

1,474 Reasons to Act: Adult Safeguarding & Inclusion Health

One of a series of Pathway Policy Papers to inform the next decade of healthcare

Gill Taylor

About the author

Gill is Pathway UK Fellow for Safeguarding and Systems Change, with 20 years experience working in homelessness and inclusion health. She specialises in approaches to safeguarding that centre lived experience, anti-oppressive practice and integrated systems change.

She is a Safeguarding Adult Review author, independent researcher and systems facilitator and Strategic Lead for the Museum of Homelessness Dying Homeless Project. She has recently published the [*Radical Safeguarding Toolkit - Homelessness*](#).

About the contributor

James Dillon is a Pathway expert by experience, based in the North East. Jamesy volunteers with a number of organisations locally and nationally to bring about positive change to homelessness and inclusion health services.

Acknowledgements

Gill would like to thank Professor Michael Preston-Shoot for his ongoing advice and commitment to sharing the human stories at the heart of Safeguarding Adult Reviews. Gill would also like to thank the community and crew at the Museum of Homelessness, for their solidarity and leadership in galvanising action to prevent the deaths of people experiencing homelessness.

Foreword

We are at a turning point in the long and proud history of our National Health Service. Described as 'broken' by the Secretary of State, there is a clear choice in how the Government restores when developing its 10-year Plan. This choice is between the continued, widespread exclusion of people facing severe deprivation from care, or rebuilding the NHS inclusively, slanting effort and resources towards those people in inclusion health groups, whose needs are among the most complex and severe in our country.

Pathway is publishing these policy papers to inform this choice. Drawing on the expertise of some of our Pathway Fellows and Faculty members, as well as our colleagues with lived experience, we offer to shine a light on what is possible and to offer thoughts and actionable ideas for change. We invite Ministers to take these ideas and the problems they are designed to solve into account when shaping the 10-year Plan.

The challenges described in the papers echo those seen every day by our Pathway hospital teams. Patients who could have received help earlier only receiving it at crisis point, wasting human potential and precious resources. The desperate challenges people face accessing help for combined mental health and substance use problem. The failure of our housing system to provide safe places to recover from illness and to stay well.

It is not like this everywhere, however, and it does not have to be like this forever. The papers point to evidence of what works in health and care services to meet the needs of people in inclusion health groups, as well as beacons of good practice around the country. Together, they show how choices could be made within the NHS to reverse the inverse care law, tilting time and resource towards those who need it most. Prevention is a strong theme throughout, showing how people's problems can and should be addressed before they spiral out of control.

The benefits of action go far beyond health - meeting people's health needs unlocks other gains, addressing underlying risks of homelessness in particular, enabling people to live well and for longer, as the Government wants to see us all do.

I am very grateful to our Pathway Fellows and other experts who have made time, often in the midst of busy clinical and frontline jobs, to share their thoughts and expertise in these papers. Britain led the world with the establishment of the NHS more than 70 years ago. As we write the next chapter of its history, let's make care and compassion for those who need them most central to its mission.

Alex Bax, CEO, Pathway

What is inclusion health?

Inclusion health is a growing field of research, activism, clinical practice, and care devoted to improving health and social outcomes for the most excluded groups in society. Although much early impetus focussed on improving health services for people experiencing homelessness, over the last 15 years the concept of inclusion health has expanded to cover a range of groups where extreme social and economic exclusion creates extreme health risks and health harms.

The degree of risk and harm observed in inclusion health groups falls far below even the depressing 'normal' range of health inequalities in British society. Disease prevalence rates can be up to 50 times higher than in the general population and mortality gaps between inclusion health groups and the average can be 30 or 40 years. Inclusion health groups can be defined by this observed extreme distance from the general population in terms of health status.

People in inclusion health groups include people experiencing homelessness, Gypsy, Roma and Traveller people, people engaged in sex work, vulnerable migrants and people in contact with the Criminal Justice System. There is a strong body of evidence of what works to improve health and care for these groups: NICE published guidance on homelessness in 2022 and NHS England produced a national inclusion health framework in 2023, but there is an 'implementation gap'. The good practice evidence is available but all too often that evidence is ignored or only followed spasmodically.

Introduction

According to the Museum of Homelessness, at least 1474 people died whilst homeless in the UK in 2023, at least one precious life lost every six hours¹.

In the same period, drug related deaths increased by 11% from the previous year, the highest number since records began². Although challenging to confidently quantify, studies have also indicated that sex workers are 12 times more likely to die by homicide³, with 90% of sex workers reporting violent victimisation whilst working⁴. Yet more research indicates that Gypsy, Roma and Traveller communities face a suicide rate six times higher than the general population⁵. Although there is not yet any official analysis into the deaths of vulnerable migrants, the Asylum Seeker Memorial⁶ has pointed to safeguarding failures in over 40 deaths since 2017. These headline statistics tell a partial but nonetheless stark story of the consequences of nearly fifteen years of hostile policy making on the lives of inclusion health populations. There is an urgent need for the new government to turn this tide and take action to prevent future harm.

Safeguarding is a key aspect of integrated health and care practice, sitting at the intersection of a range of statutory duties, policy drivers and cross-departmental priorities. The growing body of evidence from Safeguarding Adult reviews and beyond makes clear that the current law and policy framework is insufficient to enable the delivery of best practice. The very fact that the majority of learning about safeguarding practice is derived following deaths points to the need for change; inclusion health presents a key opportunity to meaningfully centre prevention, wellbeing and equity.

Integrated care systems will undoubtedly be better equipped to reduce the most entrenched healthcare inequalities, to prevent an over reliance on acute settings and to enable patients to lead health and fulfilling lives if safeguarding law and policy recognises inclusion health as a key area of shared priority and responsibility. The NHS 10-Year Plan and the proposed cross-government Ending Homelessness Strategy are key opportunities to achieve this, creating the opportunity for joint-departmental commitments to embed whole systems approaches to adult safeguarding and the prevention of future deaths.

It's important to note that inclusion health is an all-age issue. Whilst this paper is focussed on adults, a consideration of the health, care and safeguarding needs of children are absolutely crucial to efforts to tackle the barriers and exclusions facing inclusion health populations at large.

This paper will outline a number of key opportunities to embed safeguarding as a unifying driver for preventing and responding to extreme health inequalities. Starting with an overview

of the law and policy landscape and learning from practice, this paper presents seven short, medium and long-term recommendations to align government action with evidence from lived and professional experience.

Law and Policy Background

Safeguarding law and policy centres adult social care practice around traditional understandings of frailty, learning disability and mental health. Although substance misuse is included in the Care Act, the discrete needs and experiences of inclusion health populations remain, at best, on the peripheries of mainstream safeguarding policy and practice. At worst, the complex co-morbidities and overlapping needs of people living with multiple disadvantage are all too often ignored and stigmatised, with efforts to redress this too often the exception and not the rule.

Care Act 2014

The Care Act is the primary legal instrument for addressing adult safeguarding and social care needs in England. When it was introduced, this legislation represented a seismic shift in social care, introducing commitments to prevention, to promoting individual wellbeing and to meeting needs through the delivery of coordinated person-centred care. Integrated strategy, governance and commissioning through the active cooperation of statutory and voluntary agencies is a central tenet of the Act.

The Care and Support Statutory Guidance⁷ outlines adult safeguarding responsibilities, and requires that each local authority must:

- make or initiate enquiries and appropriate action if it believes an adult is experiencing, or at risk of, abuse or neglect (including self-neglect).
- set up a Safeguarding Adults Board (SAB) and ensure representation from key partners, including NHS.
- arrange a Safeguarding Adult Review when an adult in its area dies as a result of abuse or neglect and where it is indicated that lessons can be learned
- co-operate with relevant partners (which includes local and national NHS organisations and settings) in order to protect adults at risk and to develop appropriate strategic governance and local policy.

A decade on and the Care Act's wide-ranging powers and intentionally low thresholds have not been successful in meeting the needs of inclusion health populations. The national crisis in social care has resulted in ever higher eligibility thresholds, delays in accessing assessments and decision-making that too often normalises risk and entrenches stigma⁸. This affects everyone with care and support needs, but the effects on people experiencing homelessness and social exclusion are especially severe.

Despite pockets of pioneering practice, which will be described briefly in this report, the narrative that inclusion health populations are a costly additional burden on an already highly pressurised social care sector prevails. The fact that scarce attention is paid to rough sleeping and multiple disadvantage in statutory definitions, duties and guidelines supporting the Act enables this. Evidence from contemporary research and practice provides a compelling case for this to change so that delivering good practice no longer means working against the grain.

Making Safeguarding Personal

Making Safeguarding Personal⁹ forms a key element of adult safeguarding guidance, and outlines principles and practices for safeguarding interventions and decision-making that focus on the needs and wishes of individuals. This guidance made and continues to make a significant contribution to the development of anti-oppressive safeguarding practice, with an emphasis on listening to and including people in decisions made about them.

However, delivering against this guidance relies on the availability of meaningful choices around accommodation and care and support, as well as flexibility and creativity from frontline staff. With overlapping national social care and housing crises, delivering person-centred safeguarding practice for inclusion health populations is all too often impossible for already overstretched and under-resourced local systems. Personalised safeguarding practice is therefore all too often an aspiration that remains out of reach.

NHS England *Framework for NHS Action on Inclusion Health (2023)*

The framework makes a significant contribution to NHS action to safeguard adults at risk; pointing to the importance of named Inclusion Health leads on Safeguarding Adult Boards, of building safeguarding into NHS service design and delivery and strengthening collaboration between health, adult social care, housing and the voluntary and community sectors.

A key challenge lies in establishing inclusion health as a priority for Safeguarding Adult Boards, who have played a somewhat distant role in inclusion health policy and practice to date despite their broad portfolio of responsibilities and priorities that span and connect social care and health. Nonetheless, the NHSE framework is an opportunity to activate inclusion health as a concern for adult safeguarding and thereby to surface the gaps and limitations of current law, policy and practice for people whose needs and experiences remain misunderstood, invisible and too often unmet.

NICE Guideline 214: Integrated health and social care for people experiencing homelessness (2022)

NICE Guideline 214 identifies safeguarding as a critical component of integrated practice for people experiencing homelessness, setting out recommendations for frontline and strategic practice. Alongside advocating for early identification and multi-agency collaboration to protect adults at risk, the guidance emphasises the importance of embedding learning from Safeguarding Adult Reviews and of ensuring clinicians and practitioners have the appropriate legal literacy to navigate legal rights and entitlements appropriately.

This guidance is evidence-led, practical and person-centred. However, its application is inconsistent and there is no incentive for local systems to adopt it or to monitor how it is being implemented. As a result, its power as a tool to drive change is limited and reliant, as with much of inclusion health policy, on the tenacity and passion of individual clinicians and agencies.

Mental Capacity Act Code of Guidance (2007)

Assessing mental capacity is a crucial opportunity to safeguard adults at risk by understanding their ability to weigh up the consequences of decisions that might expose them to abuse and neglect. This is especially important when someone is living with self-neglect and substance/alcohol dependency, where mental capacity and executive function can fluctuate and the impact of other health conditions, such as brain injuries and learning disabilities, can be obscured.

The statutory guidance supporting the Mental Capacity Act gives scant consideration to the intersection of mental capacity, rough sleeping and addiction. It does not indicate the importance of personalised and longitudinal approaches to assessing capacity in people living with the effects multiple disadvantage, trauma and drug/alcohol dependency and nor

does it speak to how to understand the environmental factors that may influence fluctuating capacity for these groups, such as sleep deprivation, acute distress and trauma reactivation. Evidence from research indicates that negative and stigmatising professional attitudes result in significant gaps in conducting, recording and communicating capacity assessments and decisions for people experiencing homelessness¹⁰.

For an in-depth analysis of the policy opportunities around mental health, read Dr Jenny Drife's paper as part of this series.

Joint Ministerial Letter on Safeguarding and Rough Sleeping (2024)

In May 2024, a joint letter from the Ministers for Housing and Homelessness and Social Care was sent to Safeguarding Adult Board Chairs and Directors of Housing and Adults Social Care in every local authority in England. The letter made four key recommendations around the strategic prioritisation of rough sleeping at Safeguarding Adult Boards, governance and accountability and conducting and learning from Safeguarding Adult Reviews. Similarly to the NHS England Framework, the letter recommends that every SAB identify a named lead for rough sleeping.

Whilst this letter is welcome, its necessity speaks to the overall deprioritisation of the needs of people living at the most extreme risk in our communities. The letter reveals the failure of the Care Act to ensure that people rough sleeping are protected from abuse and neglect. Sadly, in its focus on learning from deaths, it also reveals an attitude of inevitability about deaths and gives limited focus to the prevention of harm.

Ending Rough Sleeping for Good Strategy (2022)

The last Government's Rough Sleeping Strategy describes rough sleeping as a key safeguarding concern and emphasises the importance of multi-agency, person-centred frontline practice, information sharing and the implementation of a range of measures, such as SWEP, to respond to known risks facing those who rough sleep. It also points to the need for strong leadership and governance practice, especially in identifying the root causes of rough sleeping.

Despite this, the strategy avoids the issue of premature deaths, not mentioning those who died whilst homeless nor the learning from Safeguarding Adult Reviews and other research. It makes no explicit commitment to prevent future deaths nor to tackling key issues, such as self-neglect. The acknowledgement of safeguarding feels tokenistic and shallow; the new

government must take the opportunity, in its Ending Homelessness Strategy, to make meaningful and incisive safeguarding commitments supported by the relevant investment and cross-departmental collaboration.

Current law and policy is outdated and insufficient to enable the prevention of harm facing inclusion health populations. Inclusion health and extreme healthcare inequalities should be a key feature in adult safeguarding, not least because of concerns about discriminatory abuse and stigma that indicate a failure to address safeguarding for these populations may also be a failure to meet Equality Act duties.

Solutions - Learning from Practice

In the last decade, a significant and growing body of work exploring and evidencing promising practice around safeguarding for inclusion health populations has emerged. The challenge now is not to seek more evidence, but to create the conditions where the evidence we already have can be meaningfully implemented.

Learning from Deaths

Despite pockets of excellent practice and a growing evidence base, learning from SARs identifies that people experiencing homelessness often receive lethargic, reactive and inflexible support to manage risk. This is driven by resource and demand pressures, negative attitudes and stigma, gaps in professional curiosity and insufficient legal literacy¹¹. Both national SAR analyses have emphasised the need for 'whole systems approaches' to safeguarding and homelessness, where creative direct practice is supported by robust organisational support and supervision, effective governance and strategic leadership and a supportive national policy apparatus¹².

A number of local authorities, Safeguarding Adult Boards and ICSs have begun to develop discrete Homelessness Fatality Reviews to learn from deaths that don't meet SAR thresholds¹³. These reviews ensure that every death is recorded and learned from, even if thresholds for SARs and other statutory reviews are not met. Importantly, these processes foster better working relationships in the local system, create space for practitioners to express grief and assure Safeguarding Adult Boards that action is being taken to learn from deaths and prevent future harm.

Analysis of drug-related deaths emphasises calls from across the substance use sector about the disinvestment in harm reduction support, as well as pointing to a concerning

downward trend in the information available to ONS about the specific substances that have caused deaths¹⁴. Learning from the introduction of naloxone¹⁵ and from Glasgow's unsanctioned overdose prevention site¹⁶ evidence real promise in reducing overdose risk through developments in harm reduction support; it's therefore hugely disappointing that funding promised for the first sanctioned service in the UK has recently been withdrawn.

There remain significant gaps in recognition, learning and action on the deaths of some inclusion health populations. There is yet to be a single published Safeguarding Adult Review concerning someone from a Gypsy or Traveller community, and only a handful about adults from Roma backgrounds, those who live in vehicles and those who sex work¹⁷. Not only does this leave gaps in the safeguarding evidence base for inclusion health, it suggests that there are structural barriers around SAR referral and commissioning practices that warrant further exploration.

Self-Neglect

Self-neglect is the most common form of abuse and neglect considered by SARs¹⁸ and a key area of concern for homeless and inclusion health¹⁹. There is no typical presentation of self-neglect and it is best understood as a spectrum of self-directed behaviours, actions and inactions that present a cumulative threat to life. Importantly, self-neglect in younger adults can be harder to detect, especially where it occurs alongside alcohol/substance dependency or rough sleeping, which are frequently determined 'lifestyle choices' rather than safeguarding concerns.

Self-neglect is under-developed within the Care Act and interventions in response to it are similarly immature and inconsistently available. Research concludes that the uncertainties within contemporary social work about how to address self-neglect, including whether people experiencing homelessness fall under the 'umbrella' of Adult Social Care and adult safeguarding²⁰ can result in a failure to act, with frontline practitioners feeling like they are simply watching people die slowly on the streets.

Whilst most local authorities have developed self-neglect guidance, the majority do not identify behavioural typologies or discrete assessment and risk management approaches for people experiencing homelessness and multiple disadvantage. Work in Northumberland and by the North East SAR Champions is a notable exception here, using learning from SARs to develop a discrete briefing note²¹ from an already wide-ranging self neglect policy²². Long-term relational support is identified as key to addressing self-neglect, there is little resource

to do this within stretch adult social departments or rough sleeping services focussed on short-term goals.

Similarly, although the assessment of mental capacity is a key element to understanding the behaviours and motivations around self-neglect, Mental Capacity Act guidance is dated and does not make a strong enough connection with between homelessness and adult safeguarding duties and powers.

Strengthening legal literacy should be a key priority for inclusion health, as should tackling stigma by strengthening professional curiosity, as research and learning from SARs strongly recommends²³. However, to have a meaningful impact on the growing threat to life that self-neglect represents, attention is needed to how law and policy, as well as nationally driven practice development initiatives, shape practice that recognises and meets the needs of inclusion health groups.

Transitions

Learning from SARs indicates that transitions, including hospital and prison discharge, leaving care settings or moving into an independent tenancy, can be positive opportunities for people to move forward in their lives. However, transitions quickly become 'cliff edges' when multi-agency arrangements fail and when people make transitions without appropriate accommodation and support in place²⁴.

In Summer 2024, the Prisons and Probation Ombudsman published an analysis of post-release deaths²⁵. It identified homelessness as a significant indicator in deaths within two weeks of release, often resulting from accidental overdose. It also points to significantly increased risk of exploitation, abuse and suicide when people do not have safe accommodation identified upon release. Clearly, those identified at risk of homelessness should be supported by a multi-agency plan that proactively addresses care and support needs, safeguarding risks, housing needs and other support issues upon release to avoid cliff edges in the availability of care. Discharge planning guidance²⁶ is clear that this should start *before release* to enable a smooth transition and that accommodation, health care and re-establishing family and other support networks should be prioritised.

Deaths and other harmful experiences following hospital discharge also point to the importance of a focus on smooth transfers of care between services and the system benefits of step-down accommodation and intermediate care. Learning from the Out of Hospital Care²⁷ programme clearly evidences the safeguarding benefits of ensuring patients are not

discharged to the streets, with the approach in Oxfordshire reducing emergency readmissions by 25% and A&E visits by 56%²⁸, providing an exemplar in good practice.

Effective transitions, whether from prison, hospital or any other setting, rely on timely inter-agency communication and a shared commitment to centre the needs and wishes of the person. Reviews²⁹ and national guidance³⁰ recommend that NHS Trusts review discharge policies and procedures to this end, and work closely with housing and social care services to prevent discharge to no fixed abode and to ensure safeguarding and other risks are properly understood as part of discharge planning. Delivering this in practice requires the availability of suitable accommodation and wrap around support, which are all too often reliant on short-term funding in the current landscape.

System Infrastructure, Leadership and Shared Outcomes

Although it is right to focus on the intricacies of direct practice, inclusion health is a field identifiable by the innovation, tenacity and quality of frontline services. Realising improvements in safeguarding practice requires a renewed focus on leadership, governance and strategic coordination.

Locally, a major cause of poor outcomes and escalating risk is delays and professional conflicts that arise from inattention to inclusion health populations in key strategies. Bluntly, resource scarcity limits local strategic prioritisation, with the resulting territorialism and gatekeeping leaving practitioners and patients 'stuck'. Although some local systems have developed multi-agency risk management panels³¹ to mitigate these gaps, these too often suffer from insufficient 'permission' and resource to take decisive and creative action. Such panels require strategic oversight and prioritisation, underpinned by permission to use discretionary legal powers, to achieve genuinely creative solutions that reduce risk.

At the national level, there is insufficient clarity about the distribution of safeguarding responsibilities between ICBs and NHS England. Should ICBs have responsibility for commissioning and NHS England have responsibility for contract and provider management there is a risk that responsibilities about engagement with SABs and disseminating learning from SARs may be lost in translation. In concluding the discussions about the split of responsibilities nationally, regionally and locally, NHS England should consult closely with the National Independent SAB Chairs Network, and ICB Chief execs with local SAB Chairs.

The cost of poorly supported transitions is both human and financial. However, some of the required infrastructure does exist and Integrated Care Boards should explore existing pooled budget arrangements, such as the Better Care Fund and Shared Outcomes Framework, as

a vehicle to resource and commission specialist services and bespoke interventions for people leaving prison and hospital. To do this, systems need targeted action by central government that incentivises and monitors safe discharges to prevent harm and premature deaths.

Workforce

Importantly, effective multi-agency safeguarding practice relies on the wellbeing and competence of the inclusion health workforce who themselves are exposed to risk and distress in their work.

Pathway's Homeless and Inclusion Health Barometer drew on published literature and a survey of frontline professionals, to reveal a growing frustration that inclusion health populations are "always at the bottom of the pile"³² in local and national policy. Confidence in government action has been severely eroded by nearly fifteen years of punitive welfare reform, hostile environment policies and housing crises that have their most severe and life-threatening effects on inclusion health populations. At the level of practice, the hostile policy environment facing inclusion health populations often exacerbates professional tensions between individuals, teams and agencies, deepening siloed working and reinforcing 'us and them' attitudes between adult social care, housing and health.

Research exploring 'moral injury' and 'systems distress' has identified that the complexity of navigating structural barriers has a direct impact on workforce wellbeing, recruitment and retention, trust in leadership and standards of care³³. Findings from the 2nd National SAR Analysis supports this, identifying missed opportunities to learn from developments during the Covid-19 pandemic, entrenched funding issues and inadequate organisational support for practitioners as barriers to working creatively and flexibly in response to complex and escalating risk³⁴.

The inclusion health workforce need supportive working environments, opportunities for reflective practice and peer support, underpinned by visible and decisive action from Westminster to reverse the systemic harms and degradation in political confidence left by successive Conservative governments.

Recommendations

The Government must prioritise the prevention of premature deaths at all levels of the system and bring law and policy instruments in line with evidence from lived experience,

research and practice. A critical first step is making a visible commitment to prevent premature inclusion health deaths.

For people in inclusion health groups, many who die on average 40 years younger than their housed counterparts, an explicit focus on their discrete experiences of harm, abuse and neglect (including self-neglect) is crucial to saving lives. The promise of prevention and wellbeing in the Care Act is simply not being delivered for inclusion health populations, highlighting the importance of renewed attention to this in any updated law and policy.

Tangible steps towards this can be made in the NHS 10 Year Plan and Ending Homelessness Strategy, as follows.

Short Term

The government must make an explicit cross-departmental commitment to ending the premature deaths of people from homeless and other inclusion health populations.

Steps include:

- Establish a cross-sector and cross-departmental Advisory Group on Preventing Inclusion Health Deaths.
- Commit to developing a national mechanism for recording homeless deaths that all local authorities are required to contribute to.
- Commit to targeting future investment on health inequalities, inclusion health, rough sleeping and multiple disadvantage towards activity that prevents and reduces deaths.
- Commit to enabling the Office for National Statistics and Office of the Chief Coroner to work together to update guidance about recording homeless deaths.
- Ensure a specific focus on preventing suicide and drug-related deaths for inclusion health populations, involving Public Health England to ensure that policy and commissioning in these areas considers the specific risks and needs of inclusion health populations.
- NHSE and DHSC to play a more visible role in Rough Sleeping Initiative and Changing Futures programmes, ensuring that health needs, services and settings are integral to systems change around rough sleeping and multiple disadvantage.
- NHSE to require Integrated Care Systems to establish robust recording of the deaths of people in inclusion health groups and to provide assurance to local Safeguarding

Adult Boards and NHS England about how learning from deaths and critical incidents is disseminated and embedded.

NHS England, MHCLG and DHSC to work with the National Safeguarding Adult Board Chairs Network to establish inclusion health as a key concern for adult safeguarding.

Steps include:

- NHSE and DHSC to clarify the role of ICBs and NHSE in respect of membership of local SABs, participation in SARs and dissemination of learning from inclusion health deaths and serious incidents.
- NHSE and the National Network of SAB Chairs to develop a joint briefing note that formally introduces inclusion health to Safeguarding Adult Boards and establishes the role of named Inclusion Health Leads in every SAB.
- NHSE to establish assurance mechanisms with ICSs to understand how safeguarding guidance within the national framework is being implemented locally.
- The newly appointed Chief Social Worker to work with NHS England to establish opportunities to strengthen, and develop where necessary, adult safeguarding policy and practice guidance to meet the care and support needs of inclusion health groups.

MHCLG must ensure that the development of the Ending Homelessness Strategy meaningfully engages with the adult safeguarding and health concerns of people experiencing and at risk of rough sleeping.

Steps include:

- Making a commitment work across government to prevent rough sleeping deaths
- As part of this, making a joint commitment with NHS England and HMPPS to end discharge to the streets from hospital and prisons
- Including an evidence review as part of the Strategy, that evidences how the development of the strategy is informed by research and practice on adult safeguarding
- Ensuring inclusion health experts and organisations are invited to participate in the development of the strategy

- Ensuring the National Network of Safeguarding Adult Board Chairs and Principal Social Worker Network are invited to participate in the development of the strategy
- Establishing clear links between the strategy and health and social care policy related to homelessness and inclusion health
- The strategy should make an explicit commitment to end rough sleeping for those leaving the secure estate.
- MHCLG should engage with HMPPS around the emerging HMPPS Safeguarding Charter, to ensure the charter reflects best practice around preventing rough sleeping after discharge. Similarly, the Ending Homelessness Strategy should provide guidance on prioritising the prevention of homelessness for people leaving prison, especially those identified as vulnerable.

Medium Term

NHS England should commit to review and update the NHSE Inclusion Health framework to strengthen the focus on safeguarding and preventing premature deaths.

Steps include:

- This should include publishing insights from the emerging inclusion health self-assessment process currently being piloted by selected ICSs.
- This should also engage with evidence from the primary care self-assessment tool³⁵ to understand how primary care networks are engaging with safeguarding roles and responsibilities.
- An updated framework should include evidence from research and practice about how ICSs are engaging with their safeguarding duties towards inclusion health populations, including any evidence about the strategic benefits of named Inclusion Health leads on SABs.
- An updated framework should also include additional guidance, and examples of good practice, in supporting staff to manage the impact of their work supporting adults at risk. This might include recommendations about the role of effective supervision, peer support and reflective practice for inclusion health practitioners and clinicians.

DHSC and MHCLG should work with relevant agencies to review and update self-neglect and mental capacity policy and practice tools with inclusion health populations in mind.

Steps include:

- Writing to Safeguarding Adult Boards seeking assurance about the effectiveness of local self-neglect policies in reducing risk for inclusion health populations.
- Commissioning national guidance about identifying and responding to homelessness and self-neglect, that builds on learning from practice and is grounded in insights from lived experience.
- Mental Capacity Act Code of Guidance should be reviewed and updated to draw attention to specific considerations relevant for people experiencing rough sleeping and multiple disadvantage, in particular highlighting the importance of professional curiosity in tackling stigma in decision-making and providing examples of good practice in assessing fluctuating capacity and executive function as they relate to self-neglecting behaviours.

Long Term

DHSC to commit to undertake a comprehensive review of the Care and Support Statutory Guidance and other key safeguarding policy instruments.

Steps include:

- Establishing a cross-sector and cross-departmental Advisory Group to determine and prioritise areas for the review. Importantly, this should include representation from people with lived experience.
- Prioritise work to review how the Care and Support Statutory Guidance considers the nature and effects of rough sleeping and multiple disadvantage when assessing care and support needs, meeting needs and enacting safeguarding duties and powers.
- Commission an evidence review about how Care Act duties and powers are currently being implemented and navigated to meet the needs of inclusion health populations. Where research and practice evidence is unavailable or limited, prioritise widespread engagement with inclusion health populations to understand their experiences and ideas for change.

- Working with MHCLG and NHSE to ensure updated statutory guidance provides clarity on duties and powers to provide accommodation at key junctures, such as discharge from hospital, when undertaking assessments with people rough sleeping and when responding to safeguarding concerns, with the aim of enabling timely shared decision-making for people at risk of dying on the streets.

MHCLG, DHSC and NHSE to work together to ensure the workforce supporting inclusion health populations is equipped with the skills and knowledge, organisational support and policy tools they need to address the safeguarding concerns of inclusion health groups.

Steps include:

- Commission a skills audit to identify the identify training and development needs within the current workforce, and importantly of their managers and leaders. This should explicitly consider gaps in legal literacy, trauma-informed care, stigma and prejudice and skills for effective multi-agency practice.
 - As part of this, make enquiries with ICSs about how mandatory safeguarding training considers the discrete needs and risks facing inclusion health populations.
- Host a series of national events focussed on the inclusion health workforce. The aim of these will be to bring together evidence from practice about effective approaches to improving workforce wellbeing, enabling peer support and learning and responding to secondary trauma.
- Promote existing training and development tools and develop new resources specific to the safeguarding needs of inclusion health populations.

Lived Experience Perspective

I've lived with addiction, periods in prison and severe mental health problems as well as experiencing homelessness for several years. As someone who's been through the system, and like many other people with lived experience, I've been let down when I needed help the most. The lack of joined up working between organisations, coupled with gaps in the law means that people with issues similar to mine are shut out of accessing the help they need. We are always falling through the net, and this makes the difficulties we experience even worse; we go round and around the system and things just don't get better.

Professionals often don't know enough about the traumatic experiences we've had, the specialist support we need or how to make services accessible to us. We get unequal access to help and as the situation nationally gets more desperate, the cracks in the system around us get bigger. Law and policy needs to change.

There must be clarification about how different laws interact with each other and how this affects the way organisations can work together. At the moment more time is spent by professionals fighting each other about who is responsible for our care. Protecting people from harm, violence and abuse needs the whole system, including the person themselves; together we are more than the sum of our parts.

When people leave prison, they must have real opportunities to restart their lives. A prison sentence shouldn't be a life sentence, but far too many people die soon after leaving prison because they don't have safe accommodation or access to healthcare. The fact that so many people go back to prison soon after being released also says a lot about how the system is failing inclusion health groups. The human and financial cost of the revolving doors of the prison and homelessness systems are huge and nobody is getting anything positive out of it.

Our capacity to make safe decisions is made impossible by the circumstances we live in; if you're sleeping outside, living with addiction or are mistrustful of services because of previous experiences then your understanding of what is safe is often a choice between the lesser of two evils. Is that really choice? Capacity to make decisions can also fluctuate and we need a system that understands this and doesn't just squeeze people into processes not designed to meet their needs. The law needs to support professionals to work with us without judgment, to prioritise our safety and take on board how our circumstances shape our relationship to risk and safety.

Harm, violence and stigma facing people living with addiction and homelessness should never be normalised, seen as inevitable or as a lifestyle choice. Doing this also normalises the life-changing consequences of trauma, experiences of physical, sexual and other abuse and adverse childhood experiences. A person asleep in a doorway should be understood as at risk of equally life-threatening and life-changing effects as someone who has been in a car accident; organisations should be supported by law and policy to act with the same urgency, compassion and understanding.

We need to look at the whole person and not just at what is wrong with them or what they've done in the past. A key way of doing this has to be recognising addiction as an illness and tackling the stigma and prejudice people face. This means working with people with lived experience to shape new ways of working that reduce harm and stop punishing people in

crisis and distress. Those closest to the problems are often furthest away from designing the solutions and that has to change; people with lived experience want to work with policymakers to bring about change that actually has an impact.

Organisations need to be held accountable and to agree ways of working together that can be measured and monitored. To do this, we need to recognise addiction and rough sleeping as key issues for health and social care policy, and make sure that mainstream services, such as mental health, aren't penalising or excluding people because their lives are complex and don't fit neatly into boxes. When organisations are supporting people at risk, experiences like homelessness and addiction should be red flags, that give people priority in safeguarding.

Surviving isn't living. Preventing harm has to be as important as learning from people who die. Everyone deserves a healthy and full life and the government need to take action to make that a reality.

References

- ¹ 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>
- ² Office for National Statistics (2024) Deaths related to drug poisoning in England and Wales: 2023 registrations. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2023registrations>
- ³ Cunningham, S., Sanders, T., Platt, L., Grenfell, P., & Maciotti, P. G. (2018). Sex Work and Occupational Homicide: Analysis of a U.K. Murder Database. *Homicide Studies*, 22(3), 321-338. Available at: <https://doi.org/10.1177/1088767918754306>
- ⁴ Brooks, L (2024) Violence against sex workers 'a daily reality', 20 years after Emma Caldwell murder, *Guardian*. Available at: <https://www.theguardian.com/society/2024/mar/01/violence-against-sex-workers-a-daily-reality-20-years-after-emma-caldwell>
- ⁵ The Traveller Movement (2019) The Traveller Movement - policy briefing addressing mental health and suicide among Gypsy, Roma and Traveller communities in England. Available at: <https://wp-main.travellermovement.org.uk/wp-content/uploads/2021/09/Mental-Health-and-Suicide-among-GRT-communities-in-England-Briefing-2019.pdf>
- ⁶ Liberty Investigates (2024) The Asylum Seeker Memorial Project. Available at: <https://www.asylumseekermemorial.co.uk/about-asylum-seeker-deaths>
- ⁷ Department for Health and Social Care (2024) Chapter 14 Safeguarding, *Care and Support Statutory Guidance*. Available at: <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>
- ⁸ Local Government Association (2024) Second national analysis of safeguarding adult reviews, Final report: Stage 2 analysis. Available at: <https://www.local.gov.uk/sites/default/files/documents/National%20analysis%20of%20SARS%20-%20Stage%202%20%28branded%20and%20proofread%29%20v6-19.pdf>
- ⁹ Local Government Association (n.d) Making Safeguarding Personal Toolkit. Available at: <https://www.local.gov.uk/msp-toolkit>
- ¹⁰ Harris, J. et al (2023) Social work practice with self-neglect and homelessness: Findings from vignette-based interviews, *The British Journal of Social Work*, 53:4, June 2023, pp2256–2276. Available at: <https://doi.org/10.1093/bjsw/bcac180>
- ¹¹ Local Government Association (2024) Second national analysis of safeguarding adult reviews, Final report: Stage 2 analysis. Available at: <https://www.local.gov.uk/sites/default/files/documents/National%20analysis%20of%20SARS%20-%20Stage%202%20%28branded%20and%20proofread%29%20v6-19.pdf>
- ¹² Local Government Association (2024) Second national analysis of safeguarding adult reviews, Final report: Stage 3 Conclusions and improvement priorities. Available at: <https://www.local.gov.uk/sites/default/files/documents/26-6-24%20National%20analysis%20of%20SARs%20-%20Stage%203%20GA-07.pdf>
- ¹³ Developments in recording, reviewing and learning from deaths outside of Safeguarding Adult Review processes has been led by London Borough of Haringey, with notable positive practice emerging in Cardiff, Exeter and Brighton.
- ¹⁴ Population Health Monitoring Group (2024) *Deaths related to drug poisoning in England and Wales - Office for National Statistics*.

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2023registrations>.

¹⁵ Advisory Council on the Misuse of Drugs (2023) *ACMD review of the UK naloxone implementation (accessible)* <https://www.gov.uk/government/publications/acmd-naloxone-review/acmd-review-of-the-uk-naloxone-implementation-accessible#effectiveness-of-naloxone>.

¹⁶ Shorter, G.W. *et al.* (2022) 'The United Kingdom's first unsanctioned overdose prevention site; A proof-of-concept evaluation,' *International Journal of Drug Policy*, 104, p. 103670. Available at: <https://doi.org/10.1016/j.drugpo.2022.103670>.

¹⁷ Determined by analysis of available SARs published in the National SAR Library: <https://nationalnetwork.org.uk/>

¹⁸ <https://www.local.gov.uk/sites/default/files/documents/National%20analysis%20of%20SARs%20-%20Stage%201%20%28branded%20and%20proofread%29%20v7-12.pdf>

¹⁹ London Network of Nurses and Midwives (2023) Identifying and working with Self-Neglect in people experiencing homelessness. Available at: <https://homeleshealthnetwork.net/wp-content/uploads/2023/07/Self-neglect-guidance-July-2023.pdf>

²⁰ Harris, J., Martineau, S., Manthorpe, J., Burridge, S., Ornelas, B., Tinelli, M., & Cornes, M. (2022) *Social work practice with self-neglect and homelessness: Findings from vignette-based interviews*, *The British Journal of Social Work*.

²¹ North East SAR Champions (2022) 7 Minute Briefing: Self neglect and homelessness. <https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Health-and-social-care/Care%20support%20for%20adults/safeguarding%20adults/7-SN-Reg7MB-Homelessness-04-04-2022.pdf>

²² North of Tyne SABs (2016) Self neglect Guidance. <https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Health-and-social-care/Care%20support%20for%20adults/safeguarding%20adults/Self-Neglect-Guidance.pdf>

²³ Local Government Association (2024) Second national analysis of safeguarding adult reviews, Final report: Stage 3 Conclusions and improvement priorities. Available at: <https://www.local.gov.uk/sites/default/files/documents/26-6-24%20National%20analysis%20of%20SARs%20-%20Stage%203%20GA-07.pdf>

²⁴ SARs identify transitions as critical points. See 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. 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.

²⁵ Prison and Probation Ombudsman (2024) Learning lessons bulletin Issue 19: Post-release death investigations 2. Available at: https://ppo.gov.uk/learning_research/learning-lessons-bulletin-issue-19-post-release-death-investigations-2/

²⁶ Ministry of Justice (2022) Guidance: HMPPS Pre-Release and Resettlement Policy Framework. Available at: <https://www.gov.uk/government/publications/hmpps-pre-release-and-resettlement-policy-framework>

²⁷ Cornes, M., Tinelli, M., Clark, M., Coombes, J., Harris, J., Burridge, S., Robinson, J., & Wittenberg, R. (2024) *Evaluation of the Out-of-Hospital Care Models Programme for People Experiencing Homelessness*. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

²⁸ <https://www.lse.ac.uk/cpec/assets/documents/Dashboard-Oxford-October-23rd-2023.pdf>

-
- ²⁹ See, for example, Redbridge Safeguarding Adults Board (2019) Annual Report 2018-2019.
- ³⁰ Department for Health and Social Care (2024) Discharging people at risk of or experiencing homelessness. Available at: <https://www.gov.uk/government/publications/discharging-people-at-risk-of-or-experiencing-homelessness/discharging-people-at-risk-of-or-experiencing-homelessness> and NICE (2022) Integrated health and social care for people experiencing homelessness. Available at: <https://www.nice.org.uk/guidance/ng214/chapter/Recommendations#transitions-between-different-settings>
- ³¹ Local Government Association (2021) Further learning for the team around the person, *Adult safeguarding and homelessness: experience informed practice*. <https://www.local.gov.uk/publications/adult-safeguarding-and-homelessness-experience-informed-practice>
- ³² Pathway UK (2024) Always at the Bottom of the Pile: The Homeless and Inclusion Health Barometer 2024. Available at: <https://www.pathway.org.uk/resources/barometer2024/>
- ³³ Perez, S. *et al.* (2024) 'When I can't help, I suffer: A scoping review of moral distress in service providers working with persons experiencing homelessness', *Journal of Mental Health*, pp. 1–16. DOI: 10.1080/09638237.2024.2426986. and Kerman, N. *et al* (2022) "Systems trauma": A qualitative study of work-related distress among service providers to people experiencing homelessness in Canada, *SSM Mental Health*, Vol2, Dec 2022. Available at: <https://doi.org/10.1016/j.ssmmh.2022.100163>
- ³⁴ Local Government Association (2024) Second national analysis of safeguarding adult reviews, Final report: Stage 2 analysis. Available at: <https://www.local.gov.uk/sites/default/files/documents/National%20analysis%20of%20SARS%20-%20Stage%20%20%28branded%20and%20proofread%29%20v6-19.pdf>
- ³⁵ Friends, Families and Travellers (2024) Inclusion Health Self Assessment Tool for Primary Care Networks Available at: <https://www.inclusion-health.org/pcn/>