Making sense of Self Neglect

2022 Conference Report

A report from the 6th Conference of the London Network of Nurses and Midwives Homelessness Group held on 1st April 2022.

London Housing Foundation

Museum of Homelessness

Contents

Note from the Chair

This report details the first face to face conference held by the London Network of Nurses and Midwives Homeless Group since the pandemic.

Nearly 100 front line health and care practitioners working in homeless and inclusion health attended a face-to-face conference on 1st April 2022 to discuss the challenges that currently exist meeting the needs of clients who self-neglect.

It was great to see the passion and dedication, and the desire to improve care shining through in our members – nurses, allied care professionals and peer workers. It was also fabulous to have the attendance of several senior leaders in the field who helped to outline the known challenges, and what ideal responses look like – but who also listened to the experiences of those who are directly involved in providing care to help inform themselves.

The aim of the conference afternoon was to:

- open up the conversation re self-neglect
- think about how self-neglect and safeguarding interrelate
- provide a safe space for frontline practitioners to decompress
- think about how to change the conversation to get better responses
- share good practice/solutions
- identify what tools practitioners can use to influence engagement and changes.

We try to make our events as interactive as possible, and our members were directly involved in three activities:

- A panel discussion focused on 5 case studies presented by front-line practitioners
- A Mentimeter interactive poll
- Focus group discussions

This report outlines key points from the presentations from the day, the findings from the panel discussion, poll and focus group discussions, and also presents the cases from the panel discussion. This information is now being used (in partnership with the Healthy London Partnership London Homeless Health Programme) to raise the profile of this issue and to help effect change.

This is an example of the value of the LNNM network, and I am very proud to present this report on behalf of the network.

Jane Cook,
Chair of LNNM

Executive Summary

Findings from the panel discussion

The 5 case studies presented and the discussion that followed revealed the following key themes:

- Getting a response from safeguarding and Social Care is difficult. Inclusion health services often feel they are unable to get the needs of their client met and are concerned about the associated high level of risk they hold as a result.
- The ability to 'wash and dress' is often being seen as the threshold of Care Act, and care needs are not being assessed 'in context'. Care needs related to brain injury and mental health are often overlooked.
- Professional expert agencies are in dispute over mental capacity assessments, and executive capacity is often not being assessed properly (or at all). Inclusion health services hold a lot of expertise in this area, but this is often overlooked.
- Some people are not being seen as a safeguarding concern despite being severely self-neglecting, because they have been deemed to have mental capacity.
- With persistence, when people do get the right accommodation and support, (often contrary to the expectations of other agencies) health can improve, and A&E and hospital attendances drop. However, this can be an exhausting process.

Mentimeter interactive poll

Conference attendees said that 40-80% of their caseload would be seen as self-neglecting from a safeguarding perspective.

However, the poll then revealed significant issues with safeguarding responses. 43% of respondents said they 'rarely' or 'never' had referrals accepted, and this went up to 92% when the answers included were 'sometimes', 'rarely' or 'never'. Only 5% said they 'mostly' had referrals accepted, and no one said they were 'always' accepted. Sadly 39% said accepted referrals 'rarely' or 'never' made a difference.

Focus group discussions

Focus group discussions backed up the findings of the panel discussion and Mentimeter poll but added the practitioner perspective on what needs to be done e.g.

'More legal training to feel secure in challenging'
'A hard-hitting report about the deaths of homeless people'
'Auditing of rejected safeguarding referrals'

The need for the provision of guidelines / advice / case discussion forums and robust reviewing of deaths came up repeatedly. There was a general recognition of the need for increased accountability around this issue, and high-level clinical leadership to tackle perceived failures and help front line practitioners to affect change.

Introduction

What is self-neglect?

Self-neglect is an extreme lack of self-care. It is sometimes associated with hoarding and may be a result of other issues such as addictions. It implies a lack of self-care that threatens personal health and safety. It includes neglecting to care for one's personal hygiene, health or surroundings, and also the inability to avoid future harm as a result of self-neglect. It often involves a failure to seek help or access services to meet health and social care needs and an inability or unwillingness to manage one's personal affairs.
https://www.scie.org.uk/self-neglect/at-a-glance

What causes self-neglect?

Self-neglect can be a result of many things including:

- a person's brain injury, dementia or other mental disorder
- obsessive compulsive disorder or hoarding disorder
- physical illness which has an effect on abilities, energy levels, attention span,
- organisational skills or motivation
- addictions
- traumatic life change

Within the Care Act (2014) statutory guidance self-neglect was included as a category under adult safeguarding.

Why is the LNNM Homelessness Group interested in self-neglect?

- Self-neglect often effects homeless clients with a background of severe and multiple disadvantage, and results in frailty and poor health.
- Self-neglect is complex area, often involving mental health, addictions and cognition issue, and requires high expertise.
- It is a matter of life and death
- Self-neglect is often a key issue for frontline staff.
- There is a lot of vicarious trauma on this issue - we all see self-neglecting clients deteriorating, but often feel powerless to intervene.
- Getting engagement with Adult Social Care on this issue remains difficult.
- This is an issue of social justice – clients have a right to a service.
- Advice and guidance in this area is rapidly changing, but also improving all the time.
- Some good practice already exists in London, and the LNNM wants to support this.

Good Practice in London

Haringey has a Multi-Agency Solutions Panel which looks at complex adult safeguarding and safety concerns and includes rough sleepers. It meets every 4 weeks and the panel is made up of managers and senior managers from Council, CCG representatives, Hospital Trusts, voluntary sector organisations, Fire, Police etc.

The aim is to find solutions to complex situations where someone is at risk / unsafe and where the standard practice and service pathways don't seem to be working. The idea is that senior managers can usually agree more flexible personalised solutions than frontline staff, who often don't have the authority to overlook eligibility criteria and / or make funding decisions etc. They feel it works really well for multidisciplinary cases as they have all the teams/orgs in the room and a single aim of reducing risk and harm that guides our decision making.

Presentation

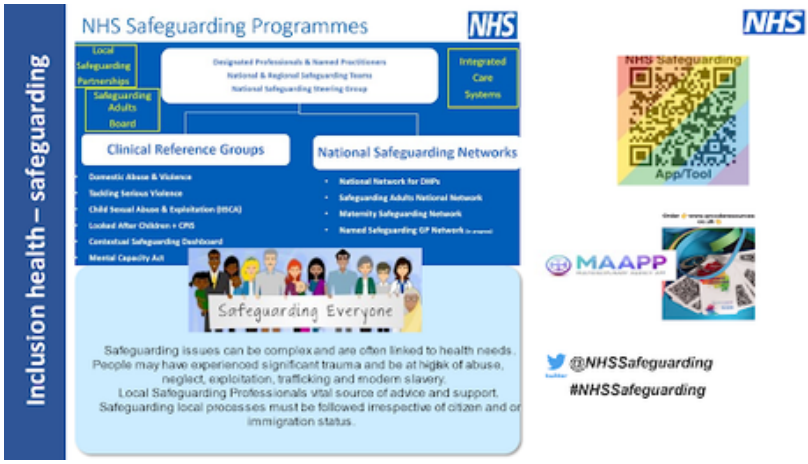
The Inclusion Health Agenda and Safeguarding, an NHSE/I perspective

Speaker profile

Elaine Goodwin, National Homeless and Inclusion Health Nursing Lead NHS England and NHS Improvement

Elaine leads the Inclusion Health strategy at NHSE / I, having previously worked at a senior level in wide range of inclusion health roles in the NHS in Leeds, Yorkshire and Humber including in asylum and refugee, Gypsy, Roma, Traveller, homelessness, sexual health, prison and custody suite services. Elaine has also led a range of mainstream services and pathways including the Leeds Diabetes strategy and the development of virtual wards.

Elaine outlined the NHS Safeguarding infrastructure, before going on to talk about the homelessness context specifically.



Key points regarding safeguarding and homelessness:

- Services need to be shaped after listening to people with lived experience
- Patients need to have access to the right information at the right time
- Barriers to accessing primary care services need to be reduced
- Complaints processes need to be made easier and accountability and responses need to improve
- Communication needs to improve across services
- There needs to be more consistent responses across geographical areas
- Access to secondary care and community support also needs to improve
- There needs to be a trauma informed approach which reduces blame 'It's not what's wrong with you, it's what has happened to you'

Presentation

Self-neglect – the perspective of an Independent Safeguarding Adult Board Chair

Speaker profile

Professor Michael Preston-Shoot
Emeritus Professor of Social Work, University of Bedford

Michael is a is a qualified social worker with huge experience of child and adult protection, mental health and family therapy practice. He has an international reputation for research and publications in the fields of law and ethics in social work education and practice, working with families, and people experiencing homelessness. He is currently an Independent Chair of a Local Safeguarding Children Board and a Safeguarding Adult Board. He recently completed research for the Department of Health on adult safeguarding and has undertaken detailed reviews of multiple homelessness SARS.

Key points from presentation

"This is challenging work!"

- 45% Safeguarding Adults Reviews involve self-neglect
- There has been an increase in Section 42 enquiries involving self-neglect
- 25-50% Safeguarding Adult Reviews involve alcohol
- Many of these involve Homelessness and self-neglect

However, there is good evidence base focused on direct practice, team around the person, roles of each organisation and governance.

1. Familiarise yourself with the evidence and understand your role. Adult safeguarding is everyone's business.
2. Legal literacy is sometimes limited in staff we interact with, particularly around mental capacity. There are frequent misapprehensions and misunderstandings.
3. If you don't agree with a decision, escalate to Safeguarding Adult Board Chair. It is better to escalate than have a death that needs reviewing.

All that is needed for you to request a Section 42.1 safeguarding enquiry is:

- Evidence that the person has care and support needs
- Evidence that as a result of those care and support needs the person is experiencing abuse or neglect (including self-neglect)
- Evidence that the person unable to protect themselves

I have seen unlawful, unreasonable and irrational responses to referrals. Escalate, escalate, escalate!

Presentation

How to use legal powers to safeguard highly dependent vulnerable drinkers

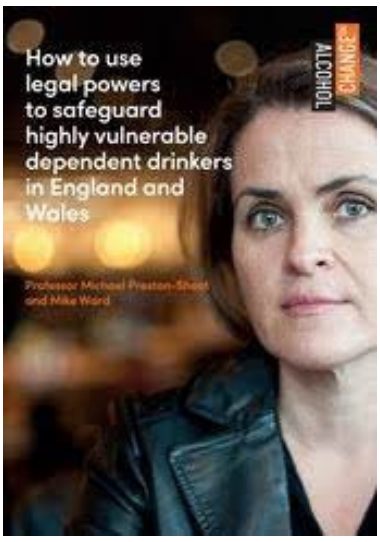
Speaker profile

Mike Ward, Senior Consultant
Alcohol Concern

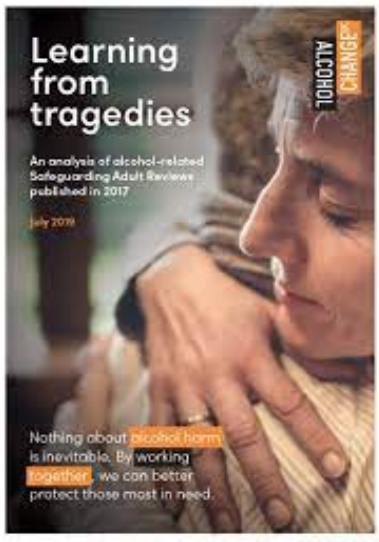
Mike has worked in the alcohol field for over 30 years as a provider, service manager and commissioner. He is a senior consultant and trainer at Alcohol Change UK providing guidance and expertise across the alcohol treatment spectrum. Together with Mark Holmes, Mike developed the Blue Light Project, Alcohol Change UK's ground breaking initiative to develop alternative approaches and care pathways to improve the response to change resistant, dependent drinkers. The project shows that there are positive strategies that can be used with this client group to help turn their lives around.

Key points from presentation

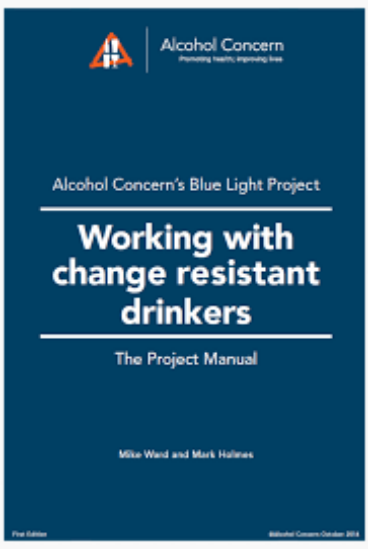
Mike introduced three documents that summarise Alcohol Concern's thinking in the area of self-neglect and alcohol misuse.



How to use legal powers to safeguard highly vulnerable dependent drinkers.



Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews.



Working with change resistant drinkers: Alcohol Concern's Blue Light Project.

In a recent review of SARS by Prof Michael Preston-Shoot:

- In 57 cases (25%) the principal focus was on a person with alcohol-related concerns
- Many involved self-neglect and/or homelessness
- The impact of personal loss and complex trauma was evident
- There were examples of fire deaths involving alcohol abuse

There were an additional 5 cases where someone in the person's environment was alcohol-dependent, and this highlights the importance of thinking 'family' (domestic abuse, impact on children, understanding family and relational dynamics). In one case the paid carer was alcohol-dependent.

Overall conclusion from the review:

These are not just "unwise decisions".

This client group face very real barriers to change and engagement. This is because of a perfect storm of concurrent conditions:

- Depression and other mental health issues
- Alcohol related brain damage / injury
- Physical health problems e.g. fatigue due to liver disease
- Confusional states e.g. liver disease, pancreatitis and urinary tract infections
- Sleep disorders
- Nutritional issues
- Addiction / dependence
- as well as many social, economic and cultural barriers to accessing services.

When considering how to respond the following containment powers for alcohol and substance misusers can be considered:

- The Care Act 2014 (England)
- Mental Capacity Act 2005 (incl DOLS and LPS)
- Mental Health Act – 1983/2007

Other relevant legislation

- Human Rights Act
- Anti-Social Behaviour powers
- CBOs and Civil Injunctions
- ASB community trigger
- Closure Orders
- Alcohol Treatment Requirement /Probation Orders with Conditions of Treatment
- Environmental Health legislation

The Care Act 2014

- Applies to people with alcohol problems
- Dependent drinkers with care and support needs have a right to assessment under the Act and if they meet criteria, the right to a care package.
- Dependent drinkers who are vulnerable, abused or self-neglecting may require safeguarding by local authorities
- Self-neglect (and/or living with abuse and exploitation) should never be regarded as a "lifestyle choice".

Mental Capacity Act 2005

A person is unable to make a decision if they cannot:

1. understand information about the decision to be made
2. retain that information in their mind
3. use or weigh that information as part of the decision-making process, or
4. communicate their decision.

Compulsion/addiction should be considered in reference to 3. e.g. a person with anorexia nervosa may understand the consequences of not eating but their compulsion not to eat might be too strong for them to ignore.

Case Study

CD: a 65-year-old man who suffers from a range of medical problems; he has a psychiatric background characterised by depression, he suffers from epilepsy and complications arising from chronic alcohol abuse. Diabetes and physical disabilities.

Complicating factors:

- *Frequent incidents of falling in his flat*
- *Non-concordant with medication*
- *Severe self-neglect - not managing his personal care, daily living activities, health and wellbeing.*
- *Home environment deteriorated to a stage that a care agency were unable to access the flat for fear of cross contamination and infection.*
- *Frequently calls to London Ambulance and Police. He attended A&E regularly*
- *CD lived alone and had a limited positive support network, he only socialised with friends in the same block of flats who had alcohol misuse problems*
- *Unable to safely complete most activities of daily living without help from his carer*

The judge ruled that CD lacked capacity in relation to decisions concerning his care. Made orders about actions to be taken in his best interest.

Executive Capacity

Executive Capacity is key in cases like this:

…the concept of "executive capacity" is relevant where the individual has addictive or compulsive behaviours. This highlights the importance of considering the individual's ability to put a decision into effect (executive capacity) in addition to their ability to make a decision (decisional capacity). Therefore, for an individual such as AW the assessment of mental capacity is unlikely to be as straightforward as a simple yes or no. Angela Wrightson SAR.

The **Mental Capacity Act Code of Practice** supports this stating that:

Information about decisions the person has made, based on a lack of understanding of risks or inability to weigh up the information, can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.

- Executive capacity should be included explicitly in mental capacity assessments for alcohol dependent clients, linked to the person's ability to use and weigh information
- Frontal lobe injury is common in drinkers which will affect executive capacity
- People may present as coherent in assessment but have very limited impulse control
- For many reasons assessing capacity in dependent drinkers is complex and should not be subject to simplistic judgements
- Decisions may require multi-agency discussion and professional discussion and challenge
- It is always important to consider what is in the client's best interest.

Mental Health Act

- The Mental Health Act (2007) defines a mental disorder as "any disorder or disability of the mind".
- The Act's definition of a mental disorder includes "Mental and behaviour disorders caused by psychoactive substances".
- Always remember that it is possible to detain someone under the Act if they have disordered mental functioning due to their chronic drinking.

Process points

- Services should have a systematic approach to reviewing vulnerable dependent drinkers to ensure everything that can be done has been done.
- Drinkers should not be let down by the system because assumptions are made.
- An MDT process and review is always needed and the document 'How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales' provides checklists for front line clinicians and practitioners to work from. https://alcoholchange.org.uk/publication/how-to-use-legal-powers-to-safeguard-highly-vulnerable-dependent-drinkers

Final points

- **It is easy to allow people "to die with their rights on".**
- **Sometimes we need to "deny autonomy to create autonomy".**

- There is current consultation on the MCA Code of Practice. Alcohol Concern is currently raising concerns about the ways the MCA is being understood in the case of people with addictions, with the consultation and the Government in order to get change.

Presentation

The role of the London Homeless Health Programme

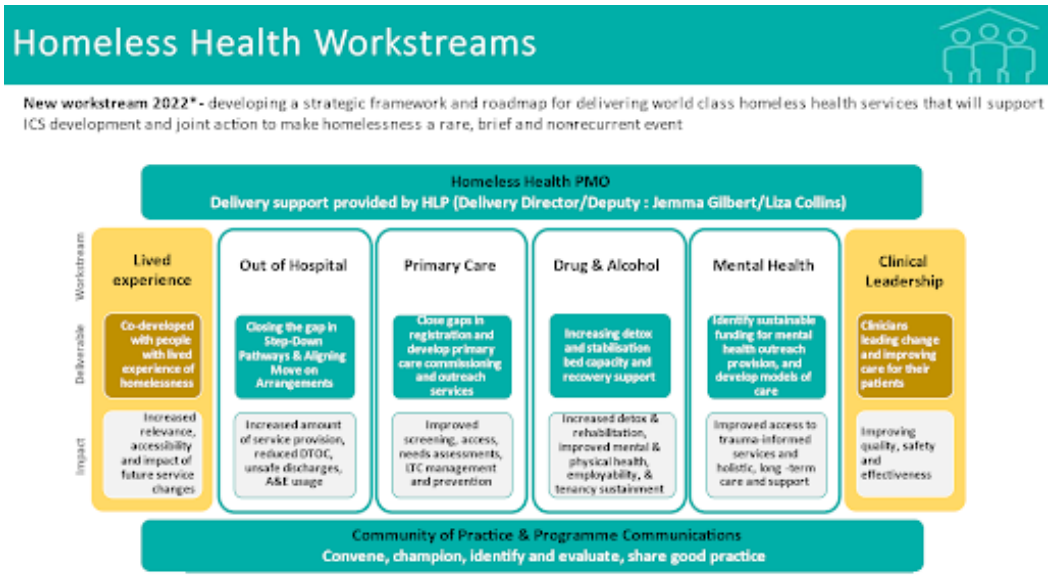
Speaker profile

Dr Caroline Shulman, Joint Clinical Lead, London Homeless Health Programme

Caroline is a clinician and researcher in Homeless and Inclusion Health. She worked for a number of years as a General Practitioner providing primary care in a specialist homeless practice and as Clinical Lead for a multidisciplinary homeless Pathway team within a hospital. She is currently co-Clinical Lead for the Homeless Health Programme at Healthy London Partnership.

Caroline is also a Pathway Clinical Research Fellow and Honorary Senior Lecturer at University College London and along with colleagues and partners leads a programme of work on palliative care, frailty and homelessness. This work has explored the challenges and barriers to accessing palliative care for this marginalized group, as well as exploring to improve access to high quality care.

Caroline introduced the role of the LHHP and explained how meeting the needs of people experiencing homelessness who are self-neglecting is a key interest that cuts across all the Homeless Health workstreams.



Pan London Homeless Health & Care Practitioners Network

Healthy London Partnership

1. Alternately chaired by Caroline Shulman and Jasmin Malik
2. Recently changed name from *"clinical leadership group"* to *"practitioners network"*
3. Meet alternate Wednesday's 4-5pm
4. Everyone working in homeless health from across London is welcome
5. Originally set up during COVID to enable clinical voice to be brought to attention of ICS leads and to share information of what was happening across London
6. Continues to be an opportunity for sharing and discussing concerns, complex cases, good practice and hearing from experts
7. If interested in joining this group, please email: hlp.homelesshealthcovid19team@nhs.net

'Self-neglect is not seen as a safeguarding issue'

Conference participant

Presentation

Evaluation of an overdose prevention facility or 'injecting room'

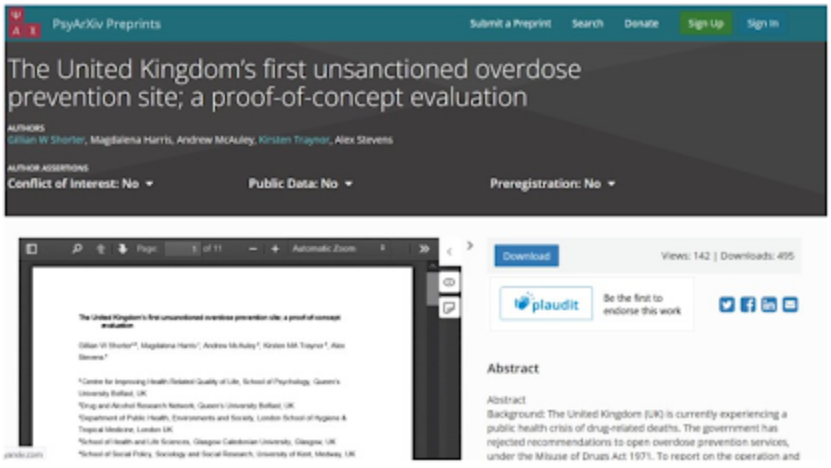
Speaker profile

Dr Gillian Shorter, Co Director of the Drug and Alcohol Research Network at Queen's University, Belfast

Dr Gillian Shorter is currently a reader in Psychology in the Institute of Mental Health Sciences at Ulster University and has been a researcher in the alcohol and drug use field for over 15 years. Her work focuses on alcohol brief interventions, hazardous drinking and patterns of consumption, long-term alcohol problems, polydrug use, and harm reduction initiatives. She works to involve experts by experience in policymaking. and is a firm believer in the key role of people with lived experience.

Since 2014, Gillian has been the research advisor to the New Strategic Direction in Alcohol and Drugs Policy Steering Group in the Department of Health (Stormont). She is also a research advisor to the North South Alcohol Policy Advisory Group convened by the two Chief Medical Officers in Northern Ireland/Republic of Ireland and led by the Institute of Public Health in Ireland to facilitate alcohol policy at an all-Ireland level.

Gillian's presentation outlined a new approach to working with self-neglect – by providing a safe space to reduce the risk of overdoses in injecting drug users. This approach was not a legally sanctioned one, but demonstrated lives saves and significant increases in engagement over time, and improved health outcomes.



https://psyarxiv.com/5bqfu/

QUEEN'S UNIVERSITY BELFAST

Key points

- 894 injection events were recorded during the time of the project (Likely over 1000 in total as some were not recorded).
- Age: 34.6 (20-65) years old, 585 (70.1%) males.
- Predominantly living in hotel accommodation (87.1%).
- 9 overdose events managed (2 cocaine, 7 opioids), 8 individuals involved. All survived, 2 ambulance call outs (1 cancelled).
- Many attendees were high risk injectors (e.g. injecting in the groin), who were already receiving opiate substitution treatment, but injecting on top.

Where are people injecting?

	Groin	Arm	Leg	Hand	Arm or Leg	Hand or arm	Anywhere can find a vein
Male	343 (62.4%)	115 (20.9%)	60 (10.9%)	6 (1.1%)	16 (2.9%)	6 (1.1%)	4 (0.7%)
Female	191 (81.3%)	15 (6.4%)	27 (11.5%)	0 (0.0%)	0 (0.0%)	1 (0.4%)	1 (0.4%)
Total	540 (68.1%)	133 (16.8%)	87 (11.0%)	6 (0.8%)	16 (2.0%)	7 (0.9%)	5 (0.6%)

QUEEN'S UNIVERSITY BELFAST

Receiving methadone or buprenorphine treatment (% yes)

	Methadone or Buprenorphine treatment
Male	410 (70.1%)
Female	136 (54.4%)
Total	559 (64.8%)

QUEEN'S UNIVERSITY BELFAST

Project staff found that trust built up over time and that clients were starting to engage and work with the team on a variety of issues when the service had to stop.

Building up trust

Injection events by month (row) frequency of visits where available (column)	Overall	First use of service	Up to 5	Up to 10	Up to 15	15+
September	30					
October	36					
November	23					
December	30					
January	17					
February**	136	12	56	13	9	21
March	438	30	85	52	61	344
April	146	9	23	4	27	146
May	38	2	9	6	4	38

QUEEN'S UNIVERSITY BELFAST

This project demonstrates how approaches to self-neglect can be looked at from a peer led perspective.

Issues that came up regularly in the process of the work were:

Qualitative comments

Abscesses and infections	Mental health (includes brain injury, and self harm or other general mental health)	HIV/ARV matters	Mobility issues including amputations	Treatment needs (incl referral to treatment, hospitalisations, etc)
DVT or blood clots	Struck off Methadone	Alcohol related brain damage	Injecting site concerns (incl bleeding, missing hit, not finding veins, changing site due to visibility in the van)	Criminal justice matters including police interference, prison release, arrests, or talking to police
Naloxone or overdose related matters	Pregnancy and post partum	Practical matters	Victim of violence	Health improvements (including housing, feeling in control etc)

QUEEN'S UNIVERSITY BELFAST

Presentation

Learning from the new NICE Guidance (published March 2022)

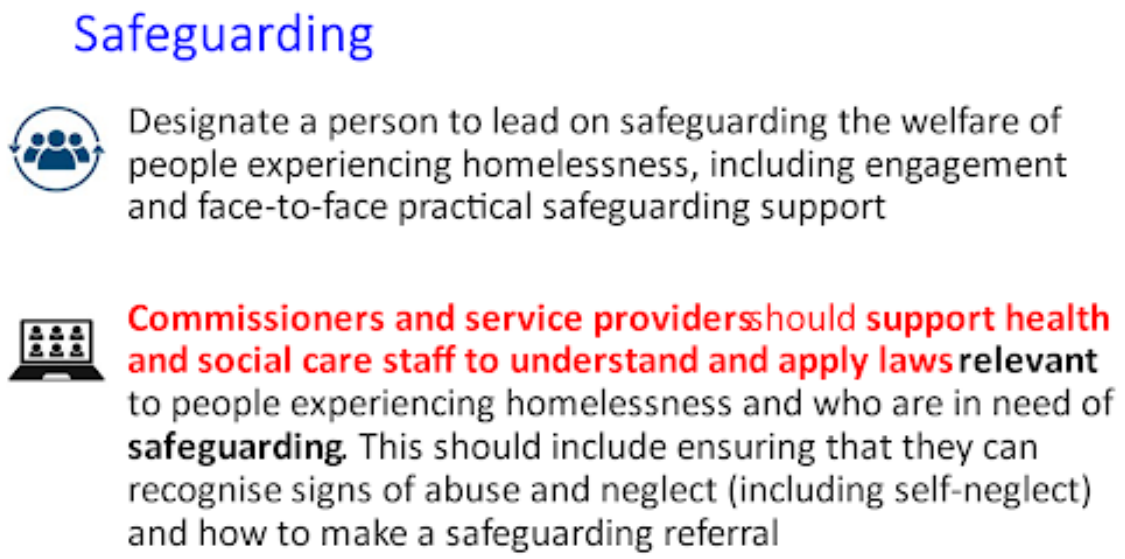
Speaker profile

Professor Al Story, Clinical Lead of the pan-London UCLH Find & Treat Service

Professor Al Story is a senior nurse and Founder of the pan-London Find & Treat Service based out of UCLH. His core expertise is in tackling tuberculosis and other communicable diseases among homeless people, drug and alcohol users, prisoners and destitute migrants.

His research interests include outreach, integrating point of care diagnostics on the street, case management, the inclusion of service users within MDTs and the use of mobile internet technologies to promote engagement with health services and treatment continuity. He is an original member of the Faculty for Homeless and Inclusion Health and a Senior Lecturer at the Farr Institute in London.

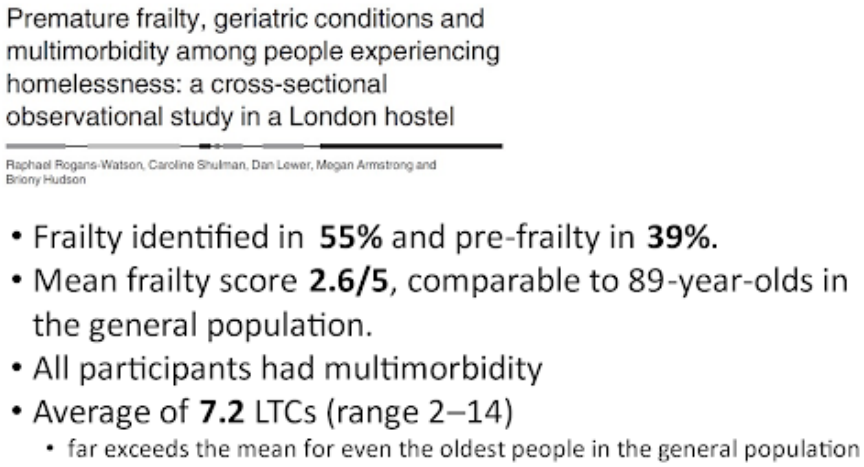
Dr Al Story was a topic advisor for the NICE guidance 'Integrated health and social care for people experiencing homelessness' – NG214, published 16 March 2022. Al outlined the key points from the guidance in reference to safeguarding.



Key recommendations from the NICE guidance

- Commission for equity
- Put in integrated MDTs and Inclusion Health Leads, with larger footprints, sustainable contracts
- Lived Experience should be at the heart of everything
- Take a 'Make Every Contact Count' approach
- Undertake comprehensive needs assessment
- Stick with people, sustained engagement is vital
- Legal Literacy is also vital – training is needed on Rights & Safeguarding
- Need to improve identification of inclusion health groups / harmonise data / measure outcomes
- Deliver outreach - Take health and social care services to people
- Focus on prevention/Early diagnosis/Long-term conditions
- Support people through transitions – 'Critical Time Interventions'
- Provide intermediate care services with intensive MDT support
- Commission accommodation based on assessed health and social care needs
- Long term care – Should be based on assessed needs NOT biological age, taking into account frailty, brain injury, cognitive impairment

Al noted that within the guidance it is underlined that premature frailty needs to be recognised as a risk and signposted this study:



In summary Al suggested that the review had led him to the opinion that reducing caseloads (and thus increasing time spent with clients) per practitioner is cost-effective:

- Compared 35 cases per practitioner over 5 years.
- Lower caseload strategy = increase in discounted costs of £4,018 per case over 5 years
- QALY gain would need to be 0.20 per case over 5 years or 0.04 per case each year for a lower caseload strategy to be considered cost-effective (threshold £20,000 per QALY gained).
- Value of improved outcomes offsets additional staff costs required to deliver lower caseloads.

Findings from the Panel Discussion

Five front line practitioners were invited to attend the conference and give their perspectives on some of the specific local challenges involved in meeting the needs to clients that self-neglect.

The 5 case studies presented and the discussion that followed revealed the following themes:

- Getting an adequate response from safeguarding and Social Care is difficult
- In many cases it was felt that Adult Social Care did not recognise the need to engage clients as part of their assessment – i.e. outreach services often build up relationships over long periods of time, but social care expect to be able to assess immediately
- The ability to 'wash and dress' is often being seen as the threshold of Care Act, and needs are not being assessed 'in context'
- Professional expert agencies are in dispute over mental capacity assessments, and executive capacity is often not being assessed properly (or at all)
- A&Es are not picking up on self-neglect and mental capacity issues
- Some people are not being seen as a safeguarding concern despite being severely self-neglecting, because they have been deemed to have mental capacity
- Sometimes this group only seem to become a concern when there is a perceived public health risk
- Sometimes when services don't know what else to do, or how / who to escalate to, they just disengage
- Arguably these cases demonstrate organisational neglect
- It is recognised there are ethical dilemmas between respecting autonomy and fulfilling a duty of care – but the teams left holding the risk feel unsupported
- Yet when people get the right accommodation and support their health can improve, and the A&E and hospital attendances drop
- It is too easy for people to slip through the net, and self neglect is not being responded to well.

Panel Discussion

Anne McBrearty, Inclusion Health Nurse Consultant. Central London Community Healthcare

Case study

Female, 50's, alcohol dependent, deteriorating health

- Living in a hostel in a mixed hostel (men and women)
- Deteriorating health relating to increasing alcohol use
- Registered with a local GP – but very limited engagement
- Known to community alcohol service, with an allocated social worker
- Multiple safeguarding concerns raised by hostel - domestic abuse (coercive control, physical), exploitation, self-neglect, all set within the hostel context. Several referrals had been made to safeguarding, but there was no active response.

Crisis Point - Dec 2021

- Hostel staff alert nurse that patient has been sleeping in the room of a male resident (not her partner), and that the male resident has been providing 'personal care'
- Male resident has also been supplying the alcohol, and has been in control of this

Homeless Health Nurse Assessment – Dec 2021

- Nurse felt patient did not have capacity around several decisions, patient incontinent of urine and faeces, unable to mobilise, not caring for herself
- Ambulance called (police were also in attendance as the male resident was becoming aggressive and initially denying staff to access patient).
- Ambulance crew deemed that patient had capacity and did not require hospital attendance
- Next day nurse visited again and situation not changed. Ambulance was called for the second time, and nurse was insistent the patient was taken to hospital. Admitted for 1 month.

Hospital discharge – Jan 2021

- Deemed **not** to have care needs or be self-neglecting whilst in hospital
- Specialist OT: thorough assessment, identified that patient would not be able to manage her self-care when she returns to drinking alcohol, and was at risk of self-neglect. However, patient says she wants to be discharged and does not want Reablement Team support. Patient has capacity and is discharged.
- Patient returned to hostel despite hostel staff stating this was not the right environment for her.
- Male resident was still living in hostel, but she was moved within hostel to safeguard patient.
- Patient deteriorated again, and is re-admitted 3 more times to A&E but discharged relatively quickly
- Another longer-term admission for 3 weeks in February 2022 to March 2022.

Hospital discharge – Mar 2021

- Hostel serves a Notice to Leave Order as they feel they can no longer support the patient's needs.
- Patient discharged to a women's only project in another borough, dry hostel
- Is doing well, not drinking, and has not returned to hostel.

Key points

- Serious level of alcohol addiction was not considered in safeguarding and deemed an active choice.
- Executive capacity was not considered in mental capacity assessments.
- Self-neglect and other safeguarding issues were not identified as a safeguarding issue by LAS or A&E.
- Inclusion health nurse decision was wrongly overruled by ambulance service in one situation.
- Care needs were set within the hospital context not her home context.
- The hostel staff were regularly having to take on a carer type role, even though not supposed to, in order to safeguard the patient against harm.

Panel Discussion

Dennis Rogers, Senior Homeless Health Care Navigator Groundswell

Case study

Male, 40s, morbidly obese, multiple health conditions

- Rough sleeping in London
- Registered with a specialist GP, and entered a step-down bed after a hospital admission
- Multiple chronic health conditions, sleep apnoea, swollen legs and feet, incontinence issues. Also had a leaking open wound.
- Was often depressed and often talked about suicide
- After step down was put into a 'half-way house' in an outer London borough. The accommodation had no staff apart from a security guard
- Was then registered with different GP nearer to where he lived
- Was referred to floating support, but the worker saw him twice and then disengaged
- Was often in severe pain so that he couldn't walk even short distances
- Couldn't fit into his shower so unable to wash. Unable to clean his room, unable to get out to buy food, no working cooker so reliant on junk food. Didn't fit into his clothes and had difficulty dressing, so was often undressed.
- Sometimes missed DWP appointments, and benefits were sanctioned
- Often said he was confused with no memory of recent incidents
- Frequent ambulance callouts and hospital admissions, yet nothing was done
- Safeguarding alert was put in by Groundswell – this was difficult because his accommodation was on the border of two boroughs and they both tried to say the other one was responsible
- Did get assigned a Social Worker and was moved to different accommodation with a care package with carers coming in three times a day. However, this accommodation was mostly for single parent families, and he felt he didn't want to leave his room and use the garden or communal spaces due to embarrassment and the noise.
- He also kept being admitted to hospital and this meant that the care package kept getting disrupted, and it would take days to get it started again, and his benefits were still being frequently sanctioned
- With the support of a Respiratory Consultant, Groundswell continued to put pressure on until he was relocated into a bungalow with a care package
- Almost overnight his physical and mental health improved. He could go outside into his garden
- He could sleep, and was able to cook and eat more healthily
- He started to lose weight, working with a personal trainer and then building his own bike and starting to cycle
- He started to manage his health issues and there were no more ambulance call outs or hospital admissions
- Now – he enjoys his life.

Key points

- Self-neglect in this case was driven by his inability to meet his own needs in the accommodation.
- A&E / hospitals and the DWP were not picking up the issues.
- Getting an adequate response from safeguarding and Social Care was difficult with the responsibility sitting with the referrer.
- A floating support worker had disengaged and left a vulnerable person with no support.
- This was a good result, but it took **a lot** of pushing over a long period from Groundswell and the Respiratory Consultant, and could so easily have been different.
- Arguably this case demonstrated organisational neglect.
- This person's health improved immediately with the right accommodation, and the A&E and hospital attendances dropped.
- It is too easy for people to slip through the net.

"The following week we referred 2 patients to Adult Safeguarding, self-neglect was the reason for the referrals for both patients"

Conference participant

Panel Discussion

Sophie Parkinson, Advanced Nurse Practitioner. Guys and St Thomas Homeless Health Team

Case study

60-year-old male, alcohol related brain damage (ARBD)

- 2 months in hospital.
- Previously lived with partner and grandchildren, partners tenancy. Partner did not want him back due to alcohol related aggression.
- Self-neglecting and refusing care. There was an obvious risk to himself and to others which would only increase if he continued to drink.
- Neuropsychiatry assessed and stated he had a ‘dysexecutive disorder within alcohol related brain damage (dementing process) with impulse-control difficulties'.
- Deemed not to have capacity for the decision of his discharge plans to support with self-care and alcohol abstinence.
- Placed under DOLS. Safeguarding referral sent.
- 3 x best interest meetings were held. Adult Social Care disputed that he lacked capacity regarding his discharge destination, or his care needs, and pushed for him to go into unsupported Temporary Accommodation.
- This Adult Social Care intervention is actually not welcomed by patient who did not want this option.

Key points

- Support needs are viewed as 'self-inflicted' due to alcohol excess. Impact of severe addiction has not been taken into account.
- Adult Social Care do not recognise issues / challenges inherent in engagement.
- Ability to 'wash and dress' is being seen as the threshold of Care Act. He is able to mobilise independently and wash and dress in hospital and thus has no care needs.
- Professional expert agencies are in dispute over mental capacity assessments.
- Capacity around discharge destination needs to involve actions required in maintaining a tenancy – executive capacity is not being delivered.
- There are ethical dilemmas between respecting autonomy and fulfilling a duty of care, who is left holding the risk?

Panel Discussion

Dianne Vigilance, Homeless Health Nurse Practitioner. Central London Community Health Care, Wandsworth

Case study

Female, in 70s when first seen, refugee status, no drug or alcohol issues. Living with family member on a bench.

- Became homeless following eviction by the local council for rent arrears.
- Describing removal from the property in 'handcuffs' (unclear whether this was true).
- Lived on bench with younger family member for 7 years (until she recently died).
- Said that living on the streets felt a lot safer than the life she had come from in her country where she faced daily bombings, running for cover and fear.
- There was also personal self-neglect, e.g. at some points smelled of urine.
- Public health issue - was toileting outside in her local surroundings.
- During Covid, had no access to public toilets.
- Viewed as a public 'nuisance' by some members of the community.
- Possible diagnosis of autism.
- Both Muslim. Younger family member would visit the Mosque from the street, but she would not.
- There were debates on the power and relationship dynamics between the two family members.
- Both refused offers of help from Social Services, refused to register with a GP, refused housing, outreach teams, community and mental health support.
- Four mental capacity assessments were undertaken, including by Psychiatrist on the streets. Each time the lady was identified as having capacity. There were a number of safeguarding, multiagency meetings, and best interests' meetings held during the course of the 7 years, but she never left.
- Was referred to safeguarding, but not seen as a concern as she was deemed to have mental capacity. Was actually discharged by safeguarding.
- Seen over a period of 7 years, died recently. RIP.
- Mosque would provide food and religion to the couple, so I engaged with the Mosque who gave valuable insights regarding how to engage.

Key points

- Was not seen as a safeguarding concern as she was deemed to have mental capacity.
- Appeared to only became such a concern when there was a perceived public health risk.
- Required significant engagement to build up any relationship - many social workers came but the nurse engaged for seven years.
- Services didn't know what else to do, and would disengage.
- Complex case in which this appeared to be a lifestyle choice but set within a very specific cultural context.

Panel Discussion

Lizzie Furber, Senior Social Work Practitioner/Street Outreach Team Liaison
Rough Sleepers Mental Health Project, Hackney

Case study/safeguarding review

MS, aged 63 years old, Hackney - SARS

- MS died in 2019 at a bus stop in the London Borough of Hackney where he had been living and sleeping for several weeks.
- Cause of death was acute myocardial infarction, and aspiration pneumonia.
- MS was beneath blankets, with assorted bags around him. He had soiled himself and had been in the same dirty clothes for some time.
- MS was Turkish with limited English.
- He had a history self-neglect and substance abuse.
- He had returned to the bus stop at the end of May 2019, after five-month placement in a nursing home had ended. MS had previously spent time sleeping at the same bus stop, in 2018.
- MS's death was widely reported by the local media and his living situation had been raised as a concern by local residents.
- In the final two months before he died, considerable efforts were made to persuade him into accommodation but he refused all offers. He also refused support for physical health.
- There were discussions between practitioners and services on whether and how to use anti-social behaviour powers, and mental capacity and mental health legislation, in order to safeguard MS's health and wellbeing.
- However no effective means of resolving the situation was found before MS died.

https://www.healthwatchhackney.co.uk/wp-content/uploads/2021/01/MS-SAR-Report-v3.2.docx.pdf

Key points

- Safeguarding concerns were raised, but not were not progressed to S42 enquiries - on one occasion the stated reason was that he was NFA.
- MS's behaviour was viewed as a 'lifestyle choice.' Rough sleeping was viewed essentially as a bad behaviour, and an extension of his substance use and contact with the criminal justice system.
- The SAR identified many areas in which care might have been improved in order to improve this outcome, and these included:

- Better use of interpreters.
- Better asking about / engaging with family / next of kin.
- Improved legal literacy across all the services involved – mental capacity decisions were not well documented, and did not consider executive capacity, or focus clearly on the inherent risks – the SAR recommends more training is needed.
- Better documentation and auditing around mental capacity.
- Improved MDT working and information sharing.
- Use of advocacy services.
- Improved professional curiosity.

'"There has been a move to neo-liberalism, locating the problem within the individual, with terms like 'lifestyle choice', and 'not taking responsibility'. Alongside this there has been a co-opting of the 'recovery model' and the 'strengths-based approach' in order to deny services, behind the smoke screen of people having the 'right' to make unwise decisions. Within this the 'presumption of capacity' has sometimes been misused to avoid taking responsibility for vulnerable adults. Although there are obviously ethical dilemmas between the protection imperative and empowerment and autonomy, neo-liberal culture always tips the balance towards autonomy rather than protection - prioritising the right to liberty and the right to private life over right to life and duty to preserve life, duty of care".

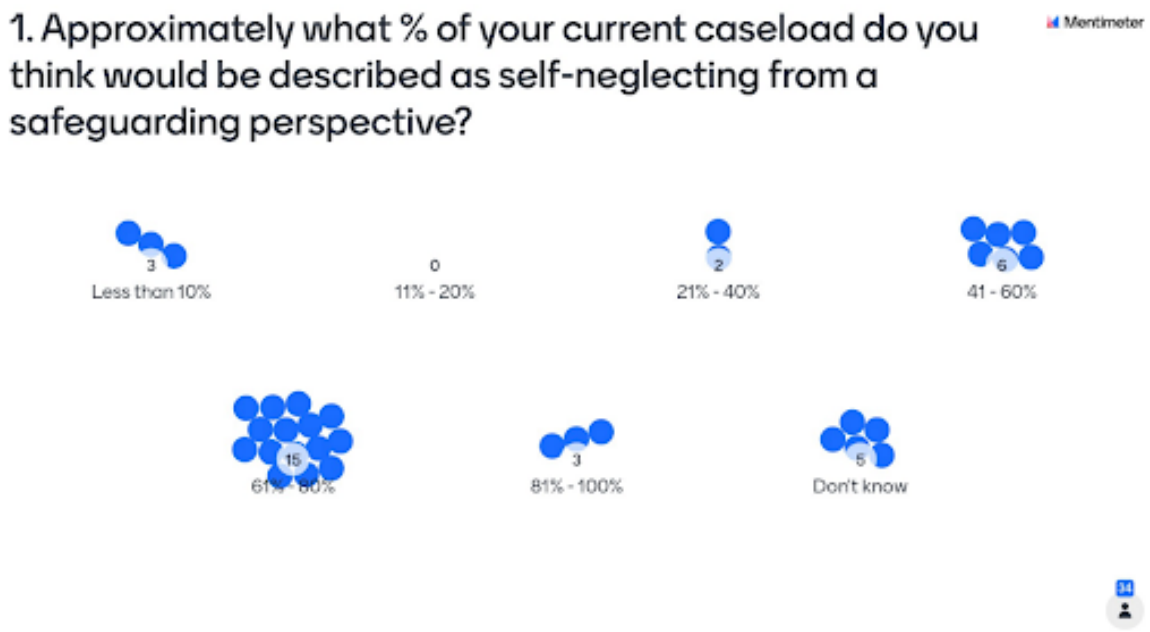
"Added to this is the cuts to the public sector since 2010. This has led to a scarcity mindset where the social work and housing job is perceived to be about protecting resources rather than protecting people, which has been compounded by the impact of COVID. Traumatised systems have led to traumatised workers, which in turn has led to increased gate-keeping and a worse deal for service users".

"As a combination these factors have contributed to many service failures in homelessness."

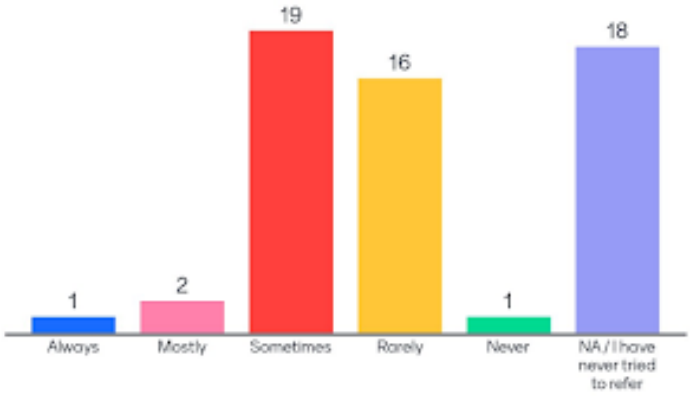
Lizzie Furber

Structured group work

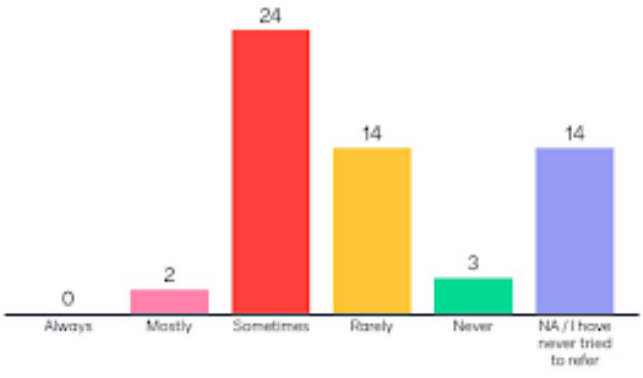
Before the interactive group discussion those delegates that were able to, were asked to engage with 4 Mentimeter questions to set the scene. The results are outlined below and indicate clearly that practitioners witness high levels of self-neglect, but face major challenges getting responses to this.



3. How often do you feel referrals your service makes to safeguarding for self-neglect get accepted?



4. How often does a referral to safeguarding make a difference to outcomes if the referral is made for self-neglect?



Focus group feedback

The focus group section of the conference followed Dr Caroline Shulman's presentation, and the scene was set jointly by Caroline and representatives of the LNNM. Questions for the groups, and the purpose for them were explained in advance.

The conference delegates were seated on 10 tables of 10 for the whole conference. Seats were not allocated, and delegates had a choice of where to sit.

Delegates were given paper and pens and asked to identify a scribe or scribe for each table. After this the table groups were asked to consider and write down their responses to the following questions. The timing for each section was 15 mins each.

Q1. What is your experience of referring someone who is homeless and/or self neglecting to adult safeguarding?

Key points which came up repeatedly:

Assessments / investigations are not being undertaken despite referrals

- There are often judgemental attitudes on what is characterised as vulnerable i.e. alcohol and drug misusers rarely seen as 'vulnerable', and referrals are pushed back on account of this
- Referrers are also often told that options are limited if the client is a rough sleeper
- It is also common to meet high barriers to the referral if someone has NRPF
- When referrals go in there is often no feedback. Referrals 'go into black hole'
- There is a perception that the push backs to referrals sometimes occur as a partial result of underfunded and understaffed services
- Squeezed services are passing responsibility due to lack of capacity

Geographical variations exist pan London in responses

- Different referral processes and responses to self-neglect referrals across different boroughs
- Some areas have very limited responses to self-neglect and hoarding, and there are also differences in responses between hospitals and community.

Where clients are transient this makes getting a response even worse

- When someone with a local connection to another borough has moved, the referrer has to start over
- It was felt that there should be one place to send referrals to, and safeguarding should decide who is responsible for taking action.

Assessments (when they do occur) are often inadequate

- It was felt that mainstream Social Workers often don't have the skills to manage this client group, and often don't know what to do with these referrals.
- It was perceived that it was often difficult for Social Services to understand the issues and the risks due to a lack of exposure
- Phone assessments have made things worse – there is a refusal to come out on the street. They need to actually see the individual, but don't.

Understanding of mental capacity differs across services

- Perceptions of what constitutes having mental capacity differs across agencies and professionals.
- A&E and the London Ambulance Service were often cited as examples of services that had limited understanding of this.

There is a lack of accountability

- It was felt homeless people do not have a voice in this area, there is little advocacy, and no way to complaint.
- Referrals are often rejected – 'no care and support needs' – but without proper enquiry.
- Lines of accountability unclear
- There are often tick box responses with the only action being advise.
- Safeguarding puts the responsibility on the referrer – e.g. this was a response from safeguarding 'Please advise what reasonable steps you are taking to mitigate the risk, and please confirm this in writing'
- The responsibility is left with individual clinicians.
- Safeguarding teams don't communicate with each other, when the clients are transient. It is not clear why not, and who is accountable for this

Lack of training and advice to assist with challenges

- It was felt it should be easier to discuss cases on phone or in person to get expert advice and support, because challenging cases in this domain is often very difficult.

'You need to re-refer several times. I never had a positive case in 4 years'

Conference participant

Focus group feedback

Q2: How do you think we can make our concerns about the adverse outcomes of people who are homeless and / or self-neglecting more visible in general?

Key points which came up repeatedly:

Be clearer when outlining the risks in referrals

- Need to identify the risks clearly - it is important to spell out exactly what the risks are
- Be prepared to tell Social Services how we want them to respond and what we would like to happen
- Training will be needed to articulate the risks in a way that generates a response
- Insist on Section 42 enquiries, using clearer requests

Be persistent and consistent

- Raise safeguarding alerts even if they are likely to get pushed back
- Keep going even when it feels really hard.

Challenge when self-neglect referrals are knocked back

- Challenging more when referrals are knocked back.
- Training is needed to build the confidence to raise these issues, and feel secure in challenging.
- Using existing systems and Datix concerns

Monitor responses to self-neglect referrals and escalate if responses are inadequate.

- Keeping records of responses to safeguarding referrals
- Keeping a record of poor outcomes post safeguarding referrals
- Information regarding safeguarding referral responses to be fed back to all involved
- Monitoring safeguarding responses in hostels and hostels including private hostels
- Get ICS Leads for patient safety and care quality involved

Ensure these clients are discussed in all relevant settings and at multi-agency meetings

- Discuss clients in clinical supervision, do audits, get client feedback, have informal conversations, Datix concerns, discuss at MDT meetings
- Have more multi-agency professionals meetings / case conferences where these individuals get flagged e.g. MARAC (multi-agency risk assessment conference), Task and Action meetings, etc
- Break down silos. Many services still not working together – this needs tackling to ensure concerns over potential adverse outcomes are shared.
- Prioritise building relationships with key services, including safeguarding, so that concerns are shared.
- Improve joint working
- Greater integration needed between primary care, outreach and mental health teams
- Recognise and anticipate where things often fail
- Think about notification process for when client's move around boroughs

Review ALL deaths robustly

- Serious incident reviews of everyone that dies
- Independent review of deaths e.g. confidential enquiry
- Case reviews

Focus group feedback

Increase awareness in the Government and the general public

- Research on safeguarding responses / death reviews would help with this
- Needs media attention through social activism, charity involvement
- Commissioners, Safeguarding at CCG / LA level, national / international Governments and players, voluntary groups and local communities all need to understand the challenges
- Case studies would be useful
- Increased awareness of the issue generally may lead to increased funding.

Involve safeguarding directly in these discussions

- Discussions between front line staff and safeguarding national leads to discuss issues / challenges
- Safeguarding presence at MDTs.

Training and awareness raising with mainstream services in contact with these clients

- More training in A&E departments
- More link workers in A&E
- Training is needed for mainstream social services because they don't understand the complexities of the client group
- More training, in particular dispelling myths about lifestyle choices – cuts have impacted awareness training
- Increased understanding of the legal framework around substance misuse is needed in key areas.

'We need to be clearer when outlining the patient risks to everyone'

Conference participant

'A hard-hitting report about the deaths of homeless people'

Conference participant

Focus group feedback

Q3. What can practitioners and policy makers do to support improved responses to safeguarding referrals for self-neglect in London?

Key points which came up repeatedly:

Raise the profile of the issue

- Push the self-neglect agenda
- Do a presentation to the safeguarding board
- Network with safeguarding commissioning boards / systems
- Get people with lived experience to present on this issue
- Identify who is accountable for inadequate responses. Find out about the commissioner's role.
- Give frontline staff a voice
- Advocate for more money, and more funding for frontline staff. More specialist workers, with more supervision is needed. Staff are overloaded
- Provide clinical leadership. Make sure self-neglect cases are still being referred and recorded.
- Provide advocacy in areas where services are struggling to get responses from safeguarding
- Link this agenda to related issues like lack of appropriate supported accommodation solutions e.g. Housing First and detox beds
- Try to move the dialogue around inclusion health services away from cost cutting to improved outcomes
- Raise the issue with ICS Leads for patient safety and care quality
- Think about notification processes for when client's move around boroughs – this applies to homeless clients with any safeguarding issues, not just self-neglect
- Tackle siloing of services
- Lead on the collection of relevant evidence of failures and concerns
- Auditing of rejected safeguarding referrals. Learning re how and why the rejections are occurring.
- Collect data, possibly having a centralised system that NHS and private / voluntary organisations can use to document and share information and concerns re homeless and self-neglecting clients
- Capturing as much data as possible to identify issues and gaps – e.g. how many rough sleepers are hoarders etc
- Go one step further beyond coroners' reports – communication of reports and shared learning
- SAR reports – thematic reviews to share failures and learn lessons
- Collate all referrals coming through and monitor
- Deep dive into self neglect issues and responses
- Understand the system dynamics and social relationships between services and the associated responses to safeguarding referrals and outcomes. Creating spaces and processes to acknowledge the challenges, and what is actually possible.
- Provide timely feedback about what has happened with data / where it is being escalated to.

Provide written guidance to front line practitioners

- Guidelines for safeguarding referrals with legislation tied to it – step by step on what to say and what to expect

- Robust guidelines – straightforward to move quickly through
- Help staff to know who safeguarding leads are for each Trust / borough, awareness of approachable resources
- Relevant Home Office contacts are needed.
- Lack of understanding of safeguarding pathways – these are a mystery – needs help to demystify what is supposed to happen
- Provide guidance
- Understand landscape of services that can help

Provide a live forum for case discussions

- Homeless safeguarding forum/hub to discuss cases/dead end referrals
- Safeguarding supervision – support and expertise to take cases forward

Promote and share good practice

- Good practice case studies / input from experts by experience
- Provide a platform for best practice sharing
- Showcase good practice
- Look at other teams who have good processes

Lead on training to the sector

- Provide or facilitate more training on self-neglect to all teams
- Support more cross training between service partners e.g. MH teams having addictions training and vice versa
- Educate grass roots / frontline workers
- Educate people about competing priorities
- Safeguarding concerns are not always obvious

'Identify who is responsible for inadequate responses'

Conference participant

'Auditing of rejected safeguarding referrals'

Conference participant

'More legal training to feel secure in challenging'

Conference participant

Conclusion and next steps

This LNNM event has provided evidence of the prevalence of self-neglect in people experiencing homelessness in London, and the numerous challenges that exist in meeting the needs of people with these issues.

The event also brought together a collection of best practice advice for practitioners to learn from on the day, and we know that there were significant changes in practice the following week as a result.

The LNNM will now be partnering with the Healthy London Partnership London Homeless Health Programme to raise the profile of the challenges, and to attempt to get better recognition of the issues within partner services, and on a pan London level.

August 2022

Appendix

Group feedback (detail)

Q1. What is your experience of referring someone who is homeless and/or self-neglecting to adult safeguarding? (10 mins)

PROMPTS:

- *Is it easy or difficult to get a helpful response from safeguarding teams? Describe*
- *Where not successful, are there any themes for rejection? E.g. around addictions, capacity etc?*
- *What impact does the response you get have on you or your work?*
- *If you have no experience of referring, in what ways have the talks from today affected how you think about safeguarding or how you will work?*

Group 1

- Difficult sometimes as when the question of capacity is raised, regardless of whether the answer is yes or no, this can affect the response from the agency. Also, perceptions of what constitutes capacity differ across agencies
- Bias on what is characterised as vulnerable i.e. drug users rarely seen as vulnerable
- Always told limited on what can be done if the client is a rough sleeper
- Also told there are restrictions on what can be done if someone has NRPF

Group 2

- Frustrating experience, futile
- Lack of definition for self-neglect
- Easier when you know how to navigate the system
- For midwives, maternity services are not well integrated with adult safeguarding – child is priority – adult less important
- Duty to refer is midwives responsibility

Group 3

- Working relationships – differences of opinions and priorities. Joint working is important but can be fragile – example of a specialised social worker's post being cut, and then the links break down
- Accountability and responsibility of decision making – differences of opinions
- The knowledge and skills of social workers in this area is niche – it's a specialised arena – whether social worker has specialised skills impacts on advice, assessment and outcomes. Training is needed for mainstream social services because they don't understand the complexities of the client group
- Underfunded and understaffed services – often both the referrer and service being referred to are in the same situations. High caseloads effects responses to referrals even though it shouldn't do.

Group 4

- Challenging, frustrating, irritating, angry, tentative
- Need to be repetitive, need to keep pushing.

Group 5

- Substance misuse social worker didn't know what to do with referrals
- Different referral processes and responses across different boroughs
- As an outreach worker I don't know what I am looking for
- Phone assessments – refusals to come out on the street, they need to actually see the individual, but don't
- When there's mental health concerns the focus is on that as a priority. But need similar process for physical health self-neglect
- Hoarding – have been told it's not a safeguarding issue

Group 6

- I work in house for a LA. We have monthly Task and Target meetings to discuss rough sleeping and individuals of concern – this has been positive as we flag cases – although out of borough cases are a challenge
- It should be more easy to discuss cases on phone or in person to get advice and support
- When someone with a local connection to another borough has moved, you have to start over
- Gate keeping – various safeguarding teams work differently. With mental health they need hand holding. Their responses sometimes feel like box ticking. Doesn't feel like it produces an outcome.

Group 7

- No feedback ? what happens to referrals
- Lines of accountability unclear. In safeguarding teams this is not clear / known
- Tick box responses
- Different organisations have different safeguarding teams – do they communicate with each other, who is accountable
- There should be one place to send referrals to, and safeguarding should decide who is responsible for taking action

Group 8

- Self-neglect is not seen as a safeguarding issue
- Homeless people do not have a voice, there is no advocate, and no complaints
- Difficult for Social Services to understand the issues and the risks
- It is important to spell out exacting what the risks are

Group 9

- Goes into black hole, no feedback
- Need to re-refer several times
- Never had a positive case in 4 years

Group 10

- Difficult to get a helpful response
- Often rejected – no care and support needs – without proper enquiry
- Often get no responses, do not find out outcomes
- Not included in meetings
- Safeguarding reviews fizzle out
- Example – one client died, and the referrer wasn't even informed
- High pressure situation / lack of multi-agency working
- A response from safeguarding - Please advise what reasonable steps you are taking to mitigate the risk, and please confirm in writing.

Q2. How do you think we can make our concerns about the adverse outcomes of people who are homeless and/or self-neglecting more visible in general? (15 mins)

PROMPTS:

- *Think about what these adverse outcomes are - early deaths, malnutrition, untreated wounds, untreated addictions, physical and mental health problems, self-discharges from hospital, poor living environments*

Then discuss:

- *Who knows about these adverse outcomes now?*
- *Who else should know? How should they be told? What difference would it make if they did know?*
- *What differences could be made both locally and nationally?*

Group 1

- Serious incident reviews of everyone that dies
- More training in A&E departments
- More link workers in A&E
- Greater integration with mental health teams
- Keeping a record of poor outcomes post safeguarding referrals
- Information regarding safeguarding referral responses to be fed back to all involved

Group 2

- Showcasing good practice
- Independent review of deaths
- Robust guidelines – straightforward to move quickly through
- Safeguarding is often used as a catalyst to address other issues
- Safeguarding concerns are not always obvious
- Need to identify the risks clearly
- Need to tell Social Services what you want them to do / expectations (realistic??)

Group 3

- Visibility of adverse concerns - who knows – staff on the ground though clinical supervision, audits, client feedback, informal conversations, Datix, MDT meetings, emails
- Who should know – Commissioners, Safeguarding at CCG / LA level also national / international Governments and players, voluntary groups and local communities
- Increased awareness generally may lead to increased funding.
- Social activism, charity involvement

Group 4

- Datix
- Death reviews
- Case reviews
- Insisting on Section 42
- Monitoring hostels and hostel responses including private hostels

- Being an independent witness
- Raise safeguarding alerts

Group 5

- More training, in particular dispelling myths about lifestyle choices – cuts impacted awareness training.
- Silo working – services not working together – needs tackling
- Increased understanding of substance misuse
- Squeezed services passing responsibility due to lack of capacity
- Need to build confidence to raise issues and challenge
- More legal training to feel secure in challenging
- Knowing who to go to challenge, and where to get support
- Understand landscape of services that can help

Group 6

- Michael Preston-Shoot reviews – not much change
- Problem is that services for complex needs and dual diagnosis clients are siloed
- They need a package of care that is flexible
- More professionals meetings / case conferences

Group 7

- Multi-agency meetings are where these individuals get flagged e.g. EVF, DAWS. MARAC
- Other than that it is left with individual clinicians

Group 8

- Need to identify the risks clearly
- Need to tell Social Services what you want them to do / expectations (realistic??)
- Prioritise building relationships with key services, including safeguarding
- MDT teams
- Use existing systems and Datix
- Look at other teams who have good processes
- Think about ICS Leads for patient safety and care quality, get them involved
- Think about notification process for when client's move around boroughs

Group 9

- Recognition of differences – one size does not fit all
- Recognition that it's not time limited
- People, not statistics
- Good access to mental health services

Group 10

- Discussions between front line staff and safeguarding national leads to discuss issues / challenges. Could they be invited to these conferences
- Safeguarding representation.

Q3. What can practitioners and policy makers do to support improved responses to safeguarding referrals for self-neglect in London? (10 mins)

PROMPTS:
e.g. monitoring of referral responses – how could this work?
Should there be monitoring of related deaths pan London?
List any specific ideas that you think could work for London

Group 1

- Collect data, possibly having a centralised system that NHS and private / voluntary
- organisations can use to document and share information re homeless and self
- neglecting clients
- Provide more training on self-neglect to all teams, and doing more cross training
- between service partners e.g. MH teams having addictions training and vice versa

Group 2

- Timely feedback about what has happened
- For LHHP to be more visible - too many abbreviations and jargon – frontline
- practitioners don't know what the role of these organisations is.

Group 3

- Go one step further beyond coroners reports – communication of reports and
- shared learning
- SAR reports – thematic reviews to share failures and learn lessons
- Recognising that there are social relationships and responses to safeguarding referrals and outcomes. Creating spaces and processes to acknowledge this.

Group 4

- Push the self-neglect agenda
- Educate grass roots / frontline workers
- Educate people about competing priorities

Group 5

- Auditing of rejected safeguarding referrals. Learning re how and why the rejections
- are occurring
- Lack of understanding of safeguarding pathways – these are a mystery
- Stop prioritising on the basis of cost cutting – money led decisions
- Homeless safeguarding hub to discuss cases / dead end referrals
- Guidelines for safeguarding referrals with legislation tied to it – step by step on what
- to say and what to expect
- Knowing who safeguarding leads are for each Trust / borough, awareness of
- approachable resources
- Capturing as much data as possible to identify issues and gaps – e.g. how many
- rough sleepers are hoarders etc
- Safeguarding supervision – support and expertise to take cases forward
- Good practice case studies / input from experts by experience

Group 6

- Give frontline staff a voice
- More money, more funding for frontline staff
- Staff are overloaded
- More specialist workers, more supervision

Group 7

- Do a presentation to the safeguarding board
- Deep dice
- Training
- Guidance

Group 8

- Network with safeguarding commissioning board / systems
- Get people with lived experience to present
- More detox beds and housing first
- Home Office contacts needed
- Making sure self neglect cases are recorded, presented

Group 9

- Advocacy

Group 10

- Collate all referrals coming through and monitor
- Identify who is accountable
- More face to face
- What is the commissioner's role?

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