West Sussex Safeguarding Adults Board

Executive Summary:

Meta-Analysis of Safeguarding Adults Reviews Featuring Self-Neglect

Introduction

This meta-analysis was commissioned by the West Sussex Safeguarding Adults Board (WSSAB). East Sussex Safeguarding Adults Board (ESSAB) and the Brighton and Hove Safeguarding (B&H SAB) Adults Board contributed to the meta-analysis by providing Safeguarding Adult Reviews (SARs) for analysis, and by being part of the review panel.

This analysis includes the circumstances of two adults who were referred to the WSSAB; IL and TB, who both had a history of self-neglect (further details about IL and TB can be found in the full analysis accompanying this summary). At the point of referral for IL and TB it was agreed that, although individually both cases met the criteria for a SAR, there was a need for wider learning regarding self-neglect within Sussex as a whole. To do this, a thematic analysis of findings from recent SARs involving self-neglect was commissioned to consider changes to practice, process, policy, and procedure.

Summary of the key areas for analysis

- The use of the self-neglect process
- Multi-disciplinary team working and practice
- The use of Mental Capacity Assessments, best interest decisions, Deprivation of Liberty Safeguards (DoLS), the Mental Health Act, and public health legislation
- The completion and implementation of risk enablement plans
- The exploration of barriers to practice
- Roles and responsibilities in working with self-neglect cases
- Further guidance for care homes/agencies and their roles in self-neglect
- The difference between keeping someone safe and safeguarding
- Determining mental capacity by looking at patterns of decision-making and understanding medical conditions that might influence capacity
- A supportive approach to ensure there is not a blame culture

Method and data set

This analysis considered seven published SARs commissioned across Sussex (published between 2020 and 2023), alongside the circumstances for IL and TB. Details of these SARs, along with the causes of death and protected characterises for adults involved, can be found in the full version of the analysis.

Findings from the meta-analysis

Multi-disciplinary working

The Sussex Self-Neglect Procedures provide a clear pathway. However, this analysis identified a series of issues implementing procedures in practice, especially across different agencies, including:

- identifying the need for/agreeing a lead agency to coordinate multi-agency actions
- identifying a lead professional to maintain contact with the adult
- recognising when multi-agency meetings are required
- clarity about when to escalate from single to multi-agency work, and that this can be done outside of a safeguarding enquiry (S42)

The analysis suggested that a safeguarding tool kit of options, assessments, and escalation routes may support practitioners.

Mental capacity

Assessment of mental capacity was evidenced as a challenging area, such as when to question mental capacity, particularly when someone is able to show decisional capacity but not executive capacity to put expressed decisions into action.

The analysis identified the link between Acquired Brain Injury (ABI) and self-neglect. Sussex Safeguarding Adults Procedures reference ABI and the need to distinguish between 'decisional and executive capacity.' However, the analysis suggests specific guidance should be included on how to distinguish this, and when to involve other professional expertise. This could also be supported by role specific training.

Risk management

The analysis identified that risk assessment and management processes in self-neglect need to be further developed to improve:

- Awareness, assessment, recording, and communicating risks
- Fire safety risk assessment

Management oversight of practice is essential and should also be improved.

Barriers to practice

The analysis identified that trauma-informed approaches need to be further developed. One of the priorities for the Sussex Changing Futures programme is to build a Trauma Informed workforce across Sussex. There is also a need to consider the impact of barriers to access to services faced by people who self-neglect.

Development in care providers and self-neglect

The analysis identified that care providers should be considered as part of a system of care and as performing an equally important role. Any challenges should be the responsibility of all partners to resolve. Care providers should know and understand what they must do in relation to self-neglect and the legal context of mental capacity.

The National Institute of Clinical Excellence produced guidance on Safeguarding Adults in Care Homes. This guidance should be used in practice development and monitoring.

Use of safeguarding adults' processes

Safeguarding Adults processes for self-neglect and any adult safeguarding thresholds should be compliant with the Care Act and should be informed by national guidance. Management oversight of the application of processes and interventions is essential.

A separate self-neglect procedure may also be useful to provide additional focus and attention to self-neglect and hoarding and to emphasise understanding that this is not always a safeguarding matter requiring a S42.

Summary of findings for IL and TB

Summary of findings for IL (full findings available in meta-analysis report)

1. If a plan is proposed outside of a S42, a system for ensuring actions taken needs to be agreed.

2. Tasks need to be allocated to a specific person with an agreed timescale to ensure accountability and completion of actions.

3. Care services may need support to recognise self-neglect, when this may be a safeguarding concern, and when to seek help from other services.

Summary of findings for TB (full findings available in meta-analysis report)

1. Strengths-based, relationship focused approaches, support engagement with people who self-neglect. Finding out more about an adult's life story can assist with identifying opportunities to do this.

2. Assess mental capacity and, where indicated, use of Deprivation of Liberty Safeguards (DoLS), particularly when adults who are self-neglecting are in hospital. This can allow time for observation, assessment, and planning.

3. For adults who self-neglect and present a range of challenges, a detailed risk assessment should be carried out which considers each risk: how it relates to another; the likelihood and severity; and how it could be managed. This can help to identify areas to focus interventions and resources.

Implementation and recommendations

In order to implement the findings from the meta-analysis, the following has been suggested:

- Hold practice development sessions to explore findings further and identify/make changes to procedures/guidance
- Integrate policies, procedures, guidance, training, systems, escalation routes, multi-agency processes etc.
- Case seminars, supervision, professional development plans and appraisal targets could be used to facilitate safeguarding practice development
- Practice aids could be developed such as guidance notes and decision support tools to support with risk identification and assessment etc.
- Possible creation of a separate Self-Neglect and Hoarding Policy and Procedure

The review panel concluded that the focus for practice and policy development should be on a small number of recurring themes:

- Multi–agency working at an earlier time in a case, with appropriate leadership
- Attention to Mental Capacity and reasons for intervention
- Knowing what to do: what approaches work and acceptance of the time that it takes to work self-neglect cases