

Self-neglect gap analysis

Safeguarding Adult Review briefing

This safeguarding adult review (SAR) has been commissioned by the Hampshire Safeguarding Adults Board (HSAB) to identify the learning from the circumstances surrounding the sad deaths of three adults in Hampshire. Before their deaths, safeguarding concerns were raised about each person, particularly relating to self-neglect, engagement with services and their decision-making capacity.

HSAB published a self-neglect thematic SAR in 2022 which identified learning from six adults who died and concerns included self-neglect. Whilst the self-neglect thematic SAR and following response from agencies was in progress, HSAB received the three further SAR referrals for the adults in this SAR.

This SAR was commissioned to use gap analysis to identify any new learning and to understand to what extent the learning from the self-neglect thematic SAR has been embedded across the safeguarding system in Hampshire.

Key Findings

The Impact of Covid:

The lockdowns, and the associated restrictions, impacted on service delivery for a range of reasons including the level of demand, health and safety changes to working practices and staff absence through sickness or self-isolation. Although the level of referrals nationally reduced significantly during the pandemic restriction periods, practitioners highlighted the fact that they increased quickly in Hampshire in the periods where the restrictions were lifted.

Practitioners highlighted the significant improvements in the use of virtual platforms for conducting and engaging practitioners in multi-agency meetings. They also reinforced that agencies did not stop doing face to face visits where the need was identified.

Engagement:

Agencies often experience difficulties in achieving engagement with individuals. Where cases of high-risk self-neglect involve individuals who refuse to engage, the relevant agencies cannot simply disengage on the assumption that the person is making a capacitated choice to refuse support.

There is a challenge with the time and resource needed to break down barriers to engagement, due to ongoing and significant demand on resources, as well as the challenge in achieving a balance between a person's autonomy and managing risk.

Practitioners spoke positively about the 'Enhanced Support Service', a pilot being led by Adults Health and Care, to provide outreach services with specialist resources, skills and capacity to build supportive relationships with those individuals identified as hard to achievement engagement with and to overcome the barriers leading to their self-neglect.

Making safeguarding personal:

Where a section 42 enquiry has been initiated, section 68 of the Care Act 2014 states that the local authority has a duty to appoint an advocate if the person may have substantial difficulty in being involved with their safeguarding support.

Appointing an advocate for the person may increase the potential to engage with them and ensure that their voice and perspective is heard. Adults Health and Care are working on improving their processes to ensure advocacy support where appropriate and that people who meet the Sec 42 criteria are always spoken to directly with a person-centred approach adopted. Practitioners were clear that the principle of making safeguarding personal underpins service provision system wide.

Professional curiosity and executive capacity

Professional curiosity is widely recognised as helping practitioners avoid making assumptions about people's lifestyle, the decisions they make and what is important to them. Practitioners need to avoid making assumptions about people making lifestyle choices without considering how mental health, addiction or perhaps shame about their environment or circumstances may influence those 'choices'.

Having the mental capacity to make a decision (Mental Capacity Act) is often assumed as a default position with limited understanding of executive capacity. Further training and the availability of specialist advice would provide a greater confidence in applying the executive capacity element of mental capacity assessments.

Section 42 (Care Act 2014)

Learning relating to use of the Sec 42 framework in situations of high-risk self-neglect is being embedded and has improved since the 2022 thematic review. This has been supported by work undertaken to review the Multi- Agency Risk Management framework (MARM) to ensure clarity about when to use MARM and when to use the Sec 42 framework. Further tools and guidance to support the identification of the level of risk will further support this area of practice.

The quality of information within referrals is important. The lack of relevant information can have a direct impact on the effectiveness of the risk assessments completed. The partnership have identified a need to strengthen the information provided within safeguarding concern referrals.

Understanding self-neglect and hoarding:

Practitioners reported that they found the hoarding guidance and clutter rating, implemented since the 2022 review, a useful tool kit and that they were more confident of identifying cases of hoarding. However, the pathway for services and support is unclear and would benefit from further exploration.

Alcohol misuse:

The ability of professionals to understand and manage the impact of addiction, (compulsive behaviours), on mental capacity, engagement and self-neglect is paramount. Alcohol and other substance misuse can make mental capacity assessments more challenging and impact on an individual's engagement with services. Inclusion Recovery Hampshire is a service to support individuals affected by drugs and alcohol and requires the consent of the individual. Consideration is needed in relation to what effective services and support are available when an individual declines Inclusion Recovery support.

Questions for the board

1. Do the board have clarity with respect to the outreach services available across the system and would a more integrated provision ensure these services are effective and responsive to the themes raised in the review?
2. What measures can the board take to support practitioners in working with executive capacity? Should the board commission additional training and guidance for front line practitioners on this issue?
3. Is the board assured that professionals, system-wide, understand the role of the Court of Protection, how to access it, the level of decision making that should be referred and the opportunities that the process provides practitioners, particularly when working with high-risk self-neglect?
4. Is the board confident that practitioners understand how to apply the section 42 criteria in cases involving self-neglect and what measures could the board take to improve the quality of section 42 referrals system wide?
5. Is the board assured that the methodology being used within the section 42 framework is effective, in particular, the level of section 42 meetings being held and that agencies are responding in a joint, coordinated manner rather than operating in silos?
6. Is the board satisfied that the HSAB Self-Neglect guidance is suitably robust with respect to determining high risk self-neglect, the impact of compulsive behaviours and managing those people who are difficult to engage?
7. There is an identified gap in the provision of services within the escalation pathway for cases of hoarding across the system, how does the board propose to address this?
8. Is the board satisfied that the skills, knowledge and confidence are in place across the wider system to deliver positive outcomes for dependent drinkers who decline engagement with inclusion?

HSAB will work with partners to develop actions to address learning and seek assurance that actions taken have resulted in positive change.

Useful resources

[Final-version-HSAB-Self-Neglect-Thematic-SAR-March-2022.pdf \(hampshiresab.org.uk\)](https://www.hampshiresab.org.uk/Final-version-HSAB-Self-Neglect-Thematic-SAR-March-2022.pdf)

[4LSAB 7min Guide to Professional Curiosity \(hampshiresab.org.uk\)](https://www.hampshiresab.org.uk/4LSAB-7min-Guide-to-Professional-Curiosity)

[4LSAB Safeguarding Concerns \(hampshiresab.org.uk\)](https://www.hampshiresab.org.uk/4LSAB-Safeguarding-Concerns)

[4LSAB Multi-agency Hoarding Guidance 2022 \(hampshiresab.org.uk\)](https://www.hampshiresab.org.uk/4LSAB-Multi-agency-Hoarding-Guidance-2022)

[VoiceAbility | Hampshire](https://www.voiceability.org.uk/) (Advocacy information)

[Making Safeguarding Personal toolkit | Local Government Association](https://www.local.gov.uk/making-safeguarding-personal-toolkit)

[Responding To Self-Neglect And Persistent Welfare Concerns \(hampshiresab.org.uk\)](https://www.hampshiresab.org.uk/Responding-To-Self-Neglect-And-Persistent-Welfare-Concerns)