

GP SURGERY NOTES

Admission Avoidance: Multidisciplinary review for adult safeguarding concern - has been escalated to Safeguarding and needs taking to ASC managers. High concerns re risk of exploitation, risk of falls and wandering and risk to himself and others due to disinhibition and sexual harassment of women both in public and in his accommodation. A formal complaint has been made by another resident at the supported accommodation scheme, and this has been reported to Police.

20/12/22

REFERRAL TO Community Mental Health Team (CMHT)

Main issues are:

Alcohol dependency

Dementia - leading to wandering / getting lost / very poor short-term memory / self-neglect / declining care and support

Sexual disinhibition and inappropriate sexual behaviour towards females both strangers and known to him (care navigator can no longer take patient on public transport due to risks). Recently accused of alleged sexual assault on a fellow resident (has been questioned by police).

Financial exploitation - withdraws large amounts of cash and money has gone within hours - known to have given it to other people who are homeless. Other incidents of financial exploitation have been noted by his support worker at the supported accommodation scheme.

Self-neglect - faeces spread over room, unable to look after himself.

27/02/23

GP SURGERY NOTES

Evidence today of deteriorating memory – Care Navigator accompanied Malcolm to his appointment, met him on Oxford Street and Malcolm agreed to come with him - but then the Care Navigator noted that Malcolm did not remember who he was and needed to be reminded

of GP appointment.

Malcolm also unable to recall meeting his social worker recently and couldn't recall his support worker at the supported accommodation scheme.

29/03/23

FINAL Multi-Disciplinary Team (MDT) MEETING

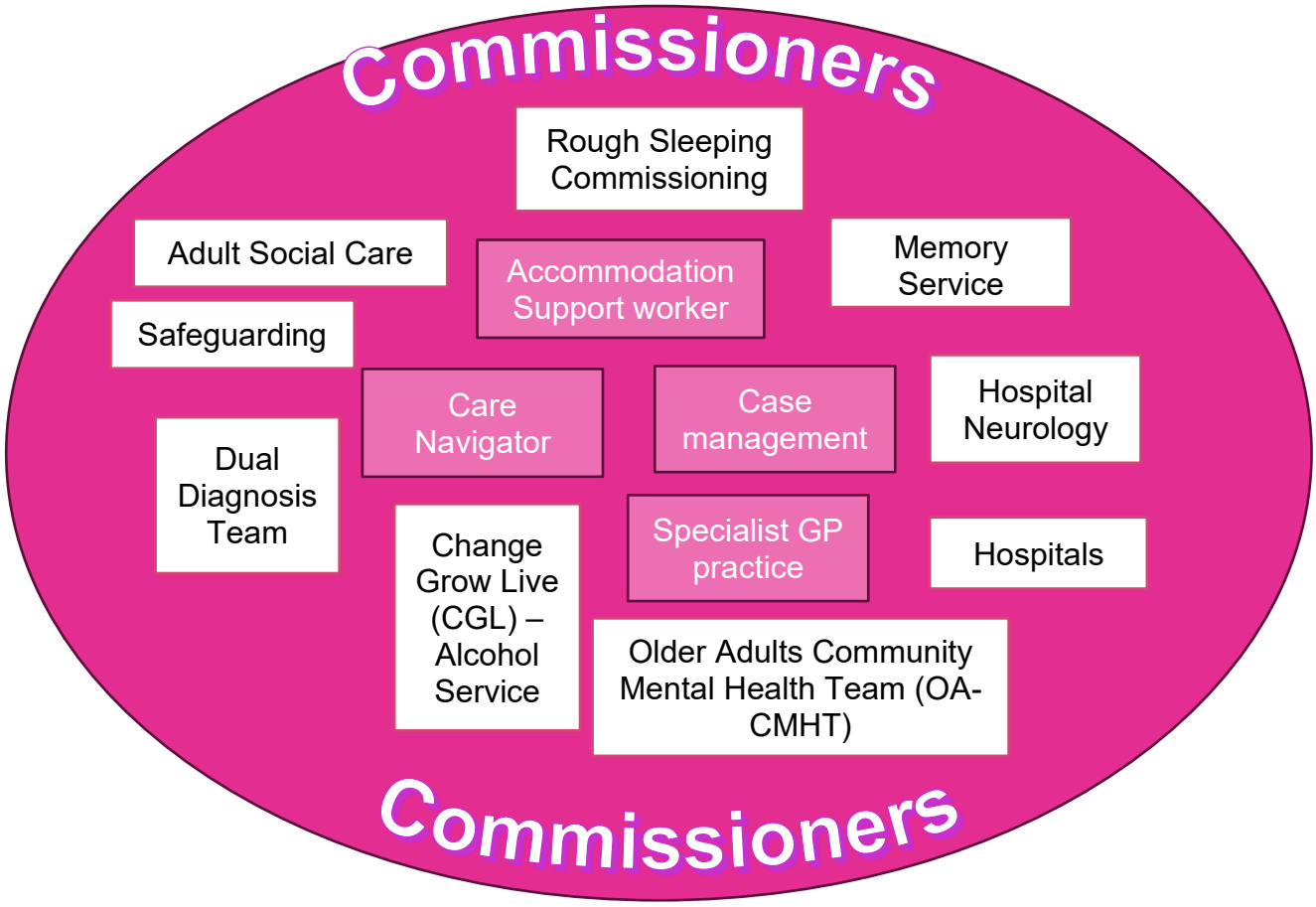
Specialist Project Worker and Specialist GP stated again their concerns around immediate risk to Malcolm of serious illness / injury / death related to all previously discussed safeguarding issues.

GP gave summary of Malcolm's health and social situation: dementia diagnosis over 18 months ago, recently confirmed as Alzheimer's disease. Increasing safeguarding concerns around risks to Malcolm – self-neglect, malnutrition, financial exploitation and assaults – and risk to others – Malcolm's sexual disinhibition towards women. Neurologist stated 2 years ago that Malcolm needed a tracker due to his risks of getting lost and into unsafe situations. Still living in low support accommodation. Has been necessary to advocate for repeated assessments by adult social care and mental health teams. Eventually referral to older person's mental health team accepted, now awaiting assessment by psychiatrist.

Specialist Project Worker confirmed that staff at the supported accommodation scheme have witnessed Malcolm's rapid deterioration over the last few months, loss of ability to recognise people and recall information. Self-neglect extreme – his room was deep cleaned last week and a few days later the floor and Malcolm himself were covered in faeces. Malcolm not cooking or eating and teeth in very poor state – missed multiple dental appointments. Malcolm suffers frequent injuries but unable to accurately report causes for these. New concern is Malcolm's recent need for treatment for alcohol withdrawal – Malcolm has not presented with withdrawal symptoms before. Specialist Project Worker stated that staff at the supported accommodation scheme are unable to keep him safe – they can only offer low support, cannot check on Malcolm and he is mainly on his own. Specialist Project Worker and staff are negatively impacted by ongoing increasing concerns about him and length of time he has remained in this inappropriate accommodation.

Care Navigator has worked with Malcolm for several years and has also seen rapid deterioration. He feels vulnerability significantly increased, and unable to lone work Malcolm in a public environment due to sexual disinhibition. Malcolm now unable to remember who Care Navigator is / location of his GP practice / conversations during health or social care consultations. Care Navigator attended his last neurology appointment where Malcolm was advised no treatment available, other than medication trial but Malcolm declined this due to need to stay abstinent from alcohol, chance of being given a placebo drug and necessity to attend multiple appointments.

It is this area of service provision, support and safeguarding around cognitive impairments for people who have experienced homelessness, that Malcolm's experiences and those of different agencies involved in helping him, have allowed us to explore in this SAR. It is this area of single and multi-agency commissioning, service provision and direct work with citizens, that Malcolm's circumstances have allowed us to open a 'window' onto. The table below gives an indication of the service providers and respective commissioners involved.



2.2.3 We have focused on supporting people who have/are experiencing multiple exclusion homelessness and have cognitive impairments that are progressing and impacting on their executive functioning and functional capacity. Through Malcolm's case, we have explored ordinary practice in this area to better understand:

- How well do we currently support people in these circumstances in Westminster?
- What are the barriers we would need to tackle to improve support to people in these circumstances?

2.3 SYSTEMS FOCUSED LINES OF ENQUIRY

2.3.1 At the point of commissioning, therefore, the following systems focused lines of enquiry were set for exploration.

1. What can Malcolm's case tell us about outstanding barriers in Westminster, to timely, accessible help for / fulfilling the rights of people facing multiple exclusion homelessness and worsening cognitive impairments, including via:
    a. Safeguarding
    b. Care Act eligibility
    c. Suitable accommodation
    d. Mental health
    e. Advocacy.
2. What can we learn from Malcolm's case about what is getting in the way of partners coming together to plan, review, troubleshoot and escalate health, care and safety plans for people in situations similar to Malcolm's in experiencing multiple-exclusion homelessness and worsening cognitive impairment?
3. What light can Malcolm's case shed on why it is still too hard to secure an urgency of response that mirrors the level of risk faced by someone experiencing multiple-exclusion homelessness and worsening cognitive impairment, including through high impact drinking, dementia, self-neglecting, falls and assaults, financial exploitation as well as being a risk to others?

2.3.2 In the event, we conclude this SAR with one single systems finding. It speaks predominantly to the first line of enquiry above. The extent of gaps and barriers this revealed has meant that we have focused exclusively on this finding, assuming that successfully addressing this broad systems issue would be a prerequisite to seeing progress on 2) and 3).

3 SYSTEMS FINDINGS & CONSIDERATIONS FOR ACTION

Currently service commissioning and ways of working mean that people who have experienced multiple-exclusion homelessness and have deteriorating cognitive impairments, can 'fall through the cracks'. This tends to leave those working directly with the person, particularly housing support workers, holding and desperately trying to mitigate the various and escalating risks the person faces, often at a huge personal expense to them both.

3.1 INTRODUCTION

3.1.1 This report does not present a detailed narrative of Malcolm's experiences. Instead, below, we present what we have learnt through an appreciative and enquiring engagement with all parties involved with Malcolm and the system more widely, about how things work in Westminster when it comes to engaging with people who have experienced homelessness and have progressing cognitive impairment that is affecting their executive functioning and functional capacity.

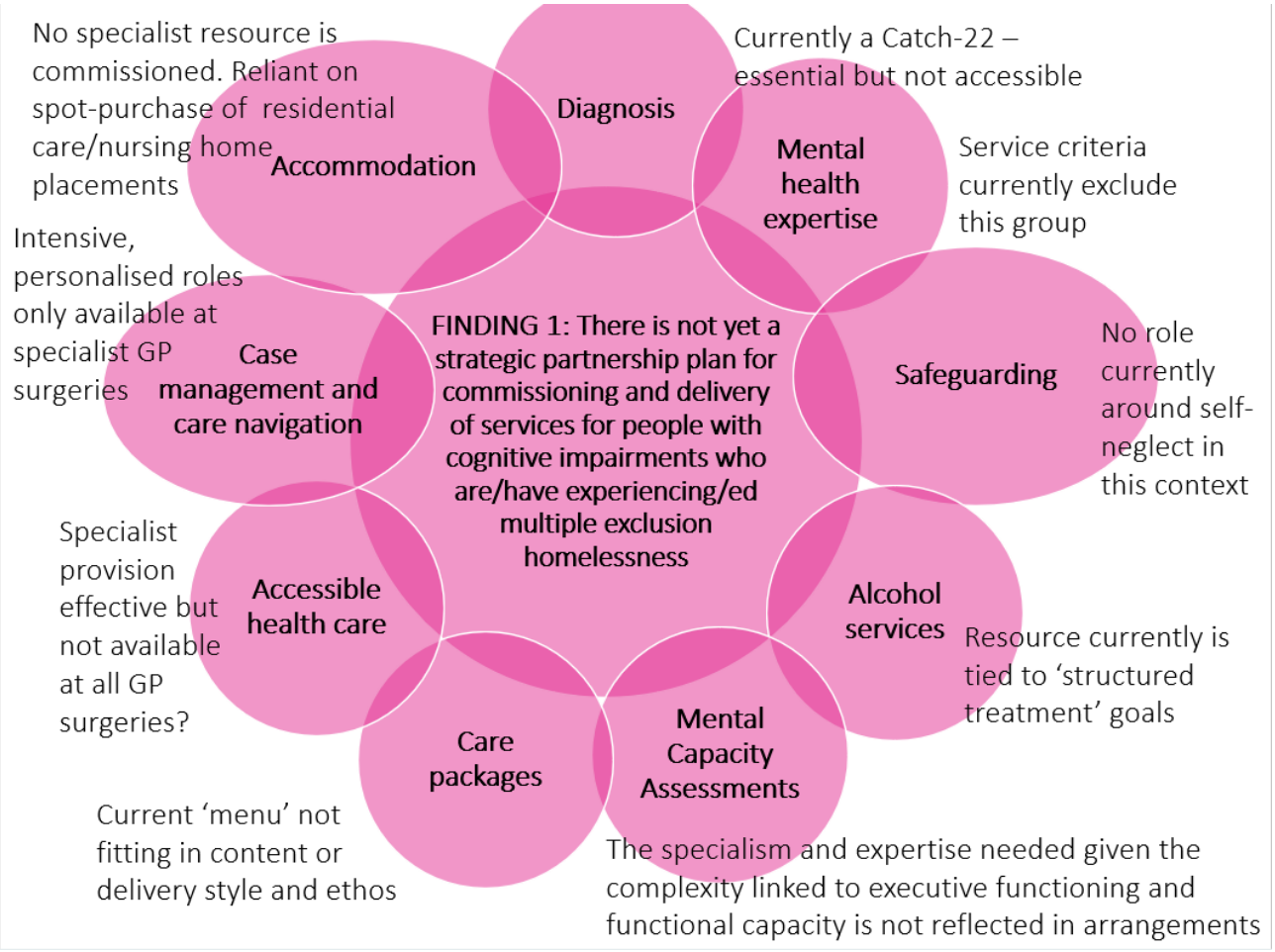
3.2 ORDINARY PRACTICE & ITS SYSTEMIC CONDITIONS

3.2.1 The picture that has emerged of ordinary practice is one of a battle against the odds to secure help for people in situations like Malcolm's. Work is being done through the Blue Light Project and through the Housing Support Grant in Westminster to ensure pathways are explored to support the most vulnerable. There are also efforts to assist those homeless or at risk of homelessness through cross partner funded provision which looks at both substance misuse, cognitive impairment and housing needs. But this SAR highlights that there is not yet a strategic partnership plan in Westminster for commissioning and delivery of services specifically for people with deteriorating cognitive impairments, who have experienced multiple exclusion homelessness. This means that that services struggle to reasonably adjust to the complexities that people in circumstances like Malcolm's present with. At best we see dedicated professionals bending backwards to try and bring flexibility and accessibility into services commissioned more rigidly. At worse we see 'table tennis' between services with the person bounced back and forth as eligibility criteria are tested and enforced. We see the necessary expertise and interventions available but struggling to adjust therefore not accessible. We also see stretched expertise in this area of work, which leads to inconsistent practice and examples of unintentionally skewing assessments, underplaying risks and blocking otherwise legal options for effective intervention.

3.2.2 Further detail of how this scenario plays out and why is summarised in the following graphic and then detailed below.

3.2.3 In addition, questions are posed for the SAEB and partners, to support their deliberations about how best to tackle the systems issues identified.

Table 4. The ordinary battle against the odds



INTENSIVE, ASSERTIVE PERSONALISED ROLES

3.2.4 At the forefront of ordinary battles to secure appropriate help, for the lucky ones, is a four-part team of professionals made up of:

- Specialist homeless support worker
- Specialist intensive case management
- Specialist homeless care navigator
- Specialist homeless GP practice.

3.2.5 People experiencing multiple exclusion homelessness are often very alone. Family members, friends and loved ones are not close at hand to be able to notice deteriorations, initiate relevant appointments, keep a tab on progress, and provide the practical help to enable someone to get to places they need to at the right times. It falls to professionals to take on these roles.

3.2.6 In Malcolm's case, the dedication, tenacity and professionalism of this four-part team was both inspiring and humbling to see. It was marked by tight teamwork, communication and collaboration that allowed an awareness of Malcolm's experiences, incidents that he suffered and changes of risk profile overtime. It required effective, proactive case management to keep efforts moving, to hold both facts and narrative together, and to follow-up on actions again and again and again. It required proactive, personable contact and communication, playing a delicate

intermediary and advocacy role in order to introduce Malcolm to new services, and the adjustments that he would need, to elicit commitment and flexibility from other professionals, and to smooth over ruptures when things did not go to plan. It also featured notable tenacity in understanding the changing landscape of individuals and innovations, to understand relative roles and identifying new forums and mechanisms to (re)escalate Malcolm's predicament, in order to try to make something happen.

3.2.7 However, Malcolm was in an unusual situation in terms of his accommodation. His support needs meant that he should have been in high needs accommodation, however he had been banned from violence from the commissioned high needs temporary hostel accommodation. He had made a homeless application, and the Council was meeting its statutory duties by providing good quality in-borough self-contained accommodation. This was 'general needs' accommodation with dedicated housing support service for residents provided by The Passage during office hours, whereby residents can 'drop in' for professional support. This set-up was not sufficient for Malcolm's needs. The support worker recognised this and responded by working significantly outside their job description for the commissioned support service. Such proactive and detailed oversight and communication provided via the support role is not commissioned for general needs accommodation; it is also unlikely to feasible for support workers in a busy hostel to provide. This point is supported by recent research funded by the National Institute for Health and Care Research (NIHR) Fellowship programme to co-produce an intervention for older people in hostel accommodation with memory problems.[8] Principle Investigator Dr. Penny Rappaport spoke to the Cognitive Impairment and Alcohol Network in Westminster in April 2022, and described early findings highlighted that many hostels, although not commissioned to provide it, are actually like proxy dementia communities. A central finding in terms of challenges faced by hostel staff was 'not being able to see the wood for the trees' i.e. the level of complexity in terms of presenting problems and what might be causing them, makes it difficult to work out where to start.

3.2.8 The specialist GP practice involved, is one of two in Westminster. This review has been incredibly positive about their work in Malcolm's case. They are however a restricted resource which means there are many people who have experienced homelessness and are experiencing worsening cognitive impairments, who are registered at mainstream GP practices. Mainstream GP practices have much higher numbers of citizens registered (10,000 compared to 300) than the specialist GP practices, and do not have resource or capacity to provide the equivalent intensity of input. A central component of the success of the specialist GP practice service is the intensive case management and care navigator roles that are essential to making primarily health care accessible for people in these circumstances. Yet the specialist GP practice involved in this review explained that these elements had been secured via a separate funding pot rather than being integral to the specialist provision and are therefore more precarious.

3.2.9 Therefore, the strengths and ways of working of this four-part team, that benefited Malcolm, do not appear to represent a reliable feature of responses for people in

[8] See **Older, homeless and experiencing memory problems: How to support a multiply disadvantaged population | RESIDE**

similar circumstances across the borough.

Questions for consideration:

- How can health accessibility be improved for people experiencing homelessness who are not at the specialist GP surgeries?
- How can intensive, personalised case management including vital 'care navigator' roles, be provided for people not at the specialist GP surgeries?
- What is known about how many people are affected by this issue?

MISSING ALCOHOL SERVICE SUPPORT WORKERS

3.2.10 Alcohol-related brain damage as a source of cognitive impairment has a high prevalence among people who have experienced multiple exclusion homelessness.[9] Yet people who do not engage with alcohol reduction services and who experience cognitive impairment of any sort do not have a specialist alcohol service worker. This means that key expertise and advice is missing from the team around the person. This absence is related to current commissioning arrangements for alcohol services, which are structured around enabling people to engage with structured treatment programmes. We learnt in the course of this SAR that neither Key Performance Indicator (KPI), nor resourcing of contracts for alcohol dependency support services allow for the type of assertive outreach and support that people experiencing deteriorating cognitive impairment require. This means that a key source of specialist expertise and advice is missing from the team around the person.

Questions for consideration:

- Is there agreement across partners about the role of alcohol services for people experiencing homelessness, with deteriorating cognitive impairments and highly unlikely to engage in structured treatment programmes?
- What changes to the commissioning of alcohol services would allow specialist alcohol workers to be part of a team around the person, for people experiencing homelessness who are highly unlikely to engage in a structured treatment programme and require on-going support?
- What is known about how many people are affected by this issue?

INACCESSIBLE COMMMUNITY SUPPORT OPTIONS FOR PEOPLE WITH COGNITIVE IMPAIRMENTS WHO EXPERIENCE HOMELESSNESS

3.2.11 The clinical picture/presentation of cognitive impairments that are impacting on executive functioning and functional capacity is broadly similar. The requisite

[9] See many resources from Alcohol Change Uk. E.g. **Alcohol-related brain damage - one-day | Alcohol Change UK**

expertise for assessment and interventions to sustain good lives and mitigate risks linked to new behaviours usually comes from a multi-disciplinary team (MDT) including psychologists, occupational therapists, nurses, social workers, who could help minimise risks. A number of such MDTs exist in Westminster but what Malcolm's case allowed us to see is that ordinarily these are not accessible for people experiencing multiple exclusion homelessness with deteriorating cognitive impairments, especially if they also have chronic alcohol dependencies.

3.2.12 The eligibility criteria of available services that would relate to cognitive impairments of people experiencing homelessness, all require a mental health diagnosis, including dementia or a very specific diagnosis such as Parkinsons. The Older Adults Community Mental Health team (OA CMHT) provide services for people with dementia, for example, but are not commissioned to support alcohol-related cognitive impairment. Korsakoff syndrome, is an exclusion criterion for their service.

3.2.13 Other teams with potentially relevant assessment and support services are set up in such a way that the CMHT is the gatekeeper. A person has to have CMHT involvement to gain access to other teams. This is the case for the Dual Diagnosis team, as well as the local authority social work mental health team.

3.2.14 This creates a catch-22 whereby a dementia diagnosis is both (relatively) inconsequential and essential because it can open the gate to relevant services. It is also ordinarily inaccessible for people in circumstances like Malcolm's. Diagnosis is usually conducted by the Memory Service but the tools they use are compromised by alcohol meaning there no flexibility is possible. The CMHT duty triage were typically turning away referrals with advice to go to alcohol services – though have been steered more recently to be more flexible. The person cannot be intoxicated at the time of the assessment, but long periods of abstinence are not required. In addition, however, diagnoses of dementia often take time to assess, which does not match the urgency of response required if someone's cognitive impairment is creating significant risks which the service made accessible with a mental health diagnosis can serve to mitigate.

3.2.15 The other (relatively new) option for a diagnosis of dementia is lumbar puncture which is only available via consultant hospital neurology teams. Also, knowns as a "spinal tap" as it involves a needle being inserted in the lower back or lumbar region of the spine to remove a sample of cerebrospinal fluid for testing. This is an option that most people would not likely be keen to agree to as the means of opening the gate to services and provision is anyway limited.

3.2.16 While other services such as the CMHT (for younger adults) can attempt to help, their willingness does not compensate for the relevant expertise and experience that sits more with the OA CMHT.

Questions for consideration:

- How can multi-disciplinary assessment and support be made accessible for people experiencing homelessness with cognitive impairments, especially where they also have chronic alcoholism and no mental health diagnosis?
- How much does a specific dementia diagnosis really need to matter to access the kind of MDT support and expertise available via the OA CMHT? Can a more flexible eligibility criteria be piloted to better support people who have experienced

homelessness and have declining cognitive impairments?

- Could a rapid review of relevant innovations and/or good practice in other areas of the country help inform such an innovation? E.g. Cheshire and Wirral Partnership NHS Trust's experience developing a clinical management guide for the psycho-social rehabilitation of people presenting with severe alcohol related brain damage.[10]

Table 5. Eligibility criteria for potentially relevant services

Service	Eligibility criteria	Client group	Description of service
Dual Diagnosis Team	Entry is through CMHT – the person needs to be in the process of being referred to or open to and likely to be agreed	Severe mental illness (SMI) and addiction issues	An MDT (Social Workers, nurses, Occupational Therapists (OTS), counsellor) deliver support over a long period akin to assertive outreach
Community Mental Health Team (CMHT)	Eligibility is for SMI - Often say are not brain injury specialists	Working age mental health	Secondary mental health
Older Adults Community Mental Health Team (OA CMHT)	- Mental ill health, mental disorder and significant physical illness or frailty and - Dementia where there is level of complexity (e.g. particular difficulties with self-care; challenging carers; aggressive, agitated or anxious; high risk of care arrangements breaking down This relates to the treatability of diagnosed Mental Health disorder. Otherwise, psychiatrists are left holding clinical responsibility but there is nothing medically	Not 'older adults' but particularly complex presentations related to mental health or dementia Limited capacity relative to demand mean very focused on criteria, and what other services are involved	An MDT (OTs, nurses, psychologists) can arrange cognitive assessments; psychosocial and behavioural interventions, strategies to manage risks associated with cognitive impairment, use telecare for wandering; strategies to manage avoidance of care

[10] See: **Microsoft Word - Guidance manual 2020.doc (arbd.net)**

	they can do. No age specific criteria. Royal College of Psychiatry state Korsakoff's is an exclusion criteria. It is not progressive in nature at the OA CMHTs do not have the skill set within current resource to manage this condition.		More familiar with complex mental capacity assessments where factors such as executive functioning can impact the outcome.
Social Work – Mental Health	Work with adults with SMI who are open to CMHT and have social care needs.		

SAFEGUARDING AND ADULT SOCIAL CARE (ASC)

3.2.17 People whose cognitive impairment is worsening, often experience difficulties with managing their own self-care leading to self-neglecting behaviours impacting on their health and hygiene, dignity and self-respect, and social interactions. Increased disinhibition can also mean they are no-longer able to manage their own finances, are vulnerable to crimes including theft, to physical and financial abuse or exploitation.

3.2.18 In line with statutory guidance and organisational policies, ordinary practice therefore often sees practitioners and clinicians making referrals to both:

a) ASC for a Care Act Assessment, to determine if the person has 'eligible needs' and can therefore have a right to some care and support and;
b) ASCs Safeguarding team, to work with the person and carry out a s.42 safeguarding enquiry to identify how any abuse, neglect or self-neglect should be addressed.

3.2.19 However, through the SAR we came to understand the different barriers to tangible help through either of these means.

3.2.20 Care Act Assessment processes and the menu of options for care packages from ASC are very standardised and are not a good fit for people experiencing multiple-exclusion homelessness and cognitive impairments. E.g. reminding and prompting someone about self-care and daily cleaning of their environment; a one-off "deep clean". Those providing the care also tend not to be familiar with this client group or supported to take on more of an optimistic, assertive outreach style of engagement and delivery.

3.2.21 The Safeguarding team in Westminster, in contrast, has not engaged routinely with cases featuring self-neglecting behaviours or risks of other types of abuse before they actually occur. Instead, ordinary practice involves re-routing these cases to ASC teams for Care Act Assessments and support. This has been deemed the more appropriate means of securing help for citizens in these circumstances. While this may work for some citizens, for the reasons detailed in the paragraph above, it

is not effective for people experiencing multiple exclusion homelessness and cognitive impairments.

3.2.22 Furthermore, it means that, unless there is a third-party perpetrator involved, people in situations like Malcolm's, facing increased risk from self-neglect and risk of other abuse linked to their cognitive impairment, do not benefit from the personalised, and rigorous information gathering and assessment that a s.42 safeguarding enquiry would allow.

3.2.23 Unfortunately, positive efforts on the part of the safeguarding team to take on 'link roles' and be active players in multi-agency meetings and contribute to case discussions, has been widely misunderstood as indicating that particular cases are 'open' to safeguarding and that statutory safeguarding duties have been activated.

Questions for consideration:

ADULT SOCIAL CARE

- What would an appropriate menu of care options look like for people experiencing homelessness, with cognitive impairments and impacted by self-neglect?
- How can the necessary flexibility and relationship-based style of engagement be fostered for carers and support staff working with people experiencing homelessness with cognitive impairments?

SAFEGUARDING

- Is there clarity and agreement within and across partners about the role of safeguarding around self-neglect in the context of dementia and other cognitive/neurological impairments, particularly for people experiencing homelessness, including on-going alcohol dependencies?
- How can local authority safeguarding teams best provide clarity to partner agencies about the safeguarding offer for people in such circumstances, in order to support appropriate referrals being made and mutual understanding of the steps that follow depending on the scenario?

ACCOMODATION AND MENTAL CAPACITY ASSESSMENTS

Accommodation provision in Westminster. There are a wide range of professional commissioned services for rough sleepers and people with long histories of homelessness:

- WCC has two large hostel provisions with shared facilities for former rough sleepers with complex needs and who require 24-hour high support (King Georges Hostel – 68 beds and Edward Alsop Court – 79 beds). Both services are supported by a variety of in-reach services to address the physical and mental health needs of its residents.
- WCC also commissions high support self-contained accommodation provision

(Montfort House - 16 flats) for clients in need of high support with complex needs but who can manage in a self-contained setting.

- Edward Alsop Court, King Georges and Montfort House are not permanent housing solutions but are part of a wider accommodation pathway and are as such designed to encourage stabilisation and independence for a move into step down semi-independent accommodation.
- *Multiple exclusion homelessness*: WCC acknowledges that there is a cohort of former rough sleepers who may not be suited to larger hostels. In response to this, WCC has commissioned and developed two Housing First schemes since 2017 for former rough sleepers who are willing to engage with tenancy support. Housing First is an evidence-based approach to successfully supporting homeless people with high needs and histories of entrenched or repeat homelessness to live in their own homes. It prioritises access to permanent housing with tailored, open-ended, wrap-around support for the resident.

3.2.24 The problems in accessing community support options via experienced MDTs, described above, is exacerbated by current options for where people with cognitive impairments, who have experienced homelessness can live. There is currently no purposefully designed high needs Extra-Care type accommodation for people in such circumstances; this gap is widely acknowledged. This is in spite of the wide provision available in Westminster – see box above.

3.2.25 The available high needs accommodation for people is a large hostel style provision, with food, activities, nursing, psychology, art therapy, carers team on site. At certain stages this is sufficient for some people. When cognitive impairments are more advanced however, such communal living can be challenging, as a more structured environment with set daily routines and prompts often help and a person's disinhibition can result in social aggravation and fights with others. Sexual disinhibition in turn can create risks to others and also risk to the person where there are also risks of false allegations which memory problems mean they are potentially unable to counter.

3.2.26 Currently the only step-up option is residential and/or nursing care. In the absence of viable community support options, this becomes the only means of addressing a person's needs and mitigating risks they face, to secure better health and well-being outcomes and fulfilled lives. The places a significant burden exclusively on the adult social care budget, despite people often requiring specialist MDT input.

3.2.27 It also creates social challenges because for many people who have experienced multiple exclusion homelessness the idea of moving into 'care' is unthinkable. A legal basis therefore needs to be established for acting against the person's will. This typically involves a mental capacity assessment being carried out by a local authority social worker, in order to determine if the person has mental capacity to make decisions about their accommodation in the context of the risks they are currently facing.

3.2.28 The sophistication and challenge of conducting mental capacity assessments involving questions about a person's executive functioning are well acknowledged. Nationally local authorities and partners struggle to achieve the standard required, risking misguided outcomes. In Westminster, a specialist lead for the Mental Capacity Act (MCA) exists and they are available to quality assure contested mental

capacity assessments. This mechanism does not appear to be effective for people with experience of homelessness and deteriorating cognitive functioning that is putting them at serious levels of risk in multiple ways. The tendency for people with reduced executive functioning ability to be able to perform normally in traditional conversation-based assessments, together with the ethos of personalisation and empowerment and prioritising the voice and wishes of the person, mean that social workers can easily over-estimate a person's mental capacity to make their own decisions about accommodation. This is exacerbated by the expectation that assessments are done in a single sitting, rather than longitudinally over a long period, to allow for triangulation in real life of what a person might say in an interview. It is also supported by the absence of a tradition of actively taking people to see the places being suggested for them to live, so they can familiarise themselves with the reality in order to inform their decisions.

Questions for consideration:

- How can learning from this SAR be incorporated into the exercise already underway to analyse the presenting needs of people experiencing and who have experienced homelessness in Westminster to inform the recommissioning of accommodation services in 2025?
- Who needs to be involved in discussion about options for addressing the gap in jointly commissioned, purposefully designed high needs Extra-Care type accommodation for people with cognitive impairments who have experienced homelessness as an alternative to the spot-purchasing of residential care home placements by ASC alone?
- Are there options in current accommodation renovations / developments that might be suitable?
- What arrangements can better enable adequate mental capacity assessments for people experiencing homelessness with cognitive impairments? How can adequate expertise in cognitive impairments be secured and assessment processes over a period of time be supported?

4 In summary

4.1.1 This report has been presented differently to traditional SAR reports that focus on the individual story of the person whose experiences led to the decision to arrange a SAR. The collaborative process of understanding ordinary practice in the Westminster context, through a detailed analysis and reflection on what happened and why in Malcolm's case, revealed a practice environment that is not designed for, nor conducive to timely, effective help for people with experience of multiple exclusion homelessness, whose cognitive impairments have deteriorated significantly. This work environment is made up of the multiple, overlapping and interacting issues that I have tried to capture in systems Finding 1, the single finding of this SAR.

4.1.2 In summary, this systems finding has highlighted how current service commissioning and ways of working mean that people who have experienced multiple-exclusion homelessness and have deteriorating cognitive impairments, can 'fall through the cracks'. While there are real strengths in existing specialist housing and GP provisions, there are notable barriers to accessibility of service evident in:

- Community support services
- Alcohol services
- Safeguarding
- Mental capacity assessments
- Care Act assessments and packages of care
- Accommodation.

4.1.3 The system across mainstream services is rigid and without reasonable adjustments in place which risks being inherently discriminatory.

4.1.4 This is not an unknown problem. But the barriers summarised in this finding, often stemming from commissioning decisions and role designs, mean that solutions are currently hard to achieve on the ground. Many hours can be spent chasing, and in escalation meetings, making no difference at all to the person affected and leaving those working directly with the person, particularly housing support workers, holding and desperately trying to mitigate the various and escalating risks the person faces, often a huge personal expense to them both.

4.2 HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLLY AFFECTED

4.2.1 Discussion with the case group and review team indicated that while this finding does relate to people who have experienced and are experiencing multiple exclusion homelessness and are alcohol dependent, it is important not to restrict the relevance of the finding too tightly. Experiences suggested that the same service gaps and barriers will impact people who've experienced homelessness and have deteriorating cognitive function for a wider range of, and potentially multiple causes – as listed in the introduction.

4.2.2 Currently there is no readily available indication of the number of people affected by this finding either who are rough sleeping pathway users or wider. An estimate

provided suggests approximately 30 people per year related to the rough sleeping pathway who are struggling to access necessary services and support.

4.3 A PARTNERSHIP STRATEGY

4.3.1 Tackling this systemic constellation will need commitment from both service commissioners, providers as well as those doing and supporting direct work with citizens.

4.3.2 This is vital in order for services to meet their public sector equality duty by giving due regard to eliminating discrimination and promoting equality and equity of opportunity.

Questions for consideration:

- How can the interconnections and interdependencies between different agency pathways, provisions, roles and responsibilities be clarified and overseen?
- Who is best placed to work together to map out the wider partnership strategic plan for people who have experienced homelessness, impacted by worsening cognitive impairments?
- How will the SAEB know if changes have had an impact?
- What can the SAEB do improve the clarity across partners, of each agency's escalation routes in order that any ongoing accessibility issues are swiftly identified?