Adult Safeguarding and Homelessness: Learning from Safeguarding Adult Reviews

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Introduction

The Government's Rough Sleeping Strategy[1], developed in response to rising concerns and the increased visibility of homelessness as an issue across the country, but particularly in big cities, commented that *"Safeguarding Adult Reviews are powerful tools, which unfortunately are rarely used in the case of people who sleep rough. We will work with Safeguarding Adult Boards to ensure that Safeguarding Adult Reviews are conducted when a person who sleeps rough dies or is seriously harmed as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Lessons learned from these reviews will inform improvements in local systems and services".*

This briefing identifies the number of Safeguarding Adult Reviews (SARs) completed in England where homelessness has been a central feature. The learning from these SARs about good practice and practice shortfalls has enabled an evidence-base for positive practice to be developed. This evidence-base can be used by practitioners working with people experiencing homelessness to advocate for best practice. It can be used by operational managers and senior leaders to evaluate what is enabling best practice and to counteract obstacles or barriers.

The evidence-base provides guidance for commissioners and service providers, for managers and practitioners across statutory and third sector agencies, and for Safeguarding Adults Boards (SABs) locally and collectively. The evidence-base represents a set of standards or quality markers against which to evaluate the outcomes in future cases and to guide the development of policies, procedures, services and practice.

Safeguarding Adult Reviews

The legal mandate

SABs have an absolute duty to conduct a SAR where an adult with care and support needs has died as a result of abuse and/or neglect, including self-neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person. There is a comparable absolute duty where the person has experienced serious abuse and/or neglect but survived. In these circumstances a review is mandatory. Serious abuse and/or neglect means where the person would have died but for intervention, or where they have experienced permanent harm or reduced capacity or quality of life (DHSC, 2020)[2]. The impact of abuse and neglect can include fear, shame, trauma, suicidal ideation, self-neglect, mental health and/or acute hospital admission, substance misuse, poverty and homelessness. The person does not need to have been in receipt of services as a result of their care and support needs[3].

SABs may also commission reviews in any other situations involving adults with care and support needs[4]. Such reviews are discretionary. SARs may also be commissioned to explore examples of good practice in order to identify lessons for future cases[5]. This would appear to be an under-utilised or missed opportunity to disseminate learning from positive practice. Not all SABs appear to have grasped the distinction between

[1] https://www.gov.uk/government/publications/the-rough-sleeping-strategy
[2] Section 44(1), section 44 (2) and section 44(3), Care Act 2014; Statutory Guidance sections 14.162 and 14.163.
[3] Section 44(1), Care Act 2014; Statutory Guidance section 14.165.
[4] Section 44(4), Care Act 2014; Statutory Guidance section 14.163.
[5] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.164).

mandatory and discretionary reviews, between the absolute duties in sections 44(1), (2) and (3) Care Act 2014 and the discretionary duty within section 44(4) (Preston-Shoot et al., 2020).

The statutory purpose of SARs[6] is to identify the lessons to be learned and apply that learning to other cases. Services have a duty to provide information to enable the SAB to complete a SAR[7]. Once completed, agencies have a duty to cooperate to ensure that lessons are disseminated and learned[8].

SAR process

Once a decision to commission a SAR has been taken, SAB partners have discretion as to the methodology to be used[9]. The approach adopted should be proportionate to the scale and complexity of the case(s)[10]. The statutory guidance recommends that the aim should be to complete a SAR within a reasonable time period and, in any event, within six months of initiating it unless there are good reasons otherwise, such as avoidance of prejudicing court proceedings[11]. If the individual is still alive, their involvement should be sought and advocacy[12] provided if they require support to participate. The statutory guidance requires early discussions with the individual, family and friends to agree how they wish to be involved[13]. It further requires[14] that families should be invited and understand how to be involved, with their expectations managed appropriately and sensitively. Practitioners should also be fully involved in reviews[15].

The statutory guidance[16] advises that terms of reference should be published and openly available, and that SARs should reflect the six adult safeguarding principles. These six principles are set out later in this guidance, applied to homelessness. SABs may decide whether or not to publish SAR reports and/or executive summaries and/or seven-minute briefings. Seven-minute briefings are short documents, usually one page. They identify key points of learning derived from the findings and recommendations in a SAR. They encourage practitioners and managers to reflect on practice, procedures, policy and systems. However, SABs must also provide detail in annual reports of the SARs that have been commissioned or completed, the lessons learned and the actions taken to implement recommendations[17].

Key definition

Care and support needs arise from or are related to physical or mental impairment or illness. This can include conditions as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury[18]. Many people experiencing homelessness will have care and support needs, but not

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[6] Section 44(5), Care Act 2014.
[7] Section 45, Care Act 2014.
[8] Section 6(6)(e), Care Act 2014.
[9] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.164).
[10] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.167).
[11] Section 14.173.
[12] Section 67, Care Act 2014.
[13] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.165).
[14] Section 14.167.
[15] Section 14.167.
[16] Section 14.166.
[17] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.156 and 14.177).
[18] Care and Support (Eligibility Criteria) Regulations 2014.

all. Mortality reviews, developed by the London Borough of Haringey[19], represent one approach to reviewing cases where individuals may not have had care and support needs[20].

Published SARs

Twenty-five cases in the first national analysis of SARs in England (Preston-Shoot et al., 2020) involved individuals who were or had experienced homelessness. This represented 11% of the sample. An earlier thematic review (Martineau et al., 2019) contained 14 reviews. These sources, coupled with searches of SAB websites, has enabled a compilation of published reviews, the more recent of which should be available on the relevant SAB's website.

Torbay	Ms Y	2011	Tower Hamlets	Ms C	2019
North Yorkshire	Robert	2012	Milton Keynes	Adult B	2019
Lambeth	Mr A	2012	Camden	UU	2019
Lambeth	Mr D	2016	Teeside	Josh	2019
Solihull	Mr S	2016	Gateshead	Winnie	2019
Southwark	Adult A	2016	Leeds	Thematic	2020
Nottingham and Nottinghamshire	Adult C	2017	Oxfordshire	Thematic	2020
Buckinghamshire	Adult T	2017	Tower Hamlets	Thematic[21]	2020
Brighton and Hove	X	2017	Cornwall	Jack	2020
Merseyside	Lynn and Natalie	2017	North Yorkshire	Ian	2020
Haringey	Robert	2017	Oldham	Thematic	2020
Lincolnshire	Thematic	2017	Manchester	Thematic	2020
Wiltshire	Adult D	2018	Bexley	Paul	2020
Essex	Frank	2018	Worcestershire	Thematic	2020
Waltham Forest	Andrew	2018	Calderdale	Thematic	2020
Doncaster	Adult G	2018	Northamptonshire	Jonathan	2020
Bexley	AB	2018	Tower Hamlets	Mr K	ND[22]
Manchester	AB	2018	Solihull	Paul	ND
Isle of Wight	Howard	2018	Stockport	Katie	ND
Devon	Adrian Munday	2018	Northamptonshire	Dean	2021
Southampton	Adult P	2019	Haringey	Thematic	2021
Newham	Mr YI	2019	Kirklees	Adult N	2021
Bournemouth, Christchurch and Poole	Harry	2019	City of London & Hackney	MS	2021
Solihull	Rachel	2019	Croydon	DC	2021

[19] MEAM (2021) Reviewing the Deaths of People facing Multiple Disadvantage. See also Preston-Shoot, M. and Taylor, G. (2022) 'Learning from safeguarding adults reviews and fatality reviews.' In A. Cooper and M. Preston-Shoot (eds) Adult Safeguarding and Homelessness. London: Jessica Kingsley Publishers (pages 174-194).

[20] Slides from a presentation delivered by LB Haringey about their mortality reviews can be found https://homeless.org.uk/statutory-frameworks-resources

[21] Ms H and Ms I.

[22] No date given.

An Evidence-Base for Positive Practice

The SARs identify multiple routes into homelessness, including relationship breakdown, poverty, unemployment, no recourse to public funds, domestic abuse, cuckooing and/or an inability to sustain placements in hostels or temporary accommodation due to anti-social behaviour and/or aggression and exploitation by others. These routes into homelessness are often accompanied by a lived experience that includes adverse childhood experiences, loss and trauma, mental health problems, physical ill-health and/or disability, suicidal ideation, self-neglect and substance misuse.

Good practice
Examples of good practice include the rapport that practitioners develop with people experiencing homelessness, demonstrations of humanity, and the quality of support being offered. There are positive assessments of colocation, where practitioners from different disciplines work together to address a person's accommodation, physical and/or mental health needs, and/or care and support needs. There are examples of timely referrals to enlist the involvement of other agencies, including adult safeguarding, and the provision of emergency accommodation. Good practice was also found regarding coordination of services, with clarity about the roles, remits and responsibilities of different services around the person.

Practice shortfalls
However, consistent and repetitive findings of practice shortcomings are reported. These include assumptions that individuals are making "lifestyle choices" rather than showing professional curiosity to explore whether a person is unwilling and/or unable to address their circumstances. There are examples of missing or significantly delayed and incomplete assessments of risk, mental capacity, mental health, and care and support needs. Pathways through which practitioners can seek to engage other services are too often unclear or, through use of thresholds and eligibility criteria, unavailable. Referrals of adult safeguarding concerns, using the criteria in Section 42(1) Care Act 2014, do not result in enquiries using the provision in Section 42(2), and the failure to escalate concerns is often noted. An often reported shortcoming is the failure to bring practitioners and services together to share information, assess needs and risks, agree upon a lead agency and key worker to coordinate a response, and devise and implement a risk management plan. Some SARs also note the failure to consider and use different legal options, such as provisions in the Homelessness Reduction Act 2017, especially the duty to refer, the Human Rights Act 1998 and the Court of Protection provision in the Mental Capacity Act 2005.

The learning from SARs translates into an evidence-base that spans four domains (Preston-Shoot, 2020). Each agency should regularly undertake an appreciative enquiry or temperature check to ascertain to identify what is enabling and what is hindering best practice. The evidence-base aligns closely with feedback received from people with lived experience and from research (Preston-Shoot, 2021).

Domain one: direct practice with individuals experiencing homelessness

Direct practice with the adult should be characterised by:

- A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes in line

with the principle of Making Safeguarding Personal; work to build motivation with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change;

- A combination of concerned and authoritative professional curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills; early and sustained intervention includes supporting people to engage with services, assertive outreach and maximising the opportunities that each encounter brings;
- When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage, recognising that how people engage may be due to past experience and/or how services are organised; failing to explore "choices" prevents deeper analysis;
- It is helpful to build up a picture of the person's history, and to address this "backstory", which may include recognition of and work to address issues of loss and trauma in a person's life experience that can underlie refusals to engage or manifest themselves in repetitive patterns;
- Contact should be maintained rather than the case closed so that trust can be built up;
- Comprehensive risk assessments are advised, especially in situations of service refusal and/or non-engagement, using recognised indicators to focus work on prevention and mitigation;
- Where possible involvement of family and friends in assessments and care planning but also, where appropriate, exploration of family dynamics, including the cared-for and care-giver relationship;
- Thorough mental health and mental capacity assessments, which include consideration of executive capacity; assumptions should not be made about people's capacity to be in control of their own care and support; nor should assumptions automatically be made that apparently unwise decisions are indicative of a lack of mental capacity[23];
- Careful preparation at the point of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;
- Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;
- Thorough social care assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs; taking into account the negative effect of social isolation and housing status on wellbeing; undertaken where the person is rather than simply expecting them to engage at times and locations specified by assessors.

Domain two: team around the person

The work of the team around the adult should comprise:

- Inter-agency communication and collaboration, working together, coordinated by a lead agency and key worker in the community to act as the continuity and coordinator of contact, with named people to whom referrals can be made; the emphasis is on integrated, whole system working, linking services to meet people's complex needs;
- A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;
- Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;

[23] See our guidance on the Mental Capacity Act: www.homeless.org.uk/our-work/resources/guidance-on-mental-capacity-act

- Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes;
- Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs associated with multiple exclusion homelessness, with specific pathways for coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital;
- Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;
- Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;
- Clear, up-to-date and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs.

Domain three: organisational support for members of the team around the person

The organisations around the team should provide:

- Supervision and support that promote reflection and critical analysis of the approach being taken to each case, especially when working with people who are hard to engage, resistant and sometimes hostile;
- Access to specialist legal, mental capacity, mental health and safeguarding advice;
- Audit decision-making about referrals of adult safeguarding concerns;
- Case oversight, including comprehensive commissioning and contract monitoring of service providers;
- Joint commissioning of providers of health, social care and housing following review of gaps in , informed by feedback from people with lived experience and frontline practitioners;
- Agreed indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;
- Seek assurance that available guidance is embedded into practice;
- Attention to workforce development, including training, and workplace issues, such as staffing levels, organisational cultures and thresholds;
- Promote trauma-informed practice and recognition of the interface between homelessness and self-neglect.

Domain four: governance

SABs should:

- Ensure that multi-agency agreements are concluded and then implemented with respect to working with high risk individuals; this will include the operation of MAPPA, MARAC, MASH and other complex case or multi-agency panel arrangements, responding to anti-social behaviour, domestic abuse, offending (community safety) and risks; strategic agreements and leadership are necessary for the cultural and service changes required;
- Develop, disseminate and audit the impact of policies and procedures regarding homelessness, ensuring that they contain explicit references to, and pathways into adult safeguarding;
- Review the interface between housing/homelessness and adult social care, mental health, and adult safeguarding, and include housing in multi-agency policies and procedures;

- Establish a system to review the deaths of homeless people and/or as a result of alcohol/drug misuse where the SAR criteria are not met[24];
- Work with Community Safety Partnerships, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely strategic leadership and oversight of the development and review of policies, procedures and practice;
- Provide or arrange for the provision of workshops on practice and the management of practice with adults who experience homelessness, including a focus on self-neglect, trauma-informed and strength-based approaches, substance misuse and dual diagnosis.
- Audit the impact of the recommendations from completed SARs.

Best practice – prevention, intervention and recovery

Another way of capturing the evidence for best practice, reflective of different components within the four domains, adopts the three strands of prevention, intervention and recovery used in the Government's aforementioned rough sleeping strategy[25]. Thus:

- Prevention - Strong governance and system-wide leadership, involving care and support, criminal justice and community safety; multi-agency strategies that cover different routes into homelessness and street-based lives (transient, frequent and embedded); hub and spoke model (core team linking with statutory and community services, groups and resources).
- Intervention - Joint commissioning; co-location and multi-disciplinary working; trauma-informed practice; persistence, assertiveness, support to manage disengagement and, sometimes, enforcement.
- Recovery - Not just housing provision; not just time-limited support; wrap-around support that sees the person, their strengths and their needs; high support and high challenge; a focus on people alongside place.

Six adult safeguarding principles for work involving homelessness

The statutory guidance[26] promotes six principles that should characterise adult safeguarding. Applied to work concerned with people experiencing homelessness, the six principles reinforce the component of the evidence-base as follows:

1. Empowerment – look beyond the presenting problem to the backstory; make every adult matter; listen, hear and acknowledge.
2. Prevention – commissioning to avoid revolving doors and to provide integrated wrap-around support; transitions as opportunities.
3. Protection – address risks of premature mortality.
4. Partnership – no wrong door; make every contact count.
5. Proportionality – minimise risk; judge the level of intervention required.
6. Accountability – get the governance right.

[24] See our related guidance: https://www.homeless.org.uk/taking-action-when-someone-dies-while-street-homeless
[25] Leeds Safeguarding Adults Board and Safer Leeds (2020) "*Understanding and Progressing the City's Learning of the Experience of People Living a Street-Based Life in Leeds*."
[26] Section 14.13.

The Fifth Domain

Safeguarding adults experiencing homelessness is situated in a legal, policy and financial context. This has impacted, often unhelpfully, on services and practice. Legal rules and national policy, for instance with respect to people with no recourse to public funds, have restricted accommodation options and increased rather than decreased the risks associated with being homeless. The legal rules concerned with care and support and with housing are fragmented rather than aligned, using different language and concepts of eligibility. Financial austerity combined with policies on social housing and welfare benefits have impacted adversely on the availability of services and also increased the risks of becoming locked into homelessness (Weal, 2020). This context has severely restricted how SABs and partner agencies can make a difference for people experiencing multiple exclusion homelessness locally. SARs comment only infrequently on this context (Preston-Shoot et al., 2020).

The government's response to the COVID-19 pandemic regarding people experiencing homelessness has demonstrated what can be achieved when the legal, policy and financial context shifts, when combined action is taken to ensure that people have accommodation and the wrap-around support to sustain it. Positive outcomes from "everybody in" and Housing First have been reported (Preston-Shoot, 2021).

The interim report of the Kerslake Commission[27] has also recognised that ultimately investment in prevention is a more cost effective approach. It recommends a combination of government support and collaboration across and between key service providers to build on the lessons learned from the Everyone In initiative. It notes that this response to the COVID-19 pandemic saved lives and enabled many people who had been experiencing homelessness to move on into longer-term accommodation. This report also recommends a whole system approach, recognising that seeing homelessness as a public health rather than simply a housing issue led to better partnership working, understanding and treatment. The report observes the importance of good quality accommodation, food and in-reach multi-agency services but criticises short-term funding. It recommends that government leads on provision of affordable housing, pathways beyond hostels, and welfare support. It too recommends reversal of disinvestment in drug and alcohol services and retention of welfare changes and the derogation of rules on priority need, local connection and no recourse to public funds.

The final report of the Kerslake Commission[28] makes recommendations to both central government and local authorities. Recommendations for central government include extending the duty to refer (Homelessness Reduction Act 2017) to incorporate a duty on services to collaborate, building on the Everyone-In programme and retaining the welfare changes introduced at the outset of the pandemic, and reviewing law and policy concerning people with no recourse to public funds. Among the recommendations for local authorities and their partners are the development of integrated homelessness and health strategies, long-term strategic planning for managing winter peaks, the development of professional accreditation for staff working in the homelessness sector, and ensuring that new ICS arrangements tackle health inequalities and provide trauma and psychologically-informed services.

[27] McCulloch, L. with Cookson, E, Currie, H., Kulkarni, D., Orchard, B and Piggott, H. (2021) *The Kerslake Commission on Homelessness and Rough Sleeping: When We Work Together – Learning the Lessons. Interim Report*. London: St Mungo's.
[28] Kerslake Commission on Homelessness and Rough Sleeping (2021) *A New Way of Working: Ending Rough Sleeping Together.*

Reflections and Actions

It is a truism but adult safeguarding is everyone's responsibility. Whatever your role when working with people experiencing homelessness, who may well have care and support needs, the availability of an evidence-base for positive practice enables you to shape your own practice and to question how statutory and third sector agencies are responding. The questions that follow are examples of how you might take forward the learning from this briefing.

Key questions for practitioners	Suggested actions
• Where does your practice correspond with the components of effective practice outlined in this document? • What supports you to deliver support and services in line with the good practice outlined in this document? • Where does the practice of other services correspond with the components of effective practice outlined in this document? • What gets in the way of practicing in line with the evidence-base? • How might you advocate for individuals experiencing homelessness with whom you are working? • What escalation pathways are open to you when you are concerned about risk? • How might you advocate for policy, organisational and system change to enable practice to mirror more closely "what good looks like"? • Do you know how to refer cases for a possible SAR?	• Undertake an appreciative enquiry or a temperature on your practice. • Undertake an appreciative enquiry or temperature check with your colleagues, perhaps in team meetings. • Read and present to your colleagues key findings from SARs. • Identify the enablers that support your best practice. • Identify the barriers or obstacles to best practice. • Raise your concerns with your supervisors and team managers. • Consult the local SAB website and read policies and procedures, including on how to raise an adult safeguarding concern and how to refer a case for a possible SAR. • Check out the training, resources and guidance included in the resource section of this document.

Key questions for operation managers	Suggested actions
• How closely does practice correspond with the components of effective practice and management of practice outlined in the evidence-base? • What supports practice in line with the evidence-base? • What gets in the way of practising in line with the evidence-base? • How might you advocate for individuals experiencing homelessness with whom your service is working?	• Undertake an appreciative enquiry or a temperature check on how you and practitioners experience of adult safeguarding work. • Share your reflections with other managers in your service and in other organisations. • Access published SARs and draw out and disseminate the implications of their findings for local policy, procedures and practice. • Identify the enablers that support best practice and the barriers to best practice. • Raise any concerns with your managers.

• What escalation pathways are open to you when you are concerned about unmet need or risks that are not being managed or mitigated effectively? • How can you promote and support effective practice when working with adults who experience multiple exclusion homelessness? • Do you know how to refer cases for a possible SAR?	• Consult the local SAB website and read policies and procedures, including on how to raise an adult safeguarding concern and how to refer a case for a possible SAR. • Develop relationships with your local Adult Social Care department to improve partnership working and share learning.

Key questions for strategic managers	Suggested actions
• How closely do single and multi-agency practices, policies and procedures correspond with the components of effective practice and management of practice outlined in the evidence-base? • What supports whole system collaborative working in line with the evidence-base? • What gets in the way of services aligning with the evidence-base? • How can you promote and support culture change and service development for work with adults who experience multiple exclusion homelessness? • What links do you have with your local SAB and how can you ensure that the effectiveness of services for adult safeguarding and homelessness is routinely audited? • What other multi-agency partnerships exist through which you can highlight best practice and/or work to achieve system change and service improvements? • Do you know how to refer cases for a possible SAR? • What process does your organisation (and local partnerships) have in place to review deaths of people experiencing homelessness who do not meet the threshold for a SAR?	• Ensure that you know how practitioners and operational managers experience adult safeguarding practice and procedures. • Audit policy and practice for the effectiveness of single and multi-agency working with people experiencing homelessness. • Ensure that dissemination of SAR findings become a regular focus of team meetings. • Address the barriers to best practice and seek to enhance the enablers. • Raise any concerns with your local SAB and with partner organisations. • Consult the local SAB website and read policies and procedures, including on how to raise an adult safeguarding concern and how to refer a case for a possible SAR. • Ensure there is an organisational policy to review deaths and for making referrals for a SAR.

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Resources

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Preston-Shoot, M. and Ward, M. (2021) *How to Use legal Powers to Safeguard Highly Vulnerable Dependent Drinkers in England and Wales.* London: Alcohol Change UK

Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.

Homeless Link's guidance on safeguarding and the Care Act:
https://homeless.org.uk/statutory-frameworks-resources

Homeless Link's safeguarding training:
https://www.homeless.org.uk/products/training/courses/safeguarding-vulnerable-adults

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Local Government Association's briefings on adult safeguarding:
https://www.local.gov.uk/

No Recourse to Public Funds Network:
http://www.nrpfnetwork.org.uk

SAR Library on the National Network of Chairs of SABs:
https://nationalnetwork.org.uk

What we do

Homeless Link is the national membership charity for frontline homelessness services. We work to improve services through research, guidance and learning, and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

Let’s end homelessness together

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