SAR YI

Cross Borough Safeguarding Adults Review

Independent Reviewer: Fiona Bateman (August 2019)

Introduction from the Chair of the Lambeth Safeguarding Adult Board

The following is a Safeguarding Adults Review that Lambeth Council Adult Social Care participated in, but for which they were not responsible.

The case of Mr YI was presented to the Safeguarding Adults Review subgroup of the Lambeth Safeguarding Adults Board on 9th April 2019. The referral came after Lambeth Adult Social Care undertook an adult safeguarding enquiry in respect of Mr Yi, following his admission to St. Thomas' Hospital.

The SAR Sub-Group noted that Lambeth had identified at the time that:

- Mr. Yi had been homeless prior to and at the time of his admission to hospital. The enquiry process successfully pieced together a full picture of his story and of all those that had worked with him along the way, including the boroughs in which he had been living
- The information gathering revealed the true extent of his vulnerability, something that was easily missed by professionals because of the way he presented
- Lambeth placed Mr. Yi into 24hr care following his discharge from hospital and took a decision to initiate this SAR because of the extent to which Mr. Yi had suffered

Lambeth SAB and Adult Social Care agreed to participate in the SAR process, as the SAR had been initiated by Lambeth but also so that Lambeth could still benefit from the learning as well as ensuring that all Lambeth agencies, partners to the LSAB could learn.

Please email LSABadmin@lambeth.gov.uk if you require any further information.

Yours sincerely,

Siân Walker
Independent Chair of Lambeth Safeguarding Adults Board

On behalf of the Independent Chairs of the City and Hackney, Islington, Lambeth and Newham Safeguarding Adults Boards

Safeguarding Adults Board members from all four London Boroughs want to begin by extending their condolences to the family and friends of “Yi”.

Newham, City and Hackney and Islington Safeguarding Adults Boards recognise that Yi was let down by most of the organisations that were meant to help and provide support to him during the months covered by this review.

This review was jointly commissioned by the four Safeguarding Board chairs to ensure that there was an independent view of the circumstances surrounding Yi’s journey and that councils have in place effective systems to help homeless adults with care and support needs. The aim was to understand the issues faced by adults with complex needs who are homeless, and to implement learning from the findings to improve professional practice.

In developing the SAR we adopted a collaborative approach, working with housing practitioners and outreach agencies in addition to stakeholders from health, the police and other agencies. Together we explored how we can secure better outcomes for adults at risk who are in need of accommodation and support. Councils across London and also nationally face similar challenges to address safeguarding issues related to homelessness. Improving how we support people who are homeless is a long term commitment that all four local authorities have prioritised.

The four Boards have already begun work to reduce, as far as possible, the same things from happening again. Practitioners from the four local authorities involved in this case have come together to improve responses to adults at risk of, or experiencing, chronic homelessness. There will be further collaboration that will enhance the learning for professionals and improve how services are delivered to people who need support from the local authority that they interact with.

The report about Yi ended with recommendations for the local authorities and their Boards to implement. Each Board will hold partners to account in their implementation of their actions and monitor the impact on improving the safeguarding and wellbeing of adults at risk.

The review recommendations are also relevant to local authorities across London. The Chair of London Safeguarding Adult Board will be asked to lead on the implementation of specific recommendations with a view to providing London-wide guidance and best practice to safeguard adults at risk from homelessness.

Supporting Adults at risk in need of accommodation based support

Report into the Safeguarding Adults Review

Prepared by Fiona Bateman, Independent Author

November 2018

In September 2018 four London SAB's[1] agreed, in accordance with duties under s44 Care Act 2014, to undertake a combined review into partner agencies' responses in the case of an adult at risk named in this report as 'Yi'. The review comprised firstly of a paper based review of the input from partners across the four SAB areas, from which an agreed chronology of events and summary of Yi's needs for care and support was developed. Thereafter a practitioners' workshop was convened to explore the key areas of enquiry and the lessons to learn in order to better support practitioners improve responses to adults at risk of, or experiencing, chronic homelessness.

Throughout this report the term 'Chronic homelessness' is used. It is characterised by prolonged or frequent periods of homelessness (including rough sleeping) together with 'tri-morbidity' conditions of physical, mental ill health and/or substance misuse.

Case narrative:

Despite regularly coming to the attention of a number of statutory services as an adult experiencing street homelessness and significant physical and mental health conditions, very little is known about Yi's earlier life experiences. He appears to have successfully built a life in the UK, securing employment which enabled him to purchase his own home in 1999. It was understood that he had a brother in the UK, but it does not appear attempts were made to encourage family involvement or assist Yi develop a non-statutory support network. Police records indicate that he likely abandoned his home and started sleeping rough in 2006; the trigger is unknown. He received a diagnosis of schizophrenia in 2008 and was seen briefly by secondary mental health services though any support (if offered) had no impact. Throughout 2008-12 there is evidence that he experienced 'self neglect', for example, we know that he stopped paying essential bills he had previously met and that his home was subject to various interventions by the local authority's private housing and environmental health departments to seek to reduce the threat posed to public health. Again there is little evidence of support being offered to Yi to address his substantial needs. Police records also indicate that during this period he experienced a number of thefts and physical assaults whilst sleeping rough. Equally he was arrested on a number of occasions.

[1] Newham SAB [linked to 'LA1'], Islington SAB [linked to 'LA2'], City and Hackney SAB [linked to 'LA3'] and Lambeth SAB [linked to 'LA4']

Attempts were made to support Yi into accommodation, in October 2012. Shelter from the Storm provided emergency accommodation and went on to assist him apply to the first Local Authority[2] [hereafter referred to as 'LA-1'] and eventually secure assistance under Part VII Housing Act (in November 2013) in sheltered accommodation. During 2013-14 he was also assisted by specialist homeless medical services and referred to secondary mental health services. Despite clinical input from that service, forensic specialist assessments which identified he would '*benefit from active engagement with mental health services and require support from social services*' and evidence that he was still exhibiting signs of hoarding and self-neglect, input from services appeared fragmented. There is no clear picture about Yi's capacity to adhere to expectations from services or plan to address his health and social care needs or treat his condition so as to enable him to manage activities of daily living and ultimately prevent further homelessness. For example, a decision was made (in apparent isolation to those responsible for his care and treatment plan) to withdraw housing benefit payments for his sheltered accommodation because of his continued ownership of a property.

During this period, he was involved in a number of physical assaults. In 2014 Police raised warning markers that he could be violent and 'showed great amount of strength.' During 2014-15 he suffered two brain injuries which affected his functioning and was assessed in May 2015 as '*unable to manage activities of daily living independently*'.[3] Insufficient consideration was given to how this might impact on his capacity to manage his financial affairs, adhere to service expectations of what constituted 'engagement' with the provision of social care support and the accommodation. As a consequence of this and the earlier decision to stop housing benefit, considerable rent arrears built up triggering, in September 2015, his eviction from sheltered accommodation. This is of particular concern, because staff responsible for initiating proceedings knew or ought to have known (because of findings in previous Court proceedings) that Yi was unlikely to have had capacity to litigate. As such arrangements should have been in place to support Yi, failure to do likely breached his article 6 (right to a fair hearing) and article 8 (right to respect of private, family life, home and correspondence). Had proper consideration occurred, it is likely that either Local Authority staff or the Courts would have identified the need for Yi to have a deputy appointed to assist him manage his property and financial affairs.[4] This would undoubtedly have assisted in preventing further periods of homelessness.

Following his eviction, Yi became street homeless again and was referred shortly after to another local authority[5] ['LA-2'] and accommodated through their NRPF team.[6] Whilst it was recognised at this time, that he needed support to manage his financial affairs, only partial support was offered. This was partly because he couldn't meet organisational expectations to keep appointments, but also due to a perceived organisational risk that supporting him to manage his finances might impact on

[2] LB Newham
[3] LB Newham, hospital team assessment (dated 20.05.15)
[4] s16 Mental Capacity Act 2005
[5] London Borough of Islington
[6] This was a specialist team responsible for assessing and meeting social care needs for those whose immigration status might otherwise mean they would be ineligible.

liability for future care costs given an ongoing dispute regarding his 'ordinary residence'. Notwithstanding that concern, the dispute between the two authorities regarding his 'ordinary residence' wasn't pursued through the statutory mechanism because of expected legal costs.

In 2016 Yi was re-admitted into hospital having suffered a subdural haemorrhage, limiting further his cognitive abilities. On confirmation he was ready for discharge, LA-2's NRPF team were notified that Yi was lawfully in the UK, so withdrew support and a decision was made that he should approach a third authority [LA-3'][7] to request support under Part VII Housing Act. He later withdrew this application, requesting (with support from officers within the third authority) to present for that support to LA-1. In line with powers under the Housing Act 1996, he was temporarily accommodated, but his application was quickly rejected on the basis that he owned property. That decision did not consider whether it was reasonable (given both his own disabilities and the condition of the property) to determine he could occupy this property.[8] This was in breach of expectations '*to consider carefully the suitability of accommodation by reference to the applicant's particular medical and or physical needs and to any social considerations relating to the applicant and his or her household*.[9]

He was subsequently found emergency accommodation by staff from LA-2 in the area of LA-3. This was reported to be 'self funded' as LA-2 were acting as DWP appointees so using his funds to meet accommodation costs. Again, little regard was had to whether this accommodation was 'suitable' given his medical and physical needs. He was later referred for specialist mental health support to services in LA-3's area. A dispute again arose as to which authority should be responsible for providing Yi with support and whether accommodation should be provided under the Housing Act 1996 or Care Act 2014. There is no evidence of a proper assessment of his capacity to make an application for support under the Housing Act 1996 or adhere to the conditions of any accommodation. Nor was consideration given to the duty to appoint an advocate. Given his cognitive impairments it is likely he would have had substantial difficulty in being involved in an assessment for his social care needs, he was unsupported by friends and family and so a duty was owed to provide this essential support.[10] He was subsequently evicted from the emergency homeless accommodation on the basis that he was 'not independent' and because his behaviour could place him or others at risk of harm in that environment. Practitioners taking part in this learning review raised concern that, rather than evict Yi, staff from the hostel should have raised a safeguarding concern that an adult at risk was without necessary care and support. Again, had this happened he would likely have received advocacy support.

The dispute over responsibility reached an impasse on the 13.07.17 when staff drove him first to LA-2 and then to LA-3 offices to require assessment. In common

[7] London Borough of Hackney

[8] In *Hague v Hackney LBC* [2017] EWCA Civ 4 the Court of Appeal confirmed that the public sector equality duty [s149 Equality Act 2010] applies to 'public authority decision making of any kind'. The law requires the decision maker to be aware of the duty and have due regard to the relevant matters, evidenced by a 'proper and conscientious focus on the statutory criteria'.

[9] set out in pg17.4-6 Homelessness Code of Guidance, 2006

[10] s67 Care Act 2014

with previous statutory interventions, staff did not share information known about his health and social care needs, mental capacity or likely presentations.[11] For example, although he was accommodated for one night, hostel staff were not advised of his brain injury and wrongly assumed he was drunk. He was not assessed by either authority for on-going support.

From 14.07.17 Yi slept rough, until on the 23.07.17 he was taken into St Thomas' hospital in a confused state. In line with their duties before discharge, hospital staff undertook an assessment of his need for continuing healthcare and identified that he would require nursing support on discharge. At this time he was appointed an advocate to support him during the assessment and care planning process undertaken by social care staff from fourth authority[12] ['LA-4']. That authority subsequently accommodated in a nursing home and initiated a safeguarding enquiry under the category of 'neglect and acts of omission'. This review arose out of a recommendation from that enquiry.

Yi passed away in September 2018 and, whilst the cause of death was unconnected to the statutory failings, practitioners involved in the discussions felt it was important to recognise he experienced serious harm and requested the review act as a springboard for discussion to support SABs, relevant partner agencies and the wider statutory and voluntary sector to work more effectively to achieve social justice for Yi and others experiencing, or at risk of, chronic homelessness.

Practitioner workshop discussions:

The workshop discussions drew on expertise from those working across the four SAB areas with housing, social care, mental health, policing and safeguarding practitioners taking active part in identifying practice issues. Discussions were also informed by input from staff working in voluntary sector undertaking assertive outreach to support individuals experiencing chronic homelessness and voluntary sector policy leads. The Independent Chairs from the relevant SABs also took part in discussions, emphasising that a SAB is well placed to champion cultural change and to monitor impact of learning against improved outcomes through their quality assurance, awareness raising and training roles. Each SAB committed to working locally with partners to implement learning from this review either by developing action plans or using this review to inform current work streams. The Chairs also committed to reflecting on this case to inform work at the regional and national SAB on cross boundary safeguarding and safeguarding for adults at risk and experiencing chronic homelessness.

The rise in the rough sleeping population with tri-morbidity conditions raises significant challenges for SAB partner agencies. Most adults in those circumstances experience a significant increase in serious abuse, exploitation and neglect, an escalation of their health and care needs and a reduction to their life expectancy (as detailed more comprehensively in https://www.bmj.com/content/360/bmj.k902/rr and https://www.mungos.org/wp-content/uploads/2018/06/Dying-on-the-Streets-Report.pdf). Given the likely risks, attendees felt that any safeguarding concern

[11] In breach of the obligations under Homelessness Code of Guidance [s2.75] and s37 Care Act 2014
[12] London Borough of Lambeth

required a proactive investigative response. They were alarmed by the failings identified in Yi's case, but equally understood how practitioners working to resolve each crisis he experienced could not see the wider impact each decision would likely have on his long-term health and wellbeing. They acknowledged that wider understanding across statutory and voluntary workforces of relevant partners' statutory duties might assist this, as would proper understanding and application of personalised, asset-based approach which aligned with equality and human rights principles. Practitioners recommended that any toolkits which are used to good effect to achieve a more personal offer when usual practice hasn't been successful should be shared.[13]

Practitioners from all disciplines highlighted that any recommendations must reflect the complexities faced by those working in frontline practice trying to support individuals with multiple needs that cut across specialisms, organisational and geographical responsibilities. Many raised concerns that changes in the legislative framework (e.g. Care Act 2014 and Homelessness Reduction Act 2017) which should've improved outcomes for those experiencing chronic homelessness had been undermined by the impact of austerity.[14] For example, there was recognition of increased access to advocacy, but highlighted that in practice there had also been a fragmentation of this vital support as services are commissioned based on specific legislative functions rather than on a wider citizenship based model. Such a model might prove much more economical and effective for those at risk of chronic homelessness.

Practitioners were aware of the expectation to carry out their own statutory functions, including assessments and eligibility decisions, in a manner that is consistent with safeguarding duties to identify, report and prevent an adult at risk experiencing abuse, exploitation or neglect. Many also recognised that practice needed to improve to further embed principles under the Human Rights Act 1998, Equality Act 2010 and Mental Capacity Act 2005. They understood the duty set out in s6-7 Care Act 2014 provided legal powers to enable cooperation, but were less confident about how to apply the legal framework in practice to secure cooperation across specialisms, organisations or geographical boundaries. They acknowledged the interface between health, social care and housing legislative duties are complex. Further complications arise because different terms are used within relevant legislation to determine responsibility for funding/commissioning treatment, care and support and/or housing. Interpreting those, alongside the individual's right to make decisions and any impact that tri-morbidity conditions could have on that ability, takes considerable skill!

[13] see http://www.voicesofstoke.org.uk/wp-content/uploads/2018/02/CareActToolKit.pdf reported in the study referenced at footnote 17 to have had good impact.

[14] This concern is well founded. The impact of austerity across housing, health and social care services is well documented, so too are the consequential effects, including an undermining of the legal rights for those with disabilities. In 2017 the UN reported concern that in the UK '*existing laws, regulations, and practises discriminate against persons with disabilities*'. The King's Fund also identified '*routine breaches of rights*' for those requiring health and social care and support warning *'more people* [will be] *denied access to authority-funded care.'* Recently, the Care and Support Alliance's survey identified 29% of respondents reported reduction in support despite unchanged care needs and reported the majority of professionals felt expected by their managers to reduce the help on offer to people in need of social care. In addition, the Care Quality Commission and ADASS have recently warned of the fragility of the social care sector, e.g. 75% of Adult Social Care directors confirmed reducing the number of people in receipt of care is required to achieve necessary savings.

It was also acknowledged that frontline practitioners can become overwhelmed, particularly as they will be dealing with large numbers of individuals at high risk of harm and with complex needs. They can experience fatigue if repeated requests for multi-agency support (under s42 Care Act or other risk management processes) appear to be ignored. The importance of providing feedback on all referrals was re-iterated. Practitioners noted that Yi's case was not unique and spoke of individuals who 'ping-pong' between services, because their conditions present considerable practical difficulties for services. They speculated whether barriers to 'professional curiosity' and ownership in such complex cases was as a result of legal or financial organisational risk and highlighted that the fact that services' responsibilities are linked to geographic footprint and ordinary residence/local connection requirements provides further obstacles for those experience chronic homelessness. Given this context, it is important to recognise and commend the practitioners within the hospital and LA-4 who did take time to understand Yi's needs, his complex background and identify appropriate care for him.

Practitioners accepted that safeguarding duties were not recognised in Yi's case, but explained that any revised guidance on safeguarding rough sleepers or commissioning accommodation based support out of area should focus on supporting frontline staff to manage demand more effectively, moving away from crisis management to early intervention models. Mindful that s42 Care Act was unlikely to provide the most effective mechanism for provide long-term intervention and that this duty was never expected to substitute for assessment and care management responsibilities, they proposed that it should only be used when concerns arise and escalation procedures for inter-agency or cross boundary disputes are blocking effective assessment/ support such that an adult at risk is at risk of abuse, neglect or exploitation. This could include consideration of whether circumstances give rise to 'organisational abuse' e.g. because a failure to consider relevant issues (such as a person's capacity to engage) obstructs access to treatment, care and support in a way that violates their dignity resulting in a lack of respect for their human rights.

They recognised that to properly embed human rights based approach throughout the health and social care workforce would require resources to provide organisational support (such as effective, reflective supervision to challenge any unconscious bias) and free up staff so they have more time to develop rapport with individuals and professional networks. Practitioners underlined the importance for frontline staff to be able to build relationships with partnership from across voluntary and statutory agencies as this will enable effective interventions, including early intervention or preventative models of support.

They also felt policy/guidance must directly address common barriers to effective interventions and provide mechanisms for overcoming these, including:

- Individuals can be difficult to find and assess. Multiple needs and the impact

of past trauma/experiences can make it difficult for an assessor working alone to ascertain all pertinent information to address multiple eligibility considerations, similarly service users report feeling frustrated or intimidated by having to repeat their personal history, again making it difficult to develop the necessary rapport for a thorough multi-discipline assessment.

- It is difficult to assess a person's capacity as they are not in one place for long and often experience fluctuating capacity.
- Traditional access routes to assessment often do not work for this cohort, but careful consideration is needed to ensure 'reasonable adjustments' are sustainable and encourage individuals to take active role in protecting themselves from abuse/ neglect.
- Specialist dual diagnosis teams have high referral thresholds and long waiting lists.
- Once assessed and found eligible, it is then often difficult to commission social care or find appropriate accommodation options, particularly if there is a history of anti-social behaviour, rent arrears, ongoing substance dependency issues.

Practitioners, including those from the voluntary sector, were able to share ways of working and current mechanisms for information sharing which, if utilised more widely, could support effective information gathering and lawful, fair and reasonable decisions regarding eligibility and placement. They also wondered if GDPR and increased portability might prove a useful means to enhance information sharing. They cited examples, such as the Westminster 'enhanced vulnerability forum,'[15] which enables statutory and voluntary organisations work together to effectively support rough sleepers at risk. In addition, assertive outreach teams can access a database to ascertain reported concerns and likely 'sleep sites' for those perceived at serious risk of harm. Staff from LA-1 also reported on the improvement in the uptake of early intervention support offered following careful screening by a senior social care practitioners of MERLIN reports received from the police. Under this scheme, social care staff check accessible health and social care records, pull together a chronology so as to identify if the adult might be at risk of abuse or neglect and ascertain any escalation or pattern of need. Triage staff are then provided guidance on what to explore before determining what level of support is required.

There is a growing evidence base[16] of the value of working with assertive outreach teams. Practitioners recommended two key actions to secure more effective engagement, namely:

- improving knowledge within the workforce of the legislative framework for health, housing and social care; and
- inspiring parity among practitioners across the disciplines and from both statutory and voluntary sectors

[15] Facilitated by the GLA, Rough Sleeper leads

[16] See 'Multiple Exclusion Homelessness and adult social care in England: Exploring the challenges through a researcher-practitioner partnership' Research, Policy and Planning (2017/18) Vol 33(1), 3-14 available at: http://ssrg.org.uk/members/files/2018/02/1.-MASON-et-al.pdf

This approach was also recommended by an international study of effective responses to homelessness.[17]

SAB chairs and practitioners recognised that adults experiencing chronic homelessness provided particular challenges for commissioners, especially in times of severe financial pressures and when funding streams are being re-configured. All understood that many areas may only be at the beginning of a process of implementing their Homelessness Strategies, but felt it was crucial to provide support and challenge to ensure focus remained on this very vulnerable cohort. Reported success of models using assertive outreach and persistent, citizen based advocacy for those experiencing chronic homelessness suggests that this may well be worth exploring as a means to complement commissioned accommodation based support. Practitioners also saw the value in extending to assertive outreach teams the 'trusted assessor' approach[18] used when people are discharged from hospital to adult social care services, provided those practitioners were supported to secure relevant expertise. This would demonstrate a real commitment to removing organisational barriers, making reasonable adjustments to take into account difficulties faced by those experiencing chronic homelessness and provide cost effective mechanisms to support statutory services carry out their assessment functions.

Findings:

Yi undoubtedly suffered abuse whilst sleeping rough. He was the victim of a number of assaults resulting in brain injuries. He also suffered neglect, both as a result of his own inability (likely linked to his cognitive impairment and mental health) to meet his daily living needs and as a result of the failings by statutory services to intervene in line with their legal powers and duties to provide necessary accommodation based support.

Practitioners involved in Yi's case did not act with deliberate intent to cause him harm. It is recognised that Yi's conditions and resulting behaviours (albeit non-intentional) coupled the complexity of the legal framework, impact of austerity and lack of organisational support already identified within this report would undoubtedly impede their ability to carry out their functions. However, his legal rights to be appropriately assessed for support to meet his housing and social care needs were also repeated ignored by a number of statutory agencies and as a consequence his health and wellbeing deteriorated. It is accepted that he suffered serious harm, such that the failings would likely have given rise to an action for a breach of his human rights. Given the definition of organisational abuse, namely '*mistreatment or abuse or neglect of an adult at risk by a regime or individuals within settings and services that adults at risk live in or use, that violate the person's dignity, resulting in lack of*

[17] 'Ending Rough Sleeping: What Works? An international evidence review' available at: https://www.crisis.org.uk/media/238368/ending_rough_sleeping_what_works_2017.pdf
[18] See CQC's guidance: https://www.cqc.org.uk/sites/default/files/20180625_900805_Guidance_on_Trusted_Assessors_agreements_v2.pdf

respect for their human rights.'[19] The SABs and partner agencies involved may wish to reflect on what actions are required to ensure staff adhere to legal obligations and protect adults at risk experiencing, or at risk, of chronic homelessness.

Recommendations:

1. **The relevant lead person responsible for the local homelessness strategy within each of the four local authorities provide assurance to their SAB that the strategy addresses those at risk of chronic homelessness, including:**
    a. **Services are coordinated to address safeguarding concerns and prevent the escalation of health/social care needs and harm through timely, coordinated assessment;**
    b. **Staff understand and act on advice from assertive outreach services when there is reasonable cause to believe a person is experiencing chronic homelessness and at increased risk of abuse, neglect and exploitation;**
    c. **The duty to provide advocacy support is met and consideration is given to commissioning this on a persistent or citizen based model for this cohort.**

2. **SAB chairs seek assurance, including from commissioners and providers responsible for supported housing[20], that staff receive training of their s42 duties to identify, report and prevent abuse to adults at risk. Consideration should also be given to how to measure the impact of that training, e.g. review of referral data, audit or MSP outcome reviews.**

3. **SAB chairs seek assurance from the relevant local authority's monitoring officer that procedures have been put in place to ensure that any civil legal action initiated by the Local Authority or providers in specified accommodation and supported living schemes (e.g. for debt recovery or eviction) actively considers whether the respondent is an adult at risk and/ or has capacity to litigate. Any policy development should also include guidance on the duty under s2 Care Act 2014 to prevent needs escalating and under s149 Equality Act 2010.**

4. **SAB chairs to directly feedback learning from this SAR to London Safeguarding Adult Board so any further revisions of the Pan London Safeguarding Adults Policy and Procedures support practitioners with**

[19] p6 Pan London Adult Safeguarding Policy and the Care and Support Statutory Guidance, 2016

[20] to also include the *specified types* of accommodation, defined in s39 and the Care and Support (Ordinary Residence) (Specified Accommodation)) Regulations 2014 as:

- Care home accommodation, defined by s.3 Care Standards Act 2000
- Shared Lives Scheme accommodation, defined by r.7 as provision under the terms of an agreement for the provision of personal care together with accommodation in the individual's home.
- Supported living accommodation, [r.8] accommodation in premises specifically designed or adapted for occupation by adults with needs for care and support or intended for occupation by adults with care and support needs and in which personal care is available if required.
- NHS accommodation

practical advice on key questions to ask (perhaps as a flowchart or decision-making tree) so they can demonstrate active consideration given to duties under the Mental Capacity Act, Human Rights Act and Equality Act when exercising functions under the Housing Act 1996 and Care Act 2014

5. **SAB chairs recommend that London SAB consider collating data to measures reduction in costs across health, housing, social care and criminal justice agencies that preventative, person-centred interventions have had for those experiencing chronic homelessness so as to inform policy and practice change.**