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To: All Directors of Housing and Directors of Adult Social Services in England, and all Safeguarding Adults Board Chairs

RECOMMENDATIONS FOR SAFEGUARDING ADULTS BOARDS REGARDING INDIVIDUALS ROUGH SLEEPING

Summary of recommendations to Safeguarding Adults Boards (SABs)

1. **Governance structure, accountability and system-wide change**:
    a. SABs should ensure their governance structure has the necessary mechanisms to hold partners working with people rough sleeping accountable.

    b. SABs should act as an active presence in system-wide governance discussions. These discussions should seek outcomes which promote the integration of experience informed practice into service standards.

2. **Named board member for rough sleeping:** SABs should designate a member of the Board to lead and update on complex or stalled cases within the local authority's Target Priority Group (TPG) of people rough sleeping. DLUHC Rough Sleeping Initiative advisers will soon be reaching out to local authorities to support closer working between rough sleeping teams and Safeguarding Adults Boards.

3. **Strategic plans, annual reports and procedures:** SABs should actively reference rough sleeping and homelessness in annual reports and strategic plans. Promoting workforce safeguarding and legal literacy is also strongly recommended.

4. **Safeguarding Adult Reviews:** In compliance with the Care Act 2014 ("Section 44"), SABs should proactively commission Safeguarding Adult Reviews in cases of deaths involving rough sleeping. There should also be a clear focus on implementing learnings from the reviews.

We write to you jointly following our 2022 'Ending Rough Sleeping for Good' strategy with recommendations for how Safeguarding Adults Boards can support individuals rough sleeping. Following this letter, DLUHC will soon be extending a support offer, specifically aimed at areas that face ongoing challenges in resolving long-term and cyclical rough sleeping for adults who are vulnerable and at risk. We want to support local areas to deliver the recommendations and

expectations highlighted in this letter, and in particular, the key role of SABs in protecting individuals sleeping rough from risk of abuse and neglect (including self-neglect).

We know given the high needs of those sleeping rough that there is considerable overlap between rough sleeping and the presence of safeguarding concerns. Most adults rough sleeping are at significant risk of abuse, neglect, and severe escalation of health and care needs.

Research published by King's College London and the NIHR Policy Research Unit in Health and Social Care Workforce and Partners in Care and Health shows that many local areas are delivering high standards across a range of practices including assessment of need and risk, provision of social care, and responses to mental and physical health needs. However, the research also points to poor multi-agency working within local authorities (LAs) and the need for good leadership in relation to joint working around individuals experiencing homelessness.

As the primary providers of rough sleeping services, LAs play a pivotal role in addressing the needs of those experiencing homelessness. Through programmes such as DLUHC's flagship Rough Sleeping Initiative (RSI), the Government is bolstering the efforts of LAs in this critical area. In tandem, we recognise that SABs hold a key position in influencing a significant proportion of rough sleeping cases that overlap with safeguarding concerns. **While individual case management and one-to-one support for individuals rough sleeping will always be taken forward by local frontline professionals, SABs are crucial in ensuring that the necessary partnerships, policies, and resources are in place to support this work.**

Whilst most of the recommendations outlined in this letter centre around responsive measures, effective work in this space requires a joined-up local approach blending both formal and supportive safeguarding measures. The proactive and effective use of the duty under the Care Act 2014 ("Section 42") can ensure strong preventative capacity within the area, avoiding fatalities and near misses before they occur.

The following recommendations are aimed at helping SABs support vulnerable individuals rough sleeping. For detail on the Government's definition of rough sleeping, homelessness, and TPG please consult Appendix A.

1. **Governance structure, accountability and system-wide change**

It is important that SABs consider the safeguarding needs of people rough sleeping in their local area – as they would for other groups facing elevated risks. This ensures that local safeguarding arrangements and partnerships adequately protect adults with care and support needs who may be vulnerable to abuse or neglect (including self-neglect).

It is important that the governance structure of SABs incorporates clear and sufficient accountability mechanisms for partners with responsibilities towards people rough sleeping.

SABs should take an active role in promoting outcome driven discussions around governance. This should centre on system-wide change and the integration of experience informed practice relating to safeguarding people rough sleeping. Whilst recognising the collective challenges faced by SABs, there needs to be consensus on a unified vision, along with clear delineation of roles and responsibilities to ensure the quality of policies, procedures, and practices for people rough sleeping.

2. **Named board member for rough sleeping**

In line with the recommendations of the National Institute for Health and Care Excellence 214 Guidelines on homelessness, and as outlined in our strategy, we expect each SAB to designate a named member on the board to lead on safeguarding the welfare of people rough sleeping,

including engagement and face-to-face practical safeguarding support. The appointed advocate should have a thorough understanding of local safeguarding arrangements for people rough sleeping to ensure adequate protection. This could be the Director of Housing or a co-opted member from the faith, voluntary, and community sector. We stress the importance of selecting an advocate tailored to each locality.

While the Board may not engage in case-by-case discussions, **the appointed advocate should provide regular updates on the long term and stalled TPG (see appendix A for definition) cases which have been referred to SABs and where resolution of need may provide the greatest challenge**.

DLUHC RSI advisers will be reaching out to local authorities to support closer working between rough sleeping teams and SABs to help drive resolutions for a small number of the TPG cases where individuals are furthest away from ending their rough sleeping. Our aim in this engagement is to understand existing barriers in this way of working, identify challenges, and promote best practices.

The emphasis is on joint working across sector specialisms for stalled and stuck cases and where housing and social care needs are inextricably linked. One example of best practice in regard to a multi-agency response is Barnsley Council in South Yorkshire. Barnsley's Housing and Adult Social Care Teams co-chair a case management forum that brings together services where a multi-agency response is required to risk mitigation and problem-solving. The focus is on collaboration and flexible responses to assessments, housing, and access to specialist accommodation with support for people who are rough sleeping and/or a part of the TPG. For more helpful insight around LAs engaging with TPG and things to consider, please refer to the illustrative case in Appendix B.

3. Strategic plans, annual reports and procedures

SABs should aim to make specific reference to rough sleeping and homelessness in their strategic plans and reports. They should also establish procedures for practitioner engagement with this cohort through promoting workforce literacy around understanding safeguarding, relevant legislation, perceived stigma, multiple disadvantage, and the roles and responsibilities of various stakeholders in supporting individuals rough sleeping.

4. Safeguarding Adult Reviews

We encourage SABs to commission safeguarding reviews for incidents involving rough sleeping deaths. While not all cases may involve care and support needs, many Safeguarding Adult Reviews feature homelessness as a factor. It is important to exercise Care Act 2014 ("Section 44.4") review rights for cases that do not meet the threshold to ensure relevant lessons learned are derived from incidents involving rough sleeping. There are many examples of good practice already, including Haringey Safeguarding Adults Board's SARs process.

Thank you for your dedication to ending rough sleeping and contributing to the wellbeing and safety of vulnerable individuals rough sleeping.

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Appendix A - Defining homelessness and rough sleeping

Homelessness: legally, a person is considered homeless if they do not have accommodation that they have a legal right to occupy, which is accessible and physically available to them (and their household) or which it would be reasonable for them to continue to live in. Rough sleeping is one form of homelessness.

Rough Sleeping: the most acute and extreme form of homelessness that is characterised by someone about to, or actually, bedding down in the open air (such as on the street, in tents, doorways, parks, bus shelters or encampments) or places not designed for habitation (including cardboard boxes, stairwells, cars and other makeshift and not fit for purpose places). Rough sleeping does not include instances of those in hostels, shelters, recreational shelters such as campsites or spaces of protest, squatters, and travellers.

Target Priority Group: people that experience long-term and cyclical rough sleeping – known to LAs as the Target Priority Group or Target Thousand in London.

Appendix B - Steve Case Study – Target Priority Group

Steve, a white British male in his 40s, has been sleeping rough for several years and has a long history of placement breakdown and tenancy failure. He has significant physical and mental health concerns often resulting in episodes of self-neglect which are compounded by a chronic substance use disorder linked to alcohol. He is well known to agencies in AnyTown and has been identified by the local authority as part of the Target Priority Group (TPG).

Due to high levels of intoxication, Steve came into repeat contact with blue light services often resulting in hospital admissions. Steve can be challenging to work with, often becoming verbally abusive and mistrusting of professionals.

Even within a hostel setting staff reported that he could not safely access facilities to meet his personal care or nutritional needs. They raised concerns that Steve was often tearful and withdrawn and he eventually abandoned the accommodation stating, “they can’t do anything for me here”.

For Steve, his housing, health and social care needs were interdependent. His alcohol use raised additional areas of risk and capacity that needed careful exploration. Many practitioners felt he was making “unwise decisions” and that this limited their ability to offer support. Numerous safeguarding alerts have been raised but responses have not always been consistent.

There are varying degrees of concern regarding Steve’s ability to keep himself safe and how his needs are understood, with views diverging across sector specialisms resulting in a high degree of uncertainty across multi-disciplinary teams. In addition, it has not always been clear which assessments have been done by whom and with what outcome.

Prompts and considerations:

This case study highlights issues that could be considered in this and other cases to improve how Steve and people like him are supported.

- What are Steve's views and how are these expressed? And does Steve understand why agencies are concerned for his wellbeing?
- How should partner agencies work together? And who is best place to lead and coordinate the case of Steve?
- Should a safeguarding enquiry be triggered under section 42 Care Act 2014? And/or a care assessment? Are assessments occurring flexibly and at a time and place to best engage with Steve, and who is best placed to do them?
- What legal powers can be considered to facilitate positive multi-disciplinary practice and interventions, including addressing immediate risk factors whilst considering medium to long term planning?
- Is a mental capacity assessment warranted? if so, what are the decisions that are required to be made by Steve and at what point?
- How are you using Safeguarding Adult Reviews to inform ways of working with Steve?
- Is there sufficient expertise and legal acumen available, including access to these, to inform assessments and case coordination that enable positive practice?
    - In the case of Steve, or similar cases, how should challenges and issues be escalated and to what role(s) and department?
    - If there are gaps in service provision, including specialist accommodation, that are required to best meet Steve’s assessed eligible needs, how should this be raised and to whom? And how could Steve’s needs be met in the interim?