directors of adass adult social services West Midlands

Local Government Association | directors of adass adult social services | Partners in Care and Health

Summary Report

Making a difference: Effective responses to self-neglect.

West Midlands ADASS and Partners in Care and Health.

Glossary

Kate Spreadbury, Independent Reviewer. April 2024

Glossary

ASC – Adult Social Care.

CARM – Complex Adult Risk Management framework.

CPD – Continuous Professional Development.

ICB – Integrated Care Board.

LGA – Local Government Association.

MASH – Multi Agency Safeguarding Hub.

MCA – Mental Capacity Act 2005.

PCH – Partners in Care and Health.

SAB – Safeguarding Adults Board.

SAC - Safeguarding Adults Collection.

SAR – Safeguarding Adult Review.

VARM- Vulnerable Adults Risk Management.

WM ADASS – West Midlands Association of Directors of Adult Social Services.

1. Introduction.

1.1 In December 2023 the West Midlands Association of Directors of Adult Social Services (WM ADASS) and Partners in Care and Health (PCH) commissioned an independently facilitated regional workshop to explore responses to common themes about self-neglect as identified in Safeguarding Adult Reviews (SARs) (2019 -2024) in the region.

This report captures the key learning from the workshop and preparatory activities and considers what steps can be taken, regionally and locally, to develop responses to people who are neglecting their own needs.

1.2 This focused work will be of interest and use to other regions and local authorities in England in considering their current response to self-neglect and how this can be developed.

1.3 The second analysis of Safeguarding Adults Reviews in England (April 2019 to March 2023)[1] reported that the percentage of English SARs on the theme of self-neglect had increased from 46% of SARs in the 2017 – 2019 Analysis[2] to 60% of SARs. Substance misuse was noted in 33% of SARs, most often with links to self -neglect. The West Midlands regional analysis identified a set of eleven recurrent themes in the SARs about self-neglect undertaken in the last four years, many of these themes were also identified in both of the national SAR analyses.

In the regional workshop these recurrent themes were used to explore the West Midlands regional response with an emphasis on collaboration, sharing good practice and creating further opportunities for development.

2.Methodology.

2.1 **Analysis of SARs**. In preparation for the workshop the findings and recommendations from thirty -seven West Midlands SARs, all with a focus on self-neglect, were considered. Three of the SARs were "thematic" and considered the circumstances of several individuals. Overall, the thirty-seven SARs considered the approach taken by organisations to fifty-two individuals.

2.2. **Survey of local authority responses**. The consideration of SARs across the region enabled the identification of recurrent findings and recommendations which were used to inform the second stage of the methodology, a survey of current local authority responses. This was developed with the support of a group of local adult safeguarding leads. The

[1] Publication to follow.
[2] LGA (2020) Analysis of Safeguarding Adult Reviews April 2017 – March 2019 find at https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

Survey questions can be found in Appendix 1. Graphs of each local authorities' self-neglect data as submitted to the SAC returns 2016 – 2023 (appendix 3) were also circulated and respondents were asked for the narrative behind the data. The survey was completed by twelve of the fourteen West Midlands local authorities although not all local authorities answered every question, the majority of questions were answered by ten respondents. The questions asked required a detailed response that required dialogue between partners. This was challenging for some areas.

2.3 **Regional workshop**. The SAR themes and survey responses were explored in an on-line workshop. Representatives from the fourteen West Midlands local authorities attended, including Principal Social Workers, operational and strategic staff. Participants also included SAB Chairs and Business Managers, with individual representatives from Fire and Rescue, the Ambulance Trust, an Integrated Care Board, NHS England, a care and support provider and a housing provider.

Workshop Purpose:

- To share and reflect on the key messages from SARs across the region.
- To explore how responses to self-neglect are developing across the region.
- To share what is working, what the challenges and gaps are.
- To identify what can we take from the workshop, regionally and locally, to continue to develop responses to self-neglect.
- To inform a report and future multi-agency workshop or seminar.

The full programme for the workshop can be found in Appendix 3 of this Report. The workshop presented the recurring themes from the SARs supplemented with the survey responses. The emphasis of the workshop was on collaboration, finding solutions to barriers or challenges, sharing good practice whilst exploring how effective practice can be identified. It was acknowledged that each local authority has its own local context, demography and resources. The overall purpose of the workshop was not to standardise responses, but to consider how each SAB and partner organisations could develop their responses further.

3. Key messages from the SARs.

Eleven themes emerged from the findings and recommendations of the SARs. These themes recurred across the majority of the regional SARs and can be considered "key messages" with application beyond the specific SAR. Each SAR also had findings and recommendations specific to the unique circumstances of the subject. In order to identify areas for development eleven key messages from the SARs were agreed with the

safeguarding leads advisory group. Some of the key messages overlap, but for ease of exploration they are grouped into four headings below.

Key Messages from the SARs – what are the significant factors in responding to people who self-neglect?

Procedures.

1. The recognition of self-neglect and making referrals.

2. The decisions made about the response to self-neglect.

3. The "pathways" used to respond to self -neglect.

Practice.

4. What guidance is available.

5. How the provisions of the Mental Capacity Act are understood and used.

6. Engaging with the person.

7. Using advocacy.

8. Skills and Knowledge – supported by the culture and practices of the organisation.

Partnerships.

9. Multi-agency working.

10. Understanding transitions and risk.

Organisational context.

11. The resources available.

4. Findings.

4.1 Within the parameters of the commission it was not possible to undertake a detailed analysis of the SARs. However, several features of the West Midlands SARs are of note.

- Of the 52 individuals 28 were men and 23 were women, and one was transgender.
- "Substance misuse" or "substance dependence" featured in 29% (n=15) of individuals whilst "alcohol use" specifically was identified in a further 21% (n=11). 50% (n=26) of individuals considered within the SARs were described as either "misusing" or "dependent" on substances.
- "Mental health concerns" were noted in 37% (n=15) of individuals.
- 15% of the individuals were experiencing third party abuse (n =8), 10% (n=5) experienced domestic abuse and 5% (n=3) were exploited or "cuckooed".
- 23% of individuals (n=12) were described as currently "rough sleeping" or as having a history of "rough sleeping."

The second National SAR analysis noted that individuals described as experiencing "substance misuse" had risen from 28% in 2017-2019 to 46% in 2019 – 2023. 29% of individuals were described as "rough sleeping" or having a history of "rough sleeping", whilst 72% were described as having mental health concerns.

4.2 Procedures.

4.2.1 The recognition of self-neglect and making referrals.

The West Midlands regional SARs noted that self-neglect was not always recognised by potential referrers and referrals were not always made. Recurrent recommendations were to promote awareness of policies and procedures. In three SARs there was a comment about referrals from family or care providers not being as valued or acted upon as referrals from other sources. In the workshop participants added housing providers as referrers who may not always have their concerns valued.

Key questions to consider:

- Is there a common understanding of what self-neglect is amongst partners?
- Are referrers confused about where to refer concerns? Or whether self-neglect is an adult safeguarding concern?
- Are referrers identifying all adults who have care and support needs? Do they know who the s42 duty applies to?
- Is everyone aware of policy and procedures – are they easy to understand and use?
- Are all referrers treated with equal respect?

There were ten responses to the survey question about whether there was a common understanding of self-neglect across all organisations. 80% (n=8) thought there was a common understanding, 20% (n=2) thought there was no common understanding. One survey respondent said that whilst "*self-neglect is recognised, there is inconsistency in the application of the self-neglect protocols*," another reported that "*we do work closely with partners, but not all referrals are appropriate*," others noted that "*there is inconsistency across our (internal) teams*." Nine respondents answered questions about preventative responses, 67% (n=6) thought that there were preventative responses or referrals for consideration of the s42 duty in their area, 33% (n=3) were concerned that responsive actions were not being taken and referrals were not being made. One respondent remarked that referrals were often '*handovers*' with limited engagement or preventative approaches taken by the referrer. Another respondent thought it "*difficult to know, we are seeing a generally increasing trend line in self-neglect referrals, but not significant jumps*." For one area, a good indicator of whether preventative action had been taken or not was the number of Vulnerable Adult Risk Management Meetings (VARMs) called by partners. Another noted that some concerns remained within ASC care management systems and the need to use the self-neglect protocols was not being considered.

Areas had undertaken a great deal of work to promote awareness of self-neglect, developing policies and procedures, pathways and referral routes. These endeavours fell into four distinct areas:

Staff development Multi-agency training connected to pathway launch. Co-produced webinar and learning events. Bite-sized sessions. Training "champions," "expert citizens" or "practice leaders." Multi-agency workshops as part of Safeguarding week. **Promoting good practice**. Guidance – "what makes a good referral?" Introduction of peer group discussions. Using organisational escalation pathways about practice issues or the need to develop skills, tools, resources. Social Work Forum.	**SAB activities** SAB priority for the year and associated events and activities. Policy launch or relaunch events. Dedicated webpage. Leaflets. Posters with QR link to videos, webinars, guidance and articles. Learning from SARs – events and learning briefings. **Using assurance processes with feedback**. Regular single and/or multi-agency audits. Auditing concerns that do not go to s42. Trauma informed self-neglect audit. Feedback to teams/team managers after audit. Feedback to SAB Quality Assurance sub-group and strategic leaders.

4.2.2 The local authority decisions made about the response to self-neglect.

The SARs noted that when concerns about self-neglect were reported to ASC or Adult Safeguarding they often resulted in limited or no action. The identified reasons for this included bias, i.e. the idea of a "*lifestyle choice*," and misunderstanding of the law, "*the right to make unwise decisions."* The SARs also noted uncertainty by decision -makers as to whether the criteria for s42 had been met, particularly for "*rough sleepers*" and people who were substance dependent. Decisions makers did not use information about historical or "cumulative" risk when making decisions as to the eligibility of or best response to the person.

Key questions to consider:

- Does your recording system enable decision makers to easily identify historical patterns and cumulative risks?
- Is decision-making influenced by biases and assumptions about 'lifestyle choice' or 'right to make unwise decisions?'

- Is decision –making informed by an objective risk assessment of the impact of self-neglect and thorough information gathering?
- How are the s42 duty criteria being interpreted by decision-makers?

Of the ten respondents to the question about recording systems 70% (n=7) said that their recording systems enabled access to historical concerns, an easy way to understand cumulative risk. 30% (n=3) had recording systems that did not enable access to historical concerns. The latter recording systems will make the assessment of cumulative risk difficult.

The survey asked what areas had done to tackle any assumptions and biases about people who self-neglect. Discussing and developing trauma informed approaches was experienced as a powerful approach, together with development opportunities co-produced with experts by experience. Workshop participants were keen to use opportunities to work with "*experts by experience*." Multi-agency meetings also provided an opportunity to understand the person and their story. One area had produced "*myth busting*" guidance whilst another promoted a person-centred approach which explored the person's history and situation rather than acting only on their response to offers of assistance.

In terms of risk assessment specific to people who are self-neglecting 30% (n=3) of respondents were using a specific self-neglect risk assessment, one local authority shared a risk matrix at the workshop which can be used to inform referrals as well as being used by decision makers and the practitioners working with person. 70% (n=7) did not have a specific risk assessment for people who are self-neglecting.

There were variations in responses to the question of how the s42 criteria were interpreted regarding people who self-neglect. The status of substance misuse is pertinent here, "*substance misuse*" or "*substance dependence*" was identified in 50% of SAR individuals. Regarding the first of the three criteria for use of the s42 duty, "*the adult has needs for care and support*"[3], 50% (n=5) of the ten respondents to this question did not reference substance misuse in the definition of "*care and support needs*." 20% (n=2) respondents were clear that substance dependence and the impact of this was seen as a "*care and support*" need. The consequences of substance dependence can of course include disability, long term illness, or mental health issues, the terms used by respondents to describe people who may have "*care and support*" needs. One respondent reflected on how care and support needs are interpreted in their local authority,

"*there are variations in practice regarding substance misuse and unclear guidance as to whether to include those dependent on substances, when feeling overwhelmed (which is unfortunately a regularity or a constant) teams will try to gatekeep by falling back on the traditional customer groups their teams represent, e.g. Learning Disabilities, Mental Health, Physical Disability. I think the concept of what constitutes a care and support need is*

[3] Care Act 2014 s42 Enquiry by local authority.
https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

thankfully moving away from a "can you wash and dress" approach …but we still have a long way to go to change the hearts and minds of some social workers when considering adults who (self-neglect) due to substance misuse."

The third criteria for use of the s42 duty, "*as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it,*[4]*"* drew a range of responses. "*Unable to protect*" was linked to:

- whether the person had the mental capacity to understand the risks and impact of self-neglect.
- whether they engaged and accepted services (if they did they were no longer "*unable to protect*" themselves, although it was recognised that continued engagement needed to be monitored).
- Whether the person had the executive functioning needed to address the risk or risk impact.

Respondents also recognised the absence of statutory guidance on the third criteria[5], and the need for local guidance on "unable to protect" in the context of self-neglect, "*we recognise that further guidance is needed with regard to self-neglect, and this is currently a work in progress*."

4.2.3 The pathways used to respond to self-neglect.

As noted in 2.3 above, the context in which local authority or SAB works will lead to different types of pathway or response to self -neglect. The SARs did not say that any of the "pathways" used were not effective, more that where they existed they were not known or used. The survey and workshop were used as an opportunity to explore and share different approaches and to ask, "*how do you know that the pathway is working well and making a difference to people who are self-neglecting*?"

Key questions to consider.

- Care Act Section 9 is frequently used – but are section 11[6] or 19[7] also being considered?
- To whom and when does the s42 duty apply?
- Do pathways reflect risk and urgency?
- Are the pathways multi-agency? Can they be used in this way as necessary?

[4] Ibid.

[5] WM ADASS (2023) Summary Report "*Exploring and understanding safeguarding reporting across the West Midlands*

[6] Care Act 2014 s11 https://www.legislation.gov.uk/ukpga/2014/23/section/11/enacted

[7] Care Act 2014 s19 https://www.legislation.gov.uk/ukpga/2014/23/section/19/enacted

- How do you know the pathway is working?

Survey responses demonstrated approaches to concerns about people who are self-neglecting falling into three areas:

- Progress using s42(1)[8] and where needed s42(2)[9].
- Use s42(1) to decide on which pathway – if s42(2) is not indicated people can be "signposted", offered a s9[10] assessment or other approaches.

The majority of respondents described a third approach – responses were made prior to any decision making under s42(1). An example of this approach was described as offering guidance to ASC and other partners to support engagement, persist and work together to mitigate risk prior to any consideration of s42. "*This will include assessments under section 9 or 11 of the Care Act 2014; advocacy, mental capacity assessments, using the "Working with Risk" framework*."

The majority of approaches begin with an offer of assessment and support, the s42 duty is then considered if the person does not engage with this, lacks capacity or there is "*high risk harm".*

In addition to the Care Act based pathways two survey respondents described frameworks used for people with "complex needs," a Complex Adult at Risk Management Framework (CARM) which supports longer term multi-agency working and a Vulnerable Adult Risk Meeting (VARM) which supports multi-agency early intervention and a risk framework.

4.2.4 How do areas know the pathways used are working well and making a difference to people who are self-neglecting?

Five survey respondents used service user feedback, two respondents relying on this as a way of assuring the pathway.

Other respondents used arrange of methods including:

- Performance data.
- Audits, either multi-agency via SAB arrangements or single agency, both using quality assurance frameworks.
- Dip sampling, outcome reviews and peer or "panel" reviews.
- Feedback from partner agencies.

One respondent noted "*we have concerns that the pathway is not as effective as it could be. We have completed a detailed self-neglect audit facilitated by the SAB to highlight areas for improvement."*

[8] Care Act 2014 ibid
[9] ibid
[10] Care Act 2014 s9 Assessments of an adults needs for care and support. https://www.legislation.gov.uk/ukpga/2014/23/section/9/enacted

How do areas keep track of people who are being assessed using section 9 of the Care Act as a result of self-neglect concerns? One authority undertakes audits of "*safeguarding Care Act assessments"* which will include all those who self-neglect but have not been engaged through the s42 duty. If people are seen under a specific framework (CARM or VARM) they are also easier to identify.

One local authority took a robust approach to reviewing pathways and practice. Reports from operational teams in the area indicated an increasing volume and complexity of self-neglect cases. The local authority service development and assurance team undertook a practice review, the methodology and outcomes were presented at the workshop.

Practice Review

Methodology.

A themed casefile audit - random sample of 38 out of 90 cases completed in the previous twelve months.

A staff survey - asking practitioners and managers to rate their confidence levels, share any difficulties experienced in practice, and make any suggestions on what they would find useful.

Peer group observation - Principal Practitioners attended peer group discussions where self-neglect cases were discussed.

Observation at Hoarding Multi-Disciplinary Teams run by Fire & Rescue where individual cases are discussed.

Attendance at training sessions on self-neglect and hoarding.

Reviewing local guidance and a general literature review.

Future assurance activities.

Themed self-neglect casefile audit process repeated in 2023 – the results are encouraging. The overarching Adult Social Care Learning & Improvement framework now includes:

- Self -neglect casefile audit added into rolling thematic audit programme- 6 monthly.
- Self-neglect specific casefile audit tool developed and integrated into a monthly programme.
- Self-neglect themed staff survey to be repeated annually.

-The outcome and analysis of the self-neglect audits and survey is reported to the ASC Management team once a year. The nature of data shared is:

- Number of audits completed and their ratings.
- Number of exemplars of outstanding practice identified.
- Recognition of areas of strength and areas for improvement.

- Any themes identified.
- Organisational learning identified. This may take the form of adapting guidance, looking at training required or carrying out CPD work with practitioners to support with improving practice.

4.3 Practice.

The majority of the recurrent themes from SARs concerned practice with recommendations intended to support best practice with people who self-neglect.

4.3.1 What guidance is available to support practice?

The regional SARs made a number of common findings or recommendations on guidance that will support effective practice.

SAR recommended approaches to working with people who self-neglect most commonly focused on how the person might be engaged.

Approaches to support engagement with the person

- Person-centred, flexible approaches.
- Single or multi-agency engagement plans.
- Taking time to understand the story.
- Trauma aware or trauma informed responses.
- Sharing information on how to prevent disengagement.
- Identifying and preparing for use of "windows of opportunity."
- Knowing what to do if the person is in a high impact risk situation, but they say go away.
- Using advocacy to promote or maintain engagement, so that the person can be heard or be at the centre of decision- making or planning, so that the persons' rights are upheld.

The majority of areas (66%) use the West Midlands Self-Neglect Guidance[11] as the basis for their approach to working with self-neglect. This may offer some opportunity to disseminate guidance across the region. 44% (n=4) of twelve survey respondents used local SAB policies and procedures which had been reviewed and amended in the light of local SARs.

Key questions to consider.

Do you have the following guidance for use when working with people who self-neglect?

[11] West Midlands Safeguarding Editorial Group (2021) "*ADULT SELF-NEGLECT BEST PRACTICE GUIDANCE*" version 3.

- Preventative approaches – these can be multi-agency.
- How to work with people organisations find hard to engage.
- Specific risk assessments for self-neglect.
- Guidance on working with people who are substance dependent.
- Contingency planning (using windows of opportunity).
- How to use the provisions of the Mental Capacity Act – including executive dysfunction; substance dependence; physical or mental illness.
- Working with people who have experienced or are experiencing trauma.

The use of the Mental Capacity Act will be explored in section 4.3.2 below.

Eleven survey respondents answered the question, "*do you have guidance on a preventative approach for early intervention?"*

67% (n=8) have guidance, whilst 18% (n=2) have no guidance on preventative approaches. Two respondents said that guidance was currently "*under development*."

Ten respondents answered the following questions.

"Do you have guidance on approaches to use when people are hard to engage?"

60% (n=6) have guidance, 30% (n=3) do not whilst one respondent thought that there was some relevant partial guidance included on how to undertake an assessment under section 11 of the Care Act.

"Do you have a specific risk assessment to use when people self-neglect?"

40% (n=4) used a specific risk assessment, 50% (n=5) did not, one respondent thought that a risk assessment would be covered within the safety plan.

"Do you have guidance on working with people who are substance dependent?"

40% of respondents have guidance, one respondent has no guidance but directed people to an Alcohol Change publication[12] on their intranet. 40% (n=4) of respondents had no specific guidance.

"Do you have guidance on using windows of opportunity or making contingency plans?"

70% of respondents have contingency planning guidance, although one respondent said that "*improvements are needed*". 30% (n=3) had no guidance.

"Do you have guidance on using advocates to support engagement and relationship building?"

[12] Alcohol Change UK (2021) *How to use legal powers to safeguard highly vulnerable dependent drinkers*. Find at https://alcoholchange.org.uk/publication/how-to-use-legal-powers-to-safeguard-highly-vulnerable-dependent-drinkers

80% (n=8) have guidance, although one respondent said that this was used *"inconsistently"*, and another that the guidance needed further improvements. 20% (n=2) had no guidance.

4.3.2 How is the Mental Capacity Act (MCA) being used in practice? What guidance exists to support practitioners?

How the MCA was being referenced or used featured in all of the SAR within the region. In the majority of the regional SARs mental capacity was presumed, the findings and recommendations focused on particular aspects of the person's ability to act on decisions or on what influenced decision making.

Key questions to consider.

- Is mental capacity being presumed appropriately?
- Who undertakes the assessment? Are some organisations reluctant to undertake capacity assessments?
- Are practitioners able to take the time to understand and observe the person?
- Do practitioners understand executive (dys)function, and how to identify this?
- Is the impact of substance dependence understood – both physically and in decision making?
- Is the impact of physical health status and mental health status on decision making understood?

Survey respondents were asked if they had guidance on assessing mental capacity and making best interest decisions about people who self-neglect. Twelve respondents answered this question, 70% (n=9) have guidance, 30% (n=3) do not.

Respondents were asked if guidance on executive dysfunction was included, 42% (n=5) have this guidance, 58% (n=7) do not.

In response to the question, "*does the guidance include information on assessing capacity when people are substance dependent or have a physical or mental illness that may influence their capacity to make decisions or to act on them*?" 33% (n=4) said that their guidance does include this information, 77% (n=8) said it does not.

4.3.3 Skills and knowledge. Lastly in this section on practice we consider practitioners' skills and knowledge and ask how these were being developed within organisations. The SAR findings and recommendations particularly focused on the development of:

- Relationship building, listening to the story, developing trust.
- Professional curiosity and the confidence to have "difficult conversations."
- Identifying and understanding trauma and defences against trauma – survival responses.
- Motivational interviewing.

- Legal literacy.
- Transitional safeguarding.
- Using tools to identify substance misuse and complexity and using dependency screening tools.

The majority of responses focused on "*training*" or "*promoting awareness*" in these areas. One respondent focused on the need to support these responses through supervision.

55% (n=5) of survey respondents had training available on trauma aware or trauma informed approaches, in one case the training was mandatory. Other respondents said that "*this is an area we are looking at*" or "*we are in the very early stages of exploration*" One respondent said that trauma training would be included in the training strategy for this year, another that there was a "*cross Children's and Adults Plan following two Child Safeguarding Practice Reviews."*

Eight respondents answered the question on developing professional curiosity, 50%(n=4) had training available and/or had issued practice guidance. The remaining respondents had dedicated webpages, and/or were actively considering how to take the approach forward.

The question on the development of transitional safeguarding was misunderstood by two respondents who talked about transitions work, this is a common misunderstanding of the term. One respondent reported that transitional safeguarding was part of their local safeguarding and exploitation guidance. Another respondent was working with the Local Children's Partnership to develop the approach.

Seven respondents answered a question about developing skills and knowledge in executive dysfunction. 43% (n=3) said that this was included in training, "*robust training has been rolled out. MCA training and workshops also explored this, and I have attended events when those with life experience are involved."* Another respondent said that executive dysfunction was considered in trauma training. Other respondents said that training was "*still in development*" or was planned for this year or that further development was needed.

Of the eight respondents who responded to a question about motivational interviewing 50% (n=4) had on-going training, two had trained some staff but further training was needed, one included the approach in trauma training, and one did not use the approach.

One respondent had screening tools to use to explore alcohol use. Two relied on "*specialist agencies*" for example drug and alcohol services or public health led policy and procedures. The Alcohol Change publication[13] was also referenced.

Legal literacy was addressed via training in 50% (n=5) of the ten respondents to this question. Other respondents reported webinars or web-resources resources, and training on specific topics from a University. Using supervision to promote legal literacy was reported by one respondent.

[13] Alcohol Change UK 2021 ibid.

4.3.4 Within the workshop discussions and the survey respondents emphasised the impact of the context in which people worked on their practice.

"A barrier is time, demand on the services time to build meaningful rapport and relationships that support change. We know that people like consistency and require on-going longer - term support. This is not always feasible within the systems and teams we currently have."

"there is a real challenge around working effectively with people who self-neglect and what we know works around relationship building, taking time to understand and work with the person. Unfortunately, that that time and capacity is in very short supply, not only within social care but actually across the whole partnership of agencies. And that is a real challenge that I'm not sure any of us has a very clear and easy answer to."

4.4 Partnerships.

4.4.1 The regional SARs all emphasised the need for positive multi-agency working at all stages of concern about self-neglect, from preventative work undertaken pre-referral, information sharing to inform decision making, and the need for multi-agency meetings and cooperation to support engagement, risk assessment, safety planning/problem solving and on-going support.

Key Questions to consider:

- Are opportunities to promote multi-agency approaches used?
- Are the right agencies represented?
- Are we clear about the prerequisites for positive multi-agency working? About the expectations of multi-agency meetings and collaborative working?
- Are "resolving professional differences" or escalation protocols being used in all of the circumstances that they can be used?

4.4.2 Promoting collaborative working. The survey asked areas what they had found helpful in promoting multi-agency collaborative working. The majority of the ten respondents to this questions talked about meetings. These meetings ranged from Multi-Agency Safeguarding Hubs (MASH), or regular short meetings, to meetings supported by a framework which focused all involved organisations (CARM/VARM/Multi-Agency Resolution Group etc.) Learning events, co-produced webinars and agreed SAB priorities were also mentioned. One area is part of a Changing Futures programme which has increased collaboration between partners.

Collaboration can be hard in the current climate, when organisations have stretched resources and focus on what they must do rather than what they could do,

"I see more and more of what we call silo working. People are saying, "no, I'm commissioned to do that, or this is what I do, because I just can't contemplate that I've got resource to do anything else." It is a really difficult time. We need the "culture of We"."

"Isn't it about not looking at just what our statutory responsibilities are but looking broader than that and looking at actually - what is in our gift? We all know that we have limited resources and limited availability of those resources, but how can we best use that across our partnerships to most effectively to work with people?"

4.4.3 Resolving professional differences. All SABs in the region have published resolving professional differences or escalation protocols. Findings from the SARs indicate that these are not always used or seen as mechanisms for resolving issues outside of the s42 duties.

"The thematic review found more of an issue in barriers to escalation where agencies stated they were not happy with the responses given to referrals or to case decisions made, but did not know where or how to escalate issues."

In workshop discussions participants referenced "risk escalation" panels or processes which were connected with unmitigated risk rather than resolving professional difference. Participants discussed their frustration about organisations that did not attend multi-agency meetings and reported that meetings chaired by senior managers attracted consistent attendance from participants who did not respond to practitioners. Escalation protocols were not routinely used to resolve these issues although one survey respondent reported frequent use of the protocol for these reasons. 80% (n=8) of survey respondents reported that they either had no difficulty with all agencies attending multi-agency meetings, or that they had good mechanisms to address non-attendance – for example asking the ICB to support a GP to attend. These mechanisms did rely on practitioners reporting difficulties. Of the remaining two, one found attendance "*inconsistent*" and another reported that *"the agency needs to send the right person and not just a representative. It needs to be meaningful."*

4.4.4 What were the barriers to information being shared between organisations? Of the eleven respondents to this question 45% (n=5) reported that information sharing was good, agreements were in place and there was a *"good relationship*" between partners. Workshop participants said that good relationships alone should not be relied on to ensure information sharing, when individual personnel leave the existing trust and understanding is lost. The culture and professional values of an organisation could dictate what that organisation thought worth sharing, but through using relationships an understanding can be reached.

The difference in recording or IT systems was mentioned by two respondents as a barrier, and without access to records the *"right professional"* had to be found, often leading to delays in information sharing. Misunderstanding of the law about information sharing and consent led to problems, one respondent found that health agencies would not share information unless the s42 duty had been used. Professionals were far more likely to share useful information in a meeting, getting good contextual information outside of a meeting was difficult.

4.4.5 How are multi-agency meetings being used? 30% (n=3) of respondents reported that multi-agency meetings happened and were used to prevent risk escalation but had no

"*consistent or structured approach*". Another respondent said that practice was generally responsive, not preventative. The remaining six respondents (60%) described a range of meetings to prevent the escalation of risk – meetings held within pathway frameworks (CARM or VARM), risk enablement panels or "multi-disciplinary "meetings and of course s42 strategy and protection planning meetings. One area had twice weekly meetings between police and social care to identify people who may be self-neglecting and had come to the attention of the police, potentially enabling preventative work at an early stage. Workshop participants were concerned that not all multi-agency partners had the skills and confidence to convene and chair multi-agency meetings and may not utilise these without training or support.

What are multi-agency meetings used for? Ten respondents answered these questions.

- Creating shared engagement plans? 50% (n=5) use multi-agency meetings for this purpose, 40% did not. Another did not recognise the terminology.
- Share perceptions of risk and contribute toward a shared risk assessment? 80% (n=8) use multi-agency meetings for this purpose, 20% do not.
- Agree protection plans? 100% (n=10) of respondents use multi-agency meetings for this purpose.
- Create and share contingency plans? 80% (n=8) use multi-agency meetings for this purpose, 20% (n=2) did not understand the question.

Practitioners at the workshop gave positive examples of how multi-agency meetings enabled challenge between agencies and created change together.

4.4.6. Transition and risk. The theme of "transition" emerged from the SARs, an aspect of partnership working. The identification or response or self-neglect was impeded by several types of transition, the person moving,

- from one geographical area to another,
- from one setting to another,
- from one service to another,
- or by entering adulthood.

The impact of self-neglect was also exacerbated for some as their situation changed or needs went unaddressed.

Key questions to consider:

What multi- agency strategies exist to address potential risk following:

- Discharge from Community Mental Health Teams to GP care.
- Discharge from an Acute trust to home or care home.
- Moving from one geographical area to another.
- Leaving prison to return to the community.

- Leaving children's services to no support or uncertain support.

The majority of survey respondents had either not been aware of or considered these recurrent findings about risk. One respondent was aware and reported that:
"the strategic priority for effective practice (strand 4) examines the work done to reduce risk when transferring between services. CQC self-assessment for LAs has highlighted the work required. Transitional safeguarding is currently a relevant workstream."

4.5 Organisational Context.

4.5.1 Many factors influence the development of responses to self-neglect including the resources available, existing partnerships as well as the demography and geography of the area. Some of the West Midlands areas are rural, others are compact urban areas. One area was part of a Changing Futures programme which promoted collaboration and enabled co-production with experts by experience. Some areas had specific teams that could focus on practice audits, others had been able to commission specific resources to support people who hoard. The types of decision made, and the quality of decision making, at the "front door" was thought to vary according to whether these arrangements were configured with social workers or staff without social work qualification. Some areas had many new or temporary practitioners, or vacancies. Making "self-neglect" a SAB priority was thought to be helpful.

Key questions to consider.

The SARs recommended a range of resources which could support responses to self-neglect.

Are these resources available or achievable in your area?

- Preventative services and relationships.
- "Complex" teams that can focus on a long-term relationship with the person.
- The ability to create a "team around the person."
- Dual diagnosis services.
- Support for people who hoard.
- Organisational commitment and capacity for relationship-based working.

At the workshop participants described resources used to support people who hoard. Two areas had been able to commission specialist support. Others found it difficult to identify the support needed, and in the current economic climate it was only possible to provide services under Care Act section 19[14] in emergencies.

"Commissioned services will not always provide support and individuals will not always be willing to pay for it."

[14] Care Act s19 ibid.

Workshop participants shared experiences of using resources that were low cost but effective, risk matrices – to be used with professional judgement, self-assessment tools, peer support, staff surveys, positive feedback after audits, good practice examples.

One area had benefitted from mentoring by another local authority who was already experienced in the use of the multi-agency pathway being implemented.

4.6 What does the data tell us?

As can be seen from the graphs in Appendix 2, the number of self-neglect s42 enquiries are stable in some local authorities over the last seven years but show wide fluctuation in others. The survey asked respondents for the narrative behind the data. Five responses were received.

- *Audit has shown that some "self – harm" cases are being badged as "self-neglect."*
- *There are increased concerns as a result of: more need, practitioner awareness, improved practice around trauma, MCA, information sharing.*
- *We have better recording with a new system.*
- *The spike is about risk aversion after SARs – we have now addressed the situation.*
- *The data is consistent with the pathway (low but consistent numbers of s42 enquiries relating to self-neglect).*

Local authorities are interrogating their data to understand what it means. Elsewhere in the survey other respondents indicated the need to *"understand and use"* performance data effectively.

5. Analysis and areas for further consideration.

These considerations can be taken forward via a multi-agency seminar and mechanisms for sharing expertise and experience in the West Midlands Region.

5.1 The self-neglect survey responses indicate considerable progress toward building effective systems to prevent and respond to self-neglect across the region. The West Midlands region has a wide range of approaches and experiences to draw on. Respondents to the survey indicated that many of these approaches were initiated in response to learning from their local SARs.

5.2 Considerations 1- 9.

Consideration 1.
Councils and partner organisations in the West Midlands region should consider how to use the individual knowledge and experience of local authorities to create a "knowledge bank" of approaches and responses to self-neglect. Consideration of arrangements for local authorities to mentor or support each other will promote the effective use of approaches that are new to some local authorities.

Rationale. The regional workshop. At which some of these approaches were presented and discussed, provided opportunities to share and explore different ideas and approaches. Participants also shared links to resources. An experience of mentoring by another local authority was shared and received positively.

Consideration 2
Council and partner organisations in the West Midlands region should consider how to support any necessary revision of the West Midlands guidance on self-neglect.

Rationale. The majority of local authorities (66%) in the region looked to the West Midlands guidance on self-neglect to inform their policies, procedures and guidance. This may be an effective vehicle with which to develop and disseminate the useful practice guidance which already exists in some local authorities in the region for general use.

Consideration 3
In addition, council and partner organisations should consider reviewing their own guidance to support practice on self-neglect.

Rationale. 44% of local authorities have developed their own guidance on self-neglect. These may also need to be reviewed in the light of the findings in this report and any changes to the regional guidance on self-neglect.

Consideration 4.
Councils and partner organisations in the West Midlands region should consider approaches to supporting risk assessment which can also be used by other agencies. This work will be collaborative with SAB partners, including care providers, and could also be considered for a co-production approach.

Rationale. Tools to support the assessment of the impact of risk in self-neglect are not widely developed in the region although experience is growing in several local authorities. Tools will be useful that

- Support all agencies in early identification and prevention of self-neglect.
- Support self-assessment and can be used by referrers.
- Can be used by decision – makers and in the on-going review of risk impact.

Risk assessment approaches should also support decisions about when escalation or multi-agency working is indicated.

Consideration 5.
Councils and partner organisations in the West Midlands region should consider if there are regional opportunities to inform the development of essential skills and knowledge in working effectively with people who self-neglect.

Rationale. Local authorities and SAB partnerships are either delivering opportunities to develop effective and legally literate practice approaches or are planning to do so. Workshop participants thought that best practice webinars or events at a regional level could inform developing approaches. Trauma informed approaches, understanding executive dysfunction and working with people who are substance dependent are developed in some areas but not across the region.

Consideration 6.
Councils and partner organisations in the West Midlands region should develop basic skills in working with people who are substance dependent.

Rationale. A significant proportion of individuals considered in the national (46%) and regional (50%) SARs are described as either "misusing" or dependent on substances. Alcohol use in particular is associated with self-neglect. Responses to people with substance dependence indicate an absence of guidance, skill and knowledge in ASC with a reliance on other agencies to respond. Basic skills are needed to enable better identification and support for people who are substance dependent in daily ASC practice. Thinking in one local authority was usefully influenced by work with Alcohol Change on the connection between deaths and ill health from smoking and use of other substances. Only one area was aware of the Alcohol Change publication on using legal approaches to support dependent drinkers, another area indicated that they were using tools to identify the impact of alcohol use[15].

[15] HM GOV (date unknown) Alcohol use disorders identification test (AUDIT)
Find at https://assets.publishing.service.gov.uk/media/6357a7af8fa8f557d85b7c44/Alcohol-use-disorders-identification-test-AUDIT_for-print.pdf
The Blue Light Project Manual (Alcohol Concern 2014) contains the AUDIT and other tools. Find at https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/The-Blue-Light-Manual.pdf

Consideration 7.
Councils and partner organisations in the West Midlands region should consider reviewing how information sharing agreements are being used in operational settings to promote a culture of information sharing; do agreements support effective information sharing and collaborative working?

Rationale. Successful partnership working, including information sharing, is based on relationships between, and meetings with, multi-agency partners. Currently, information exchange can be reliant on individual relationships rather than accepted practices. Partner's understanding of the legal basis for information sharing is not consistent, for example, in what circumstances can consent be overridden. A framework is needed to support good timely information sharing and to promote a culture of responsible information sharing.

Consideration 8.
The West Midlands safeguarding network should consider how to better engage in co-production with people with lived experience.

Rationale. Workshop participants were keen to explore how self-neglect guidance and development opportunities could be informed by co-production with people with lived experience. It is understood that WM ADASS has developed a co-production advisory network across the region.

Consideration 9.
WM ADASS and PCH should consider sharing this Report with other regions.

Rationale. Sharing with other regions will disseminate the learning and invite other councils and partner organisations to engage in sharing and mentoring the approaches that are helpful in working with people who self-neglect.

6. Considerations from the WM ADASS (2023) Summary Report "*Exploring and understanding safeguarding reporting across the West Midlands"*[16].

Three considerations from the 2023 WM ADASS report are relevant to the findings and considerations in this report on self-neglect. Councils and Safeguarding Adults Boards in the West Midlands can usefully consider what progress has been made in acting on these considerations.

Consideration. (number 3 in the 2023 Report)
Councils and Safeguarding Adults Boards in the West Midlands region may consider reviewing the definitions which inform the three criteria for use of the s42 duty within the West Midlands regional Policy and Procedure.

Consideration. (number 3 in the 2023 Report)
The region may also wish to recommend the need for a clarification of the 'unable to protect' criteria to the national ADASS safeguarding policy network.

Consideration. (number 5 in the 2023 Report)
Councils in the West Midlands region should consider how they will audit decision - making on cases referred as safeguarding concerns that are referred onto non s42 pathways for support. SABs will receive information about safeguarding trends but should also require reports on outcomes for people referred as a safeguarding concern who are offered a response assessed as more appropriate to their situation. This could produce rich learning about the wider safeguarding system.

[16] WM ADASS (2023) Summary Report "*Exploring and understanding safeguarding reporting across the West Midlands"* available at https://www.wm-adass.org.uk/media/13sepf4a/safeguarding-exploring-data-reporting-wm-23-f1.pdf

Appendix 1 Pre-workshop questionnaire.

1. Name of your local authority.

Note: The name of your local authority will not be included in post workshop written reports.

2. What specific outcomes do you want from attending the workshop? Are there areas that concern you about self -neglect in your area that you would like to discuss?
3. Please look at the data for your local authority. What is the narrative behind it?

Policies in your local authority.

4. In the context of self-neglect, what does your local authority consider a 'care and support 'need?

Note: Local authorities do vary nationally, in who they consider as having a care and support need, for example whether they consider someone who is substance dependent or has a mental health need as 'having a care and support need.'

5. In the context of self-neglect how do you define '*as a result of (care and support) … needs is unable to protect himself or herself against the abuse or neglect or the risk of it*'?
6. Do you follow the West Midlands policy and procedures on self-neglect, or do you follow your own policy and procedures?

7. Analysis of Safeguarding Adult Reviews (SARs) in the West Midlands region has identified the following as being recommended for inclusion in policy and procedure. Does your self-neglect policy and procedures include any of the following?

A preventative approach for early intervention.

Guidance on working with people who organisations find hard to engage.

A specific risk assessment for use with people who self-neglect.

Guidance on working with people who are substance dependent.

Creating and using windows of opportunity when working with people who self-neglect (contingency planning)

Use of advocacy to support engagement and relationship building.

8. Do you have guidance on assessing Mental Capacity and making best interests decisions?
9. Does guidance include Executive Dysfunction (sometimes called Executive Capacity)?

10. Does guidance include information on assessing capacity when people are substance dependent or have a physical or mental illness that may influence their capacity to make decisions or to act on them?

Processes in your local authority.

11. Describe how concerns about self-neglect are progressed in your area: Please give as much detail as you can.

Note: Some local authorities use a specific pathway for concerns about self-neglect, often using section 9 of the care act to explore support needed, others may determine the pathway after using s42(1), others may have a 'multi agency risk management' structure to enable concerned organisations to work together – there are many potential pathways. Do these pathways also have an escalation mechanism when risk is high and engagement difficult?

10. What methods are you using to evidence that the pathway is working well? Is the pathway making a difference to people who are self-neglecting?
11. Do the recording systems used enable cumulative risk to be identified? *Note: Recording systems should enable easy look up of historical concerns and/or risks.*

Partnership Arrangements in your local authority.

12. How are you encouraging collaborative partnerships in your area? What has been helpful? Do give an example of how you have encouraged collaboration below:
13. Is there a common understanding of what self-neglect is in your area?
14. Do organisations consistently refer concerns or take other preventative action?
15. What have you done to promote and maintain awareness of self-neglect and local procedures?
16. Are there any barriers to information sharing within and between organisations?
17. Are multi-agency meetings being used to prevent self-neglect escalating?

19.When the person who is self-neglecting is at risk and hard to engage, are multi-agency meetings used to:

- Create shared engagement plans?
- Share perceptions of risk and contribute toward a shared risk assessment?
- Agree protection plans?
- Create and share contingency plans?

20.Which organisations are involved in multi-agency meetings? Any missing partners?

21.Has the SAB published a Resolving Professional Differences (escalation) pathway?

Transfers between services.

22. Has any work been undertaken to reduce risk for people moving between services?

Regional SARs have identified that post mental health or acute trust hospital discharge and post discharge from a Community Mental Health team to GP care are times when risk can

increase, often because of a lack of information sharing or partnership working resulting in identified risk not being known and post discharge actions not being followed.

Practice:

23. Regional SARs recommend the approaches below to support best practice when working with people who self-neglect. How are you developing these approaches? Working with Trauma

Professional curiosity.

Transitional safeguarding.

Understanding executive dysfunction.

Motivational interviewing.

Understanding substance misuse including the use of alcohol screening tools.

Legal literacy.

24. Many SARs refer to poor decision -making on the basis of assumption ('lifestyle choice') or legal misunderstanding ("right to make unwise choices"). Please share any approaches you have used that moves practitioners away from this thinking.

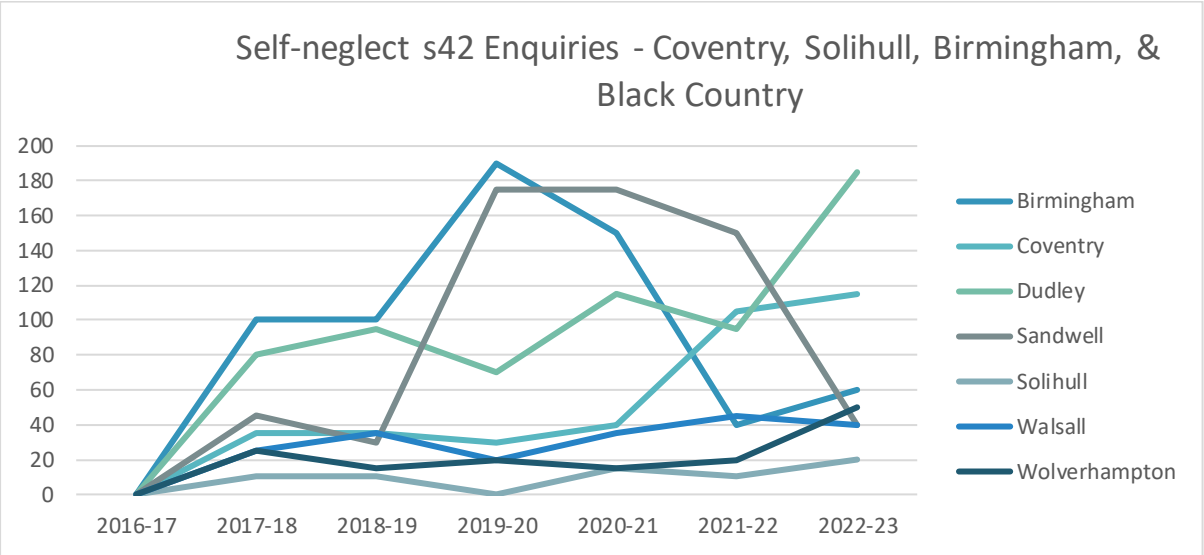
Developing an approach to self-neglect.

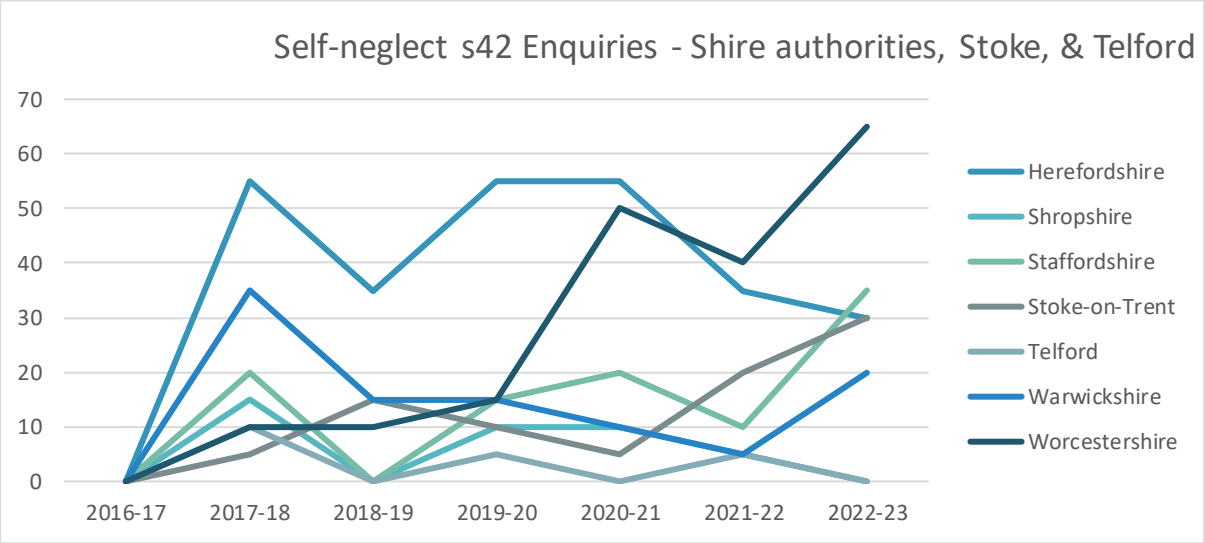
25. How have SAR recommendations on self-neglect been progressed in your area? What has supported change, what has been a barrier? How do you know that implementing change has made a difference?

26. In terms of self-neglect, are you currently putting plans into action? What are your future plans?

27. Is there anything else that you would like to tell us about the approach in your area to working with people who self-neglect?

Appendix 2.


Self-neglect s42 Enquiries - Coventry, Solihull, Birmingham, & Black Country
200
180
160
140
120
100
80
60
40
20
0
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23
Birmingham
Coventry
Dudley
Sandwell
Solihull
Walsall
Wolverhampton


Self-neglect s42 Enquiries - Shire authorities, Stoke, & Telford
70
60
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2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23
Herefordshire
Shropshire
Staffordshire
Stoke-on-Trent
Telford
Warwickshire
Worcestershire

Appendix 3.

Programme.

West Midlands Region Self-Neglect Workshop.

29th February 2024 9.30 – 3.30. Online.

9.30	**Welcome Introduction.**	
9.40	Introduction to the workshop: - Purpose of the workshop. - Participants outcomes. - Workshop principles. - Programme.	Facilitator.
9.50	Analysis of regional and national SARs – what did we learn? Narratives around the data.	Presentation – facilitator followed by discussion.
10.30	Responses – what are the challenges to developing responses to self-neglect? What has helped?	Small group discussion and feedback.
11.00	**BREAK.**	
11.15	Risk assessment to support decision making	Local authority presentation with Q and A.
12.00	Operational issues: pathways, gaps and challenges.	Facilitated discussion with short presentation on specialist hoarding services.
1.00	**LUNCH.**	
1.30	Muti-agency working.	Local authority presentation on multi-agency working Q and A.
2.10	How do we know how we are doing?	Local authority presentation on analysis with Q and A
2.30	What next? What can we take forward, regionally and locally, from today's workshop?	Small groups discussion then feedback.
3.15	**Closing thoughts.**	