THEMATIC SAFEGUARDING ADULTS REVIEW

Human stories featuring homelessness

JANUARY 15, 2025

SUNDERLAND SAFEGUARDING ADULTS BOARD
Independent Reviewer – Professor Michael Preston-Shoot

1.Introduction

1.1. This is a thematic safeguarding adult review (SAR). It has been commissioned to learn from how agencies worked with four homeless people in Sunderland who were clients of Sunderland City Council's Housing Options Team and who died. The themed review is in line with the action recommended in the joint ministerial letter to Safeguarding Adults Boards in May 2024, namely that consideration should be given to conducting safeguarding adult reviews where a person experiencing homelessness has died. The review is intended to build on the learning and outcomes of an earlier Sunderland Safeguarding Adults Board (SSAB) safeguarding adult review, Alan (2021), and to provide an opportunity to review how services work together and with individuals who experience homelessness alongside having physical and/or mental health concerns, and/or care and support needs.

1.2. The following overview issues were identified by SSAB:

- Homelessness issues and their impact on physical and mental health.
- Complex mental health & physical health issues where substance misuse is also a factor.
- Challenges associated with engaging with homeless individuals.

1.3. The following key lines of inquiry were specified:

- The actions that were taken by all agencies involved with the four individuals who died.
- The culture and knowledge in place in Sunderland to support homeless people who also may have a range of complex issues – this would include understanding of issues such as the effects of substance misuse and/or mental health issues on executive functioning and decision making, and whether any additional support or training for staff is needed in this area; the extent to which practitioners have a trauma-informed approach to their practice, and whether any additional support or training for staff is needed in this area.
- Whether different outcomes for the individuals could potentially have been achieved if services had responded or been configured in a different way.
- The learning that all agencies who support homeless people can take from these four cases, on a no-blame basis, to support better outcomes from other individuals who need these services in the future.

1.4. The services involved provided information and reflections relating to their involvement with one or more of the individuals whose human stories are the focus of the thematic review. A homelessness fatality desktop review had already been concluded for each of the four deaths, which occurred between 23rd December 2023 and 8th March 2024. This is good practice. All four individuals who died were male and White British. Two were found in their temporary accommodation, one died in hospital and one on the streets out of area. Two took overdoses, the person in hospital died of complications from COPD and the 4th, out of area, of cardiac arrest and possible overdose.

1.5. Teeswide SAB considered a SAR referral for the individual ("T") who died in their area. Having undertaken a full scoping exercise, the case was remitted for inclusion in this thematic review on the basis that services had been provided from Sunderland for this individual. The outcomes of this thematic review will be shared with Teeswide SAB. **Commentary**: the decision to remit the case to SSAB falls within the discretion given to SABs by the DHSC (2024) Care and Support Statutory Guidance. Ordinarily, the SAB responsible for conducting a review will be the Board in whose area the person died. However, there can be exceptions, as here, because of the location of service provision.

1.6. "A" was a 33-year-old white British heterosexual male with a family. His cause of death was a suspected drug overdose. Overdosing was a repetitive pattern. He had been placed out of area (Stockton) in temporary accommodation when there was nothing suitable and available in Sunderland at the time. As a result of his behaviour, he was subsequently placed in Sunderland. When the interim housing duty ended and he was declared to be intentionally homeless, he returned to the streets where he was found deceased (in Stockton). Overall, he made five homelessness applications since 2019, not all of which were in Sunderland. He was known to travel widely. He struggled to maintain tenancies and relationships. He had the following needs/issues: physical ill health/disability, history of mental health problems (anxiety, depression and suicidal ideation) drug dependency, alcohol dependency, offending history and anti-social behaviour. He also often alleged that he was at risk from others, but nothing was ever confirmed. He was, however, the victim of several assaults and had sustained a head injury. He had been identified as a perpetrator of domestic abuse.

1.7. "R" was a 46-year-old white British heterosexual male who was single. His cause of death was a suspected accidental drug overdose. He was placed in temporary accommodation in Sunderland. He had the following needs/issues: head injury, drug use (heroin x3 times per week, diazepam daily), mental health (depression, anxiety, and PTSD), physical health (mobility issues), offending and a history of rough sleeping. He had stated that he was fleeing violence but there was no proof of this. He had multiple hospital admissions as a result of overdoses, substance misuse issues and associated physical ill-health. There was a pattern of self-discharge against medical advice. It was never formally verified that he had a local connection to Sunderland.

1.8. "S" was a 58-year-old white British heterosexual male who was single. His cause of death was heart failure and exacerbation of COPD. He died in hospital. He had been placed in temporary accommodation in Sunderland that was part of the supported accommodation offer in the Rough Sleeper Accommodation Programme. He had the following needs/issues: long-standing mental health issues and a formal diagnosis of paranoid schizophrenia. His long-standing physical health issues were cirrhosis of the liver, diabetes, fractured back and blood clots on the lungs. He had been known to mental health services from the age of 21. He was described as alcohol and drug-dependent. He might have been a victim of cuckooing. He reported harassment and was known to have experienced falls. This case was scoped in March 2024 by SSAB as a possible SAR and was determined not to meet the mandatory SAR criteria (section 44 (1) (2) (3) Care Act 2014).

1.9. "T" was a 43-year-old white British heterosexual male who was single. His cause of death was a suspected drug overdose. He was placed in emergency accommodation (hotel) in Stockton as there was no suitable temporary accommodation available in Sunderland at the time. According to a homelessness fatality review he had the following needs/issues: physical ill health / disability, mental health, learning disability, perpetrator of domestic abuse, drug dependency, offending history, repeat homelessness and rough sleeping. However, he was not flagged in hospital records as having a learning disability. Rather, he was known to have learning difficulties and being unable to read or write. Some records contain references to COPD and also to various mental health diagnoses – emotionally unstable personality disorder, anti-social and sociopathic personality disorder, and bipolar disorder. There was no mental health referral when he was released from prison. He had made five homeless applications since 2019, four of which were made on release from custody. He was a victim of assaults and he had also breached a restraining order. As a child he had been in children's homes.

1.10. In summary, from these outline pen pictures, all four men had longstanding challenges involving mental health, physical health and substance misuse. Their patterns of engagement with services and acceptance/refusal of support oscillated. On occasions, some were evicted from temporary accommodation because of their behaviour. The similarity with SAR Alan is immediately obvious. Alan died aged 53. He was homeless, he engaged in substance (alcohol and drug) misuse, and he experienced physical and mental concerns, including possible acquired brain injury. He could be disruptive and aggressive, especially when intoxicated. In common with some of the four individuals whose human stories feature in this thematic review, there were incidents of overdoses and suicidal ideation. His engagement with services was sporadic. He was susceptible to exploitation.

1.11. Common across all five human stories is the experience of multiple exclusion homelessness[1]. This comprises extreme marginalisation that may include childhood trauma (abuse and neglect, domestic violence, poverty and/or parental mental illness or substance misuse), physical and mental ill-health, substance misuse, learning disabilities and/or cognitive impairments, and experiences of institutional care. For many of those who are street sleeping, living in insecure accommodation, or experiencing difficulties maintaining a habitable environment, this 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. They might experience difficulty keeping to scheduled appointments, such that assertive outreach is a recommended approach.

1.12. Where next of kin or other relatives could be identified from agency records, SSAB wrote to invite them to contribute to the review. At the time of writing this report, no family member has responded to the invitation.

1.13. A well-attended learning event was held at which practitioners and managers reflected on the learning from how services had collaborated together and worked with the four individuals.

[1] Fitzpatrick, S, Bramley, G & Johnsen, S 2013, 'Pathways into multiple exclusion homelessness in seven UK cities', Urban Studies, vol. 50, no. 1, pp. 148-168.

There was an opportunity to reflect also on what had changed as a result of recommendations in SAR Alan, and what more might be done in the name of service development and practice improvement.

1.14. In April 2024 a report for Health, Housing and Communities on deaths in temporary accommodation outlined the role of the homelessness service in providing temporary accommodation and assistance until individuals can secure permanent or longer-term accommodation. The service is responding to the complex and multi-layered needs presented by many people experiencing homelessness via the introduction of interventions such as a health navigator, an Out of Hours Service, an officer in the hospital and a new Homeless Hub.

1.15. Reflecting on the four deaths that feature in this review, the report identifies that the most successful placements of people in temporary accommodation[2] in Sunderland are where arrangements are assessed to ensure offers are fit for both the client and the accommodation provider. The service is moving away from unsupported temporary accommodation in favour of accommodation with 24/7 support. The report identifies that this transition is slow due to funding constraints and the tendering process to secure provision. The report also identifies the need for additional temporary accommodation units and for enhanced efforts to engage with people experiencing homelessness.

1.16. **Commentary**: a joint ministerial letter (2024) from DHSC and DLUHC to local authorities and to Safeguarding Adults Boards (SABs) advises that Boards should have a named member responsible for homelessness and that annual reports and strategic plans should include a focus on rough sleeping and homelessness. At the learning event it became clear that SSAB is already responding to the joint ministerial letter. **Recommendation One**: part of the response to the joint ministerial letter should include SSAB having a line of sight on the development of the homelessness service and especially the transition to temporary accommodation with wrap-around support.

[2] 1200 placements in temporary accommodation occur annually.

2. Key Line of Enquiry: The systems and approach in place in Sunderland to support homeless people who also have a range of complex physical health, mental health and substance misuse/addiction issues

2.1. SAR Alan observed that some services made significant efforts to help him. However, the review concluded that responses overall were not persistent, consistent, or sufficiently coordinated, were episodic rather than organised, reactive as opposed to assertive, with no multi-agency discussion or management. There had been a need for assertive outreach and effective care planning. He had limited coping skills and poor self-management. **Commentary**: the thematic analysis that follows enables comparisons and contrasts to be drawn, mindful of the implementation of recommendations from SAR Alan.

2.2. All four men had experienced longstanding mental health, physical health and substance misuse challenges. Once again, submitted documentation provides evidence of efforts to meet their needs and to minimize risk. The presence and use of in-reach alcohol care practitioners and psychiatric liaison practitioners, and a recovery navigator, was particularly evident. "A" was referred by the Housing Options Teams (HOT) to Adult Social Care (ASC), with "A" having indicated that he needed emotional support and prompts regarding medication and activities of daily living. When he threatened to take his own life, the police were informed for the purpose of a welfare check. When he was mentally distressed, HOT staff "*calmed him down*." HOT staff also shared concerns with Change Grow Live (CGL/Wear Recovery) when he was at risk of eviction from temporary accommodation because of his alcohol and drug-dependence. When in hospital, he was seen by the Psychiatric Liaison Team (PLT). On at least one occasion, his need for accommodation was discussed at the MASH. Police officers took him to A&E when he was making suicidal threats. **Commentary**: it is not uncommon for individuals expressing suicidal ideation to be taken to A&E departments. This can be followed by long waiting times, especially for a mental health bed.

2.3. In primary care records there is evidence of discussion between a GP and Pharmacist with the aim of carefully managing "R's" use of opioids. Primary care staff actively attempted to follow-up his non-attendance at a hospital appointment and, in a new patient appointment, completed a controlled drug medication review and discussed management options for his drug-dependence. When in hospital following drug overdoses, he was reviewed by the substance misuse team and when appropriate also by the PLT. On one occasion, staff at South Tyneside and Sunderland NHS Foundation Trust (STSFT) had enabled "R" to remain in hospital whilst a solution to his homelessness was sought. There were other attempts also by PLT and STSFT practitioners to arrange housing via a co-located housing officer. This appears to have been successful in February 2024, shortly before "R" died. STSFT referred "R" to Wear Recovery, the local authority, needle exchange and housing. CGL practitioners were sometimes successful in discussing risks with "R" and completing medical reviews. CGL/Wear Recovery also liaised with "R's" GP and HOT. A recovery navigator had a good rapport with "R." A Wear Recovery housing support worker liaised with housing support services.

2.4. Documentary evidence for "S" is noteworthy for the completion of a Section 9 (Care Act 2014) care and support needs assessment, which resulted in the provision of mobility aids, support from Oasis Community Housing, including provision of advice about mental health and engagement with a focus on maintaining his tenancy and keeping appointments, and the convening of several multi-disciplinary team meetings and multi-agency meetings. There is also some evidence of joint visiting (an occupational therapist and clinical support worker, for example) and referrals to HOT, ASC and Wear Recovery. He was rehoused following safeguarding concerns regarding exploitation (cuckooing). Occupational therapy equipment was provided to support "S" to live independently. Safeguarding concerns were referred by the police and by his support worker.

2.5. "T" was known to substance misuse and mental health services, HOT and probation. A health navigator provided support to enable "T" to keep appointments. HOT attempted to meet his need for accommodation. His GP carefully controlled prescriptions for anti-psychotic medication due to suicide risk. Taxi transport was sometimes arranged to ensure that "T" kept appointments with doctors and the Department for Work and Pensions (DWP).

2.6. At the learning event there were positive comments about communication with local pharmacies and about co-location of some services, for instance within a homeless drop-in provision, and link workers across CGL and housing. The Complex Adults Risk Management (CARM) approach had been experienced as useful, with some positive outcomes achieved. Those attending were able to think of cases where joint meetings had been held and where services worked effectively together. It was felt that the MASH was working effectively.

2.7. However, those attending the learning event also identified concerns about current systems and practice. Chief amongst these concerns was the shortage of appropriate accommodation and the availability of, or people's access to wrap-around support, especially when placed at some distance from Sunderland. Views were also expressed that housing was seen as the answer, with the onus then being placed on HOT, with insufficient focus on providing wrap-around support. When forms of accommodation were provided, the presence of other individuals misusing alcohol or other drugs could destabilise a person's placement and recovery. **Commentary**: other SARs[3] have also highlighted that placements in hotels, hostels and other types of temporary accommodation can sometimes undermine an accommodation and safeguarding plan, especially where floating or accommodation-based support is not available.

2.8. Although improvement in joint working and information-sharing was reported at the learning event, there was a recognition of "*more to do*." For example, there remained instances of a revolving door between mental health and substance misuse services, an either/or rather than both/and approach. Co-location or the use of link workers was not comprehensive. ASC does not yet have a presence in the homeless drop-in. Sunderland's MASH has adopted a multi-agency model but some services, such as housing, could be considered for inclusion in order to ensure a whole system response. It was felt that greater use could be made of multidisciplinary and multi-agency meetings, which would also help to promote awareness of the roles and responsibilities

[3] For example, Manchester Safeguarding Partnership (2020) Homelessness Thematic Review.

of different services and where flexibility in approach was possible. There was a request for examples of effective use of multidisciplinary and multi-agency meetings, expressed alongside concern that not every service might feel confident in convening and leading such meetings. It would help if it was clearer whose role it was to convene such meetings, and from whom agencies could seek advice, particularly for cases that did not meet the criteria for CARM and/or Section 42 enquiries[4]. A question asked was whether the threshold was set too high for referral to CARM. Concerns were also voiced that practitioners might be uncertain about what pathway to use for referrals, namely adult safeguarding via Section 42 (Care Act 2014), MASH[5] and/or CARM. Practitioners felt that they would benefit from the use of case studies and feedback on which pathway to use.

2.9. **Commentary**: the development of CARM has been one outcome of the recommendations in SAR Alan. Based on available documentary evidence and feedback at the learning event, the procedure might not yet be fully embedded in practice. The CARM process has recently been evaluated[6], concluding with a series of recommendations. A subsequent report to the Quality Assurance Sub Committee[7] has set out the positive actions taken in response to the recommendations. **Recommendation Two**: SSAB should continue to explore and evaluate the interface between CARM, MASH and safeguarding enquiries, to ensure pathways for each process are clear, and that the Safeguarding Adults Team and MASH direct referrers on to other suitable pathways where their criteria or thresholds are not met.

2.10. Funding constraints and uncertainties were also highlighted, namely short-term projects when what was required was a longer-term approach that would enable individuals to build up trust in service provision. Outreach being short-lived was an example given. The importance of assertive outreach was emphasised as needed but was not always available. The impact of financial austerity on statutory and third sector services reinforced the argument for a multi-agency partnership approach.

2.11. **Commentary**: what is striking in these four human stories but not unusual is the overlap and complexity of multiple physical health issues alongside substance misuse and mental distress. Variously these included mobility difficulties, fractures, head injury and falls, diabetes, cirrhosis, epilepsy and breathing difficulties. There are recorded instances of “A” and “R” reporting a lack of medication. “T” had been red carded because of his anti-social behaviour, which could mean that he was not offered non-urgent treatment. Documentary evidence demonstrates that “R” did receive annual health checks and medication reviews, with proactive follow-up attempts. Getting to appointments was sometimes challenging. To address comorbidities calls for liaison between secondary health care clinicians, and between secondary health care and primary care, as part of a whole system, whole person response. In response, some areas have commissioned a

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[4] It was suggested that the approach in children’s services might provide a model for a multi-agency response to the need to provide early help (prevention), support for adults in need, and planning for adults requiring safeguarding.

[5] MASH cases are 30 – 40 per day, mostly younger men with substance misuse & mental health issues.

[6] Ward, M. (2024) Sunderland Complex Adults Risk Management (CARM) Process.

[7] Sunderland Safeguarding Adults Board (2024) CARM Review Recommendations: Actions Response.

homeless health service, including health outreach, in-reach navigators and weekly case review meetings.

2.12. Those attending the learning event wondered whether resources were aligned to, and commissioned with an understanding of the demographic in Sunderland and hopes were pinned to a public health needs assessment that would map what was (not) available[8]. It was also acknowledged that, especially for services covering several local authority areas, practitioners such as paramedics might not know of all the services that were potentially available. **Commentary**: this and the preceding paragraphs highlight the importance of commissioners and providers holding routine discussions about where services are working well and where there are gaps in provision. **Recommendation Three**: SSAB should consider seeking assurance that there are regular meetings of health and social care commissioners and providers to review current provision and to devise and implement a strategy for service development.

2.13. One question asked was whether current policies were fit for purpose, for instance regarding transitional safeguarding and risks of homelessness and exploitation amongst care-experienced young adults. **Commentary**: the second national analysis of SARs[9] contains findings about good practice and shortcomings in transitional safeguarding. There is a detailed evidence-base for transitional safeguarding that SSAB could use for an appreciative enquiry into local procedures and provision[10]. However, there are also other drivers of homelessness, including physical disability, mental health and substance use, financial insecurity and domestic abuse. To ensure a whole system, whole person response to people experiencing homelessness, it would be timely to review all policies and procedures through the lens of homelessness and rough sleeping against the evidence-base from reviews. **Recommendation Four**: SSAB should continue the positive collaboration with the local safeguarding children partnership to ensure compliance with statutory guidance[11] on transitional safeguarding. SSAB should consider undertaking a review of all policies and procedures through the lens of homelessness.

2.14. Separate recording systems continue to be a barrier to information-sharing and collaborative working. Similarly, services had different parameters for information-sharing. **Commentary**: SSAB has embedded an information-sharing agreement within its multi-agency procedures. Feedback at the learning event might suggest that this is either not widely known and/or insufficiently robust to promote collaborative working.

2.15. The concerns expressed at the learning event underscore the findings from the documentary analysis. Documentary evidence only explicitly refers to multidisciplinary and multi-agency meetings in one case ("S"). The MASH did discuss "A" having received a referral about his suicidal

[8] Public Health have conducted a Drug and Alcohol Health Needs Analysis and their report will be presented to SSAB in March 2025. This looked at why people sometimes cannot engage. The report notes that their lived experience and views need to be captured and acted upon.

[9] Preston-Shoot, M., Braye, S., Doherty, C. and Stacey, H. with Spreadbury, K., Taylor, G., Hopkinson, P. and Rees, K. (2024) *Second National Analysis of SARs (2019-2023)*. London: Local Government Association and ADASS.

[10] 'Preston-Shoot, M., Cocker, C. and Cooper, A. (2022) Learning from safeguarding adult reviews about transitional safeguarding: building an evidence-base.' *Journal of Adult Protection*. 24 (2), 90-101.

[11] DHSC (2024) Care and Support Statutory Guidance.

ideation prompted by his housing circumstances. There was no reference to consideration of the use of the CARM process in any of the four cases. **Commentary**: the impression given is of some liaison and information-sharing rather than a whole system, whole person coordinated response to individuals with longstanding mental and physical ill-health, substance misuse and homelessness.

2.16. At the learning event some participants recounted difficulties in securing ASC support or assessment for individuals. They experienced the criteria for assessment as unclear, with some individuals refused as not meeting a threshold whilst others were accepted in seemingly similar situations.

2.17. Submitted documentation suggests that ASC had no contact with “R” but there appears to be evidence of care and support assessments in the other three cases. “T” was deemed not to have eligible needs but it is unclear whether this decision followed a detailed assessment.

2.18. “S” appears to have declined a care package on at least one occasion and, on another, to have declined to engage in a review of his needs. Documentary evidence reveals concerns about self-neglect, including poor personal care and an unkempt appearance. This did prompt liaison and information-sharing between health, social care and public protection services, including via MASH, but the main focus appears to have been on finding accommodation alongside concern for his safety. ASC did complete an assessment of his care and support needs and a referral was sent for an occupational therapy assessment. When he was not managing activities of daily living, aids were provided. Otherwise, reliance was placed on Oasis Community Housing providing tenancy support.

2.19. “A” participated in a telephone assessment, which covered telecare, his mental health (low mood and lack of motivation), alcohol-dependence, and what activities of daily living he could do or found difficult. Self-neglect is referenced in this context. However, no service was provided, it seems because he did not complete a self-assessment. ASC’s perspective appears to have been that his need for mainstream housing was the priority, with responsibility therefore resting with housing practitioners, rather than a “*both and*” accommodation and social care plan.

2.20. A view expressed at the learning event was that making safeguarding personal was not sufficiently embedded in practice for people who were not the subject of a Section 42 safeguarding enquiry. “*We don’t understand the lived experience voice*.” **Commentary**: wrap-around support would potentially facilitate the successful use of accommodation. The absence of care and support packages would appear to reinforce a concern expressed at the learning event, namely that homelessness was seen primarily as an issue of lack of accommodation. This calls into question whether there is sufficient understanding and collaboration around a housing first approach.

2.21. At the learning event it was noted that there will be a new assertive outreach team in ASC shortly, a development in response to the changing demographics in Sunderland which show many cases are now younger people with a range of complex substance misuse, homelessness, and mental health issues, as opposed to older people with physical care needs/frailty.

Commentary: this is a positive development. At the learning event it was suggested that this new model of assertive outreach should be replicated across other services also.

3. Culture and knowledge to support people experiencing homelessness

3.1. SAR Alan concluded that evidence of self-neglect did not generate referrals of adult safeguarding concerns or a safeguarding response. His mental capacity was not assessed, and his executive functioning did not appear to have been considered. With respect to both safeguarding and mental capacity, SAR Alan referred back to SSAB's SAR Eva (2018) and suggested that lessons had not been learned. It remained unclear what Alan wanted (making safeguarding personal). His pattern of behaviour was reflective of brain injury but there was insufficient curiosity about this. His human story contained recurrent overdoses, suicidal ideation, and relationship difficulties. SAR Alan recommended training on acquired brain injury and professional curiosity. **Commentary**: once again, the thematic analysis that follows enables comparisons and contrasts to be drawn, mindful of the implementation of recommendations from SAR Alan.

3.2. Some services submitted adult at risk notifications but some of the documentary evidence records "no safeguarding concerns." STSFT staff did not identify any safeguarding concerns regarding "A", for example when he had been admitted with serious injuries following assaults (twice) and when he self-discharged against medical advice. Nor did he disclose any safety or safeguarding concerns when asked. North East Ambulance Service (NEAS) have identified a missed opportunity to refer a safeguarding adult concern when he was taken to hospital with a head injury following an assault. The police have also recorded a missed opportunity to refer a safeguarding adult concern when "A" made allegations of having been raped. However, on at least five other occasions the police did refer concerns relating to "A's" need for support regarding his mental health, substance misuse and recent bereavement to both ASC, HOT and/or mental health services. The documentation does not indicate a safeguarding response to these referred concerns. Evidence of his self-neglect, known to several services, did not prompt safeguarding referrals or an enquiry.

3.3. STSFT did not identify any safeguarding concerns regarding "R" whilst he was an inpatient, even when he self-discharged, for example following admission for a heroin overdose and respiratory arrest, and again for admission following a mixed drug overdose. There were repetitive instances where safeguarding questions were asked but no concerns were identified. Nor did he disclose any concerns about his safety. NEAS made no safeguarding referrals despite "R's" homelessness, significant use of drugs and overdoses.

3.4. Some agency submissions record missed opportunities to refer adult safeguarding concerns, for example regarding "S" and evidence of exploitation, harassment and also self-neglect as a result of alcohol-dependence, struggles with activities of daily living and falls, which he did acknowledge. However, some practitioners (police and his support worker) did refer safeguarding concerns, which did result in multidisciplinary meeting discussions where the main focus appears to have been on securing accommodation where "S" would feel safe. STSFT staff asked safeguarding questions when "S" was admitted to hospital, although no concerns were identified. Nor did he disclose concerns. There is only documentary evidence in one case of a section 42 enquiry ("S"). His allocation to long-term accommodation with Oasis Community

Housing tenancy support appears to have been the reasoning behind concluding the safeguarding enquiry. He had been assessed as having low-medium support needs, with risks relating to mental health, physical health, substance misuse and vulnerability from other individuals. Mobility aids had been provided.

3.5. There is no reference in the documentation regarding "T" to safeguarding concerns or referrals. **Commentary**: the evidence that practitioners asked mandatory questions about safety and safeguarding was good practice. Often "A", "R" or "S" did not disclose concerns. Making Safeguarding Personal is a core principle in adult safeguarding. However, it is important to ensure that, alongside establishing an individual's wishes, feelings, perspectives and desired outcomes, practitioners feel confident to offer their observations and concerns as part of any conversation. The offer and provision of advocacy might be helpful in facilitating such a conversation. It is also important to recognize that the person's consent is not required for referral of an adult safeguarding concern, although it is desirable.

3.6. **Commentary**: all four men had care and support needs as defined by Care Act 2014 regulations, all four experienced abuse/neglect (including self-neglect), and at times were unable to protect themselves. A question for agencies at the learning event was whether multiple exclusion homelessness is seen as an adult safeguarding concern meriting referral and enquiry.

3.7. Some views were expressed at the learning event that referrals of adult safeguarding concerns had been rejected on the grounds of capacity and unwise decision-making. Other concerns included staff not having the knowledge and/or skills required regarding when to refer safeguarding concerns. Also, at the learning event it was suggested that the safeguarding adults threshold tool needs to reflect the complexities of this client group. **Commentary**: one outcome from SAR Alan has been increased resource for the safeguarding adults team. Nonetheless, it is important that SSAB is assured that homelessness is not just seen as a housing issue but rather as requiring a whole system, whole person response that includes planning to mitigate the risks of abuse and neglect. **Recommendation Five**: SSAB should consider seeking assurance from partners regarding communications and decision-making about referrals of adult safeguarding concerns in cases involving multiple exclusion homelessness and how services, especially ASC, are responding to referred concerns to ensure a whole system, whole person approach.

3.8. **Commentary**: recommendation five should be read alongside recommendation 2. Practitioners need to know which pathway to refer into – CARM, MASH and/or adult safeguarding (section 42 Care Act 2014) – having factored into decision-making the outcomes of mental capacity and risk assessments, the presence or otherwise of care and support needs, and observations from making safeguarding personal conversations.

3.9. Relationship breakdowns, bereavements and adverse childhood experiences were evident in documentation submitted by the services involved, for example with respect to "A" and "T". Suicidal ideation featured in at least three cases, sometimes being seen as an expression of frustration about homelessness rather than as evidence of mental illness. Questions asked at the learning event included whether services were configured for trauma-informed practice, for example through in-reach and assertive outreach, whether there was sufficient understanding

and knowledge of risk assessment and mitigation planning, especially where overdoses form a repetitive pattern, and whether sufficient emphasis was placed on relationship-building in order to build trust and to begin to respond to the person's backstory, the "*upstream*" triggers behind homelessness, mental distress and substance use.

3.10. A view was expressed at the learning event that staff might not be sufficiently attuned to the impact of trauma and adverse (childhood) experiences, might lack the skills to express concerned curiosity, and might therefore be focused on homelessness as opposed to the backstory and the triggers for homelessness. It was noted that some of the individuals whose human stories prompted this thematic review had been evicted from accommodation quite possibly because of the outcome of trauma. This reinforced the need for a multidisciplinary, multi-agency response. However, agencies tended to respond according to their own legislative duties. More positively, however, those attending the learning event were able to talk about cases where concerned curiosity had been expressed and where practice had been trauma-aware and trauma-informed.

3.11. **Commentary**: two observations in particular might be made from the submitted documentation. The first observation relates to curiosity about lack of engagement and refusal of support. Submitted documentation provides little if any insight into their oscillating engagement with services and does raise the question about whether services could have done more to seek to engage with them. One outcome from SAR Alan has been the development of SSAB's professional curiosity guidance. On the basis of the available documentary evidence a question arises as to whether this guidance has been embedded in practice.

3.12. "A" did not engage with mental health services when referred by ASC. He did not complete the assessment process with ASC, resulting in his case being closed. He missed many appointments with DWP. He self-discharged from STSFT against medical advice but conversely did attend some outpatient appointments. CGL have observed that "A's" engagement was limited. He declined to attend groups and sometimes fell out of contact. However, at other times he did undertake some motivational work and did accept some support. Outreach via the soup kitchen was successful at times with engaging "A".

3.13. "R" declined services and treatment when an inpatient and often self-discharged. For several years he was not engaged with services. He did engage with HOT staff who visited regularly and completed a housing application with him. There were occasions when he did not attend appointments with DWP or accept required claimant commitments. Mental health, physical health, drug misuse and mobility issues might all have impacted on his engagement and his lack of motivation but there does not seem to have been a plan to counteract this. However, he did engage with CGL, attending medial reviews, agreeing to being tested, and being open to discussion about his substance misuse, harm reduction, and protective factors in his life.

3.14. "S" declined to engage with CGL and was never open to structured treatment. He failed on occasions to engage with occupational therapists, and also refused a care package. It is not evident from the documentation that there was any exploration of, for example, his unwillingness to engage with addiction services. He often did not attend outpatient clinics and was discharged by the community matron service after several failed attempts to see him. There

were occasions when he declined referrals to a falls service or for telecare. However, his care coordinator was able to maintain regular contact with “S” regarding his mental health and he also did engage in monitoring of his physical health. **Commentary**: his known poor mobility might have provided one explanation for his non-attendance at appointments. Outreach and follow-up are good practice. The community matron was tenacious in rearranging appointments and did on occasions see “S” where he was living.

3.15. “T” was recorded as experiencing difficulty with engagement and making contact only at crisis points. There are reported occasions when he refused offers of accommodation and when he left health settings before being treated. There were occasions, however, when he was engaged with staff in temporary accommodation settings and by a health services navigator. The documentation provides very little insight into his backstory or glimpses into his lived experience of services.

3.16. **Commentary**: the second observation relates to advice-giving and signposting. Signposting alone, for example in situations involving self-neglect, is unlikely to be effective. The chronology from mental health services observes that “A” had not engaged with advice that had been given. He told CGL of his intention to self-refer for bereavement support but appears not to have done so before he died. “R” was “*strongly signposted*” to substance misuse services and also to housing when homeless. Advice was given about risks and harm minimization but it is less clear that he could act on that advice or use the protective factors that he had identified in his life (his mother and sisters). “S” was advised to engage with alcohol services and with practitioners who could assist in the search for suitable accommodation. “T” was given advice about services to approach for accommodation. There appear to have occasions when a referral under the Homelessness Reduction Act 2017 should have been submitted.

3.17. Documentary evidence recorded assumptions of capacity and missed opportunities to consider capacity in the face of evidence of self-neglect and dependence on alcohol and/or other drugs. Yet there is evidence of not carrying out stated intentions. In several cases there is evidence of concerns regarding brain injury. All four men had long histories of mental ill-health and dependence on alcohol and/or other drugs. There is no explicit reference to mental capacity in the documentation provided for service involvement with “A”, “S” or “T”. STSFT clinicians assessed “R” as having capacity in relation to declining community input after being seen by the alcohol liaison team when an inpatient, again when he refused naloxone, and again twice when he was advised of the risks of self-discharge following admission for a suspected drug overdose.

3.18. A question at the learning event, therefore, was whether mental capacity assessments were considered and whether they explored executive functioning and the possibility of executive dysfunction because of frontal lobe brain damage as a result of long-term dependence on alcohol and/or other drugs. Particularly in Emergency Departments and when other services are also responding to crisis scenarios when interventions are by their nature time-limited, there can be diagnostic issues with determining mental capacity and executive functioning. Practice guidance for staff, it was suggested, would be useful. **Recommendation Six**: SSAB should review available resources on mental capacity assessment, with a particular focus on executive

functioning, and consider whether further practice guidance should be produced and disseminated.

3.19. At the learning event participants felt that there was greater awareness of executive functioning but not everyone knew how to include it in mental capacity assessments[12]. A particular challenge was assessing mental capacity, including executive functioning, when individuals self-discharged, as happened with some of the individuals included in this thematic review. Training on executive functioning was requested. It also appeared that some services did not routinely undertake mental capacity assessments, expecting mental health or primary care practitioners to do this. **Commentary**: this is not necessarily a sound approach, if mindful of the decision that should form the focus of an assessment and a service with appropriate subject expertise and relationship with the person.

3.20. "A" experienced head injury and was known to and discharged from the Community Acquired Brain Injury Service (CABIS) after an opt-in letter had been sent. "T" was known to the brain injury service. "S" also experienced falls, commonly associated with alcohol-dependence. **Commentary**: outreach rather than opt-in letters is more likely to be helpful with respect to maintaining contact. Falls and acquired brain injury highlight the relevance of assessing executive functioning.

[12] Reference was made at the learning event to the Montreal Cognitive Assessment tool.

4. Further learning to support better outcomes

4.1. At the learning event observations were offered in the quest for better outcomes for people experiencing homelessness, in a context where positive work was also being achieved and/or underway.

4.2. In response to the joint ministerial letter on rough sleeping and homelessness, SSAB's strategic plan includes homelessness as a strategic priority. The Board has historically received regular updates from the Assistant Director Housing and Communities, Sunderland City Council, who attended meetings and reported on data and service matters and was open for challenge by the group[13]. Any partner issues will be raised through this process. Meetings are also attended by the Executive Director Health, Housing & Communities. **Commentary**: this commitment to implementing the recommendations in the joint ministerial letter, together with this thematic review, should enable SSAB to obtain assurance about the effectiveness of adult safeguarding with respect to people experiencing homelessness.

4.3. At the learning event it was suggested that a greater use of advocacy would have helped some individuals to engage. For example, this might have benefited "T" who is recorded as having learning difficulties and unable to read and write. He also experienced what were recorded as memory issues. Advocacy might also have benefited "S" who is recorded as having struggled to read and write. **Commentary**: SSAB could consider the frequency with which it requests assurance reports on the use of advocacy.

4.4. Considerable attention was paid to the enablers in place facilitating how services work together and to obstacles and barriers. BASIS was given as a good example of a service where a multi-agency approach is taken, where several services are co-located, with a drop-in model. It was observed that ASC does not yet have a presence there. NEAS representatives stated that agencies in Sunderland were amongst the best North East areas for picking up individuals experiencing homelessness and holding safeguarding meetings. The MASH in Sunderland, it was observed, was one of only two in the North East to have a multi-agency model.

4.5. The Links for Life Sunderland platform is now up and running and was highlighted as a useful source for where to access services and where to signpost people: Links for Life Sunderland | Links for Life Sunderland (Links for Life Sunderland - Helping people in Sunderland make Links for Life. Get information about your health and wellbeing, explore our community directory, and get help).

4.6. However, although it was felt that the MASH was working well, it was questioned whether it was truly as multi-agency as it could be. It was suggested that housing and health could be part of MASH, although a health navigator does attend, or at least additional information could be obtained through use of a proforma, as occurs in another North East MASH. Information-sharing was cited as an obstacle, with agencies holding different views about what should be shared.

[13] Now, updates are provided by the Senior Manager Homeless and Vulnerable People. The Director of Public Health also attends SSAB and speaks to this area of policy and practice.

CNTW staff have access to STSFT records. Doubt was expressed about whether information-sharing agreements are sufficiently robust and whether decision-making about information-sharing was fully recorded. Record systems are not interlinked. In that context it was suggested that Great North Care Record developments could help with information gathering. **Commentary**: this too is a topic on which SSAB could schedule regular assurance reports.

4.7. Suggestions were offered for further improvements to multi-agency collaboration. The Fire and Rescue Service observed that most people placed in short-term accommodation do not receive a home fire safety visit. Fire stations could also be "safe havens" but staff would need information about other services available and the skills to support individuals in crisis.

4.8. Some uncertainty was expressed about how to trigger a multidisciplinary meeting. This returns the discussion to the relative absence of multidisciplinary and multi-agency meetings within the four human stories that comprise this thematic review, and uncertainty about which pathways to use. **Commentary**: regional work has apparently begun on improving multidisciplinary team meetings as part of the transforming care (learning disabilities) agenda. The same principles could be used when thinking about homelessness.

4.9. Some concern was expressed regarding whether there is sufficient management oversight of complex and challenging cases, whether practitioners feel they have permission to move beyond their normal role and to "*think outside the box*," and whether sufficient support is offered to staff. Examples were given where each agency saw their role or responsibility narrowly through the prism of statutory duties, which acted as a barrier to a wrap-around, whole system whole person response. It could also further undermine rather than build trust with individuals, many of whom would have had negative prior experiences of statutory services. Outreach services were seen as one key to establishing levels of trust with people who might feel let down by services but available provision did not match the level of known need.

4.10. Three additional features concerning multi-agency collaboration emerge from the documentation submitted by the services involved. Firstly, both "A" and "T" had children. Records indicate that "A" was not allowed family time with his children and that he was a perpetrator of domestic abuse. "T" was also recorded as having twice breached a restraining order in the year before he died. **Commentary**: highlighted here is the positive collaboration that SSAB has established with Sunderland's community safety partnership and safeguarding children partnership, and the importance of ASC maintaining operationally a "*think family*" approach with children's social care.

4.11. Secondly, "R" had spent time in prison and was known to the probation service. His reported lack of motivation to comply with the terms of his probation was linked to his mental health, physical health and substance use. "T" also spent two periods in prison during the time covered by this thematic review and was homeless on release. Records show some liaison between ASC and HOT with probation. There is no record of a mental health referral from prison for "T". **Commentary**: both men did not have secure accommodation on release from prison. This highlights the importance of the duty to refer (Homelessness Reduction Act 2017). There is evidence that staff in STSFT complied with the duty to refer in respect of "R" and "S". Both men

would have been known to the prison service as having mental and physical health concerns, and a history of substance misuse. This highlights the importance of liaison between the prison service with health and social care in whose area the custodial institution is situated, to ensure that their health and social care needs are met on release, acknowledging that this might require transfer of information across geographical boundaries. The collaboration that probation officers can establish with health, housing and social care will be crucial in creating a wrap-around, whole system whole person response.

4.12. Thirdly, people experiencing homelessness do have family networks, however fractured. “A” and “T” are recorded as having wider family. “S” sometimes stayed with his mother. There is little sense from submitted documentation regarding whether information was sought from family members that might have helped practitioners to understand the backstory, and if there was any exploration of whether or not family members could contribute to a circle of support. **Commentary**: family members often hold useful information and might also be able to contribute in other ways. Family group conferences can sometimes prove useful in building a circle of support when individuals and their relatives voluntarily consent to work together with support from a coordinator[14].

4.13. More than a decade of austerity has impacted significantly on statutory and third sector resources. Nationally there has been a significant disinvestment in substance misuse treatment and recovery services[15]. The Black Report strongly recommends a whole system approach that provides people with somewhere to live and something meaningful to do. It recognises that addiction is a chronic health condition requiring long-term follow-up, and observes that prevention is ultimately more cost effective and that trauma and/or mental ill- health are drivers of much addiction, with the consequence that commissioners of substance misuse and secondary mental health services must ensure that individuals do not fall through the cracks.

4.14. The Kerslake Commission[16] also recommends a whole system approach, recognising that seeing homelessness as a public health rather than simply a housing issue leads to better partnership working, understanding and treatment. The report observes the importance of good quality accommodation, food and in-reach multi- agency services but criticises short-term funding. It recommends that government leads on provision of affordable housing, pathways beyond hostels, and welfare support. It too recommends reversal of disinvestment in substance misuse services and the removal of housing legislative rules on priority need, local connection and no recourse to public funds. The Commission also recommended extending the duty to refer (Homelessness Reduction Act 2017) to incorporate a duty on services to collaborate, building on the Everyone-In programme and retaining the welfare changes introduced at the outset of the

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[14] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness: A Briefing on Positive Practice. Local Government Association. See also Salford SAB (2019) SAR Andy.

[15] Black, C. (2021) *Review of Drugs, Part 2, Prevention, Treatment and Recovery*. London: The Stationery Office.

[16] McCulloch, L. with Cookson, E, Currie, H., Kulkarni, D., Orchard, B and Piggott, H. (2021) *The Kerslake Commission on Homelessness and Rough Sleeping: When We Work Together – Learning the Lessons. Interim Report*. London: St Mungo’s.

COVID pandemic, and reviewing law and policy concerning people with no recourse to public funds. Among the recommendations for local authorities and their partners are the development of integrated homelessness and health strategies, and long-term strategic planning for managing winter peaks.

4.15. Unsurprisingly, given this national context, the availability of resources was a theme at the learning event. Difficulties were reported in accessing suitable accommodation for individuals experiencing homelessness alongside complex substance misuse issues and mental health issues. The shortage of housing options was exacerbated by anti-social behaviour that resulted in "A" having to leave allocated temporary accommodation, and "R" returning to the streets because of violence and substance use in a hostel. Several of the four individuals had to be placed in hotels or hostels outside Sunderland because of the shortage of available accommodation which, despite the best efforts of housing and outreach practitioners, disrupted the provision of treatment and support.

4.16. Resources for "*out of hours*" provision and for anticipating and responding to Winter pressures were seen as challenging. Uncertain funding streams, it was emphasised, limited the transformation that would otherwise be possible. The transient nature of the workforce also presented challenges, with a suggestion at the learning event that knowledge of services and procedures required constant reinforcement.

4.17. A potentially helpful development was referenced at the learning event, namely "*Nap Pads*". These are a "*prefab*" sleeping pod with toilet and bed for short term use for homeless people to help the flow of people out of hospital. These will be put in the grounds of Swan Lodge (Salvation Army hostel premises). The Council's Housing Options Team will then visit people in the pods and offer help to move the person on to medium or long term accommodation.

4.18. The STSFT integrated discharge team has a homeless reduction officer co-located in the team and this was observed to be very valuable. However, there is only one person doing this role and when on leave/not at work, staff do not know who to contact. The local authority is looking at a second housing officer role, with a focus on the complex cases. It is also developing a standard operating procedure for when the existing homeless reduction officer is not available, so people know who to contact.

4.19. "*Hubs*" where health, housing, welfare benefit advice and social care services for people experiencing homelessness are co-located are one means of providing wrap-around support. When people experiencing homeless inevitably are transient, a hub offers a location where an individual can be found and progress potentially made with referrals and access to welfare benefits and other support. With access to provision often now being online, a hub is a space that can facilitate entry into systems of support.

4.20. **Commentary**: having acknowledged the challenging national context in which agencies in Sunderland are situated, the sections above demonstrate that there are examples of positive practice. A new governmental strategy on homelessness and rough sleeping is being developed and examples of multi-agency collaboration are being sought that demonstrate what is possible

to prevent and respond to homelessness, especially when individuals present with complex needs. Examples are also being sought of how services have been developed following the findings of safeguarding adult reviews. Contributing to a new cross-government strategy on homelessness is also an opportunity to encourage a review of the legal rules. Specifically, individuals such as "A" can be deemed intentionally homeless following anti-social behaviour. However, acts should not be considered deliberate where someone is incapable of managing their affairs because of mental illness or disability, or where behaviour is the result of limited mental capacity or is caused by mental illness or a substance misuse problem[17]. Further guidance on how to respond to cases where both anti-social behaviour and mental illness and/or substance misuse are present would be helpful, as well as review of how housing legislation as it applies to homelessness people interfaces with provisions in the Care Act 2014.

4.21. **Recommendation Seven**: SSAB should consider sharing this thematic review with the National Network for SAB Chairs so that through the Network's meetings with DHSC and other government departments it can contribute to the cross-governmental work on developing a new strategy on homelessness.

[17] Ministry of Housing, Communities and Local Government (2024) Homelessness Code of Guidance for Local Authorities.

5. Concluding Discussion and Recommendations

5.1. There is a wider regional context surrounding this thematic review into the deaths of people experiencing homelessness. A Museum of Homelessness report[18] has referenced a recent national study[19] exploring "*Deaths of Despair*", which are those occurring due to alcohol, drugs and suicide. This research exposed severe regional inequity; in the North East of England more than twice as many people lost their lives due to "*Deaths of Despair*" compared to London. **Commentary**: alcohol, drugs and suicidal ideation were all prominent in the four human stories within this thematic review. Suicide prevention policies should fall within SSAB's mandate to seek assurance about the effectiveness of adult safeguarding. All four individuals, either because of the availability of temporary accommodation outside Sunderland and/or because they moved across geographic boundaries, were known to services within other North East local authorities. **Recommendation Eight**: given the regional context highlighted in the "*Deaths of Despair*" research, SSAB should consider sharing this thematic review report with other SABs in the North East to contribute to service development and practice improvement with people experiencing multiple exclusion homelessness.

5.2. There is an increasingly well-developed evidence base of "*what works*." For example, the rough sleeping support service in Manchester[20] includes extensive use of outreach engagement officers and in-reach navigators whose role is to coordinate a multi-agency approach to support. There are daily case panels and weekly multidisciplinary team meetings that focus on developing individual tailored plans and on target groups, such as transitional safeguarding with care-experienced young people/adults, people with complex needs, and people who have experienced homelessness long-term. Interpretation of housing legislation, especially around local connection, is also very flexible.

5.3. The second national SAR analysis[21] contains findings about good practice and practice shortcomings in relation to people experiencing homelessness and/or alcohol-dependence or dependence on other drugs, and recommendations for the Department of Health and Social Care. Partners in Care and Health (Local Government Association and ADASS) have also contributed to the evidence base on adult safeguarding and homelessness[22]. **Commentary**: pointers for the further development of practice and services in Sunderland can be derived from an appreciative enquiry and temperature check of comparing current provision with this evidence base.

[18] Taylor, G., Vale, J, Turtle, J and Turtle, M (2024) Dying Homeless Project 2023, Museum of Homelessness, London, UK. Available at: https://museumofhomelessness.org/dhp
[19] Camacho, C., Webb, R. T., Bower, P., & Munford, L. (2023). Deaths of despair in England: an observational study of local authority mortality data. Lancet (London, England), 402 Suppl 1, S31. https://doi.org/10.1016/S0140-6736(23)02124-4
[20] Presentation by Peter bell to the Chief Social Worker's forum, October 2024.
[21] Footnote 7.
[22] Footnote 11. Also, Preston-Shoot, M. (2021) Adult Safeguarding and Homelessness: experience Informed Practice. Local Government Association.

5.4. There is a clear commitment in Sunderland from services to work together and to use data from population studies and findings from reviews for service development and practice improvement. There is, however, a recognition of "*more to do*" with respect to coordinated planning with people experiencing multiple exclusion homelessness. With a strategic priority focused on homelessness, SSAB is well placed to seek assurance about the effectiveness of multi-agency work going forward.

5.5. This thematic review has shone a light on the outcome of the recommendations from SAR Alan. It has been possible to observe the impact of the Alcohol Care Team and the recovery navigator but the "*more to do*" includes ensuring that their work is adequately resourced and is supported by other services. On the basis of the evidence concerning the four human stories in this thematic review, there would appear to be "*more to do*" to ensure awareness of the impact of brain injury on behaviour and mental capacity, and use of professional curiosity to understand and respond to the backstory, drawing on SSAB's good practice guide. On the basis of the four human stories, SSAB should seek assurance on the use of CARM and on the liaison between prison staff and probation to ensure that plans are in place to meet individuals' care and support needs. Finally, there remain questions about the referral of adult safeguarding concerns regarding people experiencing homelessness and/or self-neglect, and feedback on referrals. **Recommendation Nine**: SSAB should consider undertaking an annual audit of the impact and outcomes of the recommendations in SAR Alan and in this thematic review.

5.6. **Recommendation One**: part of the response to the joint ministerial letter should include SSAB having a line of sight on the development of the homelessness service and especially the transition to temporary accommodation with wrap-around support.

5.7. **Recommendation Two**: SSAB should continue to explore and evaluate the interface between CARM, MASH and safeguarding enquiries, to ensure pathways for each process are clear, and that the Safeguarding Adults Team and MASH direct referrers on to other suitable pathways where their criteria or thresholds are not met.

5.8. **Recommendation Three**: SSAB should consider seeking assurance that there are regular meetings of health and social care commissioners and providers to review current provision and to devise and implement a strategy for service development.

5.9. **Recommendation Four**: SSAB should continue the positive collaboration with the local safeguarding children partnership to ensure compliance with statutory guidance[23] on transitional safeguarding. SSAB should consider undertaking a review of all policies and procedures through the lens of homelessness.

5.10. **Recommendation Five**: SSAB should consider seeking assurance from partners regarding communications and decision-making about referrals of adult safeguarding concerns in cases involving multiple exclusion homelessness and how services, especially ASC, are responding to referred concerns to ensure a whole system, whole person approach.

[23] DHSC (2024) Care and Support Statutory Guidance.

5.11. **Recommendation Six**: SSAB should review available resources on mental capacity assessment, with a particular focus on executive functioning, and consider whether further practice guidance should be produced and disseminated.

5.12. **Recommendation Seven**: SSAB should consider sharing this thematic review with the National Network for SAB Chairs so that through the Network's meetings with DHSC and other government departments it can contribute to the cross-governmental work on developing a new strategy on homelessness.

5.13. **Recommendation Eight**: given the regional context highlighted in the "*Deaths of Despair*" research, SSAB should consider sharing this thematic review report with other SABs in the North East to contribute to service development and practice improvement with people experiencing multiple exclusion homelessness.

5.14. **Recommendation Nine**: SSAB should consider undertaking an annual audit of the impact and outcomes of the recommendations in SAR Alan and in this thematic review.