Safeguarding for People Experiencing Homelessness
Monday 13th July, 4-5pm

The latest practice sharing session in our homeless health series. Hear about:

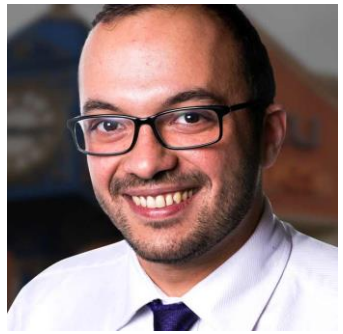
- The issues, priorities and challenges for safeguarding as we approach the next phase of accommodating rough sleepers
- The responsibilities of those who work in homelessness, housing, health and social care to safeguard those who are risk of abuse or neglect (including self-neglect)
- Good practice tips and resources for safeguarding as we approach the next phase of accommodating those who are experiencing homelessness, including a new prototype safeguarding toolkit

Olivia Butterworth
Head of Public Participation
NHS England & Improvement

Prof Michael Preston-Shoot
Emeritus Professor of Social Work
University of Bedfordshire

Gill Taylor
Strategic Lead for Homeless and Vulnerable Adults
London Borough of Haringey

Fiona Bateman
Chair, Board of Trustees
CASCAIDr



Bruno Ornelas
Head of Safeguarding & Services, Voices of Stoke/Brighter Futures Housing Association

#homelesshealth

NHS England and NHS Improvement

#safeguarding

Housekeeping

- Webinar is live & recorded
- Use the Q&A function to ask any questions – we will try to answer as many of these as we go and we'll follow up on those we don't manage to get to afterwards.
- Slides & recording will be uploaded to the **Homelessness Covid-19 Cell Future Collaboration Platform**
- Email england.covid-homeless@nhs.net after today for questions or topics you want addressed in future webinars

Our speakers

- **Olivia Butterworth**, Head of Public Participation, NHS England and Improvement
- **Michael Preston-Shoot,** Emeritus Professor of Social Work, University of Bedfordshire
- **Gill Taylor,** Strategic Lead for Homelessness and Vulnerable Adults, London Borough of Haringey
- **Fiona Bateman,** Chair - Board of Trustees, CASCAIDr
- **Bruno Ornelas,** Head of Safeguarding and Services, Voices of Stoke / Brighter Futures Housing Association

Learning for positive practice

Messages from research and reviews

Multiple Exclusion Homelessness

- Extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care.
- Adverse experiences in childhood can include abuse and neglect, domestic violence, poverty and parental mental illness or substance misuse.
- For many of those who are street sleeping, homelessness is a long-term experience and associated with tri-morbidity (impairments arising from a combination of mental ill-health, physical ill-health and drug and/or alcohol misuse) and premature mortality.
- Presence of other chronic and acute physical health conditions, physical disabilities, learning disabilities and/or cognitive impairments.
- Do not assume or expect that individuals can keep to scheduled clinic appointments, in our time and space; assertive outreach.

Using the voice of lived experience (SAR - Ms H and Ms I – Tower Hamlets SAB)

- In the context of people's experiences of multiple exclusion homelessness, the notion of lifestyle choice is erroneous.
- The problem is not the problem; it is the solution that is the problem. Tackling symptoms is less effective than addressing causes.
  - Attempting to change someone's behaviour without understanding its survival function will prove unsuccessful. The problem is a way of coping, however dysfunctional it may appear. Too often we are responding to symptoms and not causes. Put another way, individuals experiencing multiple exclusion homelessness are in a "life threatening double bind, driven addictively to avoid suffering through ways that only deepen their suffering."
  - At times "she could not help herself" because of the feelings that were resurfacing; access to non-judgemental services was vital and helpful, and that support is especially important when individuals are striving to be alcohol and drug free. It was during these times that stress, anxiety and painful feelings could "bubble up", prompting a return to substance misuse to suppress what it was very hard to acknowledge and work through.
- Making Safeguarding Personal is not just about respecting the wishes and feelings that an individual expresses.
  - He reflected on the challenge of knowing when to allow a person freedom of movement and when, for their own benefit, to curtail or supervise this. He described this as a "moral question." It is indeed a question that, in a multi-agency and multi-disciplinary forum, needs to be answered in each unique situation, drawing on an analysis of risks and mental capacity.

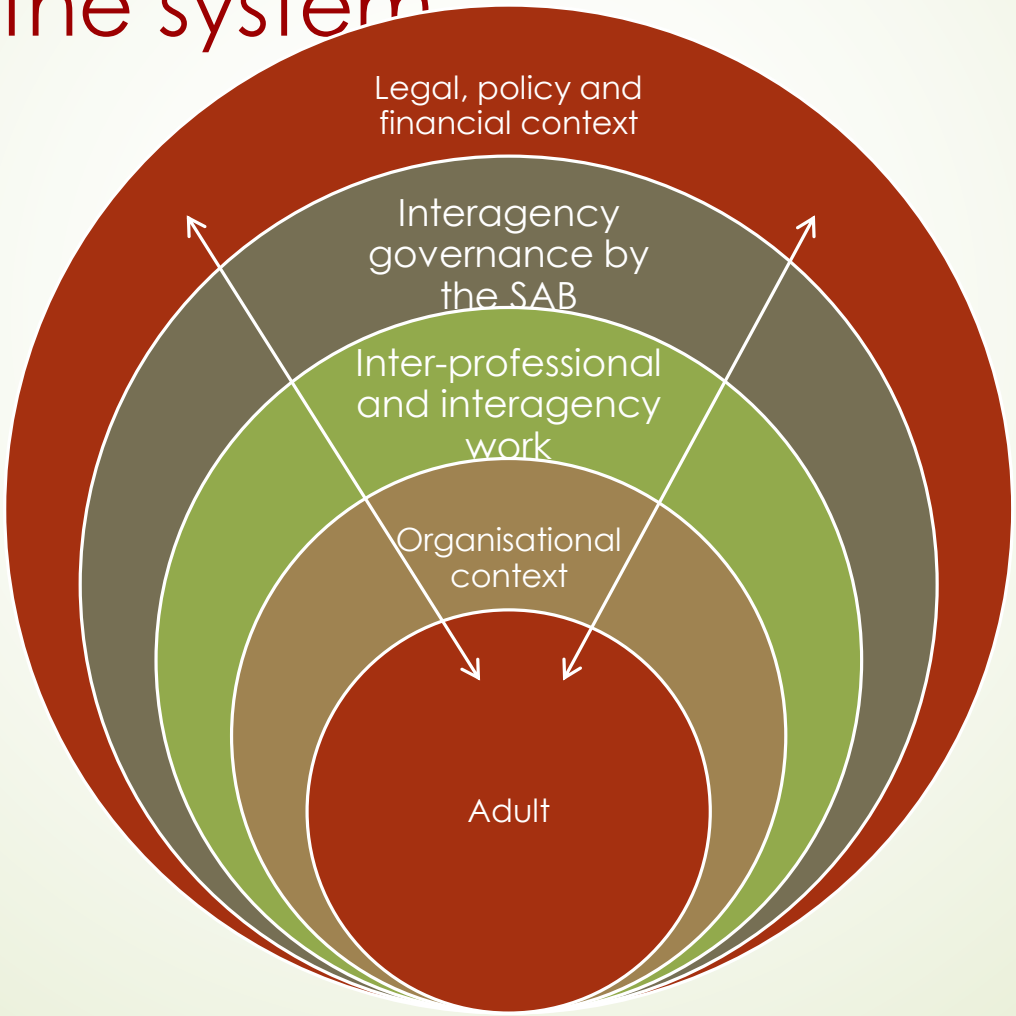
Milton Keynes – Adult B (2019)

- Adverse childhood experiences; substance misuse as response to trauma
- Unable to sustain hostel place due to substance misuse
- Unplanned hospital discharges
- Adult Social care assessments of his needs arising from autism and homelessness delayed and incomplete at time of death
- No lead agency or practitioner championing his unmet underlying needs
- Lifestyle and health concerns mount with no signs of professional scrutiny – no professional curiosity
- No mental capacity assessment or full safeguarding assessment
- No use of advocacy or escalation of concerns
- Lack of inter-agency response including multi-agency meetings
- Lack of management guidance, direction and supervision

Isle of Wight – Howard (2018)

- Homeless single adult without local family support
- Longstanding alcohol misuse and physical ill-health
- Hospital and prison discharges to no fixed abode
- Police and ambulance crews concerned about risks of financial and physical abuse, and his self-neglect
- Refused housing as not regarded as in priority need
- No wet hostel available
- Referrals to adult safeguarding do not prompt multi-agency meetings or investigation; no completed Care Act 2014 care and support assessment
- No lead agency or key worker; no risk assessment or mitigation plan
- No holistic approach – services in silos.

A safe system has alignment of checks and balances between the different layers of the system



Direct practice with the adult

Organisational factors

Interagency cooperation

Crisis as opportunity

- Response to Covid-19, investment in providing accommodation for people experiencing homelessness.
- Provision of wrap-around support – GP registration, responses to health care needs.
- Work to do to increase capacity in substance misuse services and to achieve access to mental health provision
- Housing support on site, outreach provision and risk management processes
- Moving on focus – support planning into interim settled accommodation
- Regional partnership working involving PHE, NHS E&I and ADASS.
- Homelessness Guidance updated on priority need in response to the pandemic
- Building on what we know about integrated commissioning – specialist pathways and contracts, support to engage, co-location, design around individuals, coordination and flexibility

Learning from Homelessness Fatality Reviews

Homelessness in the UK

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

The most common reasons for homelessness are loss of Assured Shorthold Tenancies and family breakdown

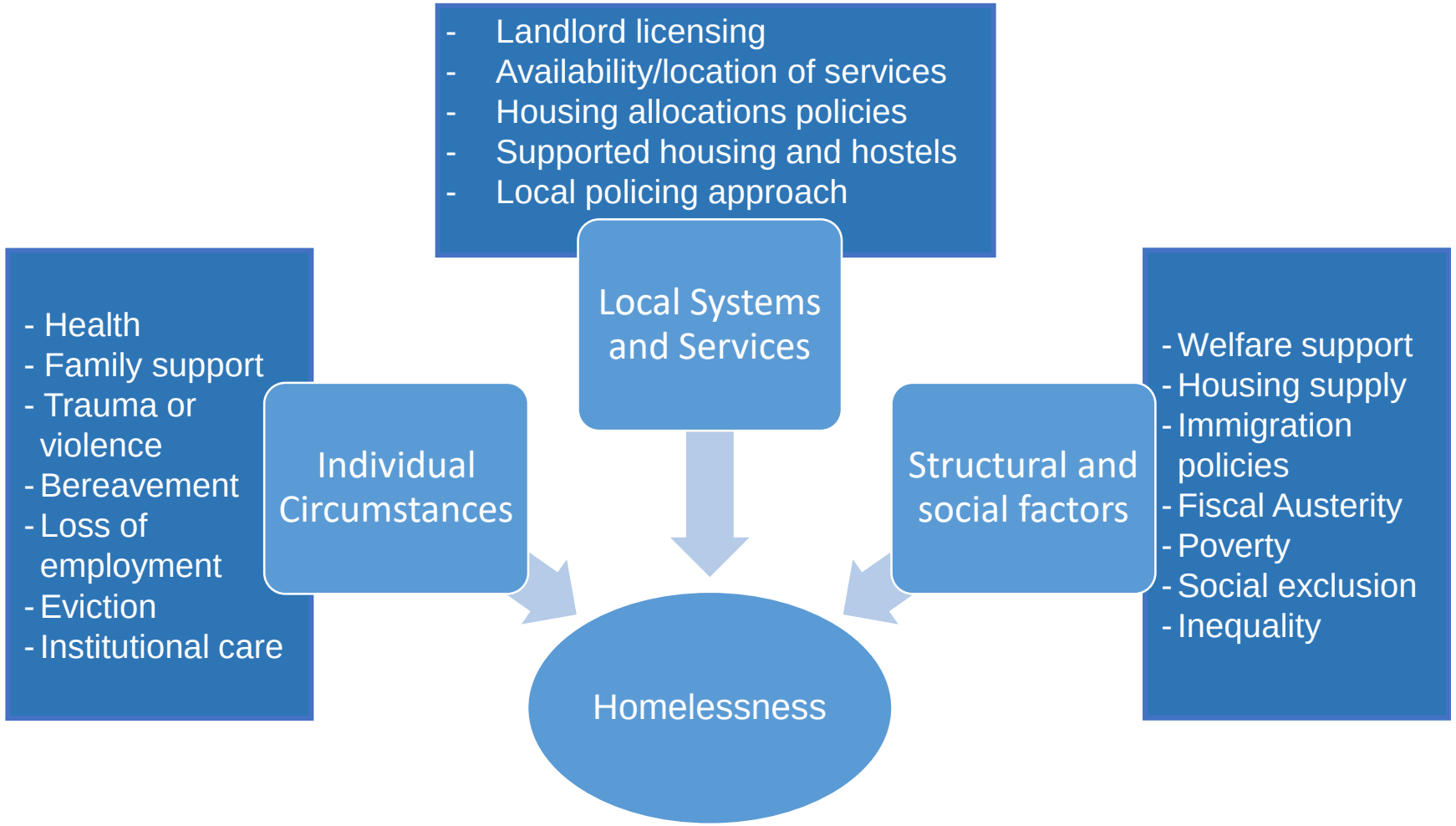
83,700 households are living in Temporary Accommodation, a 74% rise since 2010.

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

25% of homeless young people are LGBTQ+

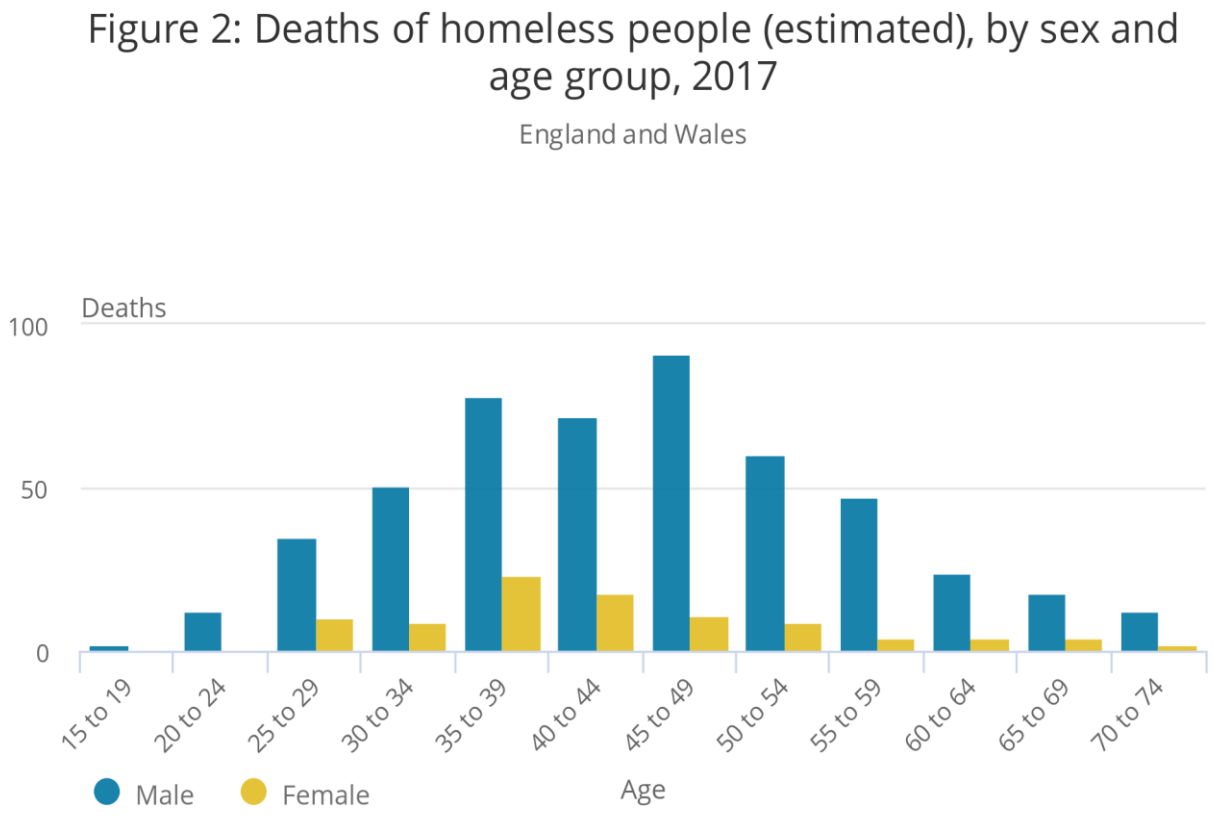
It is estimated that homelessness costs £1.5bn per year in public spending, illness, lost work days etc

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



Factors that Influence Homelessness

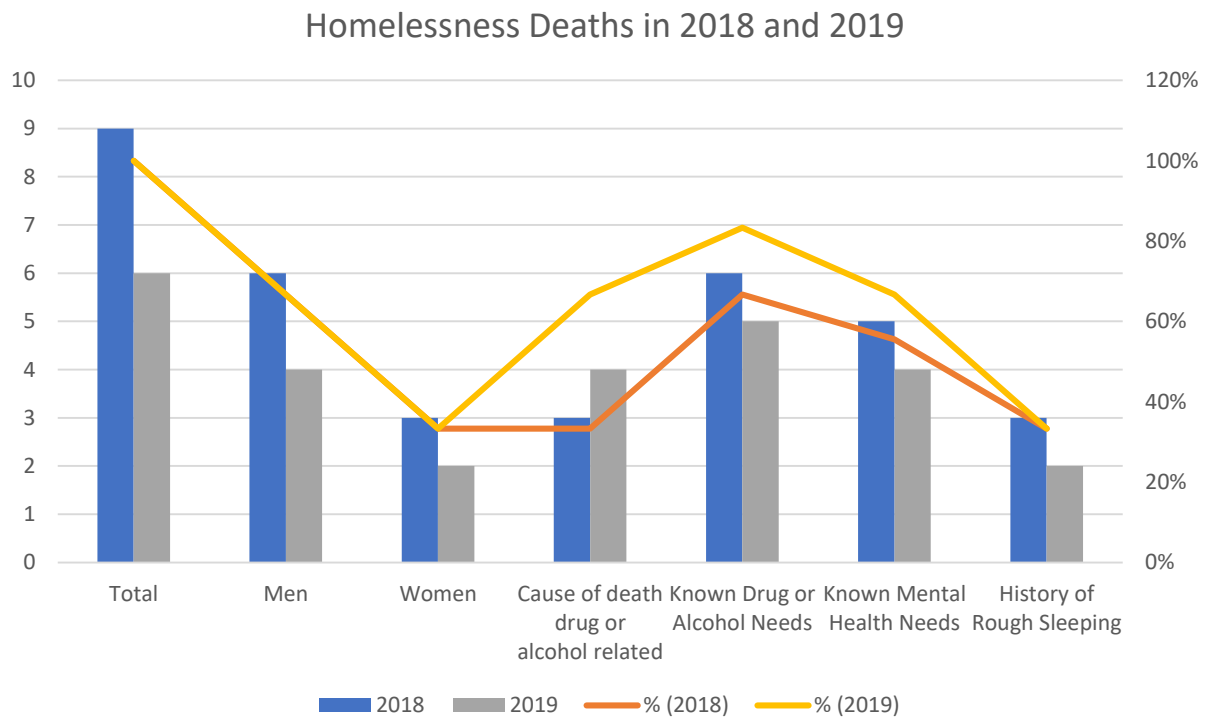
Homeless Deaths (National)



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

- There were 722 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

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.
- The average age at death for homeless people in Haringey is 41 years old,
- 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%

National Rough Sleeping Strategy

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, halving it by 2022

Makes a clear connection and commitment around the health and care needs of people who are rough sleeping

Recommends a more consistent use of SAR's and other review processes when a person rough sleeping dies

Encourages learning, reflection and change at local level

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

Commitment of £100m funding to deliver these commitments

Homelessness Fatality Review

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

Secondary Aims:

1. To improve multi-disciplinary partnership practice
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 ‘deficits’

Implemented in February 2019

Adopted using powers under Care Act 2014 (Section 44)

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

Submits an annual thematic review to the local SAB

Key Learning - Individual

- **Grievability** – are we allowed to grieve for the lives of people who society deems responsible for their own fate?
- Severe **loneliness & social isolation** are key determinants of poor health outcomes for homeless people
- **Relationships** between professionals, and between professionals and service users are crucial
- 'Cliff edges' – **transitions between services**, from hospital to community, from one worker to another present significant risks if poorly managed
- Timely **access** to services is a major issue, usually due to eligibility criteria which inadvertently exclude street homeless people

Review Process

- **Celebrating and learning** from achievements is as important as learning from what went wrong

Key Learning - Organisational

- Discharge to the street kills
- Crucial role of primary care in reducing acute admissions and building relationships
- Thinking about **homelessness as a health diagnosis**
- Practitioners and clinicians who have the **flexibility** to visit people where they are (literally and figuratively)
- Information Sharing Agreements are the roots of strong partnership between sectors
- An attitude of **'inevitability' creates lethargy** around risks and vulnerabilities

Review Process

- Value of **reflective discussion** for practitioners
- Platforming tensions, limitations and conflicting practices between organisations is crucial
- **Accountability** is a key enabler to change

Good multi-agency practice

DON’T BE AFRAID TO ASK QUESTIONS

IDENTIFY LEAD PRACTITIONER

IDENTIFY KEY CONTACTS

INFORMED CONSENT

COLLABORATE AND SHARE EXPERTISE

CASE CONFERENCING

INFORMATION SHARING PROTOCOLS

JOINT ASSESSMENTS

In health settings…

- Ask *'Have you got somewhere safe to stay when you leave hospital?*
- Professional curiosity
- Discharge planning from acute settings - ensure continuity of care
- Social prescribing
- Consider contextual and executive capacity
- Don't neglect smoking cessation & sexual health
- Get legally literate
- Rights to GP registration
- Training on trauma-informed care

Are you worried about someone who is rough sleeping?

StreetLink exists to help end rough sleeping by enabling all members of the public to connect people sleeping rough with the local services that can support them.

- Don’t assume someone else has made a referral!
- Telephone, online or download the app
- 0300 500 0914 or https://www.streetlink.org.uk/
- Share as much information as possible about the person and location
- Outreach teams will try to locate someone for 3 days before closing the referral

HOMELESSNESS AND ADULT SAFEGUARDING: ADOPTING A HUMAN RIGHTS BASED APPROACH

Human rights- based approach to safeguarding and risk management

Emphasis must be on sensible risk appraisal. Seeking a proper balance and being willing to tolerate manageable or acceptable risk as the price appropriately to be paid in order to achieve some other good. What good is it making someone safer if it merely makes them miserable?"

Munby J, *Local Authority X v MM* [2007]

"Between active decision makers and those certified as lacking mental capacity is a category of vulnerable adults who are open to exploitation." *DL v A local Authority* [2012]

'The healthy and moral human instinct to protect vulnerable people from unwise, potentially catastrophic decisions must never be permitted to eclipse their fundamental right to take their own decisions where they have the capacity to do so. Misguided paternalism has no place in the Court of Protection.'

Hayden J, *LB Tower Hamlets v PB* [2020]

National and local guidance advocates a human rights based approach to safeguarding and risk assessment, moving away from paternalistic protections of those with care and support needs to supporting people to understand their legal rights, identify coercive or exploitative behaviours, make informed decisions about risk based on potentially differing viewpoints and manage risk from a person centred, strength based perspective!

S42 Enquiry duty is triggered when you have reasonable cause to suspect …

An adult in the area

- Responsibility for considering any adult safeguarding concern under s42 Care Act lies with the local authority where the adult is physically present, '***whether or not the adult is ordinarily resident there***'.
- Local connection/ ordinary residence is relevant to ongoing assessment duties- interim protection plans should set out how the adult will be able to access follow up support to address longer-term needs.

with care and support needs

- This can include conditions linked to physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. See pg6.104 Care and Support guidance.
- Consider whether 'reasonable adjustments' are necessary to access assessment and if any accommodation offered if appropriate to meet their daily needs.
- Range of useful toolkits to help identify specific conditions e.g. autism, pregnancy, brain injury. [see p25)

is experiencing or at risk of abuse/ neglect

- There is NO threshold of 'significant harm' regarding safeguarding duties to those over 18
- Guidance [pg 14.16-14.35] and your local SAB webpages provide an '*illustrative guide to the sort of behaviour which could give rise to a safeguarding concern*'. It is important to remain up to date with research regarding types of abuse as this will inform your understanding of risk assessment and provide insight into the questions or scope of any investigation.

unable to protect himself

- Safeguarding practitioners should actively consider if risk of abuse is more acute because of the adult's care and support needs. Look for patterns of neglect/ abuse.
- Making safeguarding personal and Mental Capacity Act principles require practitioners to ask the adult '*do you understand why I am concerned about the level of risk to your wellbeing*?' Providing opportunity to work with the adult at risk to understand what might be preventing them from protecting themselves.

- **Empowerment**: Understanding how the person's needs for care and support impacts on their ability to make a decision, be involved in safeguarding process and ultimately protect themselves is a legal duty- s68 and *R (SG) v Haringey* [2015].
- **Prevention:** This is a pro-active duty which requires active investigation with relevant partners to obtain pertinent information. Practitioners must take into account everything you can reasonably be expected to know and respond appropriately. Be confident, if necessary, use the assertive outreach as trusted assessors and your local safeguarding information sharing protocol:
- **Proportionality:** This requires inquisitive enquiry, including reviewing the case history so presenting safeguarding issue is understood in context.
- **Protection:** Assessment and safeguarding duties can't be triaged on basis of the setting where care is provided, the person's mental capacity or access to services. Duty to assess service users/carer arises on the appearance of need and continues, despite capacitated refusal by an adult, if the LA has concerns there is a risk of abuse or neglect- s11(2) Care Act] and *South-end on Sea Council v Meyers* [2019]

NB: HCOG [8.44-45] amended to include a requirement to consider clinical vulnerability to Covid-19 for those with history of rough sleeping: https://www.pathway.org.uk/wp-content/uploads/COVID-19-Clinical-homeless-sector-plan-160420-1.pdf

- **Partnership: Reciprocal duties to refer** if a person may require social care support on discharge from hospital [discharge regs 2014] or is threatened with homelessness [s213B Housing Act] if the person is young (16-17) or a care leaver (18-24) or would leave custody without accommodation [pg23.4 HCOG]. Practitioners must also make **reasonable adjustments** so that organisational barriers (e.g. rigid operational service criteria, appointment times) don't prohibit people from securing support: *Haque v Hackney* [2017]
- **and to co-operate across agencies** [s6-7 Care Act]. Relevant partners, including Police, DWP, health and housing providers, must co-operate when exercising their functions. Refusals only permitted if in writing and show incompatible with their own duties or would have adverse effect on their own functions.
- **Accountability**: The public law nature of safeguarding decisions means an practitioners, esp. those working within 'relevant partner' agencies must be able to satisfy they have met their professional clinical and care governance duties. It may not be possible to persuade or compel an adult at risk to accept support, but this alone will not itself absolve practitioners of their duty of care! Careful recording of the person's capacity to understand, retain, weigh up and communicate the decision will also require evidence that practitioners have explained, in line with their professional standards and the MCA code of practice, any actions they are required to take to fulfil their wider core duties and the options available to the person.

Practitioners role is to facilitate safety planning, but to do so effectively, they must:

- Explore the likelihood and severity of harm, consider all available choices and the adult's view of the impact that each choice may have on their wellbeing. Research warns risk tools should complement professional judgement and be a continuous process.
- Work collaboratively on understanding risk and underwriting safety- building trust with adult's social network, recognise protective value of increased choice and develop techniques to detect and obstruct abuse but guard against placing undue confidence on ability of individuals, families or their informal support networks to care effectively.
- Protect against unintended collusion with perpetrator- findings from DHR/SAR provide examples where victims are seen as lacking creditability due to the extreme/unbelievable nature of the abuse they report, an inability to give logical or ordered account or because they present as angry with professionals rather than a 'passive' victim.
- Build contingency into safety plans - ensuring this is a shared responsibility between professionals and the adult! Especially at times of increased risk.
- Do not ignore perpetrators responsibility for harm, stopping the abuser may assist the victim/ other family members to play a protective role.

Introduction to our safeguarding toolkit

Multiple Exclusion Homelessness: A safeguarding toolkit for practitioners

VOICES
VOICES OF INDEPENDENCE CHANGE & EMPOWERMENT IN STOKE-ON-TRENT

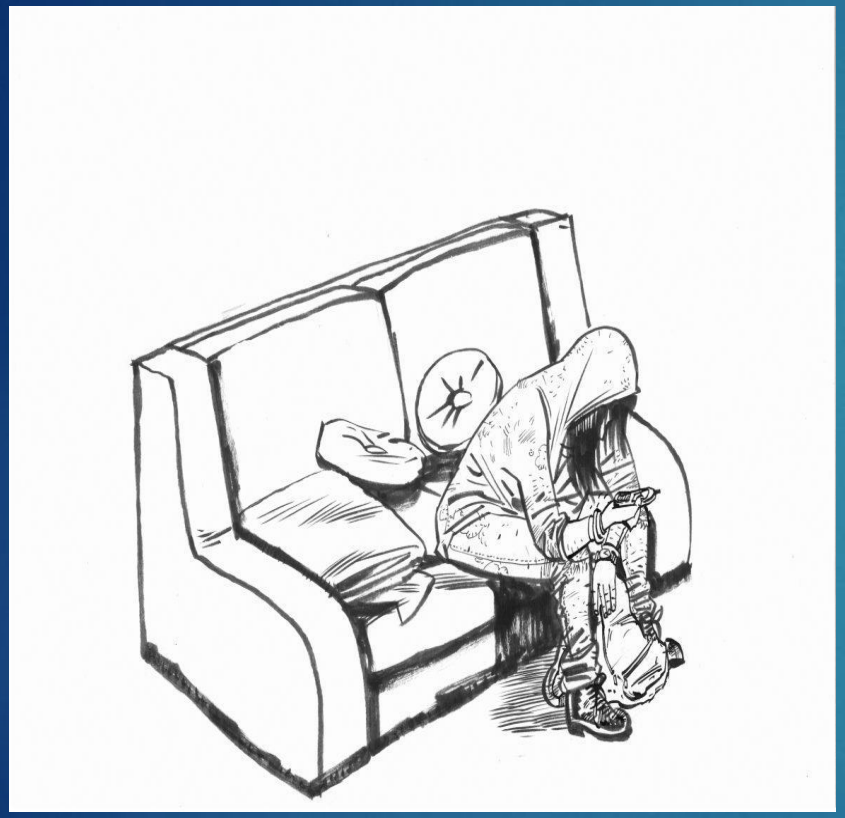
brighter futures
creative support, housing and employment

KING'S College LONDON

Keele University

COMMUNITY FUND

"D"



- Physically disabled
- History of multiple exclusion homelessness
- Under 55
- Needs 'too high' for traditional homelessness services
- Deemed to be 'non-engaging' and making 'poor lifestyle choices'
- Capacity Vs Incapacity
- Normalisation of risk and multiple handoffs
- Complexity is high, including risk of 'cuckooing'
- Lack of consensus across disciplines
- Risk is not being shared across teams
- Poor legal literacy and safeguarding literacy

What worked

- Getting to the know the person
- Initial fact finding is carried out
- Contextualising needs as it relates to people experiencing MEH
- Understanding care and support needs i.e. not what services are required but what the person's ability to achieve actually is
- Mapping out care and support needs against eligibility domains using the Care Act Toolkit (Section 9, Care Act 2014)
- Exercising the person's rights to have an Independent Care Act Advocate (Section 67 and 68, Care Act 2014)
- Seeking expert legal advice from CASCAIDr
- Constructing a legally literate case to help the team and organisations around the person in the performance of its statutory functions
- Persistence, tenacity and legally literate advocacy is key

Outcome

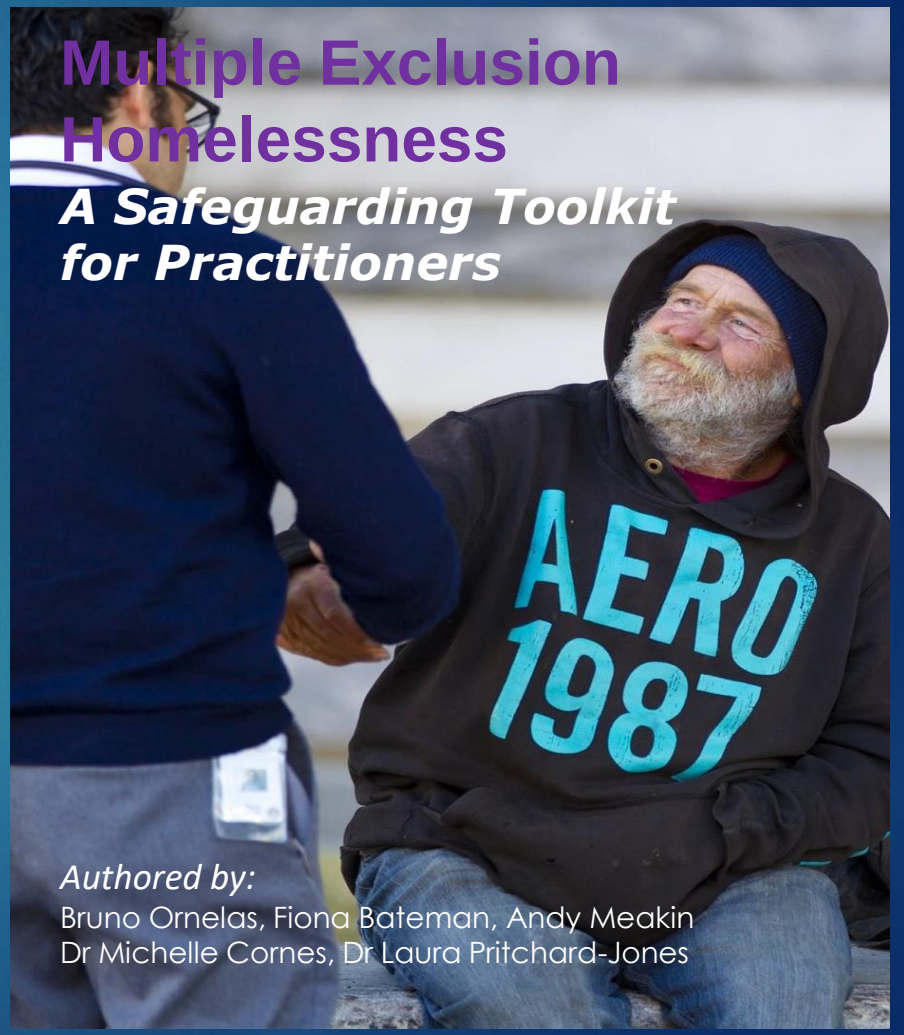
- Parallel enquiry – social care assessment and safeguarding running concurrently
- Fully adapted accommodation to suite physical needs
- Regulars visits from carers to help with cooking, cleaning and to attend appointments
- Appointeeship to help manage money
- An allocated Social Worker providing case management i.e coordination
- Robust and coherent risk management planning to mitigate risk of cuckooing
- A test case for improved partnership working across disciplines and sector boundaries

Moving from initial conflict to collaboration

- CASCAIDr provided training to teams from across statutory and voluntary sectors on legal literacy and human rights based approaches to practice
- Local authority housing officers carry out outreach alongside rough sleeper outreach staff
- Social Workers commence outreach with homelessness staff
- Care and Support needs of people experiencing MEH are more readily identified
- Lifestyle choice narratives are seldom heard in relation to MEH populations
- Risk is more frequently shared and hand-offs have reduced
- Co-development of the Safeguarding toolkit – VOICES, CASCAIDr, Kings College London and Keele University

Safeguarding Toolkit: why, when and how

- To support fact finding, thinking, communication, and decision-making
- When there are safeguarding concerns about a person experiencing multiple exclusion homelessness
- By completing the document to set out the known facts and recognising any unknowns relevant to the concerns
- While reading the guidance and making use of the resources highlighted
- The outcome is intended to aid communication across multi-disciplinary teams
- It does not replace any local systems
- The toolkit is available as a prototype for testing



Safeguarding toolkit (structure)

This toolkit draws on three key questions which practitioners are encouraged to use throughout the completion of the toolkit:

1) Have you somewhere safe to stay tonight, can you get the help you need to meet your basic needs there?
2) Do you understand why I am concerned about the level of risk to your well-being?
3) What help do you need now to protect you and how should partner agencies work together?

There are **4 sections**

1) The adults needs and the risks they face,
2) Chronology of events (short term and long term)
3) Immediate risk factors
4) Protection planning

Also included:

On the margins of each page there are things for you to consider when working through the document. Please note that this is to help you in your thinking and **not to replace formal procedures** for raising safeguarding concerns.

DOWNLOAD THE TOOLKIT HERE

The toolkit…

- Can be used by **any practitioner** working across homelessness or with adults experiencing other deep forms of exclusion where they have care and support needs and are at risk. The toolkit is not the final version so we're releasing it as a **working prototype for testing**.

- **At this stage**, the format is for use as a **hard copy annotated by hand**. However, our intention is that the **final version** will be completed by **electronic** means or on-line

Download the toolkit at:

Queens Nursing Institute

https://www.qni.org.uk/wp-content/uploads/2020/05/SafeguardingToolkitDRAFT-PDF.pdf

VOICES

https://www.voicesofstoke.org.uk/2020/06/01/multiple-exclusion-homelessness-a-safeguarding-toolkit-for-practitioners/

Assist us in the final stages of development by sending your feedback to:

Enquiries@voicesofstoke.org.uk

Useful resources

Email england.covid-homeless@nhs.net after today for questions or topics you want addressed in future webinars

Slides & recording will be uploaded to the **Homeless Health Covid-19 Future Collaboration Platform – email** HomelessHealthCOVID19-manager@future.nhs.uk to access