OXFORDSHIRE SAFEGUARDING ADULTS BOARD

THEMATIC REVIEW – HOMELESSNESS

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MAY 2020

This report was commissioned by Oxfordshire's Safeguarding Adults Board (OSAB) to help agencies working across Oxfordshire to learn lessons from the circumstances surrounding the tragic deaths of 9 individuals who had all experienced what the report terms "multiple exclusion homelessness" leading up to, and at the time of, their deaths in 2019.

All 9 of them, whilst their individual circumstances were very varied, lacked a place to live where they felt safe and secure and where their complex needs and vulnerabilities could be consistently supported. All of them died before their time and in tragic circumstances.

The reviewers and all members of Oxfordshire's Safeguarding Adults Board are grateful to those individuals' family members who felt able to contribute to the review and who gave their views about what might have helped their loved ones. To all of them and to all families and friends effected by the tragedies of these individuals, we want to extend our condolences and our sincere determination and commitment that this review, and the work that follows it, will improve the way services work in future with such vulnerable people.

The report provides many challenges to all agencies across Oxfordshire, if we are to better fulfil our responsibilities to safeguard vulnerable adults in Oxfordshire.

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1. Introduction

1.1. Oxford City Council referred five deaths of individuals who were homeless, their deaths occurring between November 2018 and February 2019. The information received from partners (Oxford City Council, Thames Valley Police, Adult Social Care, Oxford Health, Oxford University Hospitals, Public Health, Turning Point) indicated a high level of substance abuse and undiagnosed mental health issues. Between February 2019 and June 2019 there were a further four deaths.

1.2. Three were in the homeless pathway and accommodated at the time of their death. One had refused all services and professional involvement. The most recent appeared to have only arrived in Oxford the previous day. The three who were accommodated appeared to have suffered drug-related deaths. The other two died of causes unrelated to their homelessness (sudden unexpected death due to epilepsy and a stroke).

1.3. It appeared from the information presented that all services were as involved with the subjects as they were willing to allow. Therefore, based on the information presented, the Safeguarding Adult Review (SAR) subgroup did not believe the cases, either singularly or as a whole, met the criteria for a SAR.

1.4. Subsequently Oxfordshire Safeguarding Adults Board (OSAB) became aware of four further deaths of individuals who were homeless. Additionally, the SAR Subgroup was also presented with two reports. These concerned a review of a homeless service in Oxfordshire from 2013. The thematic issues identified by that review were felt to be the same as in the cases presented to the SAR subgroup, namely:

- 1.4.1. High level of alcohol and drug use
- 1.4.2. Multiple health need including epilepsy and heart problems
- 1.4.3. Reluctance to engage with services e.g. health services in some instances
- 1.4.4. Long history of rough sleeping/being known to homelessness services

1.5. The SAR sub-group considered whether the five cases originally referred by Oxford City Council, together with the additional four cases, constituted singly or collectively grounds to recommend the commissioning of a SAR but concluded they did not. The SAR Subgroup recommended to the Executive that while the cases did not meet the SAR criteria there was a need for a systemic review of homelessness.

1.6. The Executive of the OSAB accepted that a systemic thematic review should be undertaken to draw out any safeguarding lessons for policy and practice in working with vulnerable individuals who are presenting as homeless.

1.7. This report was commissioned to look at the individual cases within scope of the review and does not therefore consider recent or current initiatives being undertaken which seek to address some of the issues highlighted. The Safeguarding Board would be expected to publish such progress alongside publication of this report.

1.8. The focus of this report are the issues professionals encountered in working with the nine individuals experiencing multiple-exclusion homelessness. Examples of good practice were highlighted at the learning event, as was a clear commitment from frontline professionals to working with those experiencing multiple-exclusion homelessness, however these are not the focus of this report and therefore have not been explored further.

2. Safeguarding Adults Reviews

2.1. OSAB has a mandatory statutory duty[1] to arrange a SAR where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. OSAB has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. Abuse and neglect includes self-neglect.

2.3. It is important to emphasise the distinction between the mandatory and the discretionary criteria because this is not always appreciated. Under current law (Care Act 2014), for the mandatory criteria to be met, a SAB must have reasonable reason to believe that the adult whose case has been referred has/had care and support needs, has/had experienced abuse or neglect, including self-neglect, and there is/was reasonable cause for concern about how agencies have worked together in that case.

2.4. In response to rising concerns and increased visibility of homelessness as an issue across the country, but particularly in big cities, the Government has released its Rough Sleeping Strategy: https://www.gov.uk/government/publications/the-rough-sleeping-strategy

2.5. The Strategy says…

"We agree with the Advisory Panel, who were clear 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".

2.6. The reason for emphasising the distinction between mandatory and discretionary reviews in section 2.3 above is that the Government Strategy appears to fail to recognise that, for the mandatory criteria to be met, the adult must appear to have/have had care and support needs as defined by the Care Act 2014[2].

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[1] Sections 44(1)-(3), Care Act 2014

[2] The Care and Support (Eligibility Criteria) Regulations 2014

2.7. The Executive of the OSAB, following the suggestion of the SAR Subgroup, considering that a causal link had not been clearly established in every case between self-neglect and the deaths of people experiencing homelessness that had been referred, recommended that a discretionary thematic learning review be commissioned. This was agreed by the Independent Chair of OSAB.

2.8. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[3]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.9. The question of whether there should be a specific pathway for reviews of street homeless deaths or whether the discretionary provisions in section 44 Care Act 2014 should be used is considered further in section 9.3.

[3] Section 44(5), Care Act 2014

3. Review Process

3.1. Focus

3.1.1. OSAB agreed a specification for the thematic review on homelessness. Its purpose was to examine the events and circumstances that led to the deaths of this group of people, explore what if anything could have been done to avert this outcome, and capture learning as to what might be done to improve the effectiveness of services in Oxfordshire that support people experiencing homelessness, including mainstream services. The basis for the review would be to examine policy and practice surrounding the nine cases where the death of a person experiencing homelessness was a factor.

3.1.2. The review would also look at the range of existing provision, including statutory services, outreach work and third sector organisations in order to gain a better overview of whether and where the system had failed these individuals, and identify what actions agencies can take to seek to address those gaps.

3.1.3. A wide range of organisations were involved with some or all of the nine individuals at one time or another. Representation was therefore sought from:

3.1.3.1. Organisations that work exclusively with people experiencing homelessness including St Mungo's – Service Provider, OxSPOT; providers of supported accommodation where the person was accommodated at the time of their death, including Homeless Oxfordshire – Service Provider, O'Hanlon House; Luther Street Medical Centre;

3.1.3.2. Organisations that provide services to the wider population, including people experiencing homelessness, namely Oxfordshire County Council, Oxford City Council, Thames Valley Police, Oxford Health NHS Foundation Trust, Turning Point and South Central Ambulance Service.

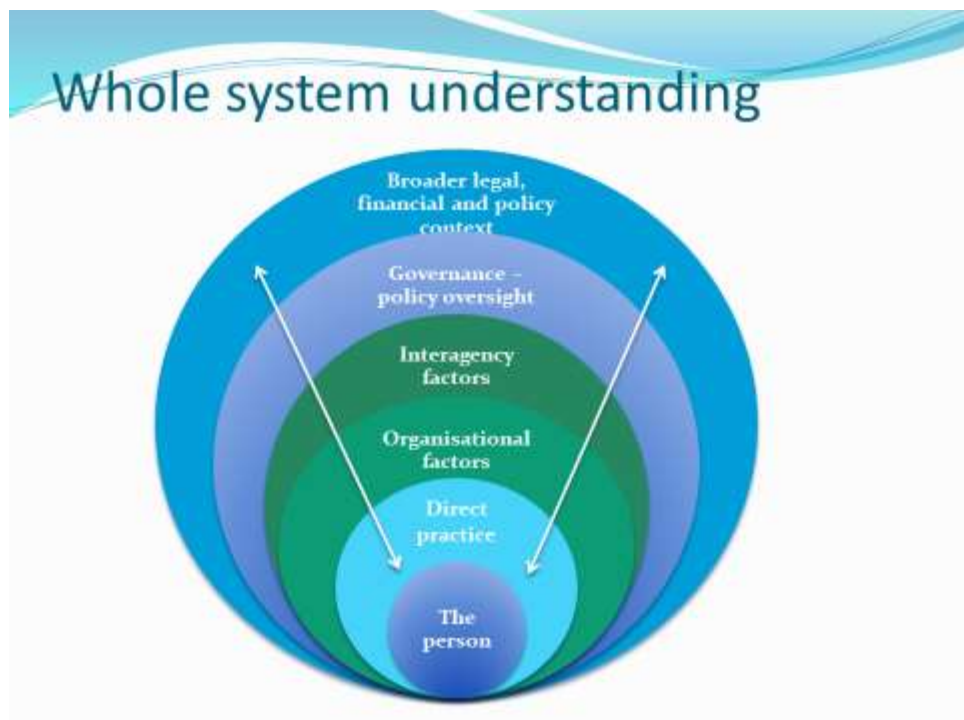
3.1.4. The review also brought together commissioners/senior managers who have responsibility for the commissioning/management of these services. The purpose of their involvement was to identify strategic and commissioning level learning.

3.1.5. The review focused on the period from November 2018 to July 2019, during which time the deaths occurred.

3.1.6. The nine individual cases are summarised below. However, rather than a traditional review that would concentrate on a detailed

chronology of a single case, this thematic review would look across all nine cases for learning from recurring themes that would indicate systemic issues to be addressed.

3.1.7. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



3.2. Methodology

3.2.1. Combined chronologies were compiled regarding the nine people who died from information supplied by partner agencies. The level of detail varied considerably. Some individuals were hardly known to services in Oxfordshire. Others, as emerged in the workshop sessions, were very well known to workers but, because they were seldom seen to be eligible for services, there is little about them, or their histories, in documented records. However, from the combined chronologies it proved possible to identify themes for further exploration.

3.2.2. The review followed a blended approach incorporating elements of traditional case review methodology and Appreciative Inquiry (AI), primarily through two facilitated workshop sessions, one with commissioners and senior managers, and one with professionals working with the organisations expected to have been involved with these individuals. This combined approach is rooted in action research and organisational development, and is a strengths-based, collaborative approach for creating learning change while providing assurance of a thorough investigative process. The approach was underpinned by use of the evidence base now available for working with people who self-neglect[4] and with people experiencing multiple exclusion homelessness[5].

3.2.3. Two learning events were held. The event with practitioners discussed learning from the nine cases and the degree to which the challenges and concerns highlighted by these cases represented systemic issues in Oxfordshire. The event with strategic managers similarly considered learning from the nine cases but also explored the strategic direction of homelessness services and barriers to commissioning effective services. The learning events offered an opportunity for those involved in commissioning and in working with people who are homeless and with adult safeguarding more generally to comment on what they believed was working effectively in Oxfordshire and on where they felt that improvements were required.

3.2.4. Broad questions were set by OSAB for this enquiry, namely:

3.2.4.1. Is there a clear pathway from someone presenting as homeless to being found accommodation?
3.2.4.2. Are referral routes and thresholds for other services clear and well-understood?
3.2.4.3. What are the barriers/challenges along the homeless pathway?
3.2.4.4. How and when is mental capacity considered along the pathway?
3.2.4.5. What risk assessments are completed and by whom?
3.2.4.6. How are complex needs understood and managed within the pathway?

[4] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. 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.

[5] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.

3.2.5. These questions were refined into terms of reference as the detail in the combined chronologies was analysed. The terms of reference are captured in the diagram below.

3.3. Family Involvement

3.3.1. No family contact details could be obtained from any agency or service for three of the individuals. Steps were taken to identify and interview relatives, including the father of Adult P, the father of Adult T, and the sister of Adult U. Their observations and views are incorporated into the sections that follow. Their cooperation with the review was very valuable to the reviewers and to the OSAB in their consideration of the actions that should follow from the lessons learned from the sad deaths of their relatives.

3.3.2. The family members who participated in the review will be consulted over the publication of the findings.

4. Case Narratives of Nine People

4.1. Initials have been used for the nine individuals, following the sequence used by OSAB for the SARs it has commissioned.

4.2. These nine people exemplify to varying degrees experiences of multiple exclusion homelessness. This comprises extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care[6]. Adverse experiences in childhood can include abuse and neglect, domestic abuse, poverty and parental mental illness or substance misuse[7]. Individuals in the sample demonstrate that, for many, street sleeping 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[8].

4.3. Person One: Adult P

Adult P died aged 37. He was a White British man who collapsed and suddenly died. He was accommodated at time of death, with long history of homelessness, beginning when changes in housing benefit policy were introduced for single adults supported in one bedroom accommodation (age raised from 25 to 35). His history involved disengagement, substance misuse and significant impact on physical and mental health. There were references to negative "memories" arising for him, particularly when he was reported to be in an emotionally charged state when he attempted to detox; and he was in and out of treatment. He had convictions for assault, theft, possession, criminal damage and disorder, and had been in prison. He was also a victim of assault. He had been hospitalised due to the impact of drug use on his physical health. He had some contact with his father in Wales. He had been adopted as a child. There were reports of lifelong struggles from adverse childhood experiences.

[6] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.
[7] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.
[8] See note 5.

He was diagnosed as not being clinically depressed but situationally depressed, with impact of drugs on his brain.

4.4. Person Two: Adult Q

Adult Q died aged 36. He was a White European man.

He had no fixed abode when he died.

Cause of death was respiratory arrest secondary to acute alcohol intoxication.

His picture included epilepsy and alcohol abuse, violence and suicidal ideation, and non-engagement with services. He was offered help and turned it down.

He had been unable to work following injury.

He had contact with O'Hanlon House and there were references to multi-agency meetings considering his case.

He experienced a pattern of seizures, falls, and violent behaviour.

He had family in Oxfordshire.

4.5. Person Three: Adult R

Adult R died aged 50. He was a Black British man. His was a sudden death in a homeless pathway flat and the cause of death was not specified. The accommodation had some support services but was not staffed 24/7.

There was little detail in the combined chronology but some evidence of homelessness dating back to 2012. There were reported assaults on his ex-partner leading to imposition of a restraining order, as well as other offences, supplying drugs and custodial sentence(s).

He was well known to Police and Turning Point; and had some contact with Hospital Trusts. He had previously been injecting drugs.

4.6. Person Four: Adult S

Adult S died aged 64. His ethnicity was not specified in the combined chronology.

He was homeless when he died of multi-organ failure, having been found collapsed in a churchyard, with pressure sores and hypothermic, and taken to ED, where he died.

He was alcohol dependent and self-neglected.

Services appear to have had contact with his step-sister. He was not known to the Homelessness Team.

He appears to have been offered accommodation in Warwickshire but chose to leave it.

4.7. Person Five: Adult T

Adult T died aged 44. She was a White British woman. Her death was unexplained.

She was accommodated in a women only hostel at the time of her death.

Her history included failed hostel placements and temporary accommodation, and drug and alcohol abuse.

She was a victim of domestic abuse and sexual offences. She was diagnosed to have a borderline personality disorder.

She had convictions for shoplifting and drunkenness.

She had three children living elsewhere (with different relatives). The children had witnessed domestic abuse and also her substance abuse. Child protection procedures had been invoked. Observations offered by Adult T's father about the involvement of children's social care and substance misuse services are woven into the analysis from section 6 onwards.

There was negative impact of substance misuse on her physical health; and she maintained erratic compliance with treatment.

There is reference to adverse life experiences/trauma.

She accessed 'sit up' services at O'Hanlon House.

There were two contacts with ASC in 2018, she was assessed in hospital as having no eligible care and support needs when she was discharged from hospital; her case was closed by an addiction service due to non-engagement.

4.8. Person Six: Adult U

Adult U died aged 39. She was a woman, and her ethnicity was not recorded in the chronology.

She had 'no fixed abode' at the time of her death, which seems to have involved a head injury; morphine, cocaine and methadone were present in her body when she died.

Her son lives with her brother and his wife, with the chronology stating that Adult U had had very little contact with him. The chronology does not provide details of how this arrangement came about. However, her sister clarified that Adult U had been "highly addicted" to Class A drugs by the time her son was born, with the result that he was placed with her brother.

She had a history of alcohol and drug abuse, of erratic engagement with treatment plans, with negative impact on her physical health.

Her history included time in prison and release on licence, with which she did not comply, so she was recalled.

MAPPA[9] was involved – she had a conviction for indecent assault.

4.9. Person Seven: Adult V

Adult V died aged 35. He was a White European man. He died from progressive multi-organ failure following hospital admission for sepsis.

He had 'no fixed abode' at the time of his death.

He had lost his job due to an injury and suffered from epilepsy as well as alcohol withdrawal induced seizures.

He used facilities at O'Hanlon House but declined some treatment for alcohol abuse and routinely did not engage with SPOT.

He had arrests for assaults and had also been attacked on the streets.

There were references to his case being considered in multi-agency meetings.

He was estranged from his family in Poland.

He was on probation before his death.

He had no recourse to public funds.

4.10. Person Eight: Adult W

Adult W died aged 40. She was a Black African woman.

She was accommodated at the time of her death and was found dead in her bed.

She had a history of alcohol abuse, which her children had witnessed.

[9] Multi Agency Public Protection Arrangements – partnership working across agencies to manage sex and violent offenders in the community, and other offenders who also pose a serious risk of harm to the public.

Her children were living with her former partner and had been subject to child protection plans for emotional abuse when Adult W had been living with them.

There were incidents of domestic abuse between Adult W and the children's father.

There was the possibility that her alcohol misuse masked her mental health issues and she was reported as having anxiety, depression and PTSD at different times.

She maintained erratic engagement with treatment options.

There was reference to major trauma when she was living in Kenya. She was prescribed medication for depression.

Her chronology includes references to adult protection following a suicide note and again when possibly being exploited by a landlord.

She was evicted by court order from her family home; there were reported breaches of a non-molestation order.

Probation services were involved with her before her death.

4.11. Person Nine: Adult X

Adult X died aged 58. His ethnicity has been recorded as White - Other.

He had 'no fixed abode' at the time of his death, of severe pneumonia.

He had a history of drug and alcohol misuse, also depression.

He was asthmatic and dyslexic, and had a history of COPD.

He had no contact with his siblings in Nottingham; he had previously been homeless in Staffordshire.

There was OxSPOT[10] involvement, advising him to use O'Hanlon House and supporting him with his housing application under priority need; he was willing to return to Staffordshire where a tenancy agreement was in place.

There was one reference to an adult protection referral being raised to the internal safeguarding team but it was not shared with the Adult Safeguarding Team as he was not thought to have a care and support need beyond being homeless.

[10] Oxford Street Population Outreach Team.

Sometimes he self-discharged from hospital; he was sometimes noted as confused about his medication.

There was reference to his social care needs being looked at by Adult Social Care shortly before he died.

4.12. Premature mortality is evident in all nine cases. In five of the cases the individuals died before the average age of deaths for men (44) and women (42) who are homeless and sleeping on the streets[11].

4.13. Referring back to the components of multiple exclusion homelessness, drawing on the combined chronologies:

4.13.1. there is evidence of substance misuse in all nine cases;
4.13.2. there is evidence of physical health concerns in all nine cases;
4.13.3. mental health concerns are referred to in five cases (Adults P, T, U, W AND X);
4.13.4. adverse childhood experiences are referred to in three cases (Adults P, T and W);
4.13.5. as mothers, Adults T and W experienced involvement of children's social care, both family support and child protection procedures, as a result of the children witnessing domestic abuse and substance misuse; Adult U was also a mother. The combined chronology offers no detail of how and when her son came to live with Adult U's brother, other than specifying that there was minimal contact between them. Adult U's sister clarified that her son had been placed with her brother as a result of her addiction to Class A drugs. A Special Guardianship Order has been made.
4.13.6. there is evidence of domestic abuse in three cases (Adults R, T and W);
4.13.7. two individuals appear to have been victims of assault (Adults P and T) and three to have perpetrated violence (Adults Q, R and W);
4.13.8. six individuals appear to have committed offences (Adults P, Q, R, T, U and V); and two to have been imprisoned (Adults R and U).

[11] ONS Deaths of homeless people in England & Wales 2013-2017 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2013to2017#deaths-of-homeless-people-have-increased-by-24-over-five-years

5. The Evidence-Base for Best Practice

5.1. Reference was made earlier (section 3.2.3) to research and findings from SARs[12] that enable a model of good practice to be constructed in relation to adults who self-neglect. The model comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect. The domains are summarised here.

5.2. For the purposes of this thematic review, evidence has been integrated into these domains regarding best practice drawn from research and SARs on multiple exclusion homelessness and substance misuse.

5.3. It is recommended that direct practice with the adult is characterised by the following:

5.3.1. 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; work to build motivation with a focus on a person's fluctuating and conflicting hopes, fears and beliefs, and the barriers to change[13];

5.3.2. A combination of concerned and authoritative 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 encounter brings[14];

5.3.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of

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[12] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. 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.

[13] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[14] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. 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: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

what might lie behind a person's refusal to engage; failing to explore "choices" prevents deeper analysis;[15]

5.3.4. It is helpful to build up a picture of the person's history, and to address this "backstory"[16], 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;

5.3.5. Contact should be maintained rather than the case closed so that trust can be built up;

5.3.6. 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[17];

5.3.7. Where possible involvement of family and friends in assessments and care planning[18] but also, where appropriate, exploration of family dynamics, including the cared-for and care-giver relationship;

5.3.8. 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[19];

5.3.9. Careful preparation at the point of transition, for example hospital discharge, prison discharge, end of probation orders and placement commissioning;

5.3.10. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;

5.3.11. Thorough assessments, care plans and regular reviews, comprehensive enquiries into a person's rehabilitation, resettlement and support needs[20]; taking into account the negative effect of social isolation and housing status on wellbeing[21].

5.4. It is recommended that the work of the team around the adult should comprise:

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[15] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

[16] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[17] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[18] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

[19] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[20] Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[21] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

5.4.1. Inter-agency communication and collaboration, working together[22], coordinated by a lead agency and key worker in the community[23] to act as the continuity and coordinator of contact, with named people to whom referrals can be made[24]; the emphasis is on integrated, whole system working, linking services to meet people's complex needs[25];

5.4.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;

5.4.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;

5.4.4. Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequent implement planning and review outcomes[26];

5.4.5. 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[27];

5.4.6. 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;

5.4.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;

5.4.8. Clear, up-to-date[28] and thorough recording of assessments, reviews and decision-making; recording should include details of unmet needs[29].

5.5. It is recommended that the organisations around the team provide:

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[22] Parry, I. (2014) 'Adult serious case reviews: lessons for housing providers.' *Journal of Social Welfare and Family Law*, 36 (2), 168-189. Ministry of Justice (2018) *Guidance: The Homelessness Reduction Act 2017 Duty to Refer*. London: MoJ.

[23] Whiteford, M. and Simpson, G. (2015) 'Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.' *Housing, Care and Support*, 18 (3/4), 125-135. NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

[24] Parry, I (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[25] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping).* London: PHE. Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.

[26] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

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

[28] Parry, I. (2013) 'Adult safeguarding and the role of housing.' *Journal of Adult Protection*, 15 (1), 15-25.

[29] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.

5.5.1. Supervision and support that promote reflection and critical analysis of the approach being taken to the case, especially when working with people who are hard to engage, resistant and sometimes hostile;
5.5.2. Access to specialist legal, mental capacity, mental health and safeguarding advice;
5.5.3. Case oversight, including comprehensive commissioning and contract monitoring of service providers;
5.5.4. Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning;
5.5.5. Attention to workforce development[30] and workplace issues, such as staffing levels, organisational cultures and thresholds.

5.6. SABs:

5.6.1. 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[31] and other complex case or multi-agency panel arrangements, responding to anti-social behaviour, domestic abuse, offending (community safety) and vulnerability[32]; strategic agreements and leadership are necessary for the cultural and service changes required[33];
5.6.2. Develop, disseminate and audit the impact of policies and procedures regarding self-neglect;
5.6.3. Review the interface between housing/homelessness and adult social care, mental health, and adult safeguarding, and include housing in multi-agency policies and procedures[34];
5.6.4. Establish a system to review the deaths of homeless people and/or as a result of alcohol/drug misuse;
5.6.5. Work with Countywide Community Safety Partnership group, Health and Wellbeing Boards and partnership arrangements for safeguarding children and young people, to coordinate governance, namely oversight of the development and review of policies, procedures and practice;
5.6.6. Provide or arrange for the provision of workshops on practice and the management of practice with adults who self-neglect.

[30] Whiteford, M. and Simpson, G. (2015) ‘Who is left standing when the tide retreats? Negotiating hospital discharge and pathways of care for homeless people.’ *Housing, Care and Support*, 18 (3/4), 125-135. The MEAM Approach (2019) *Making Every Adult Matter*. London: Homeless Link and Mind.
[31] Multi-Agency Public Protection Arrangements (MAPPA), Multi- Agency Risk Assessment Conferences (MARAC), Multi-Agency Safeguarding Hub (MASH)
[32] Parry, I. (2013) ‘Adult safeguarding and the role of housing.’ *Journal of Adult Protection*, 15 (1), 15-25.
[33] Ward, M. and Holmes, M. (2014) *Working with Change Resistant Drinkers. The Project Manual.* London: Alcohol Concern.
[34] Parry, I. (2013) ‘Adult safeguarding and the role of housing.’ *Journal of Adult Protection*, 15 (1), 15-25.

5.7. This model enables exploration of what facilitates good practice and what acts as barriers to good practice. The thematic analysis that follows draws on information contained within the chronologies and group discussions during the learning event. Where relevant, it also draws on available research. It follows the whole system framework for analysis presented above, beginning with the components of direct work with individuals and moving outwards to the legal, policy and financial context within which adult safeguarding and work with people who are homeless are situated.

6. Thematic Analysis – Direct Work with Individuals

6.1. From a reading of the combined chronologies, and mindful of the evidence-base, the following themes were explored at the learning event and are further analysed here.

6.2. Responses to repeating patterns. One particular reported danger was that staff could become inured to or could normalise risk when what was being presented was repetitive. Within the chronologies is evidence of repeating patterns of attendance at Emergency Departments and/or self-discharge and/or non-engagement or disengagement and/or non-attendance at arranged appointments. In response there were examples of cases being closed and/or renewed attempts to maintain contact by offering "more of the same", namely appointments at designated times and places. There were, however, occasional examples of wrap-around support that included outreach and support to attend appointments. Advice to contact services and signposting to services as single strategies are unlikely to be effective with people experiencing multiple exclusion homelessness and self-neglect.

6.2.1. Lack of understanding of behaviours was identified by participants as a barrier to providing effective support, for example practitioners not considering why people disengage or are unable to engage with treatment, and not seeing repeated patterns of such behaviours as information to address. It was felt that there was a need for a better understanding of how to work with people who do not prioritise their own needs, in other words who self-neglect.

6.2.1.1. The observations offered by the sister of Adult U and the father of Adult P reinforce the need for this better understanding. Adult U was often not amenable to support and yet in her sister's words "highly addicted." Adult P sometimes "blew it" and was "not motivated." The father of adult T observed that her personality changed when she took drugs and she "spiralled downwards."

6.2.2. What was seen as working well by practitioners was that the voluntary sector was good at focusing on the person and their outcomes, and that there were services available in the City (compared to other areas and districts). Some practitioners valued that they were able to provide choice to the people they worked with. However, feedback from the workshop with practitioners was also cautionary in that the voluntary sector and particularly housing support workers were often left "holding the baby" when all the statutory agencies appeared to deny eligibility for services for very vulnerable high risk individuals. Characteristically the least qualified and experienced workers were being left to deal with the hardest and most complex individuals. To respond adequately to this cautionary observation requires attention to workforce

development, access to specialist advice, and commissioning and thresholds, addressed below.

6.3. Risk assessment. As was recognised at the operational staff learning event, risk assessment and risk management are crucial, with plans preferably co-designed with service users/patients and shared across partners. This approach was seen as especially supportive of staff in accommodation settings whose training is often limited.

6.3.1. There were occasions when reading the combined chronologies that a risk assessment and mitigation plan would have been expected. For example, in one situation, no multi-agency risk management plan was evident when the individual was evicted from accommodation; such a plan was needed to address mental health and cognitive issues alongside housing and substance misuse. There were other examples where individuals had been evicted from temporary or hostel accommodation and where the risk management plan was not evident.

6.3.2. It may be that risk assessments and management plans are completed but not recorded in a way that can be easily captured by case chronologies. Alternatively, it may be that practitioners would be assisted by having risk assessment templates from which to draw. OSAB should engage with partner agencies on the subject of risk assessment and mitigation planning, as well as exploring how practitioners and managers understand and respond to situations of self-neglect, self-harm and risks associated with multiple exclusion homelessness.

6.4. Mental capacity assessment. Operational staff reported that cases of fluctuating capacity were particularly challenging and that easier access to specialist assessors would be helpful. There were very few references to mental capacity assessment in the combined chronologies, which is perhaps surprising given that the Code of Practice[35] refers to symptoms of alcohol or drug use in the context of disorders of mind or brain. There were examples in the individual narratives of missing mental capacity assessments. For example, one individual appeared unclear about when to self-administer his medication. Another was diagnosed with global cerebral atrophy but the implications for decisional and executive decision-making were not recorded as having been considered.

6.4.1. From reading the combined chronologies, and speaking with three relatives of the adults whose cases are considered herein, three questions arise that OSAB should raise with partner agencies as part of its statutory mandate to seek reassurance that adult

[35] Department of Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice* (London: The Stationery Office.

safeguarding services are working effectively in preventing abuse and neglect, including self-neglect. Firstly, is there an understanding of executive capacity? Especially where there are repetitive patterns, it is essential to assess executive capacity as part of mental capacity assessment. Guidance has commented that it can be difficult to assess capacity in people with executive dysfunction. It recommends that assessment should include real world observation of a person's functioning and decision-making ability[36], with subsequent discussion to assess whether someone can use and weigh information.

6.4.2. Secondly, is sufficient recognition given to the impact of trauma and adverse childhood experiences? Her sister located the beginning of Adult U's substance misuse to her father, with whom she had been particularly close, leaving home. She had begun to run away from home and had become "highly addicted" to Class A drugs. Thirdly, is drug and/or alcohol abuse seen as a lifestyle choice and unwise decision-making or possibly invoking considerations of mental capacity and self-neglect? The absence in the combined chronologies of explicit reference to self-neglect and to following agreed multi-agency procedures is a concern. To varying degrees all three questions are engaged when individuals were known to have experienced trauma, were revealing that they were drinking to control anxiety, were wanting to control their substance misuse but could not carry this through and/or were sad and unable to implement their stated intentions.

6.5. Domestic abuse. Police liaison officers working alongside other services in Oxford City was experienced as helpful by those attending the learning event. There was particular mention of work being done by police officers and NHS staff in relation to people at risk of exploitation and assault on the street. Nonetheless, from reading the combined chronologies, two questions arise that OSAB might raise with partner agencies concerned with adult safeguarding and community safety. Firstly, some of the individuals who are the focus of this review were known as both domestic abuse perpetrators as well as victims. MARAC arrangements are well established for victims of domestic abuse. It is less clear what provision is available for individuals with the particular constellation of complex needs as seen in the cases here. Secondly, when domestic abuse happens on the street, rather than in a home, when is this considered a safeguarding concern?

6.6. Care and support assessment. The absence of requests for an Adult Social Care assessment for care and support in the majority of cases in the sample drew comment. Adult Social Care assessment was seen as an essential part of any support plan. Outreach social work was also seen as a possible

[36] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.

helpful future development, alongside other practitioners, reaching out and assessing the person in their locations.

6.6.1. The statutory guidance[37] identifies that care and support needs arise from or are related to physical or mental impairment or illness. Substance misuse is included here. Thus, OSAB's statutory mandate, to ensure the effectiveness of what partner agencies do, requires that it questions them about how the interface between housing/homelessness and adult social care is seen. Research elsewhere[38] has found that agencies can be deterred from making referrals to Adult Social Care because of potential volumes and/or that Adult Social Care is operating a higher threshold for care and support assessments than Section 9 (Care Act 2014) permits. OSAB needs to be reassured that these factors are not present in Oxfordshire.

6.6.2. Within the narratives of the nine cases were instances where individuals who potentially had care and support needs, although none were referred for an Adult Social Care assessment of their needs and therefore did not receive an assessment.. The eligibility criteria are set out in the Care and Support (Eligibility Criteria) Regulations 2015. An individual's needs meet the eligibility criteria if (a) the adult's needs arise from or are related to a physical or mental impairment; (b) as a result of the adult's needs the adult is unable to achieve two or more of certain specified outcomes; and (c) as a consequence there is, or there is likely to be, a significant impact on the adult's well-being. Thus, such needs may arise from physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. The specified outcomes include being appropriately clothed, being able to maintain a habitable home environment, and being able to use facilities and services in the community. These are needs that many people experiencing multiple exclusion homelessness have and outcomes which they may not be able to achieve. If the needs are urgent, care and support can be provided before an assessment is completed (section 19(3)).[39]It should be remembered also that, besides a duty to meet eligible needs, local authorities also have a power to meet other care and support needs, again for adults ordinarily resident in their area or present and of no settled residence (section 19 (1), Annex H – Statutory Guidance[40]).

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[37] DHSC (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014.* London: The Stationery Office.

[38] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

[39] Braye, S. and Preston-Shoot, M. (2016) Practising Social Work law (4th ed). London: Palgrave Macmillan.

[40] Department of Health and Social Care (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014.* London: The Stationery Office.

6.7. Responses to substance misuse and mental distress. Operational staff at the learning event observed that individuals in the grip of substance misuse would not find change easy to achieve and this realisation had to be factored into how services were set up to provide support. This reinforces the commentary on executive decision-making and mental capacity assessment above. This links also to later sections on commissioning and on workforce development.

6.7.1. The father of Adult P acknowledged that his son received support from both O'Hanlon House and Simon House but was often not motivated to accept offers of help and sometimes "blew it." Adult P's father thought that what might have helped would have been more flexibility from services – groups, classes and meetings were always in the mornings (whereas he was up all night, because he couldn't sleep, and slept during the day). He tried to persuade his son to take up the offers of support but Adult P wasn't motivated and "wanted everything on a plate". A more flexible approach to service delivery might have been able to engage with Adult P, for example later afternoon/evening classes or appointments.

6.7.2. The father of Adult T thought that what should change is that the person should be seen for themselves – in her case, as a mother, rather than a drug addict and a problem. He thought that more could have been done to prevent her becoming homeless and to support her when she was homeless. There were endless "battles" with the Council to get accommodation, and he felt that she was abandoned and there was no support for her to maintain the tenancy when she got one as she was left alone. His observations strengthen and reinforce the evidence-base for best practice with regards to personalised and wrap around support being required, and improving how children's social services, substance misuse services and homelessness services work together.

6.8. In the learning events additional features of the evidence-base emerged in discussion when the focus was on the cases in the sample. One was "think family" which, in this instance, referred to Children's Social Care automatically referring adults with care and support needs and/or self-neglecting and/or misusing substances to Adult Social Care. Thinking family needed to become standard practice, for example in child protection scenarios.

6.8.1. There is no reference in the combined chronologies to any of the men having fathered children. All three women were mothers. The combined chronology offers no detail of how Adult U had come to be separated from her son but Adult U's sister was able to provide this detail, as indicated in section 4 of this report. She was also able to provide some family background, including separation and loss,

which she related to Adult U's substance abuse. She indicated that Adult U was out of contact with her family for around eight years, kept much from her mother and siblings, and only rarely approached them for support. Indeed, the sister had been unaware that Adult U had been homeless at the time of her death.

6.8.2. Adult T and Adult W were no longer living with their children when they died. Both had experienced family support and child protection procedures, especially when living with their children, mainly as a result of the children witnessing substance misuse and domestic abuse. In both cases there were child protection conferences and reviews, and core group meetings. Adult Social Care does not appear to have been involved. For Adult T especially, much of children's social care involvement preceded introduction of the Care Act 2014. Nevertheless, it should be remembered that the Care Act 2014 is clear that care and support needs may arise from substance misuse. Duties to assess (section 9) and to conduct adult safeguarding enquiries (section 42) should therefore be considered.

6.8.3. Adult T's father commented that, in his experience, agencies/services did not work well together. He described meetings as "awful" where he felt there was nothing offered/no support. In particular he recounted that Adult T's children weren't offered support and he felt that was a real gap. He said they were "battling against them for everything". He thought that social services made unreasonable demands on the family and provided no help. By this he meant that, in his experience, Adult T had no support with her addiction; rather children's social services and schools required the family to support her and the children, and offered nothing at all. Her two sons lived with him for some time (their maternal grandfather) in his one-bedroom flat, and the daughter with her aunt (Adult T's step-sister).

6.8.4. The father of Adult P maintained regular contact with his son. Even when this became difficult because Adult P lost or sold his mobile phone for drugs, contact was maintained through getting messages to him via O'Hanlon House. The continuity of this contact should remind practitioners of the importance, where possible, of involving family members in planning and the provision of support. Family Group Conferences may be useful in this regard[41]. Adult P's father did not have appear to have had any formal contact with O'Hanlon House staff until after his son's death.

6.9. Another component of the evidence-base referred to <u>transitions</u>. In the context of this review, transition refers to the point at which people transfer

[41] Preston-Shoot, M. (2020) Adult safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.

from one service to another. It is a point of movement between, for example, hospital and community services or between community and supported living provision. At the learning event there was some focus on prison discharge processes. In the opinion of those attending the learning event, Information-sharing and discharge planning were reported as poor, with packages of provision to meet health and/or care and support needs not set up in time, or services not being informed of people approaching discharge from prisons. The role of the National Probation Service is important here, ensuring links are made between that service and other agencies whose resources are needed to support a successful transition from prison to community.

6.9.1. Prison discharge and also hospital discharge are key points of transition. Both learning events identified that transition points represent opportunities but also bring attendant risks. Looking at the nine cases, some of the individuals did not appear to have the skills, resilience and capability, at least not without wrap-around support, to successfully manage transitions, for example into supported accommodation. Some had died when their situation was beginning to improve. What is being highlighted here was the need to consider what wrap-around support was necessary in order to support those who were trying to recover from the impact of trauma and adverse experiences and trying to manage their emotional responses.

6.9.2. In one instance a GP expressed surprise that his patient had been discharged from hospital. There is NICE guidance about the transition between inpatient mental health or general hospital settings and community settings. For people with serious mental health issues who have recently been homeless or are at risk of homelessness, the guidance[42] recommends intensive structural support to assist with finding and retention of accommodation. This support should begin prior to discharge and continue for as long as necessary. Housing and mental health services should work together to jointly problem solve. Similar guidance for people in inpatient general hospital settings[43] recommends on admission that a person's housing status is established and that, prior to discharge, if a person is likely to be homeless, liaison occurs with the local authority's Housing Options service to ensure that advice and help is offered. Homelessness and safeguarding issues should be addressed by agencies working together to ensure a safe and timely discharge. Those at risk of readmission should be referred to

[42] NICE (2016) *Transition between Inpatient Mental Health Settings and Community or Care Home Settings*. London: National Institute for Health and Clinical Excellence.

[43] NICE (2015) *Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs*. London: National Institute for Health and Clinical Excellence.

community practitioners prior to discharge for health and social care support.

6.9.3. When hospital discharge also involved transfer of responsibility, for example from secondary mental health care to primary care, this transfer of care had to be handled carefully. Senior managers, for example, felt that the cases in this sample highlighted the need to improve case transfers and, with a link to a later section on commissioning, to reflect on whether primary care currently had the resources to offer continuity of care to individuals with complex mental health histories and needs. OSAB could engage with partner agencies to explore how effectively transitions are managed in cases involving self-neglect and/or multiple exclusion homelessness.

6.9.4. Another transition is when someone moves off the streets and into some form of accommodation. The combined chronologies reveal incidences when individuals were not provided with the basic necessities for such a move and occasions when, for those attempting to address their substance misuse, the proposed accommodation felt unsafe because of the perceived high level of drug and/or alcohol abuse on site. There is a link here to commissioning and quality monitoring, discussed below (section 8.4).

6.9.5. The father of Adult T identified what may be regarded as a transition, potentially one that has been neglected hitherto. He said that her problems had begun when she was employed by an agency that worked with drug addicts in custody. She had become involved with one of them who injected her with heroin. She was then sacked and he felt that the agency did not undertake their duty of care to her.

6.9.6. Another transition, although not represented within the nine cases in this review's sample, was leaving care. If not managed carefully and supportively, young people leaving care could find themselves homeless.

6.10. A further element that emerged from the evidence was provision or lack of provision of advocacy, and Appropriate Adult support for those involved with the criminal justice system. Neither appeared in the combined chronologies. One angle on the need for advocacy that was offered in the learning event with commissioners and senior managers was that health systems are based on self-reporting and attendance at appointments at specified times and places. Not everyone can easily engage with such a system, at least not without outreach support. If this is not provided, cases may be closed when individuals do not engage and/or are unable to readily explore what lies behind their presenting problems.

7. Thematic Analysis – Team around the Person

7.1. From a reading of the combined chronologies, and mindful of the evidence-base, the following themes were identified for exploration at the learning event and are analysed here.

7.2. Working together. Operational staff at the learning event talked about how a more joined up multi-agency approach could be effective and purposeful, but a collaborative approach was undermined by elements of competitiveness between third sector organisations. Their solutions to agencies being reluctant to work together included agreement on joint key performance indicators and co-location, for instance of clinical specialists in staff teams, mental health practitioners with supported housing and/or substance misuse services, and third sector workers practising alongside statutory agency practitioners. A 'wrap around' approach where partners were jointly accountable, had agreed shared values of social inclusion and resilience, building shared trust and flexibility on the 'lead agency' were seen as desirable goals. A greater use of joint visits and assessments was also recommended.

7.2.1. Senior managers also perceived that work was fragmented, with a lack of join-up both operationally and strategically, and "referral bouncing" or non-acceptance of roles and responsibility to be "part of the solution". There were also suggestions in this learning event of too much responsibility being placed on accommodation providers to engage with other services and to coordinate their involvement. Further causes of 'referral bouncing' cited were thresholds for accessing services or exclusion from services, for example due to dual diagnosis or personality disorder.

7.2.2. One area where improved multi-agency collaboration was felt to be needed was in relation to hospital discharge, with hospital staff, GPs and outreach workers meeting together to plan case management. This links back to the discussion in section 6.9.2. There were examples from the combined chronologies where agencies worked together well, for example liaison between primary and secondary healthcare practitioners, or between the National Probation Service and Adult Social Care. There were other examples where working together was less apparent, for example between accommodation providers and the National Probation Service when someone was homeless and with no recourse to public funds. OSAB must pay further attention to how effectively agencies are working together in cases of self-neglect and/or multiple exclusion homelessness.

7.3. Information-sharing. Operational staff perceived that practitioners were "nervous" about sharing information, reflecting uncertainty about legal literacy in respect of when the Data Protection Act 2018 permits provision

of otherwise confidential information. This was notwithstanding an information-sharing agreement being in place. The combined chronologies contained examples where information was shared but, as an example of working together, OSAB are strongly advised to review other situations involving multiple risks and repetitive complex needs to ensure that information is being shared appropriately. This advice is given because OSAB has a clear duty to ensure that appropriate data-sharing protocols are in place and embedded in practice.

7.4. Referrals. Operational staff observed that referral practice could be improved, with escalation of concerns when necessary. There were also concerns about the experience of "not being heard" when making referrals to Adult Social Care and/or Adult Safeguarding services, especially in relation to people assessed as having decisional capacity. Even when referrals were accepted, there were concerns about waiting times. There was a lack of understanding reported about different services; for example, non-statutory services not understanding criteria and thresholds for statutory services. Thresholds for each service were criticised for not taking into account 'multiple needs' and there was a suggestion that a 'threshold of needs matrix' might be a helpful tool to understand and manage complexity. As such a threshold exists for safeguarding, this feedback highlighted a lack of awareness amongst attendees of the thresholds document. The document is published on the Safeguarding Board website and it is a mandatory question for those raising a safeguarding concern online that they confirm they have read the Safeguarding Thresholds of Needs Matrix.

7.4.1. These reported concerns echo what may be observed in the case narratives. For example, in one case mental health services are reported to have stated that they would only accept a referral if the individual would engage. Wrap-around support and discussion about flexibility about how mental health support was delivered might have been a more appropriate response. It appears that in a second case a mental health referral was not accepted. The above would suggest that OSAB reviews pathways into mental health support, especially for those whose mental health challenges do not reach the threshold of severe and enduring mental ill-health, and including for those whose mental health and behavioural issues co-exist alongside substance misuse concerns.

7.5. Multi-agency meetings. There were reported to be a range of opportunities for case discussion – 'vulnerable adult meetings' and 'working with people who don't engage' meetings. However, it was suggested by operational staff that there was no agreed format for multi-agency meetings nor a standardised approach to risk assessment and management plans (see also section 8.8 below). They questioned whether there was a clear pathway for convening multi-agency meetings or case conferences. It was felt that it would be useful to have adult safeguarding specialists present at multi-agency risk management meetings and

case conferences. Senior managers commented on accountability in multi-agency meetings, highlighting examples where those present had not followed through on delivery of decisions, with insufficient managerial oversight. These observations resonate with examples from the case narratives. There were examples where multi-agency meetings were held to formulate a plan but not apparently reconvened when events disrupted what had been agreed. There were other instances where it was apparent that not all agencies with a potential contribution to make appear to have been present and where it was not clear that what had been outlined was subsequently followed through. In none of the nine cases did there appear to have been a nominated lead agency and/or keyworker to coordinate the multi-agency input.

7.5.1. It was recognised that a pathway with panels was being developed, both to facilitate access to the homeless pathway and to enable individuals to move on, but all agencies needed to be present when cases were being discussed. It was also reported that in Oxford City operational monthly meetings are being convened by Thames Valley Police to share information and to plan multi-agency responses to complex cases. Equally, as was recognised at the learning events, relevant expertise needs to be available, for example relating to addiction, and for cases involving complex mental capacity and mental health questions. It was suggested that a map or organogram would be useful to identify pathways into multi-agency meetings and panels and to ensure that the right professionals were present. OSAB should further review the use of multi-agency meetings in complex cases.

7.5.2. There was a range of opinion regarding <u>access to housing provision</u>. This was expressed as a barrier, such as ‘having to sleep out before you get help’. Some said that this was a gap and that thresholds prevented access to Local Authority housing assessment (especially regarding requirements for a ‘local connection’). Housing provision to support hospital discharge was not always available. However, once accessed, ‘housing first’ was really helping to reduce social exclusion, as was ‘no second night out’.

7.6. <u>Use of policies and procedures</u>. A self-neglect policy was available at the time of the cases in the sample for this thematic review, with procedures to follow when individuals do not engage. The evidence from the combined chronologies and from those attending the learning events appears to be that the self-neglect policy is not being used by all staff across all agencies. It was also suggested that the self-neglect policy could refer more explicitly to procedures and practice with people experiencing multiple exclusion homelessness. OSAB should use the opportunity afforded by this thematic review to consider whether revision of available procedures is necessary and whether further dissemination work is required.

7.7. Safeguarding literacy. Operational staff expressed concern that the response from Adult Safeguarding and from Adult Social Care services was, on the one occasion someone was referred, something along the lines of “what can we do that you are not doing already”. Moreover, just because the case is open to another provider does not necessarily mean that the individual’s care and support needs are being met or that the person is being adequately protected from abuse and neglect (including self-neglect).

7.7.1. A recurrent theme that emerged from discussion was the lack of recognition of safeguarding needs, although all nine people had histories of misusing substances, physical and/or mental health problems and several had been subject to assault, abuse, and/or self-neglect. This links to issues raised elsewhere regarding the lack referral for a Care Act assessment (6.6). Some decisions as recorded in the case narratives are suggestive of a lack of safeguarding literacy. For example, in one case, an adult protection referral was contemplated but not apparently sent or shared as the individual was assessed as having no vulnerability other than homelessness and that they had capacity to self-refer. The individual concerned had a range of disabilities and substance misuse issues. In another case, the individual was possibly being exploited by the owner of a shed in which she was sleeping. She was seen as having decisional capacity and as not having care and support needs. Accordingly, the decision was that there was nothing to stop her protecting herself. However, this individual had a range of physical health needs including acute kidney injury, cirrhosis, and alcoholic hepatitis, and mental health issues. This calls into question the understanding of legal literacy and safeguarding thresholds.

7.7.2. To reinforce the concern about safeguarding literacy, OSAB has provided a procedure known as a threshold of access to safeguarding services (threshold of needs) matrix. Published in July 2018, it contains a section on self-neglect. It advises that “all standard interventions must be used first to manage risk”. OSAB is recommended to evaluate whether this guidance is being used on the basis that, in these nine cases, there is evidence that standard interventions were not reducing the risks involved in self-neglect and yet few referrals were made to adult safeguarding services and no enquiries[44] were initiated at the time the individuals were alive.

7.8. Legal literacy. Operational staff expressed concern about differing interpretations of the Homelessness Reduction Act 2017 and hesitant transfer of information to assist with housing decision-making. Senior managers expressed concern at the apparent absence of Human Rights Act 1998 assessments for those individuals within the sample with no recourse to public funds, which would have been triggered if these individuals were referred for a Care Act assessment. Indeed, in one case where the individual clearly had no recourse to public funds,

[44] Section 42, Care Act 2014.

the combined chronology provides no evidence of a Human Rights Act 1998 assessment. It is relevant to note here that a Human Rights Act 1998 assessment may be required to determine whether support is necessary to prevent a breach of their human rights, especially the right to live free of inhuman and degrading treatment (Article 3, European Convention on Human Rights). In the context of homelessness, this might require consideration of whether the decision to withhold accommodation-based support or health care would result in actual bodily harm or intense mental suffering and physical harm[45]. Improving confidence in professional decision making, however, was recognised by some participants.

7.9 Recording. Operational staff attending the learning event indicated that recording systems currently in use did not facilitate access to a chronology or history of a case. Equally, agencies using their individual systems does not facilitate information-sharing.

[45] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.

8. Organisations around the Team

8.1. Oxfordshire County Council is a two-tier authority. There are five district councils. In the learning event with commissioners and senior strategic managers, there were references to the complex dynamics between Oxford City Council and Oxfordshire County Council, and between all the District Councils and the County Council with respect to ownership of 'homelessness' as a shared responsibility. Observations such as "a whole system is not in place" and "cohesiveness is not there" capture the concerns about the absence of, and need for, a county-wide strategy. There had been, it was suggested, a history of fragmentation and retrenchment.

8.2. It was suggested that the County Council had pulled back from being the principal commissioner of supported housing, and from its statutory responsibilities regarding homelessness, and that a joint pooled budget was needed involving not just the councils but also the clinical commissioning group. This suggestion was accompanied by a plea for greater integration and strategic leadership.

8.3. Operational staff in their learning event also observed that strategically organisations needed to "buy into a model". It was observed that the priorities for housing, adult social care and health were, currently, all different. There was an absence of strategic agreement. These observations mirror the evidence-base regarding strategic leadership and agreements (section 5.6.1). Research[46] has also highlighted the importance of local leadership modeling positive relationships and effective partnership working. OSAB has a statutory mandate for holding senior leaders to account for how they propose to improve the health, social wellbeing and housing situation of people experiencing multiple exclusion homelessness.

8.4. The evidence-base also refers to commissioning issues (section 5.5.3). Here too the learning event with commissioners and strategic managers was critically reflective. Thus, access to dual diagnosis provision and to mental health services for people in the homeless pathway were described as "very difficult". Although a homeless pathway exists, it was unclear whether there was agreement about which agencies were responsible for commissioning aspects of the provision. It was suggested that the focus had been on service provision at the point of crisis and that there was a need to focus more on services to achieve and maintain recovery. Further there were concerns regarding the way in which services were commissioned, which was that they were often time limited. OSAB has a statutory mandate to seek reassurance that, in order to prevent and to safeguard people from abuse and neglect, commissioners are responding effectively to meeting the needs of people experiencing homelessness. Research[47] strongly

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[46] 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: King's Fund.

[47] 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: King's Fund. Weal, R. (2020) *Knocked*

recommends new commissioning approaches that deliver integrated provision and a greater number of specialist multi-disciplinary services.

8.4.1. The appropriateness of a review of what services are being commissioned emerges also from the interviews with relatives. Adult U's sister was clear that persistence would have been necessary because Adult U was disinclined to seek support. The father of Adult P related how his son would sometimes call him in the middle of the night asking for help but there seemed to be no duty support arrangements. He said that it would have been helpful to know where to refer him to for some local help – someone on the end of a phone. What the relatives are pointing to and reinforcing is the need to ensure that there are flexible and proactive approaches to support and outreach for people who misuse substances and/or are homeless.

8.5. As often in appreciative inquiries into service provision, there was recognition of the increasing levels of need and complexity being managed by statutory and third sector agencies, where staff may not have the skills to support people, alongside concerns about the quality of supported accommodation, staff turnover, and gaps in data about people who are either street homeless or living in supported accommodation. Concern about the quality of accommodation also emerged from the case narratives, with past experiences of hostel and temporary accommodation sometimes acting as a deterrent for individuals wanting some form of housing. There were concerns about flooding adult safeguarding services with referrals. This concern has also been reported in research studies[48]. Housing provision with the right support was described as 'variable', for example shortages of resources with 24 hour staffing for people under 65, or 'wrap around' support was identified. A shortage of resources also emerged from some of the case narratives, especially regarding accommodation options and the use of "sit up" provision.

8.6. Operational staff who attended a learning event bemoaned the dismantling of the Supporting People programme, reporting its negative impact with loss of provision and increased silo working. Research supports this reported experience. Reducing support for people to help them maintain tenancies[49] and changes in Housing Benefit have rendered some people homeless[50]. They reported gaps in service provision, for example the lack of emergency beds for people who are homeless, resulting in hospital discharge to no

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Back: How a Failure to Support people Sleeping Rough with Drug and Alcohol Problems is Costing Lives. London: St Mungo's.

[48] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.

[49] Pleace, N. (2013) Measuring the Impact of Supporting People: A Scoping Review. Cardiff: Welsh Assembly Government

[50] The Impact of Welfare Reform on Homelessness in London. Undated report, accessed 23rd August 2020 at https://www.london.gov.uk

fixed abode. They suggested that it was not just accommodation of different types that was required but also wrap-around integrated support provision.

8.7. Workforce and workplace development are other components of this part of the evidence-base (section 5.5.5). At the learning event with commissioners and strategic managers it was suggested that staff in some sectors lacked confidence in presenting assessments of need to statutory services and did not necessarily understand the criteria for accessing provision and triggering statutory duties. Participants also recognised that much, perhaps too much, was expected from staff across the statutory and third sectors in relation to skilled assessments of people with complex needs and co-morbidities. There was reference to a design fault in the system, namely front-line staff often being the least experienced and lowest paid members of the workforce. These observations were echoed in the operational staff learning event, namely expecting staff, often with limited training, to deliver very specialist services.

8.7.1. Operational staff attending a learning event also referred to workforce development, particularly training to develop assessment skills and also appreciation of agencies' roles and responsibilities which, they felt, would increase the confidence of staff in the third sector, especially to challenge decisions taken by statutory services. There were references to the need to improve levels of staff competence and salary at the learning event.

8.7.2. Those commissioners and senior managers at the afternoon workshop also appreciated that the emotional impact on staff of working with people experiencing multiple exclusion homelessness could be significant and that there was a need to support practitioners (section 5.5.1 of the evidence-base) and improve their status.

8.8. The evidence-base also advises use of risk assessment templates (section 5.5.4). Senior managers and commissioners suggested that, whilst risk assessment tools were available, they were not being used and there was no standardisation of risks. They advised that risk assessment tools should be revisited, publicised and promoted, especially as there appeared in their view to be differences of understanding regarding "vulnerability", as they do not appear to be used consistently. Operational staff also commented on the lack of standardised risk assessment and risk management plans and approaches.

9. Governance

9.1. Operational staff suggested that OSAB should take the lead in setting standards for commissioning, service provision and practice with respect to people who experience multiple exclusion homelessness. Commissioners and senior managers also observed that leadership was required at all levels, including from OSAB which should be using its statutory mandate[51] to hold District Councils and the County Council to account for how adults experiencing multiple exclusion homelessness are safeguarded. The OSAB could also seek to influence the culture of the multi-agency partnership towards more of a "no wrong door" approach since they perceived that multiple exclusion homelessness was not uniformly seen as an adult safeguarding issue and as "everyone's responsibility".

9.2. Getting the governance right is important. Clearly the SAB holds the statutory mandate for governance of adult safeguarding. However, there is no one model for where governance of multiple exclusion homelessness might reside – the SAB, Health and Wellbeing Board, countywide Community Safety Partnership group or Homelessness Reduction Board may all be appropriate choices for 'holding the ring', for providing strategic leadership and holding partners to account. What works may vary depending on local government structures. Thus, a governance conversation is needed, inclusive of elected members, partnership and board chairs and strategic leaders, where agreement is reached on a common and shared vision, alongside roles and responsibilities for assuring the quality of policies, procedures and practice. Whatever governance arrangements are agreed locally, they must be able to hold relevant organisations and system leaders to account for delivering strategic objectives and service improvement[52]. The OSAB should initiate that governance conversation.

9.2.1. It has been suggested to the independent reviewers that hitherto no-one (partnership/body) in Oxfordshire has taken responsibility for homelessness in terms of governance and strategic oversight. What would be unacceptable would be for such a position to continue. As has been expressed to the independent reviewers, "if not OSAB, then who?" That question must be answered.

9.3. This thematic review has been commissioned by OSAB using its mandate in Section 44 Care Act 2014.The OSAB with its partner agencies should now consider its approach to reviews of cases involving people experiencing homelessness, especially those that appear not to meet the criteria for a mandatory review under Section 44. Haringey SAB has

[51] Section 43, Care Act 2014.
[52] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.

supported the development of homelessness fatality reviews.[53] As with SARs the focus is on implementing learning, for example on making safeguarding pathways and high risk panels more accessible, and providing staff development opportunities on safeguarding and relevant law. As with SARs, fatality reviews remind managers and practitioners of the importance of relationships in people's lives and also of the impact on staff of fatalities, whether or not they were directly involved in the case. This would be one response to the call[54] for a review of every death of an individual while sleeping rough or in emergency accommodation.

9.4. Recommendations (sections 12.1.1 and 12.1.4) reflect the observations on governance and OSAB's statutory responsibilities referred to above.

[53] Presentation by Gill Taylor (2019) Homelessness Fatality Review. Reported in Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness. A Briefing on Positive Practice. London: LGA and ADASS.
[54] Weal, R. (2020) *Knocked Back: How a Failure to Support people Sleeping Rough with Drug and Alcohol Problems is Costing Lives*. London: St Mungo's.

10. Connecting Learning - Other Safeguarding Adult Reviews

10.1. There are clear parallels between the findings of this thematic review and learning available from SARs commissioned and completed by other SABs. It is incumbent on all SABs to learn and to implement in policy and practice the lessons gleaned from reviews, irrespective of by whom they have been commissioned. This is central to each SAB's statutory mandate to oversee and hold partners to account for the quality, responsiveness and effectiveness of adult safeguarding services.

10.2. There are three women whose cases have been included in this thematic review. In one analysis of SARs[55] only one case involved a woman, who was in a permanent tenancy at the time of her death but who had experienced homelessness alongside physical and mental ill-health. Another review[56] of a woman with experience of homelessness, domestic abuse and substance misuse expresses concern regarding decisions by Adult Social Care not to assess for care and support needs, and not to invoke safeguarding procedures to facilitate multi-agency risk and safety planning. It criticises too the absence of psychological support or rehabilitation to address her mental health needs because she was not drug free. It concludes with recommendations that focus on information-sharing, use of multi-agency meetings and high risk panels, support for victims of domestic abuse, safety plans for high risk cases and provision of supported accommodation for people who want to recover from substance misuse.

10.3. Another thematic review[57] focused on two women who experienced multiple exclusion homeless. It found that repetitive patterns of behaviour were not addressed and thorough mental capacity assessments, including of executive decision-making, were missing. Substance misuse was not recognised as a form of self-neglect and the drivers of alcohol and/or drug use were not appreciated. There was an absence of case coordination and of multi-agency meetings, and there were gaps in provision and wrap-around support. There appeared to be difficulties accessing personalised support through Adult Social Care and the interface between use of the Care Act 2014 and housing legislation appeared tenuous. There appeared to be need for a clearer homeless pathway from secondary care settings. This thematic review concluded with recommendations for developing and using a self-neglect procedure, and a clear pathway for multi-agency risk management meetings. Guidance was recommended for effective practice with people experiencing multiple exclusion homelessness, including access to mental health provision and trauma-informed practice. Similar themes will be explored in this thematic review.

10.4. Research[58] has found that the causes of homelessness are multi-faceted and impact differently on men and women. Routes into homelessness can have a gendered

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[55] 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.

[56] Bexley Safeguarding Adults Board (2019) *AB: Safeguarding Adult Review*.

[57] Tower Hamlets Safeguarding Adults Board (2020) Ms H and Ms I: Thematic Safeguarding Adults Review.

[58] Cameron, A., Abrahams, H., Morgan, K., Williamson, E. and Henry, L. (2016) 'From pillar to post: homeless women's experiences of social care.' *Health and Social Care in the Community*, 24 93), 345-352.

dimension, founded in abuse and violence in close relationships. Support is often fragmented, available across separate agencies, with budget cuts intensifying this picture. The research has found positive appreciation of keyworker and women only provision but frustration at having to engage with multiple services at the same time and with provision that was not personalised to their needs. Adverse childhood experiences have resulted in women who are homeless experiencing a complex range of social and health needs and their situation exposes them to risk of further abuse.

10.5. A thematic analysis of SARs where alcohol abuse was significant[59] has clear resonance for OSAB and its partners. That analysis concluded that alcohol abuse was poorly managed. Those people who were dependent on alcohol had complex needs, which included mental health problems, chronic physical conditions, self-neglect and past trauma. They were at significant risk of exploitation by others and, when not homeless, were often living in unfit conditions. Assertive outreach services were often not available but were essential for people who were lacking motivation and/or whose chaotic lives meant that they found it difficult to respond to the expectations of services. The analysis observed that services were often failing to cope with that complexity, with disputes about how to ensure that services engaged with someone's co-morbidities rather than passing the buck.

[59] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017*. London: Alcohol Change UK.

11. Revisiting the Terms of Reference

11.1. Policies pursued by central government have clearly made the challenge of ending rough sleeping more difficult. Two, in particular, were raised in the meetings with operational staff and strategic managers. Firstly, concerns were expressed regarding the lack of regulation of housing support services leading to variable quality and practice. Poor quality hostels, 'unsafe' and 'dirty', were cited as a factor affecting people moving into them. Secondly, a further theme that emerged from the chronologies and workshops was how EU nationals and other people who have no recourse to public funds were 'falling through the net'. It was suggested that there should be a clearer policy towards EU clients as the interpretation of 'local connection' was described as 'discriminatory.'

11.2. Other SARs, including thematic reviews of people experiencing multiple exclusion homelessness[60], have pinpointed policies on universal credit, financial austerity and social housing as having a negative impact on the ability of local authorities and their partner agencies to combat homelessness.

11.2.1. The father of Adult P was firm in his view that his son had been coping well in a one bedroom flat on Housing Benefit (HB) after losing his job when the HB changes came in regarding single people (support threshold move from 25 to 35 years). This policy change is what made him homeless and he started sleeping rough in Oxford.

11.3. The same reviews have also suggested that consideration should be given to the creation of civil containment powers where a person has lost capacity due to substance misuse and addiction, with their self-determination compromised due to behavioural compulsion, in order to promote their wellbeing and future autonomy. The argument for such powers rests on the basis that the Mental Health Act 1983 and Mental Health Act 2007 explicitly exclude dependence on alcohol and/or drugs as disorders or disabilities of mind for the purposes of that legislation. The Acts cannot be used simply because an individual has an addiction.

11.4. A similar critique has been offered in an Oxfordshire public health research report[61]. Acknowledging that prevention is a broad and complex issue, it observes that it is shaped particularly by the availability of appropriate affordable housing, the unequal distribution of wealth, the strength of communities and the accessibility of appropriate services.

11.5. Clearly what SABs can accomplish locally with respect to counteracting

[60] Tower Hamlets SAB (2020) *Thematic Review: Ms H and Ms I.* Manchester SAB (2020) *Thematic Review: Homelessness.*

[61] Ghinai, I. (2019) *A Health Needs Assessment of the Adult Street Homeless Population in Oxfordshire*. Oxfordshire County Council.

multiple exclusion homelessness will be impacted by central government policies. Thus, OSAB may choose to join with other SABs in making the case for more integrated policy-making across relevant government departments. As recent research[62] has recommended, relevant government departments need to build positive examples of cross-departmental working, and to ensure that funding is increased for public health and specifically for drug and alcohol services[63].

11.6. Findings with respect to the terms of reference for this thematic review are now summarised below.

11.6.1. Work with adults who self-neglect – the OSAB has published policies and procedures relating to self-neglect but these are not fully embedded in practice and do not refer to people experiencing multiple exclusion homelessness.

11.6.2. Responses to adults with multiple needs – increasingly, as exemplified by the nine narratives within this thematic review, adults are presenting with a complex set of needs. Commissioners and providers could usefully engage in continuing conversations to identify gaps in provision and to address barriers that obstruct integrated care.

11.6.2.1. An Oxfordshire public health research report offers similar conclusions[64]. For example, it observes that services for people with very complicated needs are concentrated mainly in Oxford City and recommends that commissioners aim to build provision elsewhere.

11.6.3. Responses when adults are homeless – the OSAB might work with partner agencies and other partnership bodies to encapsulate how in Oxfordshire the evidence base for positive practice, as identified in this thematic review, will be implemented. In order for a homelessness pathway to be fully effective, partner agencies need to work together to identify current facilitators and barriers with respect to implementing the evidence-base. Where barriers are found, an action plan is indicated to address them. Barriers may include how complex co-morbidities are understood and managed currently; an absence of an integrated housing, health and care response to need; inflexible referral criteria and thresholds for services, and resource shortfalls and gaps.

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[62] 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: King's Fund.
[63] Weal, R. (2020) *Knocked Back: How a Failure to Support people Sleeping Rough with Drug and Alcohol Problems is Costing Lives*. London: St Mungo's.
[64] Ghinai, I. (2019) *A Health Needs Assessment of the Adult Street Homeless Population in Oxfordshire*. Oxfordshire County Council.

11.6.3.1. A similar conclusion was reached in an Oxfordshire public health research report[65]. It found some positive practice when reviewing services to meet the health needs of people experiencing homelessness in Oxfordshire, citing particularly provision for people with substance misuse issues, primary care in Oxford City and secondary care in Oxfordshire's largest hospital. However, it observed that data was patchy, with shortcomings therefore in evidence-based policy development.

11.6.4. Assessment of mental capacity – the impact of trauma and adverse (childhood) experiences, and of prolonged substance misuse, on mental capacity, and especially executive decision-making, needs to be better understood in order to effectively safeguard people who experience multiple exclusion homelessness.

11.6.5. Assessment of risks – OSAB with partner agencies could draw on risk assessment templates to help practitioners identify and manage the likelihood and significance of different risks associated with self-neglect and multiple exclusion homelessness.

11.6.6. Assessment of care and support needs – the duties and powers in the Care Act 2014 need to be considered with respect to individuals who self-neglect and/or experience multiple exclusion homelessness.

11.6.7. Partnership and collaborative working – there is evidence of effective liaison in some cases but it is variable rather than fully embedded. Further work is necessary to embed multi-agency risk management meetings in everyday practice alongside integrated commissioning, confident information-sharing and collaborative problem-solving. At a strategic level, joint and collaborative leadership, including County and District Councils, could be enhanced.

11.6.7.1. A public health research report for Oxfordshire[66] also concluded that there was room for improvement in partnership working. It comments approvingly on examples of collaboration between GPs and street outreach practitioners and between substance misuse and mental health workers but concluded that an enhanced level of multi-disciplinary working was required and specifically recommended the use of multi-disciplinary

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[65] Ghinai, I. (2019) *A Health Needs Assessment of the Adult Street Homeless Population in Oxfordshire*. Oxfordshire County Council.

[66] Ghinai, I. (2019) *A Health Needs Assessment of the Adult Street Homeless Population in Oxfordshire*. Oxfordshire County Council.

case conferences. As found in this thematic review also, it observed that people who were homeless were sometimes discharged from hospital before being linked into appropriate services and recommended greater partnership working between housing officers and clinicians.

11.6.8. Assessment of practice against the evidence-base – there is, as this thematic review has highlighted, an evidence-base for positive practice with respect to adults who self-neglect and/or experience multiple exclusion homelessness. Recent research[67] has captured this evidence succinctly in five shared principles – find and engage people, build and support the workforce to go beyond existing service limitations, prioritise relationships, tailor local responses to people sleeping rough and, finally, use the full power of commissioning. Practice and management of practice in the nine cases included in this review did not fully conform to all the components of the evidence-base.

11.6.8.1. Assessment of need and using commissioning to develop service provision also featured in an Oxfordshire public health research report[68]. In particular it cited three areas for improvement and made recommendations accordingly. Firstly, noting that services were insufficiently targeted at people with less severe mental illness, it recommended audit of provision followed by further commissioning of mental health provision. Secondly, it noted the particular health care needs of the increasing number of women experiencing homelessness, especially surrounding sexual and reproductive health, and recommended assessment of the needs of this group. Thirdly, it concluded that the pathway from rough sleeping, through hostel accommodation, to move-on accommodation was not suitable for everyone. It recommended that Housing First be included in the recommissioning of the adult homeless pathway.

[67] 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: King's Fund.
[68] Ghinai, I. (2019) *A Health Needs Assessment of the Adult Street Homeless Population in Oxfordshire*. Oxfordshire County Council.

12. Recommendations

12.1. Arising from the analysis undertaken within this review, the independent reviewers recommend that the Oxfordshire Safeguarding Adults Board:

12.1.1. Engages with the Health and Wellbeing Board, countywide Community Safety Partnership group, Countywide Homelessness Steering Group and local partnership arrangements for the safeguarding of children, to agree roles and responsibilities with respect to services for people experiencing multiple exclusion homelessness – undertakes to hold the 'governance conversation' (section 9.2).

12.1.2. Reviews its policy and procedure on self-neglect, with reference to people who experience multiple exclusion homelessness, and subsequently ensures that all agencies disseminate the requirements and expectations to all staff so that they are consistently followed across Oxfordshire (section 7.6).

12.1.3. Engages with partner agencies on developing policy and procedures for work with people experiencing multiple exclusion homelessness, to include arrangements for accessing the adult homelessness pathway (section 7.6).

12.1.4. Engages with the Health and Wellbeing Board, countywide Community Safety Partnership group, and partner agencies to consider the local process to be adopted for future reviews of cases involving the deaths of people experiencing multiple exclusion homelessness (section 9.3).

12.1.5. Maps current service provision for adults who self-neglect and/or have complex needs/or misuse substances and/or are homeless or threatened with homelessness and, at a summit with commissioners and providers, considers what refinements, resources and further developments are advisable in light of learning from this SAR in order to deliver an integrated and collaborative system for meeting people's complex needs (section 8.4). This summit should also review progress on the recommendations made in Oxfordshire's own health needs assessment of people experiencing street homelessness[69].

12.1.6. Maps current service provision for women who experience multiple exclusion homelessness, which includes domestic abuse, and reviews how children's services and adult services respond individually and work together in cases where child protection

[69] Ghinai, I. (2019) *A Health Needs Assessment of the Adult Street Homeless Population in Oxfordshire*. Oxfordshire County Council.

concerns are engaged alongside adult care and support needs and adult safeguarding (section 6.8).

12.1.7. Reviews multi-agency procedures for working with people who self-neglect to ensure that they include clear pathways for convening multi-agency panel meetings and for escalation of concerns, and arrangements for agreeing on lead agency and key worker to coordinate practice (sections 7.2 and 7.5).

12.1.8. Produces guidance and tools for assessing risk in respect of adults who self-neglect and/or experience multiple exclusion homelessness (section 6.3).

12.1.9. Monitor the outcomes of referrals for Safeguarding enquiries for those experiencing multiple-exclusion homelessness(section 7.7).

12.1.10. Promotes with partner agencies the development of trauma-informed practice and the assessment of mental capacity, with specific reference to executive decision-making (sections 6.4. and 6.7).

12.1.11. Seeks reassurance that discharge arrangements/transitions from prison or hospital settings conform to best practice guidance (section 6.9).

12.1.12. Seeks reassurance that people experiencing multiple exclusion homelessness are benefiting from an integrated approach to meeting their care and support, mental health, physical health, substance misuse and accommodation needs (sections 6.6 and 6.7).

12.1.13. Ensures the availability of procedures for responding to self-discharge and to patients/service users who do not engage or attend appointments in situations where risks are significant (section 6.2).

12.1.14. Promotes through the network of SAB independent chairs a "whole system" conversation, including with central government departments, about the learning from this thematic review and other SARs that have considered cases of people experiencing multiple exclusion homelessness (sections 10.1 and 10.2).

12.1.15. Audits progress on learning from this SAR after one year from publication, using the evidence-base in section 5 to identify and tackle where barriers and obstacles to effective practice and policy or management for practice remain.