Safeguarding people sleeping rough

homeless link

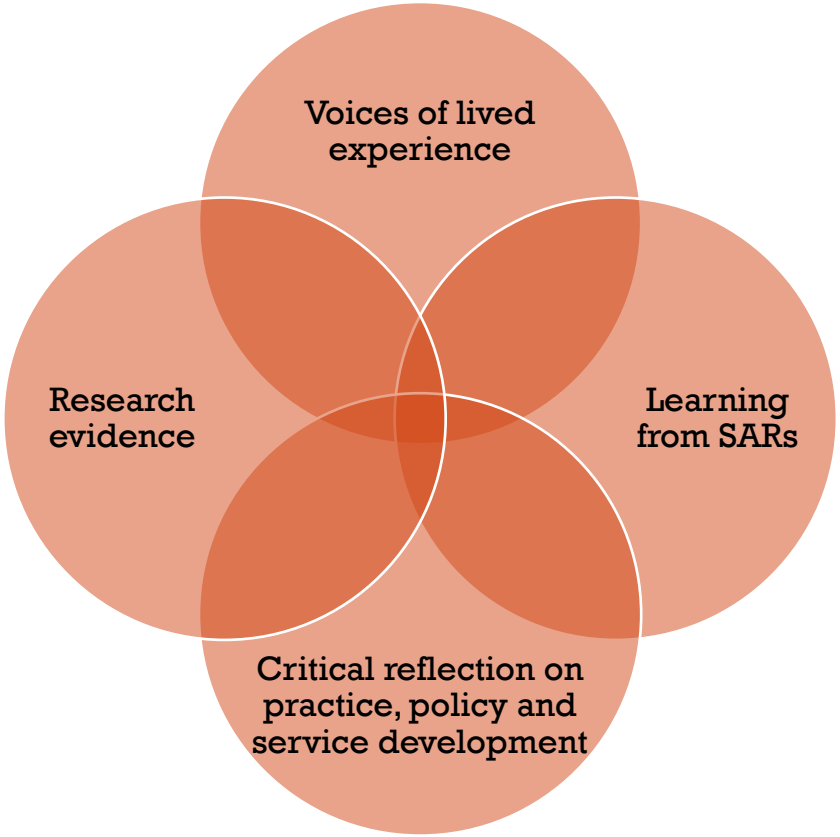
Webinar starting soon….
Please use the chat box to introduce yourselves ensuring it is set to ‘everyone’

ADULT SAFEGUARDING AND HOMELESSNESS

Learning from SARs: the evidence-base for best practice as a temperature check

Homeless Link November 2021

THE EVIDENCE-BASE



VOICES OF EXPERTS BY EXPERIENCE

- When asked what he needed, Terence replied: "Some love, man. Family environment. Support." He wanted to be part of something real, part of real society and not just "the system". (reported in a thematic review on people who sleep rough, Worcestershire SAB (2020)).

- Adult N (Kirklees SAB) – a poem about alcohol dependence that challenges the narrative of lifestyle choice. Periodically homeless, he died in temporary accommodation.

- From the Leeds Thematic Review (2020):
  - "I lost everything all at once: my job, my family, my hope."
  - "Without [this help in Leeds], I'd already be dead. I've no doubts about that. If the elements hadn't got me, I would have got me. Sometimes I have rolled up to this van in a real mess and they have offered help and support and got my head straight."

- Ms I's partner commented (Tower Hamlets SAB (2020) Thematic Review):
  - 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.

LEARNING FROM THE VOICES OF LIVED EXPERIENCE

- Seeing the whole person in their situation
- A trauma-informed, whole system response to the person in context
- Being careful and care-ful when thinking about removing a coping strategy
- In the context of people's experiences of multiple exclusion homelessness, the notion of lifestyle choice is erroneous
- Tackling symptoms is less effective than addressing causes.
  - Attempting to change someone's behaviour without understanding its survival function will prove unsuccessful. The presenting problem is a way of coping, however dysfunctional it may appear. 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."

WHAT PEOPLE WITH LIVED EXPERIENCE SAY ABOUT WORKING WITH THEM

- *Engagement* – recognise that people may be wary of professionals and services, possibly due to past experiences of institutions and the care system; appreciate that individuals may feel alone, fearful, helpless, confused, excluded, suicidal and depressed, unable to see a way out.
- *Professional curiosity* – "I was not asked 'why?'" There is always more to know. Experiences (traumas) had a "lasting effect on me." "Appreciate the beginning of the journey."
- *Partnership* – "work with me, involve me, and support me." "Keep in touch so that we know what is going on." Help with form filling, bank accounts and other practicalities.
- *Person-centred* – see the person and, where necessary, adapt our approach; "people did not see beyond the sleeping bag"; challenge misconceptions of people who are homeless and any evidence of assumptions (unconscious bias) that someone may be undeserving; there are multiple reasons behind why a person may become homeless.
- *Assessment* – what does this individual need? Do not assume or stereotype.
- *Language* – be careful and respectful about the language we use; words and phrases can betray assumptions. For example, who is not engaging? What does substance misuse imply?

WHAT PEOPLE WITH LIVED EXPERIENCE SAYS ABOUT HOW SERVICES WORK TOGETHER

- *Collaboration* – widen the multi-agency, partnership and colocation approach; a breadth of expertise is needed to respond to individuals' complex needs involving physical and mental health, substance use and homelessness.
- *Safeguarding* – do not assume that people know what adult safeguarding actually is; for some it may be understood as the removal of children and as practitioners "working against, not with me."

WHAT PEOPLE WITH LIVED EXPERIENCE ADVISE ORGANISATIONS

- *Commissioning* – focus on evidence-based practice and what works. Hostels and night shelters are not suitable for everyone and can be more frightening than the streets. Wrap-around support is often crucial – "I would not have coped otherwise."
- *Managerial oversight* – understand the barriers to effective practice and learn from positive outcomes.
- *Supervision and staff support* – support a culture of reflective practice across teams to enhance practitioner wellbeing and resilience.
- *Service development with commissioners and providers* – use our expertise and experience to promote improvement and enhancement.

COMMENTS FROM PEOPLE WITH LIVED EXPERIENCE ABOUT GOVERNANCE AND SOCIAL POLICY

- *Review* – learn from failures.
- *Training* – education is essential so that practitioners and managers understand the multiple routes into homelessness and the pathways for prevention, intervention and recovery.
- *Involvement* – use our expertise.
- *Audit* – not just tick boxes but outcomes that matter to people.

- *Policy* - reform should be guided by evidence.
- *Covid-19* - learn from the "everybody in" initiative during the pandemic, which enabled people living street-based lives to settle in accommodation, with support to meet their health and social care needs.

NATIONAL SAR ANALYSIS: APRIL 2017 – MARCH 2019

- N = 231
- London region (66), followed by the North West (38), South East (28) and Social West (24)
- 132 SABs in England. 29 had not completed any reviews in the two years in scope
- 25 SARs in the national analysis (11%) contain references to homelessness, majority published
- 57 SARs in the national analysis (25%) contain references to alcohol abuse and dependence
- Self-neglect the most prominent type of abuse and neglect reviewed in the sample (n = 104; 45%)
- Clarity about section 44 Care Act 2014 – mandatory and discretionary SARs: all reviews are statutory

AVAILABLE REVIEWS

- Doncaster SAB (2018) 'Adult G'
- Bexley SAB (2019) 'AB'
- Wiltshire SAB (2018) 'Adult D'
- Tower Hamlets SAB (2019) 'Ms C'
- Redbridge SAB (only available in an annual report 18/19)
- Brighton and Hove SAB (2017) "X"
- Southampton SAB (2019) Adult P
- Newham SAB (and others) (2019) Mr YI

SOME RECENT REVIEWS

- Thematic review – Leeds SAB (street homeless deaths)
- Thematic review – Manchester SAB (seven street homeless deaths involving self-neglect, substance misuse, homelessness, imprisonment, mental and physical ill-health) (2020)
- Thematic review – Oldham SAB (four cases involving self-neglect, substance misuse and housing/homelessness issues) (2020)
- Thematic review – Oxfordshire SAB (nine cases involving self-neglect, domestic abuse, no recourse to public funds, substance misuse and housing/homelessness issues) (2020)
- Thematic review – Ms H and Ms I Tower Hamlets SAB (two cases involving self-neglect, substance misuse and homelessness issues) (2020)
- A SAR – "Jack" Cornwall and Isles of Scilly SAB (a homeless person now in nursing care following a Court of Protection ruling) (2020)
- Milton Keynes SAB (2019) 'Adult B' – former care leaver
- Worcestershire SAB (2020) Thematic Review. People Who Sleep Rough.
- Haringey SAB (2021) Thematic Review.
- City of London and Hackney SAB (2021) MS.
- Calderdale SAB (2021) Thematic Review.
- Kirklees SAB (2021) Adult N.
- Croydon SAB (2021) Duncan.

Findings on multiple exclusion homelessness

- 14 references to good practice
  - Rapport building, expression of humanity, provision of care and support and emergency accommodation, health services outreach, colocation of practitioners, clear referrals
- 42 references to practice shortfalls
  - Delayed or missing risk, mental health and mental capacity assessments, unclear referral pathways, discharges to no fixed abode, lack of use of available legal rules, absence of consideration of vulnerability
- 18 recommendations
  - Wrap-around support (health and care and support as well as housing), coordination of response, legal literacy, commissioning for health and social care as well as housing, governance oversight

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

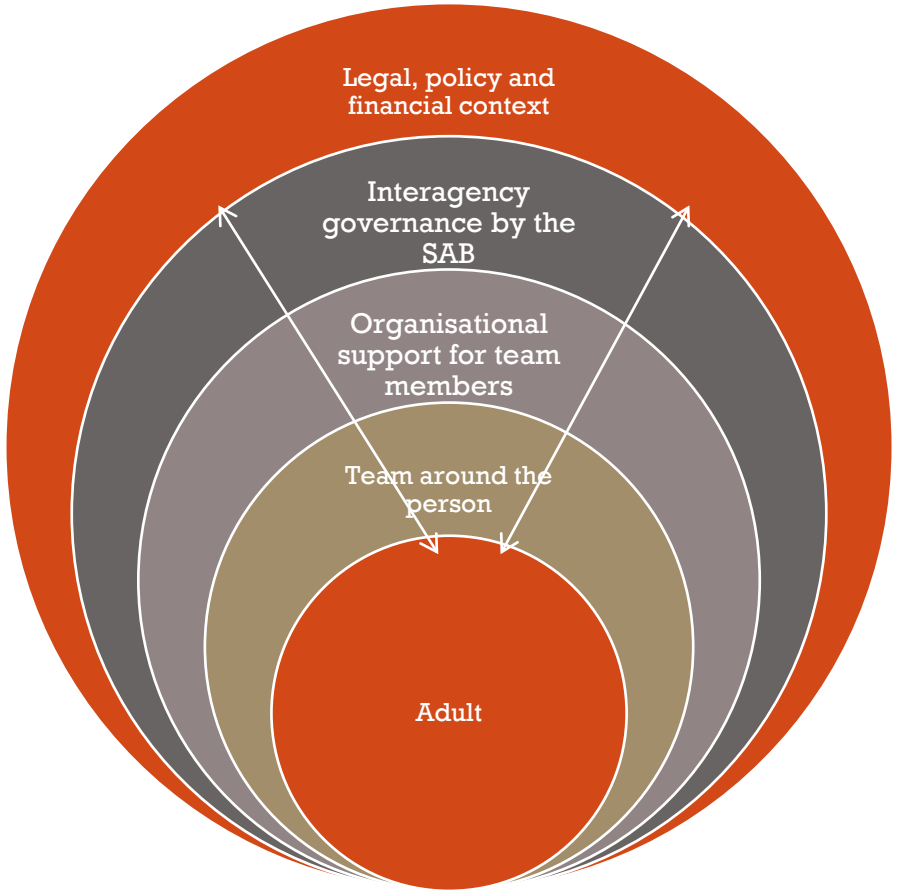
ISLE OF WIGHT – HOWARD (2018)

- 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.

CITY OF LONDON AND HACKNEY SAB: MS

- MS died, aged 63, on 30th July 2019. Cause of death was acute myocardial infarction, coronary artery atherosclerosis and aspiration pneumonia. He died at a bus stop in the where he had been living and sleeping for several weeks.
- MS was Turkish (Kurdish ethnicity) with limited understanding of English and a history of homelessness, self-neglect and substance abuse. He had returned to the bus stop where he eventually died at the end of May 2019, having spent the previous five months in a nursing home. When that placement came to an end he was offered a hotel room but declined. He said that "something brings [me] back to the bus stop."
- There were discussions on whether and how to use anti-social behaviour powers, and mental capacity and mental health legislation, in order to safeguard his health and wellbeing, and to address expressed concerns from local residents. No effective means of resolving the situation was found before MS died.
- Adult safeguarding concerns were referred to the local authority but the duty to enquire was not used.

A SAFE SYSTEM HAS ALIGNMENT OF CHECKS AND BALANCES BETWEEN THE DIFFERENT LAYERS OF THE SYSTEM



DIRECT PRACTICE – BEST PRACTICE

Person-centred approach, keeping in contact	Professional concerned curiosity	Thorough risk and care and support assessments
Seeing transitions as opportunities	Thorough mental capacity and mental health assessments	Thinking family
Exploring the impact of trauma and adverse exepriences	Exploring non-engagement and repeating patterns	Understanding the person's history

INTER-ORGANISATIONAL ENVIRONMENT – BEST PRACTICE

Services work together to provide integrated care and support	Information-sharing & communication	Referrals clearly state what is being requested
Use of multi-agency risk management meetings	Exploration of all available legal options	Clear roles and responsibilities (lead agencies and key workers)
Comprehensive recording of practice and decision-making	Use of safeguarding enquiries to coordinate prevention and recovery	Clear pathways for prevention, intervention and recovery

ORGANISATIONAL ENVIRONMENT – BEST PRACTICE

Developing commissioning to respond to the needs of people experiencing multiple exclusion homelessness	Management oversight of decision-making	Supervision to promote reflection and analysis of case management
Supporting staff	Providing workforce development and ensuring that workplace culture and policies enable effective practice	Access to specialist legal, safeguarding, mental capacity and mental health advice

SAB GOVERNANCE – BEST PRACTICE

SAB audits cases involving self-neglect and multiple exclusion homelessness

SAB uses the evidence-base to hold partners accountable for practice standards

SAB coordinates governance with Community Safety Partnership and Health and Wellbeing Board

Workplace as well as workforce development

SAB promotes procedures for working with self-neglect and multiple exclusion homelessness

Use of SARs to inform policy development, practice audits and training

RECOMMENDATIONS FROM SARS ON GOVERNANCE

- Involve people with lived experience in the development of policies, procedures and protocols
- Agree the main location for strategic leadership and oversight (two tier authorities)
- Ensure strategies on homelessness contain overt references to (pathways into) adult safeguarding
- Review range of procedures (people living street-based lives; high risk cases where individuals have capacity; risk assessment; frequent flyers; self-discharge)
- Reach out to national services (Royal Mail, utility companies, DWP)
- Clarify pathways for case reviews
- Review impact of previous SARs

RECOMMENDATIONS FROM SARS ON ENHANCEMENT OF PRACTICE AND MANAGEMENT OF PRACTICE

- Ensure guidance is embedded in practice (training, case and supervision audits)
- Promote recognition of interface between homelessness and self-neglect
- Audit adult safeguarding decision-making (section 42(1) and 42(2))
- Review pathways (mental health; services for women)
- Review commissioner-provider relationships, including gaps in provision
- Promote trauma-informed practice
- Promote shared databases to build a shared case narrative

LEEDS THEMATIC REVIEW (2020)
PREVENTION, INTERVENTION AND RECOVERY STRANDS

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

Multi-disciplinary working

Trauma-informed practice

Persistence, assertiveness, support to manage disengagement and, sometimes, enforcement

Recovery

Not just housing

Not just time-limited

Wrap-around support that sees the person, their strengths and their needs

High support and high challenge; people and place

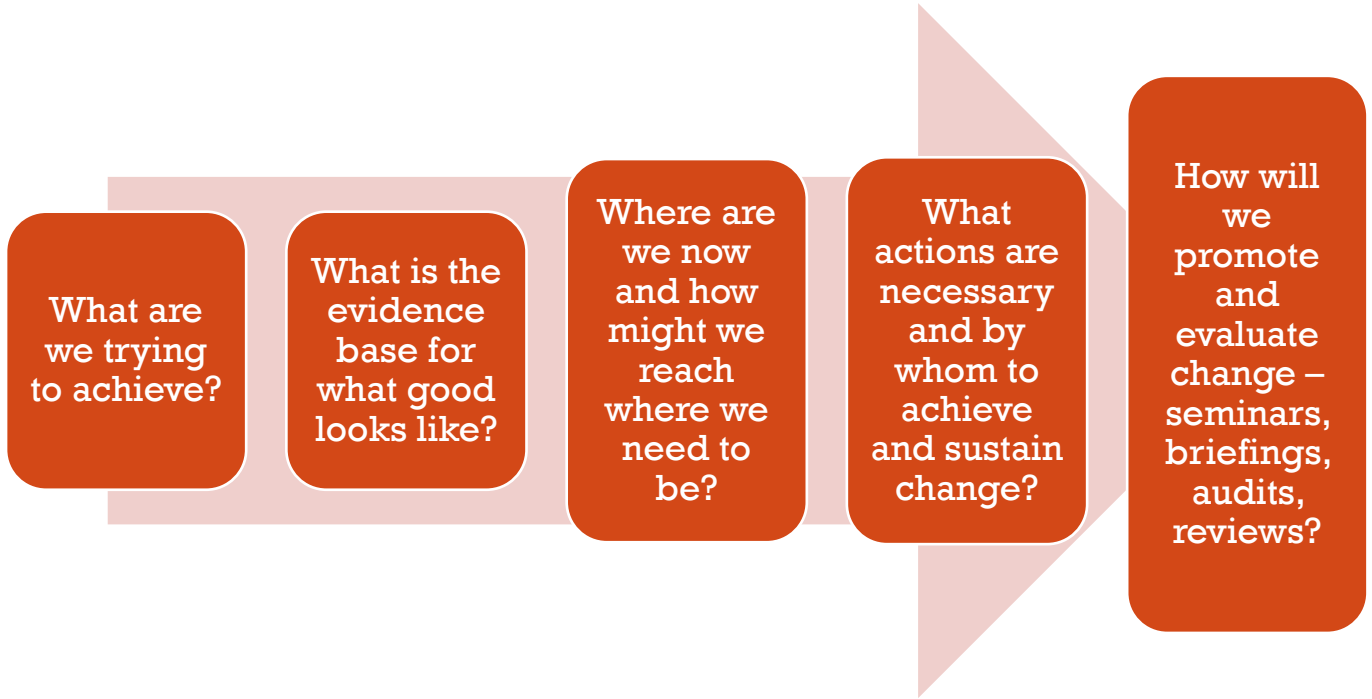
APPLYING THE SIX PRINCIPLES

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

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

THINKING ABOUT CHANGE – A WHOLE SYSTEM CONVERSATION WITH SAB AS THE GUIDING PRESENCE



Where are we hoping to see change?

Partner reactions	•Views of their experience of working with the SAB and in the domain of adult safeguarding and homelessness
Changing attitudes	•Perceptions of partnerships in adult safeguarding and of people experiencing homelessness are modified
Knowledge and skill acquisition	•Developing understanding and application in practice of procedures regarding assessment, intervention, purchaser/provider roles in adult safeguarding and homelessness
Changes in practice	•Implementing new learning about adult safeguarding and homelessness by the workforce
Changes in organisational behaviour	•Implementing new learning in organisational culture and procedures
Benefit to service users and carers	•Improvements in wellbeing

BEING KNOWLEDGE-INFORMED

- Braye, S., Preston-Shoot, M., Preston, O., Allen, K. and Spreadbury, K. (2020) *Biennial Analysis of Safeguarding Adult Reviews April 2017-March 2019: Findings for sector-Led Improvement.* (forthcoming)
- Cream, J., Fenney, D., Williams, E., Baylis, A., Dahir, S. and Wyatt, H. (2020) *Delivering Health and Care for People who Sleep Rough. Going Above and Beyond*. London: Kings Fund.
- Martineau, S., Cornes, M., Manthorpe, J., Ornelas, B. and Fuller, J. (2019) *Safeguarding, Homelessness and Rough Sleeping: An Analysis of Safeguarding Adult Reviews*. London: Kings College London.
- Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.
- Preston-Shoot, M. (2019) 'Self-Neglect and Safeguarding Adult Reviews: Towards a Model of Understanding Facilitators and Barriers to Best Practice.' *Journal of Adult Protection*, 21 (4), 219-234.
- Preston-Shoot, M. (2020) *Adult Safeguarding and Homelessness. A Briefing on Positive Practice*. London: LGA and ADASS.
- Preston-Shoot, M. (2021) *Adult Safeguarding and Homelessness: Experience-informed Practice*. London: LGA and ADASS.
- St Mungo's (2020) *Knocked Back. How a Failure to Support People Sleeping Rough with Drug and Alcohol Problems is Costing Lives*.

PROFESSOR MICHAEL PRESTON-SHOOT

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Foundations for positive practice in safeguarding people who are rough sleeping

Bruno Ornelas
Head of Homelessness
SAR author and consultant

3 November 2021

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www.thisisconcrete.org.uk

- How are you using Safeguarding Adult Reviews to inform everyday working practices?

Commonly heard phrases – not always defensible statements

"They don't engage"

"It's a housing issue"

"There are no services for their needs"

"I can't get hold of them"

"No local connection"

"We don't provide XYZ"

"No personal care needs"

"Mobilising safely on ward – able to go out for a cigarette"

"They have mental capacity"

"Refused an assessment"

"They haven't consented "

"They live in supported housing"

And for social care referrers /safeguarding alerters – lost in 'Albert Square' or otherwise 'crisis fighting'

"X is rough sleeping !!!"

"Housing First with wrap around support works!!"

"Y needs 24/7 care!"

" He can't manage a home, cook, clean, pay bills etc."

"She can't manage medication or finances"

"Intensive support is needed!"

Acknowledging care and support needs

- Remember, assessment duty is based on the 'appearance of' care and support needs
- Challenges acknowledging care and support needs, but why?
- A tendency to **confine homelessness** to a 'housing issue' only and failure to recognise the relationship between housing and social care outcomes, when these are **inextricably linked**.
- Referrals and assessments that focus on securing services i.e. what we think the person needs by way of services. Rather than **focusing on understanding and defining needs, including ability to achieve,** through an assessment, that's what this is all about!
- Adopting a **'hierarchy of needs'** approach to outcomes - the Ombudsman reminds us how not to do this stage. Eligibility regulations now include **housing related outcomes** and each area should be assessed **equally**. [19 000 200] (LGSCO, 7 September 2020)
- Statements that start with ***'we don't provide XYZ'*** *or* ***'they won't meet the criteria'*** *or* otherwise **signposting back to services** that haven't worked for the person and without carrying out **further enquiries or checks.**
- Taking what people tell you at **'face value**': *"All I want is a flat"* John said/ *"He said all he wants is a flat"* said the Assessor. This is not **working curiously with the person's expressed wishes** or otherwise being person-centred – what it is, is paraphrasing!

Supporting the person's *involvement* in the assessment

- **Para 6.30** Putting the person at the **heart of the assessment process** is crucial to understanding the person's needs, outcomes and wellbeing, and delivering better care and support.

- The local **authority must involve the person being assessed** in the process as they are best placed to judge their own wellbeing. In the case of an adult with care and support needs, the local **authority must also involve any carer** the person has (which may be more than one carer), and in all cases, **the authority must also involve any other person requested**.

- The local authority should have processes in place, and **suitably trained staff, to ensure *the involvement* of these parties**, so that their perspective and experience supports a better understanding of the needs, outcomes and wellbeing.

Recognising when you need help! Your professional curiosity applied practically

- **Para 6.86** Where the assessor does not have the necessary knowledge of a particular condition or circumstance, **they must consult someone who has relevant expertise**.
- This is to ensure that the assessor can **ask the right questions** relating to the condition and **interpret these appropriately** to identify underlying needs.
- A person with **relevant expertise** can be considered as somebody who, **either through training or experience**, has **acquired knowledge** or skill of the particular condition or circumstance.
- Such a person may be a doctor or health professional, or an **expert from the voluntary sector**, but there is **no obligation** for the local authority to source an expert from an outside body **if the expertise is available in house.**

No single practitioner is expected to know it all!! But you must act on what you are reasonably expected to know!

Now required: advance notice of what it's all about!
And sensitivity to the implications of being assessed, itself!

- **Para 6.38** To help the adult with needs for care and support, or the carer, prepare for the assessment **the local authority should provide in advance, and in an accessible format, the list of questions to be covered in the assessment.** This will help the individual or carer prepare for their assessment and think through what their needs are and the outcomes they want to achieve

- **Para 6.40** Local authorities should also consider the impact of the assessment process itself on the individual's condition(s). People may feel uncertain and worried about what an assessment involves and may find the process itself to be strenuous. **Local authorities should therefore give consideration to the *preferences* of the individual with regards to the timing, location and medium of the assessment.**

Balancing the 'do not engage' narrative by asking: "How do I/we engage!"

‘Not engaging’ or ‘substantial difficulty’ being involved?

Formal funded Advocacy Rights under the Care Act

- There are now rights under the Care Act, 2014 (s67) to **independent advocacy** for representation and support with assessment, including care planning and reviews. This duty is **triggered if it appears to the authority that a person has substantial difficulty in being involved,** for example if the person had cognitive difficulties. There is case law that has established that an assessment would not be rendered as valid if the individual required an advocate but didn’t get one.
- Councils **must fund** these rights, when triggered, so it should mean that all vulnerable adults, without anyone to help them with involvement, will now have someone who’s **clued-up** to support them in discussions about their council’s views about their needs and budgets.

Care assessment toolkit

- A clear explanation of an assessment
- What happens following an assessment
- 3 way description
- Guidance and Handy Hints based on statutory guidance and good practice
- Links needs to ability to achieve
- Considers fluctuating needs
- Key to Eligibility Outcomes

Giving different types of knowledge base a fair and equal say: *valuing* everyone's experiences and expertise

Pausing the assessment process

- **Para 6.25** …Early or targeted interventions such as universal services, a period of re-ablement and providing equipment or minor household adaptions can **delay an adult's needs from progressing**. The first contact with the authority, which triggers the requirement to assess, **may lead to a pause in the assessment process to allow such interventions to take place and for any *benefit* to the adult to be determined**.

How NOT to do this stage, if you are a social services body:

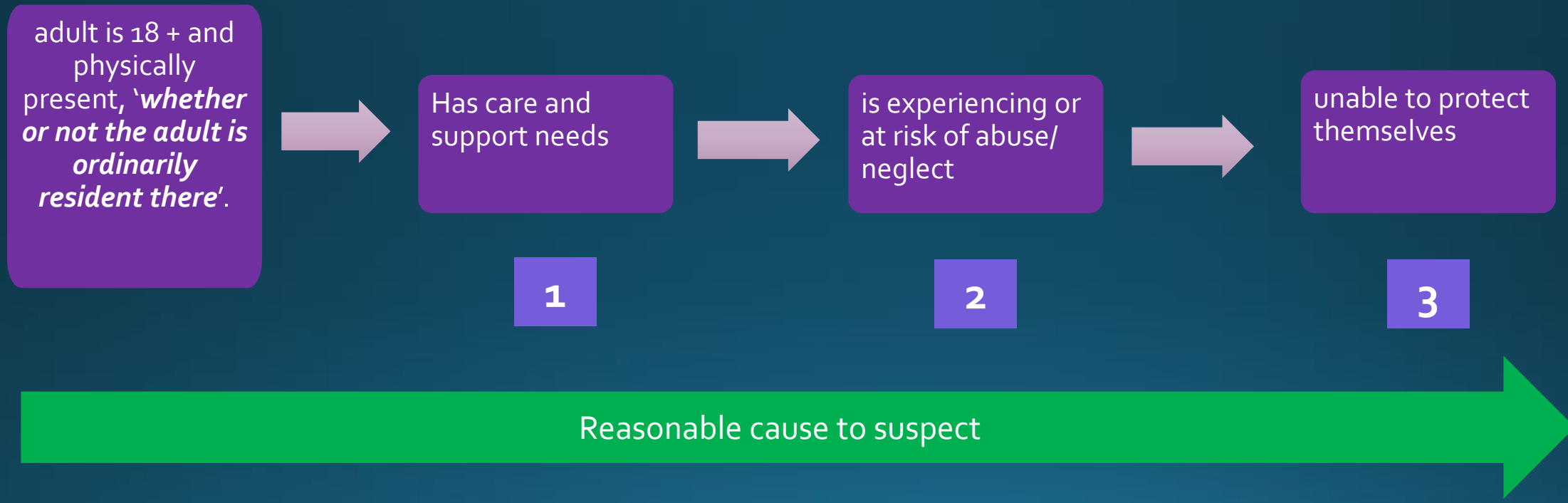
- Signposting, without finding out if there are actually vacancies or services out there still!
- Signposting away from the actual assessment itself!!

Positive practice:-

- **Advance notification of the questions**
- **How the assessment should occur** and why its appropriate and proportionate to be carried out in a particular way
- Think about an **engagement strategy** early on – who and how.
- **Find** a professional with **relevant expertise** to support the assessment process
- Utilising services as '**trusted assessors'**
- Consider whether an **Independent Advocate** is needed. People's difficulties may not be apparent i.e. hidden needs linked to cognitive difficulties, executive impairment, trauma
- **Assessments can continue** if the person is at risk of or experiencing abuse and neglect, **irrespective of capacity**. Section 11 (2), Care Act.
- Short term **preventative** enablement support as part of the assessment process.
- Consider **discretionary powers to meet urgent needs** under section 19 (3), Care Act.
- Engagement can be secured through the **agencies that have made the referral**
- Focus on **understanding and defining needs**, not assessing people for services!
- Using the Toolkit to record views side by side, **reconciling different viewpoints.**
- Steer away from a 'hierarchy of needs' approach, assessing all outcomes equally.

Safeguarding in practice

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



When the duty is not triggered it does not absolve practitioners of their duties…

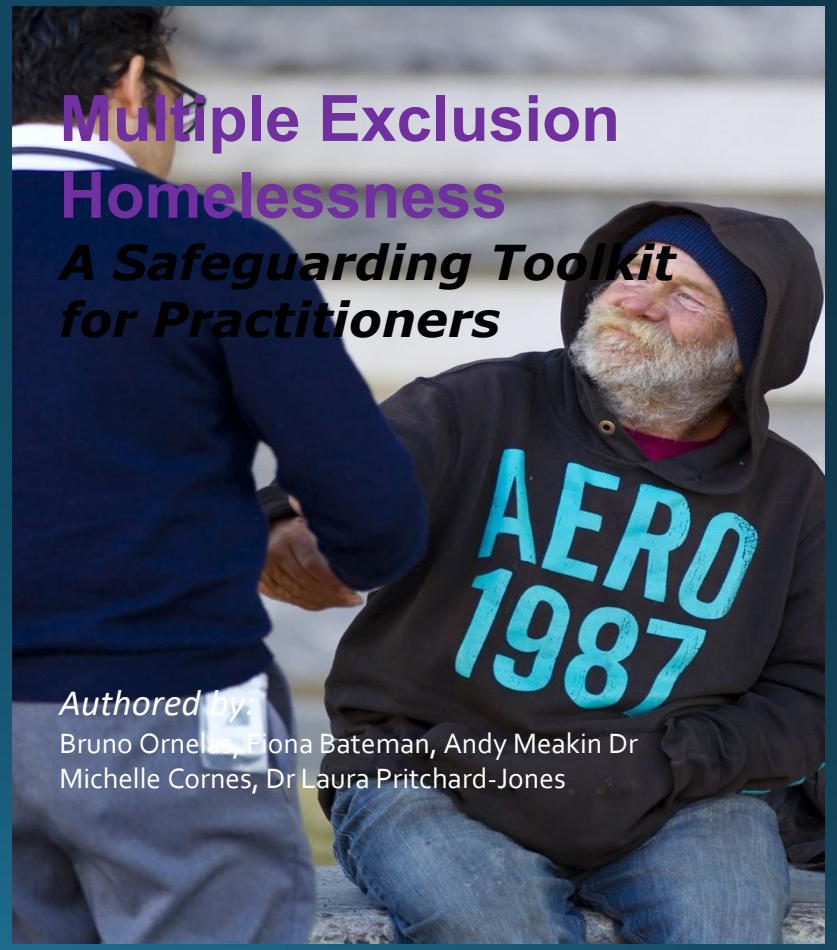
- In the event that there is **no duty to make enquiries,** guidance provide by ADASS called 'Making decisions on the duty to carry out safeguarding adult enquiries' (2019) states that *"practitioner(s) **must still consider and record how any identified risk will be mitigated** (including through communication with partner agencies) and how that will be communicated to the adult concerned…"*(page 8).

The importance of fact finding in safeguarding

- Objectively set out the person's needs and ability to protect themselves from harm
- No solitary practitioner is expected to have all the required expertise; instead what is needed is sufficient knowledge to trigger active assessment in line with the relevant statutory eligibility criteria for those at risk of homelessness
- To do this successfully requires legal acumen and investigative skills because people experiencing homelessness may still feel stigmatised by their circumstance, may be reluctant to acknowledge the true extent of their inability to meet basic needs or may have become reliant on informal support and relationships which remain important to them, even if abusive or the carer is unable to safely provide necessary care.

Safeguarding Toolkit: why, when and how

- A collaboration between Voices, King's College London, Keele University and CASCAIDr
- Put together by practitioners, academic researchers, Independent Safeguarding adult consultants and legal experts and peer reviewed.
- 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**



How is it structured

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.

SECTION 1 - The adults needs and the risks they face

1. Cognitive impairment
2. Executive decision making
3. External factors impairing informed decision making
4. Psychological and emotional health
5. Physical health
6. Medication and treatment needs
7. Challenging, risky and / or distressed behaviour
8. Nutrition
9. Maintaining personal care and toileting
10. Mobility
11. Communication
12. Maintaining the home and using it safely
13. Developing and maintaining family or other relationships
14. Engagement in work, employment, or volunteering
15. Managing finances

Not all areas will be relevant and some will be more prominent than others!

READ THE MARGINS "THINGS TO CONSIDER" These can be used as questions to answer within each domain of need/risk

SECTION 2 - Chronology of events

1. Most recent six-months
2. Longer-term view
3. Summary of observations

To protect against normalisation of risk or, conversely, a lack of professional curiosity it is important to objectively document the person's relevant past history (or 'chronology') and their current ability to manage daily living and health needs

SECTION 3 – Immediate risk factors

This section concerns itself with understanding whether there are any immediate risks to the adult that require an urgent intervention to prevent harm; e.g.

- Provision of accommodation
- Interventions to remove risk from a 3rd party
- Reconnecting an adult with care and support needs to existing family or statutory support

SECTION 4 - Protection planning

Preparatory checklist -for referrers

Closing an enquiry

Enquiry closure checklist - for safeguarding teams, but good for everyone to know this irrespective of role or sector.

Download Safeguarding Toolkit at:

- Voices

https://issuu.com/voicesofstoke/docs/safeguardingtoolkit

- Queens Nursing Institute

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

- NHS Safeguarding App

http://www.myguideapps.com/projects/safeguarding/default/s3/NHS-safeguarding-programmes/s3-22.html

Further resources…

A recording of this webinar, along with the slides, will be added here soon:
https://homeless.org.uk/our-work/resources/webinar-catchup

Guidance and toolkits can be found in our resource library
https://homeless.org.uk/statutory-frameworks-resources
(these include links to more resources)

Webinars, communities of practice, workshops and events
https://homeless.org.uk/events

We would love to know how you use our resources and ideas for other topics.
Please complete the pop up survey on the website or email joanne.prestidge@homelesslink.org.uk