Self neglect and hoarding multi-agency Guidance and procedures
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Managing the balance between protecting adults at risk of self-neglect against their right to self-determination is a serious challenge for services. Working with people who are difficult to engage with can be exceptionally time consuming and stressful to all concerned. However, failure to engage with people who are not looking after themselves, (whether they have mental capacity or not) may have serious implications for, and a profoundly detrimental effect on, an individual’s health and well-being. It can also impact on the individual’s family and the local community.

Often the cases that give rise to the most concern are those where an individual refuses help and services and is seen to be at grave risk as a result.

If an agency is satisfied that the individual has the mental capacity to make an informed choice on the issues raised, then that person has the right to make their own choices, even if these are considered to be unwise. But, in cases of significant vulnerability there should be on-going engagement with the individual applying the principles outlined in this policy.

Serious self-neglect is a complex issue which usually encompass a complex interplay between mental, physical, social and environmental factors. It frequently covers inter-related issues such as drug and alcohol misuse, homelessness, street working, mental health issues, criminality, anti-social behaviour, inability to access benefits and / or other health related issues.

The Care Act, which came into force on 1 April 2015, sets out the Local Authority’s responsibility for protecting adults with care and support needs from abuse or neglect in primary legislation. For the first time, this makes direct reference to self-neglect. The Act provides particular focus on well-being in relation to an individual (Section 1), and requires that organisations should always promote the adult’s well-being in their safeguarding
arrangements. This includes establishing with the individual what ‘safe’ means to them and how this can be best achieved. Well-being in the Act is described as:

a. Personal dignity (including treatment of the individual with respect)
b. Physical and mental health and well-being
c. Protection from abuse and neglect
d. Control by the individual over day to day life (including over care and support, or support provided to the individual and the way in which it is provided)
e. Participation in work, education, training or recreation
f. Social and economic well-being
g. Suitability of living accommodation
h. The individuals contribution to society

The principles of promoting a person’s wellbeing are also supported by Making Safeguarding Personal (2014), and subsequent toolkit Making Safeguarding Personal: A Toolkit for Response (2015), which seeks to ensure that where possible, the individual is involved in their own safeguarding and that it is ‘person-led’, ‘out-come’ focused but not process driven.
1. Purpose of the policy

1.1
This document outlines a multi-agency procedure and guidance for dealing with issues and concerns of self-neglect in relation to adults (over the age of 18) with care and support needs and should be read alongside Salford’s Safeguarding Adults Policy and Procedures.

1.2
This guidance is aimed at a wide range of professionals involved in working with people who may self-neglect (including first responders whose role is to identify issues of self-neglect, respond appropriately in the moment and then refer on to other agencies as appropriate). Appendix 1 gives an overview of indicators of self-neglect and best practice guidance to engage individual).

1.3
The policy aims to prevent serious harm or even the death of individuals who appear to be self-neglecting by ensuring that:

• Individuals are empowered as far as possible, to understand the implications of their actions
• There is a shared, multi-agency understanding and recognition of the issues involved in working with individuals who self-neglect
• There is effective multi-agency working and practice
• Concerns receive appropriate prioritisation
• Agencies and organisations uphold their duty of care
• There is a proportionate response to the levels of risk to self and others
1.4
This guidance does not include issues of risk associated with deliberate self-harm. If self-harm appears to have occurred due to an act of neglect or inaction by another individual or service, consideration should be given to raising a safeguarding adults concern with Adult Social Care.

2. Definitions of self-neglect and hoarding

2.1 - Self neglect
The Care Act statutory guidance 2014 defines self-neglect as;
“self-neglect - this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding”
The term itself can be a barrier to working with the issues, and some individuals do not identify with this term or description of their situation. As a result, it is important that practitioners seek to negotiate a common ground to understand the individuals own description of their lifestyle rather than making possible discriminatory value judgements or assumptions about how it can be defined.

2.2 - Hoarding
Hoarding behaviour was previously seen as a symptom of Obsessive Compulsive Disorder (OCD) but it has now received a separate clinical definition of ‘hoarding disorder’ and is defined as:
‘A psychiatric disorder characterised by persistent difficulty discarding or parting with possessions, regardless of their actual value resulting in significant clutter that obstructs the individual’s living environment and produces considerable functional impairment.’ (GMFRS Hoarding, Prevention and Protection)
2.3 - Characteristics of self-neglect

There are various reasons why people self-neglect. Some people have insight into their behaviour, while others do not; some may be experiencing an underlying condition, such as dementia.

The following characteristics and behaviours are useful examples of potential self-neglect and consequent impairments to lifestyles:

- Living in very unclean, sometimes verminous, circumstances, such as living with a toilet completely blocked with faeces, not disposing of rubbish;
- Neglecting household maintenance, and therefore creating hazards;
- Obsessive hoarding creating potential mobility and fire hazards;
- Animal collecting with potential of insanitary conditions and neglect of animals’ needs;
- Failing to provide care for him/herself in such a way that his/her health or physical well-being may decline precipitously;
- Poor diet and nutrition, evidenced for instance by little or no fresh food or mouldy food in the fridge;
- Failure to maintain social contact;
- Failure to manage finances;
- Declining or refusing prescribed medication and/or other community healthcare support – for example, in relation to the presence of mental disorder (including the relapse of major psychiatric features, or a deterioration due to dementia) or to podiatry issues;
- Refusing to allow access to health and/or social care staff in relation to care needs, health needs or property maintenance, or, being unwilling to attend appointments with relevant staff.
2.4 - Characteristics identified by people deemed to self-neglect

Research has identified the following:

- Fear of losing control
- Pride in self sufficiency
- Sense of connectedness to the places and things in their surroundings
- Mistrust of professionals / people in authority

2.5 - Common responses by people deemed to self-neglect

- I can take care of myself
- I do my best to make ends meet
- I prioritise and let other things go

2.6 - Characteristics of hoarding

Hoarding behaviour is typically manifested in three ways:

**Acquisition**

Compulsive buying and/or the accumulation of free items such as newspapers, junk mail and items left at the side of the road. This can be motivated by the belief that having an item will bring comfort and make the person happy or that they are ‘rescuing’ items so that they are not wasted or lost. It can also provide a sense of security (especially where the person has been a victim of crime).

**Saving**

There are three common reasons for saving: ‘sentimental’ which can be motivated by grief and refers to the emotional attachment a person feels toward an object i.e. it may become linked to a happy memory or someone they love and miss; ‘instrumental’ which can often stem from a history of having experienced deprivation, or of having had possessions forcibly taken from them in the past and so items are saved ‘just in case I need them’ or to guard against ‘being without’ again in the future; ‘intrinsic’ or ‘aesthetic’ where items are saved because they are seen as too beautiful to be discarded.
**Disorganisation**

Items of value are mixed in with rubbish and items of no apparent value. People who hoard often have difficulty with information processing, categorisation, sequencing tasks and decision making. They may also believe that they have a poor memory which leads to items being stored where they are visible instead of put away in cupboards i.e. ‘if I put them away, I won’t be able to see them and if I can’t see them I won’t remember I have them and they will be lost to me’.

The complexities around the reasons why a person hoards and their emotional attachment to the items hoarded means that simply ordering or telling a person to clear their home will likely have no effect and/or may increase the person’s anxiety, potentially exacerbating the problem.

The emotions stirred up when attempting to discard hoarded items can be too distressing and/or leave the person feeling vulnerable and insecure. In addition, difficulty with decision making and not being able to break a task down into smaller steps could mean that the process of clearing hoarded items is overwhelming for the person and so avoided.

It is also common for people who hoard not to recognise the severity of the problem and ignore, or not see, the clutter in their home. Conversely, the person who hoards may be acutely aware of the issue and feel embarrassed, leading them to feel defensive and/or deny that there is a problem. All of this can prevent a person from discarding hoarded items.

**2.7 - Clutter images**

Greater Manchester Fire Service hoarding policy gives additional best practice on hoarding. It references clutter images to support an impartial assessment of scales of clutter and hoarding (See appendix 8).
3. Principles for effective working with self-neglect and hoarding issues

3.1

The following are the key principles that should be applied to all areas of safeguarding adults practice (Care Act 2014 statutory guidance).

**Empowerment** - People being supported and encouraged to make their own decisions and informed consent.

“I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”

**Prevention** - It is better to take action before harm occurs.

“I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.”

**Proportionality** - The least intrusive response appropriate to the risk presented.

“I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.”

**Protection** - Support and representation for those in greatest need.

“I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.”

**Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

“I know that staff treats any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.”

**Accountability** - Accountability and transparency in delivering safeguarding.

“I understand the role of everyone involved in my life and so do they.”
3.2

The following principles underpin this guidance in working with self-neglect and hoarding issues:

- Promoting a **person centred approach** that supports the right of the individual to be treated with respect and dignity, and, as far as possible, to be in control of their own life. The focus should be on person centred engagement and risk management, and consideration should be given to if the individual is more inclined to engage with some organisations than others – if so, this should be optimised in the engagement with the individual.

- The response needs to be **proportionate to the level of risk** to the person and others, the self-neglect and hoarding tools (see appendices 3 and 8), can be used to determine the level of risk as low, moderate or high. The risk should be monitored where it is moderate or high, making proactive contact with the adult to ensure that their needs and rights are fully considered in the event of any changed circumstances.

- Each organisation needs to take responsibility for their role in supporting the adult to address issues caused through self-neglect.

- Partnership approach should be used in cases where appropriate to enable powers and abilities of different organisations to be implemented.

- Multi-agency meetings are a helpful approach for more complex cases that are higher risk – these should be considered in cases where a single agency approach has been exhausted and a substantial risk still remains. Balancing choice, control, independence and wellbeing calls for sensitive and carefully considered decision-making.

- **Accepting self-neglect as a “lifestyle” choice and closing a case without having assessed the risk and engaged with the adult in a meaningful way is unacceptable as this exposes the adult at risk to ongoing or increased harm or risk, and organizations to failing in their duty of care.** Social workers should refer to guidance on closing cases (see multi-agency policy and procedures guidance).
3.3
Part of the challenge is knowing when and how far to intervene when there are concerns about self-neglect and a person makes a capacitated decision not to acknowledge there is a problem or to engage in improving the situation, as this usually involves making individual judgments about what is an acceptable way of living, balanced against the degree of risk to an adult and/or others.

3.4
Assessing mental capacity and trying to understand what lies behind self-neglect is often complex. It is usually best achieved by working with other organisations and, if they exist, extended family and community networks.

3.5
It is important to understand that poor environmental and personal hygiene may not necessarily always be as a result of self-neglect. It could arise as a result of cognitive impairment, poor eyesight, functional and financial constraints. In addition, many people, particularly older people, who self-neglect may lack the ability and/or confidence to come forward to ask for help, and may also lack others who can advocate or speak for them.

4. Empowering/engaging the adult at risk

4.1
Building a positive relationship with individuals who self-neglect is critical to achieving change for them, and in ensuring their safety and protection.

4.2
Positive outcomes can be achieved through operational approaches informed by an understanding of the unique experience of each individual balanced with strategic and management input.
4.3 In engaging with the adult:

- Consider if they have the necessary information in a format they can understand
- Check whether they understand options and consequences of their choices
- Listen to their reasons for mistrust, disengagement, refusal and their choices
- Ensure there is the time to have conversations over a period and building up of a relationship
- Consider whom (whether family, advocate, other professional) can support you to engage with the adult
- Always involve attorneys, receivers, or representatives if the adult has one
- Establish if a plan for agreed actions / outcome for person who has fluctuating capacity is in place during a time when they had capacity for that decision
- Support/encourage the adult to attend meetings where possible

4.4 Mental capacity -

consideration needs to be given at an early stage, to determining if the individual has the mental capacity to understand and make informed decisions about their response to agencies concerns about their apparent self-neglecting behaviour (see section 8).

4.5 Risk Enablement -

there is a need to be mindful that organisational and professional risk aversion can hinder choice, control and independent living. This poses real challenges for practitioners/professionals in balancing risk enablement with their professional duty of care to keep people safe. Risk enablement therefore should always be a core part of placing people at the centre of their own care and support. Providing real choice and control means enabling people to take the risks that they choose and incorporating safeguarding and risk enablement into relationship-based, person centred working.
5. Responses to service refusal

5.1
The most frequent concern raised by professionals when working with adults who may self-neglect or hoard is the challenge when adults refuse to engage or accept services.

5.2
Self-neglect or hoarding needs to be understood in the context of each individual’s life experience; there is no one overarching explanatory model for why people self-neglect or hoard. It is a complex interplay of association with physical, mental, social, personal and environmental factors. A starting point is trying to understand why the person is disengaging and the context for why they may mistrust services.

5.3
Actions which can help to get engagement in self-neglect are suggested by Braye et al. (2015) as:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building rapport</td>
<td>Taking the time to get to know the person, refusing to be shocked</td>
</tr>
<tr>
<td>Moving from rapport to relationship</td>
<td>Avoiding kneejerk responses to self-neglect, talking through the interests, history and stories</td>
</tr>
<tr>
<td>Finding the right tone</td>
<td>Being honest while also being non-judgmental, separating the person from the behaviour</td>
</tr>
<tr>
<td>Going at the individuals pace</td>
<td>Moving slowly and not forcing things; continued involvement over time</td>
</tr>
<tr>
<td>Agreeing a plan</td>
<td>Making clear what is going to happen; a weekly visit might be the initial plan</td>
</tr>
<tr>
<td>Finding something that motivates the individual</td>
<td>Linking to interests (e.g. hoarding for environmental reasons, link into recycling initiatives)</td>
</tr>
<tr>
<td>Starting with practicalities</td>
<td>Providing small practical help at the outset may help build trust</td>
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<td>-----------------------------</td>
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<tr>
<td>Bartering</td>
<td>Linking practical help to another element of agreement – bargaining</td>
</tr>
<tr>
<td>Focusing on what can be agreed</td>
<td>Finding something to be the basis of the initial agreement, that can be built on later</td>
</tr>
<tr>
<td>Keeping company</td>
<td>Being available and spending time to build up trust</td>
</tr>
<tr>
<td>Straight talking</td>
<td>Being honest about potential consequences</td>
</tr>
<tr>
<td>Finding the right person</td>
<td>Working with someone who is well placed to get engagement</td>
</tr>
<tr>
<td>External levers</td>
<td>Recognizing and working with the possibility of enforcement action</td>
</tr>
</tbody>
</table>

**5.4**

It is important to consider in multi-agency partnership settings which agency is best placed to work with an adult who is disengaging to build links and trust.

**5.5**

If a person has capacity, is refusing to engage and there remains ongoing significant harm to a person’s health, safety or wellbeing then consideration should be given to the benefits of convening a multi-disciplinary meeting to ensure all available powers and duties are considered. Again, this needs to be balanced and proportionate and take into account a person’s right to self-determination. If a person lacks capacity the need for Court of Protection involvement should be considered.

**5.6**

If any agency is considering legal remedies, then a multi-agency meeting should be convened in most cases to ensure that all other potential options have been fully considered.
5.7
Research suggests that people who self-neglect or hoard appreciate the following in professionals working with them
• Humanity/empathy
• Calm and understanding approaches
• Reliable/patient/honest
• Normalising self-neglect (neither dismissing it or treating it as exceptional)
• Recognising and working with strengths of individuals
• Recognising resilience and determination in individuals
• Understanding people’s individual stories and reasoning
• Not walking away…respect for autonomy should not prevent you from Challenging a person’s life style if it is causing them harm
• A conversation and being challenged even if did not agree
• Work at individual’s own pace – not being overly directive

6. Engagement/support with the adult’s at risk family/informal carers

6.1
Carers have the same rights as people with care and support needs under the Care Act 2014. In situations where a carer is supporting someone who self neglects or has hoarding behaviours or indeed lives with the person, then there are statutory requirements.

6.2
Carers’ assessments must seek to establish the carer’s need for support (practical and emotional), and the sustainability of the caring role itself. The local authority must include a consideration of the carer’s potential future needs for care and support
6.3
Families and informal carers can often make a very valuable contribution especially in terms of history of behaviour and what is “normal” for this person. They may well also be able to assist in building trust between services and the individual.

6.4
Engaging family members/informal carers - the family member or carer of an adult at risk should be engaged wherever possible when the adult at risk has provided consent. This will include being part of planning, decision making and whether they are willing and able to provide support.

6.5
Consent not given - where the adult does not give consent to engage with an informal carer, the carer is still entitled to a carer’s assessment, and if they raise concerns in their own right, or if they have made the referral about the self-neglect concerns then these should still be discussed and their concerns heard.

Factors to consider in engaging with family/informal carers:

- Ensure the person is aware and consenting to the proposed role of family/carer in his/her care/treatment plan
- Offer/carry out carers assessment
- If family are needed/expected to provide care or support
- Involve the family/relative/carer in the development of any care and support plan. consider if it’s appropriate to invite carers to planning/discharge meetings.
- Ensure that the carer’s role and responsibilities are clearly recorded on formal care and support plans
- Check that they are willing and able to provide care and support.
- Provide them with necessary training, information to do what is expected
- Mentor/supervise, review to ensure they understand and have the skills
- Explore the dynamics between family members – these may underpin the self-neglect and influence their decision making
• Find creative solutions working with family members and other community resources
• Challenge informal carers (appropriately and safely) if there is reason to believe that the person is being manipulated or intimidated by them – concerns should be referred on to statutory agencies as appropriate

7. Legal framework

7.1
Public authorities, as defined by the Human Rights Act 1998, must act in accordance with the requirements of public law. In relation to adults perceived to be at risk because of self-neglect, public law does not impose specific obligations on public bodies to take particular action. Instead, the authorities are expected to act fairly, proportionately, rationally and in line with the principles of the Care Act 2014, the Mental Capacity Act 2005, and, where appropriate, consideration should be given to the application of the Mental Health Act 1983. Where appropriate, concerns may be referred to the Court of Protection. In rare cases, where the individual has capacity, but is unable to exercise choice, for example – appears to be acting under duress, consideration should be given to options available under the Inherent Jurisdiction of the High Court.

7.2
The Care Act 2014 places specific duties on the Local Authority in relation to self-neglect as follows:

**Assessment** (Care Act Section 9 and Section 11)
The Local Authority must undertake a needs assessment, even when the adult refuses, where-
– it appears that the adult may have needs for care and support,
– and is experiencing, or is at risk of, self-neglect.
This duty applies whether the adult is making a capacitated or incapacitated refusal of assessment.
**Enquiry - (Care Act Section 42)**

The Local Authority must make, or cause to be made, whatever enquiries it thinks necessary to enable it to decide what action should be taken in an adult’s case, when:

The Local Authority has reasonable cause to suspect that an adult in its area

– has needs for care and support,

– is experiencing, or is at risk of, self-neglect, and

– as a result of those needs is unable to protect himself or herself against self-neglect, or the risk of it.

**Advocacy -**

If the adult has ‘substantial difficulty’ in understanding and engaging with any social care process, including a Care Act Section 42 Enquiry, the local authority must ensure that there is an appropriate person to help them, and if there isn’t, arrange an independent advocate.

**7.3**

It is important that all staff are familiar with, and are mindful of their ‘Duty of Care’ when dealing with cases of self-neglect or hoarding, even if the adult has mental capacity to make decisions specifically related to their care.

‘**Duty of Care**’ (established through common law) can be summarised as ‘the obligation to exercise a level of care towards an individual, as is reasonable in all circumstances, by taking into account the potential harm that may reasonably be caused to that individual or his property’.

Any failure in the duty of care that results in harm could lead to a claim of negligence and consequent damages.

**7.4**

Human Rights Act 1998 article 8 gives everyone the right to ‘respect for his private and family life, his home and his correspondence’ and needs to be considered at all times.
**Legal Interventions**

7.5
There will be times when the impact of the self-neglect on the person’s health and well-being or their home conditions or neighbours’ environmental conditions are of such serious concern that practitioners may need to consider what legislative action can be taken to improve the situation when persuasion and efforts of engagement have failed. Such considerations should be taken as a result of a multi-disciplinary, multi-agency intervention plan with appropriate legal advice.

7.6
Possible legislative remedies that might need to be considered are outlined in appendix 2. Please note all legal routes would need to be considered in consultation with legal advice and the options outlined here are for information only.

It is important to note that s46 of the Care Act 2014 abolishes Local Authorities’ power in England to remove a person in need of care under s47 of the National Assistance Act 1948.

**8. Mental capacity**

8.1
Mental capacity is a key determinant of the ways in which professionals understand self-neglect and how they respond in practice. The autonomy of an adult with mental capacity is respected, and efforts should be directed to building and maintaining supportive relationships through which services can in time be negotiated if required.

8.2
When a person has been assessed not to have capacity to understand and make specific choices and decisions, interventions and services can be provided in the person’s best interest.
8.3
Mental capacity however involves not only the ability to understand the consequences of a decision, known as decisional capacity, but also the ability to execute the decision, known as executive capacity. The mental capacity assessment should entail both the ability to make a decision in full awareness of its consequences and the capacity to carry it out.

8.4
It is also important to understand the function-specific nature of capacity, so that the apparent capacity to make simple decisions is not assumed automatically in relation to more complex ones.

8.5
Careful attention should be paid to the assessment of mental capacity, especially with regards the person’s ability to weigh up and make use of information. It is important to be aware that people can be articulate and superficially convincing regarding their decision making but when probed about their behaviour are unable to identify risks and indicate how they are able to address the concerns of others. The nature of any intervention will to a certain extent centre on the question of whether the adult concerned has the mental capacity to make decisions. Consideration should also be made for people who may fall under the substantial difficulty criteria.

8.6
Respect for the persons wishes and beliefs needs to be central. Professionals need to find creative, sensitive ways to work with people who self neglect or hoard, understanding what the behaviour means to them and how they themselves wish to address the problem.

8.7
Where an adult has fluctuating capacity, it may be possible to establish a plan when they are capacitated which determines
what they want to happen when they lack capacity and it is important to make every effort to ‘enhance’ the person’s capacity through the timing of discussions etc.

8.8
For adults who have been assessed as lacking the mental capacity to make specific decisions about their health and welfare, the Mental Capacity Act 2005 allows for agency intervention in the person’s best interests. In urgent cases, where there is a view that an adult lacks mental capacity (and this has not yet been satisfactorily assessed and concluded), and the home situation requires urgent intervention, the Court of Protection can make an interim order and allow intervention to take place.

8.9
A person who lacks capacity has recourse in law to the Court of Protection (See Appendix 2). The court will however expect to see evidence of professional decision making and recording having already taken place.

Practitioners should:
• Check whether the adult has made an advanced directive when involved with significant decisions about health
• Involve the adult in meetings and decision as much as possible
• Always involve attorneys, representatives such as IMCAs or other advocates
• Ensure that the engagement and the individual’s decisions are clearly recorded within the relevant documentation e.g. support plans, risk assessments, meeting proforma.

8.10
Guidance on assessing mental capacity in connection to self neglect or hoarding
When assessing capacity, it is important to remember this is an assessment of capacity for whether the adult has capacity to access help for their self neglect or hoarding –
so, does the adult understand they have a problem? Is the adult able to weigh up the alternative options, e.g. being able to move around their accommodation unhindered? Can the adult retain the information given to them e.g. if the accommodation is cleared, you would be able to move around your accommodation? Can the adult communicate their decision? It is essential that any capacity assessment is clearly documented on case records.

9. Children

9.1
If there are any children or young people in the home consider whether the clutter/cleanliness in the home is such that the child/children may be subject to risk, harm or neglect. Please see the Safeguarding children’s website for guidance on neglect of a child

www.partnersinsalford.org/sscb/neglectsubgroup.htm

If in doubt, a referral should be made to children’s safeguarding

9.2
If the child is caring for the adult in any way they may be a young carer and consideration should be given to a referral to children’s services for support for the young carer.

10. Self neglect and Domestic Abuse

Domestic violence can be so embedded into the pattern of family life that the victims, perpetrators and other family members may not define or recognise their experience as domestic abuse.

The Home Office defines Domestic Violence and Abuse as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:
• Psychological;
• Physical;
• Sexual;
• Financial;
• Emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

This definition includes so called ‘honour’ based violence, Female Genital Mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

The Serious Crime Act 2015 creates a new offence of controlling or coercive behaviour in intimate or familial relationships. Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another. Such behaviours might include:

• Isolating a person from their friends and family;
• Depriving them of access to support services, such as specialist support or medical services
• Depriving them of their basic needs;
• Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
• Repeatedly putting them down such as telling them they are worthless;
• Enforcing rules and activity which humiliate, degrade or dehumanise the victim;
Cases where an informal carer is very involved in the person’s care, can involve a complex mix of elements including controlling and coercive behaviour, dependency and self neglect. In these cases it is important to:

- Have discussions with the adult who is self-neglecting separately in order to discuss any aspects of coercion
- Establish with the informal carer, how they perceive their caring role, what care and support they provide, what care and support they believe the person requires and if they need any support in their role as an informal carer – a carer’s assessment should be offered
- Consider if the case should be referred to MARRAC
11. Assessment

Making Sense of the self-neglect

Partner agencies will conduct a range of assessments according to their role and involvement with a person who may be self-neglecting or hoarding. Self-neglect is complex and it’s important to understand as far as possible each person’s particular circumstances and their perceptions of their situation as part of assessment and intervention.

Sensitive and comprehensive assessment is important in identifying capabilities and risks. It is important to look further and tease out through a professional relationship possible significance of personal values, past traumas and social networks. Some research has shown that events such as loss of parents as a child, abuse as a child, traumatic wartime experiences, and struggles with alcoholism have preceded the person self-neglecting. The self-neglect could also be the result of domestic abuse (current or historic).

11.2 Assessment in Adult Social Care Contact Centre

For any self-neglect referrals made to ASC, an initial risk assessment and decision at the Adult Health and Social Care Contact Team is the first aspect of assessment and an initial decision re the appropriate response to a referral is made.

General principles for assessing risk at the Contact Centre

As Health and Social Care Contact Team staff are not able to do face to face assessment, staff will apply the general principles of this policy to a ‘long arm’ assessment process by:

- Ensuring that where possible they will make contact with the individual and/or their representative/friend/family member to seek their views of the situation and level of risk
• Ensuring that as far as possible other services who are aware of the individual are contacted for their perspective on the situation and risk
• Applying the self neglect risk assessment tool with a specific focus to the following issues;
• Poor hygiene that is or could cause significant health issues
• Significant health issues that area already causing or could cause high risk
• Deterioration in health and weight loss
• Lack of ability to care for basic requirements (hygiene, health and nutrition) and a refusal to accept any support
• Isolation from family and friends
• Possible coercion by informal carers leading to any of the above high risk concerns

11.3 Police welfare notices – many of the self neglect referrals may present as police welfare notices which will have been risk assessed as either medium or high risk

Time scales for the review of welfare notices by the Adult Health and Social Care Contact Team

• The contact team will conduct an initial screening of all welfare notices on the day they are received (the service operates Monday to Friday).

• All welfare notices will be completed within 10 working days

11.4 General principles for face to face assessment

• it is important to consider how to engage the person at the beginning of the assessment. Careful consideration should be given to the method of making contact to ensure it is not perceived as impersonal or authoritative. The usual standard appointment letter is unlikely to be an effective way of beginning a lasting trusting professional relationship.

• Home visits are important and practitioners should question if third party information or a telephone conversation is sufficient to make an informed assessment/decision.
• It is important that the practitioner uses their professional skills to be invited into the person’s house and observe for themselves the conditions of the person and their home environment. Practitioners should discuss with the person any causes for concern over the person’s health and wellbeing and obtain the person’s views and understanding of their situation and the concerns of others.

• The assessment should include the person’s understanding of the overall cumulative impact of a series of small decisions and actions as well as the overall impact.

• Repeat assessments might be required as well as ensuring that professional curiosity and appropriate challenge is embedded within an assessment.

• It is important that when undertaking the assessment the practitioner does not accept the first, and potentially superficial, response rather than interrogating more deeply into how a person understood and could act on their situation.

11.6

Information sharing across all relevant agencies (subject to appropriate info sharing protocols) is crucial so that all agencies involved to better understand the extent and impact of the self-neglect and to work together to support the individual and assist them in reducing the impact on their wellbeing and on others.

11.7

Multi-agency meetings to share information should be considered in complex cases, where there are significant risks in order to better understand and manage risk (see section 15). Wherever possible the person themselves should be included in the meeting along with significant others and an independent advocate where appropriate.

11.8

Risk Assessment - In potentially complex situations or where there is thought to be significant risk to the person’s health, wellbeing or environment or to others, practitioners should
use a risk assessment tool (see appendix 3), to evaluate the risks and where required, it is important to take into account individuals' preferences, histories, circumstances and lifestyles to achieve a proportionate and reasonable tolerance of acceptable risks.

11.9

Refusal of assessment/engagement in the assessment process - If an assessment is refused, then there should be a clear record of any concerns by agencies involved or informal carers/other parties, the perceived risk from the information know at this point, and any system for monitoring the situation (see section 5). Any involved parties that have concerns should be advised that they can refer again if the situation deteriorates/changes and they have additional concerns.

11.10 Recording

General principles

- It is important to record assessment, decision-making and intervention in detail to demonstrate that a proper process has been followed and that practitioners and managers have acted reasonably and proportionately.

- There should be an audit trail of what options were considered and why certain actions were or were not taken.

- At every step and stage in the process record the situation, what has been considered, who has been consulted with and what decisions have been reached.

- This may appear a time consuming process, but it is simply a case of putting your activity notes into a framework of considerations and why you have chosen a particular course of action.

- Mental capacity considerations should be routinely recorded, including explicitly where there is no reason to doubt the adult’s ability to make their own decisions and why this is.

- Formal mental capacity assessments need to be recorded fully in line with the Mental Capacity Act Code of Practice.
12. Interventions

12.1
The starting point for all interventions should be to encourage the person to do things for themselves. Where this fails in the first instance, this approach should be revisited regularly throughout the period of the intervention. All efforts and response of the person to this approach should be recorded fully.

12.2
Efforts should be made to build and maintain supportive relationships through which services can in time be negotiated. This involves a person-centred approach that listens to the person’s views of their circumstances and seeks informed consent where possible before any intervention. It is important to note that a gradual approach to gaining improvements in a person’s health, wellbeing and home conditions is more likely to be successful than an attempt to achieve considerable change all of a sudden, which is how the adult may perceive it (see case examples).

12.3
A multi-agency approach is often most successful for self-neglect cases. Co-ordinated actions by housing officers, mental health services, GPs and DN, social work teams, the police and other public services and family members have led to improved outcomes for individuals.

12.4
A list of the range of agencies who can offer support for people who self neglect can be found in appendix 5.

12.5
Research supports the value of interventions to support routine daily living tasks. However cleaning interventions alone, where home conditions are of concern, do not emerge as effective in the longer term. They should therefore take place as part of an integrated, multi-agency plan.
12.6
As self-neglect is often linked to disability and poor physical functioning, often a key area for intervention is assistance with activities of daily living, from preparing and eating food to using toilet facilities.

12.7
Where agencies are unable to engage the person and reach an agreement to implement services to reduce or remove risks arising from the self-neglect, the reasons for this should be fully recorded and maintained on the person’s case record, with a full record of the efforts and actions taken by the agencies to assist the person.

12.8
The person, carer or advocate should be fully informed of the services offered and the reasons why the services were not implemented. There is a need to make clear that the person can request assessment for services at any time in the future and the ways of making contact should be outlined to them.

12.9
Depending on the risks, arrangements may need to be made for ongoing monitoring and, where appropriate, making proactive contact to ensure that the person’s needs, risks and rights are fully considered and to monitor any changes in circumstances.

12.10
In cases of collecting pets/animals, the practitioner will need to consider the impact of this behaviour carefully. Where there is a serious impact on either the adult’s health and wellbeing, the animals’ welfare, or the health and safety of others, the practitioner should collaborate with the RSPCA and public health officials. Although the reason for animal collecting may be attributable to many reasons, including compensation for a lack of human companionship and the company the animals may provide considerations have to be given to the welfare of the animals and potential public health hazards.
12.11
Where the conditions of the home are such that they appear to pose a serious risk to the adult’s health from filthy or verminous premises, or their living conditions are becoming a nuisance to neighbours/affecting their enjoyment of their property, advice from Environmental Health should be sought and joint working should take place.

12.12
If as a result of hoarding the practitioner thinks there may be a risk of fire they should seek advice from GMFRS

13. Frameworks for managing/monitoring self-neglect cases

13.1
There are three broad approaches to monitoring/addressing self-neglect cases depending on the individuals involved, the issues and the level of risk.

The self neglect assessment tool can be used to support decision making on the most appropriate approach to take.

• Single agency response
• Formalised multi-agency response
• Section 42 safeguarding Adults referral/enquiry

13.2
Possible approaches that have been shown to work well are summarized below:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being there</td>
<td>Maintaining contact; monitoring risk/capacity, spotting motivation</td>
</tr>
<tr>
<td>Practical input</td>
<td>Household equipment, repairs, benefits, ‘life management’</td>
</tr>
<tr>
<td>Risk limitation</td>
<td>Safe drinking, fire safety, repairs</td>
</tr>
<tr>
<td>Health concerns</td>
<td>Doctors’ appointments, hospital admissions</td>
</tr>
</tbody>
</table>
Care and support | Small beginnings to build trust
---|---
Cleaning / clearing | Proportionate to risk, with agreement, ‘being with’, attention to what follows
Networks | Family/ community, social connections, peer support
Therapeutic input | Replacing what is relinquished; psychotherapy/mental health services
Change of environment | Short term respite, a new start
Enforced action | Setting boundaries on risk to self and others

(Braye et al. (2005))

### 14. Single agency response

#### 14.1

This level of response could involve one agency or a number of agencies working directly with the individual. This is the most likely response for low/moderate risk cases with engagement/ partial engagement of the adult (see assessment tool).

#### 14.2

Incidents that are low risk would most likely be managed outside formal procedures and addressed through mechanisms such as engagement with the adult, supporting the person to address their concern, engagement with community activities, or access to health care and counseling – this approach could be most appropriate particularly where the adult is engaging with services to some extent and there is an expectation of decreasing the level of risk with continued engagement.

#### 14.3

Professional judgment is key, any factor or issue may move a low risk case into a higher threshold which would warrant a more formalised multi-disciplinary response.
There may be a level of coordination required across different agencies involved with the individual, in order to have a consistent approach in working with the person e.g. emails, telephone conversations, case updates etc, however, this level would not require a formalised multi disciplinary meeting to assess and record significant risk. Most recording (which could include risk assessment) would be made in individual case files of agencies involved and should include clear rational for all decisions made.

15. Formalised multi-agency response

15.1
A coordinated response across agencies through a multi-disciplinary meeting may be required for cases that are moderate to high risk with non engagement or high risk with engagement, where one of the agencies involved feel that a more formal multi-agency meeting is required in order to: assess risk, share information, agree an approach to working/engaging with the individual that is outlined in an action plan with clear monitoring/reviewing in place. The person could either be receiving services or not and/or engaging with services or not.

A multi agency meeting in Salford would usually take one of two formats:

- Multi Disciplinary Group (MDG) meeting held in each health locality - if needs relate mainly to health needs
- Multi-disciplinary meeting (MDT) coordinated by Salford Health and Social Care - if needs relate mainly to social support needs

15.2
A Multi-disciplinary meeting should be convened in the following circumstances:

- The adult has needs for care and support (whether or not
the local authority is meeting any of those needs) and is experiencing, or is at risk of, abuse or neglect. As a result of those care and support needs the adult is unable to protect themselves from either the risk of, or the experience of, abuse or neglect;

- The adult has mental capacity to make unwise decisions and choices about their life, and the identified risks are high.
- The adult’s decision making means they are unable to protect themselves from the risk of serious abuse or neglect from themselves or others.
- The adult is not engaging with services/support, has capacity and remains a moderate/high risk

A multi-disciplinary meeting provides an opportunity to:

- Identify with the adult at risk their wishes, views and beliefs - what outcome they want to achieve
- Conduct appropriate assessments around capacity and best interest decisions
- Share information across agencies and form a shared assessment of risk
- Establish a multi-agency risk management plan
- Consider what may be contributing to the behaviour and work to address this from a preventative framework.

15.3 MDG meetings

The MDG meeting would most likely be the appropriate setting for an initial discussion of an individual who is at risk due to self neglect. These meetings are held fortnightly across the localities and create a regular forum for multi-agency working across health, Adult Social Care and other key agencies working with the individual.

MDG meetings are a professionals meeting, they are not a suitable forum for the individual or family/informal carer to attend due to the format of the meeting. Therefore, careful consultation to ensure that the individual’s views are known and represented is required. A separate MDT meeting coordinated by Salford Health and Social care may be required in some cases to facilitate the involvement of the individual in meetings.
Requesting a multi-disciplinary meeting

Any agency (including voluntary agencies) can request an MDG or MDT

To request an MDG

Email to mdg.coordinators2@srft.nhs.uk with the subject heading ‘New Referral’

1. Name, DOB and NHS Number (if known)
2. Reasons for referral
3. Concerns and risks
4. Consent gained from patient/service user – if consent cannot be gained, or a referral is being made without consent, please state why.
5. Does the patient/service user have a formal/informal carer?
6. Does the patient/service user have any other professionals involved in their care and support?

See flow chart in appendix 6

Each referral is assessed within the locality by the MDG Nurse, Social Work Advanced Practitioner and the patient’s GP who make a joint decision regarding appropriateness to be taken to MDG.

Referrals are triaged within 48hrs.

Feedback will be given to the referrer by any of those involved in assessing the referral.

All MDG Meetings are chaired by either the MDG Nurse or the linked Social Work Advanced Practitioner, and take place every 2 weeks. The MDG is not an emergency service.

The referrer will be invited to attend the MDG Meeting (if appropriate). If they are not able to attend the MDG Nurse, Social Work Advanced Practitioner or Care co-ordinator (identified in the meeting) will feedback following the MDG Meeting.

Monitoring/review

The meeting would determine when the person should be reviewed again based on the individual circumstances, level of perceived risk and actions agreed to be taken outside the meeting.
15.4 MDT meetings

Once a Heath and social care team has identified an MDT as appropriate the social worker will co-ordinate the meeting and a chair will be identified.

**Purpose of the meeting:**

The joint decision making process/multi-disciplinary meeting should:

- Determine if the individual poses a significant risk to their own health and wellbeing and that of others or whether the risks are low/a matter of the individual choice around lifestyles/unwise choices.
- Consider if mental capacity is an issue, whether a formal capacity assessment is required and who is the best agency to undertake this.
- Assess the degree to which the individual is likely to engage with services.
- Assess the level of risk if not already done.
- Decide if further intervention is required and recommended next steps
- Consider if there is a risk to any children

Please see Multi-Agency Risk Management Meeting Agenda (Appendix 7).

Individual agencies will have their own risk assessment formats and policies relevant to their service area. Where available these need to be shared and discussed alongside all the other detail discussed in the meeting.

**The social worker co-coordinating the meeting will:**

- Invite all relevant partners to the MDT
- Ensure that the adult at risk is consulted and that their views and wishes are represented at the meeting
- Ensure that the views family members are considered as appropriate and in line with the consent of the adult at risk
- Ensure that all agencies that have been involved with the adult at risk are consulted and invited to the meeting (including the voluntary sector)
• Ensure that a clear summary is made of the main points
discussed, all recommendations, all decisions
• Ensure that there is clarity about who is monitoring and
updating on any identified risks
• Arrange a further meeting unless agreed by all parties this is
not necessary
• Circulate minutes of the meeting

All partner agencies invited should:
• Commit to attendance.
• Commit to undertake any recommendations where they are
the appropriate agency to follow up.

A request for an MDT is made through the Adult Social Care
Contact Team Tel 0161 631 4777 (see 11.2 for more detail about
time frames and initial assessment).

15.5 Multi-agency decision making/monitoring and review
At this stage decisions must be made in partnership with all the
relevant agencies, be formally documented and circulated to all
the partners.

Decisions and actions proportionate to the level of risk and
professional responsibility should be recorded. The self neglect
assessment tool (appendix 3) identifies 3 levels of risk, this
guidance can be utilised to help formulate appropriate actions
for:
– Low risk agreed
– Moderate risk agreed
– High risk agreed

15.6 Outcome of intervention: low risk agreed
If the individual has capacity, is unwilling to engage
and the immediate risks are deemed to be low suitable
approaches might include;
• Multi-disciplinary decision for some services to continue to
engage with the individual and monitor the situation
• Multi-disciplinary decision that no further involvement is
considered necessary at this point
• Record of the decision including a risk assessment and action plan and communication plan where appropriate

• Explanation of the decision where no further involvement is considered necessary

• Update/inform any other relevant services/parties as appropriate including carers and relatives where permission has been given

• If agencies disagree about any on-going involvement with the individual, this should be discussed and a decision made at the meeting

• Ensure the individual and their carers or agencies (as appropriate) know how and who to refer to if circumstances change (this would need to be agreed at the meeting).

If the individual lacks capacity, but the risks are deemed low:

• A best interests decision will be needed, to help make a decision about further actions.

• Where capacity fluctuates ensure an advance plan is made with the person when they have capacity to cover decision for when they lack capacity.

15.7 Outcome of intervention: moderate/high risk agreed

If the risks to the safety and wellbeing of the individual and/or others are assessed as moderate/high suitable approaches might include;

• Clear recording of the identified risks with the views and wishes of the individual

• A clear plan of action with named individuals responsible for actions

• A clear time frame to monitor and review with named individuals responsible

15.8

If the risks to the safety and wellbeing of the individual and/or others are deemed critical:

• Ensure there is legal representation at the meeting to ensure all reasonable legal options have been explored NB The outcome may be one which confirms that the agencies
involved have undertaken all reasonable steps within their powers, as the law is clear that there are circumstances where intervention could be illegal.

- Ensure there are carefully documented minutes of the meeting outlining the risks and decisions taken and any legal framework used in the decision (including clear documentation of capacity issues)

It is essential that all those who are involved in working with the individual, whether in a paid or voluntary capacity, have the opportunity to raise concerns and voice their views about the level of risk for the individual – each person will bring a different perspective and have seen a different side to the self-neglect situation. If some agencies still feel that there is too much risk to walk away from the case and close on-going monitoring then the multi-disciplinary meeting needs to consider if there is a need for an agreed method of engagement with the individual to monitor and review the situation or simply to build up a more trusting relationship that may lead to engagement with services in the future.

A referral under safeguarding adults could be made alongside convening a multidisciplinary meeting or be the result of the meeting.

16. Safeguarding Adults Referral and Section 42 enquiry

16.1

This level of response is appropriate where an adult is at significant risk and unable to protect themselves from harm - most likely to be appropriate where there are issues of fluctuating capacity and significant risk (moderate/high risk) with significant safeguarding concerns (which could include coercive behavior from an informal carer).

Safeguarding Adults Referral Criteria

The Care Act (2014) Statutory Guidance (section 14) states that safeguarding duties now apply to any adult who:
• has needs for care and support (whether or not the local authority is meeting any of those needs); and
• is experiencing, or is at risk of, abuse or neglect; and

as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect. (Clause 14.1 of the Guidance). Under Section 42 of the Care Act, local authorities must make enquiries, or cause another agency to do so, whenever abuse or neglect are suspected in relation to an adult and the local authority thinks it necessary to enable it to decide what, if any, action is need to help and protect the adult at risk.

The decision to carry out a Section 42 Enquiry under the Care Act 2014 does not depend on the person’s eligibility, but should be taken wherever there is reasonable cause to think that the person is experiencing, or is at risk of, abuse or neglect.

The local authority must arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has ‘substantial difficulty’ in being involved in the process and where there is no other suitable person to represent and support them (Clause 14.43 of the Guidance). The Care Act (2014) does not determine any thresholds of ‘harm’ against which a referral for safeguarding procedures is made.

16.2

Once a self neglect or hoarding case is within the safeguarding remit, a decision will be made in line with policies around the agency best suited to undertake the enquiries or work with the adult at risk. Adult Social Care retains the responsibility for co-ordination and having assurance that risk has been managed appropriately before any closure can take place.

16.3

Risk assessment in cases of hoarding should take into account the Clutter Image Scale (see appendix 8).
The case can be transferred out of a section 42 enquiry and into a multidisciplinary process with MDT or MDG meetings at any time if appropriate once initial safeguarding meeting has been held.

Section 42 enquiries provide an opportunity for brief interventions with the adult at risk to obtain the outcome they have identified, while addressing areas of risk through the safeguarding plan.

Section 42 enquiries in relation to self-neglect and hoarding can include, but are not limited to,

- Any enquiry into abuse and neglect that may have contributed to or precipitated the self-neglecting behavior or hoarding
- Therapeutic responses, such as access to mental health, drug and alcohol services, bereavement services
- Brief interventions, particularly those that work to enable changes in attitude or behaviour and to handle underlying issues

If an adult at risk refuses or declines an assessment, services or support, a risk assessment must be carried out to determine the level of seriousness of each identified risk.

- Intervention must be person centred, involving the individual as far as possible in understanding the risk assessment and the alternatives for managing the risk.
- Information should be shared with other relevant professionals who may have a contribution to make in managing or monitoring the risks.
- Consideration must be given to the mental capacity of the individual and whether they require support in their decision making
- Following an assessment that the individual lacks capacity, best interest decisions need to be considered.
In cases where the individual refuses help and services and is seen to be at grave risk as a result, if an agency is satisfied that the individual has the mental capacity to make an informed choice on the issues raised, then that person has the right to make their own choices, even if these are considered to be unwise. **But, in cases of significant vulnerability there should be on-going attempts at engagement with the individual applying the principles outlined in this policy to monitor risk and continue to build up a relationship with the individual (see section 5).**

17. **Assurance Framework**

Consideration should be given to the review of cases subject to the Multi-Agency Policy and Procedure to support people who self-neglect as part of the Salford’s Safeguarding Adults Board assurance framework. This may include some or all of the following:

- Bi-annual audit and presentation of a case to Salford Safeguarding Adults Board Performance and Quality sub group by ASC where a Section 42 Safeguarding Enquiry further to a concern of serious self-neglect was carried out.

- Bi-annual audit and presentation of a case to Salford Safeguarding Adults Board Performance and Quality sub group where the self-neglect policy and procedures were followed as a result of a concern of self-neglect being raised.
Appendix 1 Definitions and indicators of self-neglect and how to engage with the individual

**Self neglect**
The Care Act statutory guidance 2014 defines self-neglect as;

"self-neglect - this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding"  

**Hoarding**
Hoarding behaviour was previously seen as a symptom of Obsessive Compulsive Disorder (OCD) but it has now received a separate clinical definition of ‘hoarding disorder’ and is defined as:

‘A psychiatric disorder characterised by persistent difficulty discarding or parting with possessions, regardless of their actual value resulting in significant clutter that obstructs the individual’s living environment and produces considerable functional impairment.’

GMFRS Hoarding, Prevention and Protection policy gives clutter images to support with assessing the risk.)

**Characteristics of self-neglect**
The following characteristics and behaviours are useful examples of potential self-neglect and consequent impairments to lifestyles:

- Living in very unclean, sometimes verminous, circumstances, such as living with a toilet completely blocked with faeces, not disposing of rubbish;
- Neglecting household maintenance, and therefore creating hazards;
- Obsessive hoarding creating potential mobility and fire hazards;
- Animal collecting with potential of insanitary conditions and neglect of animals;
- Poor diet and nutrition, evidenced by for instance by little or no fresh food or mouldy food in the fridge;
- Failure to maintain social contact;
- Failure to manage finances;
- Declining or refusing prescribed medication and/or other community healthcare support – for example, in relation to the presence of mental disorder (including the relapse of major psychiatric features, or a deterioration due to dementia) or to podiatry issues;
- Refusing to allow access to health and/or social care staff in relation to personal hygiene and care – for example, in relation to single or double incontinence, the poor healing of sores; Refusing to allow access to other organisations with an interest in the property, for example, staff working for utility companies (water, gas electricity); Being unwilling to attend appointments with relevant staff, such as social care, healthcare or allied staff.

**Characteristics of hoarding**
**Hoarding behaviour is typically manifested in three ways:**

**Acquisition**
Compulsive buying and/or the accumulation of free items such as newspapers, junk mail and items left at the side of the road.
Saving
People save for ‘sentimental’ reasons (it reminds them of someone they love and miss), ‘instrumental’ reasons (saved in case they are needed at a later date), or ‘aesthetic’ reasons (items are too beautiful to be discarded).

Disorganisation
Items of value are mixed with rubbish and items of no apparent value.

It is common for people who hoard not to recognise the severity of the problem and ignore, or not see, the clutter in their home. Conversely, the person who hoards may be acutely aware of the issue and feel embarrassed

Empowering/engaging the adult at risk
Building a positive relationship with individuals who self-neglect is critical to achieving change for them, and in ensuring their safety and protection.

- Consider if they have the necessary information in a format they can understand
- check whether they understand options and consequences of their choices
- listen to their reasons for mistrust, disengagement, refusal and their choices
- ensure there is the time to have conversations over a period and building up of a relationship
- consider whom (whether family, advocate, other professional) can support you to engage with the adult
- The family member or carer of an adult at risk should be engaged wherever possible with the consent of the adult at risk
- Consider if the person has capacity in relation to the decisions they are making to self-neglect/hoard

<table>
<thead>
<tr>
<th>Build rapport</th>
<th>Take time to get to know the person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finding the right tone</td>
<td>Being honest while also being non-judgmental, separating the person from the behaviour</td>
</tr>
<tr>
<td>Going at the individuals pace</td>
<td>Moving slowly and not forcing things; continued involvement over time</td>
</tr>
<tr>
<td>Agreeing a plan</td>
<td>Making clear what is going to happen; a weekly visit might be the initial plan</td>
</tr>
<tr>
<td>Finding something that motivates the individual</td>
<td>Linking to interests (e.g. hoarding for environmental reasons, link into recycling initiatives)</td>
</tr>
<tr>
<td>Starting with practicalities</td>
<td>Providing small practical help at the outset may help build trust</td>
</tr>
<tr>
<td>Keeping company</td>
<td>Being available and spending time to build up trust</td>
</tr>
<tr>
<td>Straight talking</td>
<td>Being honest about potential consequences</td>
</tr>
<tr>
<td>Finding the right person</td>
<td>Working with someone who is well placed to get engagement</td>
</tr>
</tbody>
</table>
Appendix 2: Legal options

There are many legislative responsibilities placed on agencies to intervene in or be involved in some way with the care and welfare of adults who are believed to be vulnerable.

It is important that everyone involved thinks pro-actively and explores all potential options and wherever possible, the least restrictive option e.g. a move of the person permanently to smaller accommodation where they can cope better and retain their independence.

The following is a summary of the powers and duties that may be relevant and applicable steps that can be taken in cases of dealing with persons who are self-neglecting and/or living in squalor. It is not necessarily an exhaustive list and in all cases legal advice should be sought as appropriate.

**Human Rights Act 1998**

Public authorities must act in accordance with the Convention of Human Rights, which has been enacted directly in the UK by the Human Rights Act 1998 and therefore can be enforced in any proceedings in any court.

Article 5 – Right to Liberty and Security.
Everyone has the right to liberty and security of persons.

Article 8 – Right to Respect for Private and Family Life
Everyone has the right to respect for his private and family life, his home and his correspondence.

There shall be no interference by a public authority with the exercise of this right except such as permitted by the law, is for a lawful purpose e.g. is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country; for the prevention of disorder or crime; for the protection of health or morals, or the protection of the rights and freedoms of others and is proportionate.

The First Protocol Article 1 – Protection of Property
Every natural or legal person is entitled to the peaceful enjoyment of his possessions. No one should be deprived of his possessions except in the public interest and subject to the conditions provided for by law and by the general principles of international law.

**Environmental Health**

Environmental Health Officers in the Local Authority have wide powers/duties to deal with waste and hazards. They will be key contributors to cross departmental meetings and planning, and in some cases e.g. where there are no mental health issues, no lack of capacity of the person concerned, and no other social care needs, then they may be the lead agency and act to address the physical environment.

Remedies available under the Public Health Acts 1936 and 1961 include:

- Power for LA to remove accumulations of rubbish on land in the open air (section 34)
- Power of entry/warrant to survey/examine (sections 239/240)
• power of entry/warrant for examination/execution of necessary work (section 287)
• Power to require vacation of premises during fumigation (section 36)
• Power to disinfect/destroy verminous articles at the expense of the owner (Section 37)

Remedies available under the Environmental Protection Act 1990 include:
• Litter clearing notice where land open to air is defaced by refuse (section 92a)
• Abatement notice where any premise is in such a state as to be prejudicial to health or a nuisance (sections 79/80)

Other duties and powers exist as follows:
• Town and Country Planning Acts provide the power to seek orders for repairs to privately owned dwellings and where necessary compulsory purchase orders.
• The Housing Act 2004 allow enforcement action where either a category 1 or category 2 hazard exists in any building or land posing a risk of harm to the health or safety of any actual or potential occupier or any dwelling or house in multiple occupation (HMO). Those powers range from serving an improvement notice, taking emergency remedial action, to the making of a demolition order.
• Local Authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice under the Prevention of Damage by Pests Act 1949.
• The Public Health (Control of Disease) Act 1984 Section 46 sets out restrictions in order to control the spread of disease, including use of infected premises, articles and actions that can be taken regarding infectious persons.

**Housing – landlord powers**

These powers could apply in Extra Care Sheltered Schemes, Independent Supported Living, private-rented or supported housing tenancies. It is likely that the housing provider will need to prove the tenant has mental capacity in relation to understanding their actions before legal action will be possible. If the tenant lacks capacity, the Mental Capacity Act 2005 should be used.

In extreme cases, a landlord can take action for possession of the property for breach of a person’s tenancy agreement, where a tenant fails to comply with the obligation to maintain the property and its environment to a reasonable standard. This would be under either under Ground 1, Schedule 2 of the Housing Act 1985 (secure tenancies) or Ground 12, Schedule 2 of the Housing Act 1988 (assured tenancies).

The tenant is responsible for the behaviour of everyone who is authorised to enter the property.

There may also be circumstances in which a person’s actions amount to anti-social behavior under the Anti-Social Behaviour, Crime and Policing Act 2014. Section 2(1)(c) of the Act introduces the concept of “housing related nuisance”, so that a direct or indirect interference with housing management functions of a provider or local authority, such as preventing gas inspections, will be considered as anti-social behaviour. Injunctions, which compel someone to do or not do specific activities, may be obtained under Section 1 of the Act. They can be used to get the tenant to clear the property or provide access for contractors. To gain an injunction, the landlord must show that, on the balance of probabilities, the person is engaged or threatens to engage in antisocial behaviour, and that it is just and convenient to grant the injunction for the purpose of preventing an engagement in such behaviour. There are also powers which can be used to require a tenant to cooperate with a support service to address the underlying issues related to their behaviour.
Powers of Entry

The following legal powers may be relevant, depending on the circumstances:

• If the person has been assessed as lacking mental capacity in relation to a matter relating to their welfare: the Court of Protection has the power to make an order under Section 16(2) of the MCA relating to a person’s welfare, which makes the decision on that person’s behalf to allow access to an adult lacking capacity. The Court can also appoint a deputy to make welfare decisions for that person.

• If an adult with mental capacity, at risk of abuse or neglect, is impeded from exercising that capacity freely: the inherent jurisdiction of the High Court enables the Court to make an order (which could relate to gaining access to an adult) or any remedy which the Court considers appropriate (for example, to facilitate the taking of a decision by an adult with mental capacity free from undue influence, duress or coercion) in any circumstances not governed by specific legislation or rules.

• If there is any concern about a mentally disordered person: Section 115 of the MHA provides the power for an approved mental health professional (approved by a local authority under the MHA) to enter and inspect any premises (other than a hospital) in which a person with a mental disorder is living, on production of proper authenticated identification, if the professional has reasonable cause to believe that the person is not receiving proper care.

• If a person is believed to have a mental disorder, and there is suspected abuse or neglect: Section 135(1) of the MHA, a magistrates court has the power, on application from an approved mental health professional, to allow the police to enter premises using force if necessary and if thought fit, to remove the person to a place of safety if there is reasonable cause to suspect that they are suffering from a mental disorder and (a) have been, or are being, ill-treated, neglected or not kept under proper control, or (b) are living alone and unable to care for themselves.

• Power of the police to enter and arrest a person for an indictable offence: Section 17(1)(b) of PACE

• Common law power of the police to prevent, and deal with, a breach of the peace. Although breach of the peace is not an indictable offence the police have a common law power to enter and arrest a person to prevent a breach of the peace.

• If there is a risk to life and limb: Section 17(1)(e) of the PACE gives the police the power to enter premises without a warrant in order to save life and limb or prevent serious damage to property. This represents an emergency situation and it is for the police to exercise the power.

Anti-Social Behaviour 2003 (as amended)

Anti-social behaviour is defined as persistent conduct which causes or is likely to cause alarm, distress or harassment or an act or situation which is, or has the potential to be, detrimental to the quality of life of a resident or visitor to the area.

Questions about whether an application for an Anti-Social Behaviour Order would be appropriate should be made to the Designated Police Officer (it may be appropriate to involve the police in the multi-agency work), the Registered Social Landlord or the Local Authority.
**Misuse of Drugs Act 1971**

Section 8 (this creates an offence if the occupier of premises permits certain acts to take place on the premises)

‘A person commits an offence if, being the occupier or concerned in the management of the premises, he knowingly permits or suffers any of the following activities to take place on those premises…’

s8 (a) Producing or attempting to produce a controlled drug…'

s8 (b) Supplying or attempting to supply a controlled drug to another ………or offering to supply a controlled drug to another….'

s8 (c) Preparing opium for smoking

s8 (d) Smoking cannabis, cannabis resin or prepared opium

**Mental Health Act 1983**

Sections 2 and 3 of the Mental Health Act 1983

Where a person is suffering from a mental disorder (as defined under the Act) of such a degree, and it is considered necessary for the patient’s health and safety or for the protection of others, they may be compulsorily admitted to hospital and detained there under Section 2 for assessment for 28 days. Section 3 enables such a patient to be compulsorily admitted for treatment.

Section 2 - Admission for Assessment
Duration of detention: 28 days maximum

Application for admission: by Approved Mental Health Professional or nearest relative. Applicant must have seen patient within the previous 14 days.

Procedure: two doctors (one of whom must be section 12 approved) must confirm that:

a) the patient is suffering from a mental disorder of a nature or degree which warrants detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period; and

b) S/he ought to be detained in the interests of his/her own health or safety or with a view to the protection of others.

Section 3 – Admission for Treatment
Duration of detention: six months, renewable for a further six months, then for one year at a time

Application for admission: by nearest relative or Approved Mental Health Professional in cases where the nearest relative consents, or is displaced by County Court, or it is not ‘reasonably practicable’ to consult him

Procedure: two doctors must confirm that:

a. the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment in hospital; and

b. it is necessary for his/her own health or safety or for the protection of others that he/she receives such treatment and it cannot be provided unless s/he is detained under this section; and

c. appropriate treatment is available to him/her

Renewal: under section 20, Responsible Medical Officer can renew a section 3 detention order if original criteria still apply and treatment is likely to ‘alleviate or prevent a deterioration’ of patient’s condition.
In cases where patient is suffering from mental illness or severe mental impairment but treatment is not likely to alleviate or prevent a deterioration of his/her condition, detention may still be renewed if s/he is unlikely to be able to care for him/herself, to obtain the care s/he needs or to guard himself against serious exploitation

Section 117 allows for aftercare following a section 3 detention in certain circumstances

Section 7 of the Mental Health Act 1983 – Guardianship

A Guardianship Order may be applied for where a person suffers from a mental disorder, the nature or degree of which warrants their reception into Guardianship (and it is necessary in the interests of the welfare of the patient or for the protection of other persons.) The person named as the Guardian may be either a local social services authority or any applicant.

A Guardianship Order confers upon the named Guardian the power to require the patient to reside at a place specified by them; the power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training; and the power to require access to the patient to be given, at any place where the patient is residing, to any registered medical practitioner, approved mental health professional or other person so specified.

In all three cases outline above (i.e. Section 2, 3 and 7) there is a requirement that any application is made upon the recommendations of two registered medical practitioners.

Section 135 Mental Health Act 1983

Under Section 135, a Magistrate may issue a warrant where there may be reasonable cause to suspect that a person believed to be suffering from mental disorder, has or is being ill-treated, neglected or kept otherwise than under proper control; or is living alone unable to care for themselves. The warrant, if made, authorises any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove them to a place of safety.

Section 135 lasts 72 hours and is for the purpose of removing a person to a place of safety with a view to the making of an assessment regarding whether or not Section 2 or 3, or 7 of the Mental Health Act should be applied.

Section 136 Mental Health Act 1983

Section 136 allows police officers to remove adults who are believed to be “suffering from mental disorder and in immediate need of care and control” from a public place to a place of safety for up to 72 hours for the specified purposes. The place of safety could be a police station or hospital.

Mental Capacity Act 2005

Five Key Principles to determine Mental Capacity

Principle 1:
A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that it cannot assumed that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

Principle 2:
Individuals are supported to make their own decisions – a person must be given all practicable help before they are treated as not being able to make their own
decisions. This means that every effort should be made to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that the person is involved as far as possible in making decisions.

Principle 3:
Unwise decisions – people have the right to make decisions that others might regard as unwise or eccentric. A person cannot be treated as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.

Principle 4:
Best interests – anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

Principle 5:
Less restrictive option – someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person’s rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention should be weighed up in the particular circumstances of the case.

The powers to provide care to those who lack capacity are contained in the Mental Capacity Act 2005. Professionals must act in accordance with guidance given under the Mental Capacity Act Code of Practice when dealing with those who lack capacity and the overriding principal is that every action must is carried out in the best interests of the person concerned.

Where a person who is self-neglecting and/or living in squalor does not have the capacity to understand the likely consequences of refusing to cooperate with others and allow care to be given to them and/or clearing and cleaning of their property a best interest decision can be made to put in place arrangements for such matters to be addressed. A best interest decision should be taken formally with professionals involved and anyone with an interest in the person’s welfare, such as members of the family.

The Mental Capacity Act 2005 provides that the taking of those steps needed to remove the risks and provide care will not be unlawful, provided that the taking of them does not involve using any methods of restriction that would deprive that person of their liberty. However where the action requires the removal of the person from their home then care needs to be taken to ensure that all steps taken are compliant with the requirements of the Mental Capacity Act. Consideration needs to be given to whether or not any steps to be taken require a Deprivation of Liberty Safeguards application.

Where an individual resolutely refuses to any intervention, will not accept any amount of persuasion, and the use of restrictive methods not permitted under the Act are anticipated, it will be necessary to apply to the Court of Protection for an order authorising such protective measures. Any such applications would be made by the person’s care manager who would need to seek legal advice and representation to make the application.

Emergency applications to the Court of Protection

An urgent or emergency court order can be applied for in certain circumstances, e.g. a very serious situation when someone’s life or welfare is at risk and a decision has to be made without delay. However, a court order will not be obtained unless the court decides it’s a serious matter with an unavoidable time limit.
Where an emergency application is considered to be required, relevant legal advice must be sought.

Inherent Jurisdiction

There have been cases where the Courts have exercised what is called the ‘inherent jurisdiction’ to provide a remedy where it has been persuaded that it is necessary, just and proportionate to do so, even though the person concerned has mental capacity.

In some self-neglect cases, there may be evidence of some undue influence from others who are preventing public authorities and agencies from engaging with the person concerned and thus preventing the person from addressing issues around self-neglect and their environment in a positive way.

Where there is evidence that someone who has capacity is not necessarily in a position to exercise their free will due to undue influence then it may be possible to obtain orders by way of injunctive relief that can remove those barriers to effective working. Where the person concerned has permitted another reside with them and that person is causing or contributing to the failure of the person to care for themselves or their environment, it may be possible to obtain an Order for their removal or restriction of their behaviours towards the person concerned.

In all such cases legal advice should be sought.

Animal welfare

The Animal Welfare Act 2006 can be used in cases of animal mistreatment or neglect. The Act makes it against the law to be cruel to an animal and the owner must ensure the welfare needs of the animal are met. Powers range from providing education to the owner, improvement notices, and fines through to imprisonment. The powers are usually enforced by the RSPCA, Environmental Health or DEFRA.

Fire

The fire brigade can serve a prohibition or restriction notice to an occupier or owner which will take immediate effect (under the Regulatory Reform (Fire Safety) Order 2005). This can apply to single private dwellings where the criteria of risk to relevant persons apply.
Appendix 3: self-neglect assessment tool

In all instances consider:

Does the person have capacity to make decisions with regard to issues such as care provision/housing?

Does the person have a diagnosed mental illness?

Does the person have support from family or friends?

Does the person accept care and treatment?

Does the person have insight into the problems they face?

In all instances all workers to engage with the person, develop a rapport, supporting the person to address concerns, getting the person to engage with community activities and develop / repair.

This document should be read in conjunction with Greater Manchester Fire Service Policy on hoarding

<table>
<thead>
<tr>
<th>Low risk</th>
<th>Moderate risk</th>
<th>High risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person is accepting support and services</td>
<td>The indicators below may also imply low risk. Each is contextual, dependent upon individual circumstances they may trigger concern in the moderate risk category.</td>
<td>Where moderate concerns have been raised and despite all efforts they continue and/or increase.</td>
</tr>
<tr>
<td>Health care is being addressed</td>
<td>Access to support services is limited but there are no other factors of concern</td>
<td>The person refuses to engage with necessary services, they have capacity and there is limited or no evidence of their health/wellbeing being adversely affected.</td>
</tr>
<tr>
<td>Person is not losing weight</td>
<td>Health care and attendance at appointments is sporadic but there is evidence of</td>
<td>Health care is poor and there is deterioration in health</td>
</tr>
<tr>
<td>Person accessing services to improve wellbeing</td>
<td>There are no carer issues</td>
<td>Weight is reducing</td>
</tr>
<tr>
<td>There are no carer issues</td>
<td>Person has access to social and community activities</td>
<td>Wellbeing is affected on a daily basis</td>
</tr>
<tr>
<td>Person is able to contribute to daily living activities</td>
<td>Personal hygiene is good</td>
<td>Person is isolated from family and friends</td>
</tr>
<tr>
<td>Personal hygiene is good</td>
<td>The indicators below may also imply low risk. Each is contextual, dependent upon individual circumstances they may trigger concern in the moderate risk category.</td>
<td>Care is prevented or refused despite efforts to engage the person</td>
</tr>
</tbody>
</table>

Where moderate concerns have been raised and despite all efforts they continue and/or increase.

The person refuses to engage with necessary services and where their health and wellbeing is being adversely affected and where there is evidence of trying to engage and work with the person.

Health care is poor and there is deterioration in health and there is no overt cause and/or professionals involved.

Weight is reducing

Wellbeing is affected on a daily basis and there is no overt cause and/or professionals involved.

Person is isolated from family and friends, this may not be a lifestyle choice.

Care is prevented or refused despite efforts to engage the person.
Examples of concerns that do not require formal safeguarding procedures and can be dealt with by other systems e.g. Health / GP intervention, community engagement, counselling, developing a rapport. It is likely that only concerns in the moderate and high risk need to be reported – Use professional judgement.

Response and responsibilities

Single agency response

- Minimal risk is often managed via single agency response. If in doubt consultation from other agencies should be sought and documented.
- Clear documentation of plans and decisions made should be kept.
- Chronologies evidencing improvement and/or deterioration should be maintained.
- In some instances professional judgement may result in a multi-agency response (with the consent of the person) in order to minimise and reduce risk.

High risk should involve a multi-agency response.

- Clear documentation of plans and decisions made should be kept.
- Chronologies evidencing improvement and/or deterioration should be maintained. Consideration should be given as to whether the safeguarding threshold has been met.
- Professional judgement may result in a referral to safeguarding.
**Example 1**

Two brothers with mild learning disabilities lived in their family home, where they had remained following the death of their parents some time previously. Large amounts of rubbish had accumulated both in the garden and inside the house, with cleanliness and self-neglect also an issue. They had been targeted by fraudsters, resulting in criminal investigation and conviction of those responsible, but the brothers had refused subsequent services from adult social care and their case had previously been closed.

The local authority received a concern that the brothers were at risk of self-neglect. It was not known if there was reasonable cause to suspect brothers were able to protect themselves from self-neglect or the risk of it, and so a s42 enquiry was not triggered. The needs assessment commenced, and as this progressed, it became clear that with the right level of support to encourage the brothers to accept services, they were able and had mental capacity to take measures to protect themselves from the risk of self-neglect.

They developed a good relationship with their social worker, and as concerns about their health and wellbeing continued it was decided that the social worker would maintain contact, calling in every couple of weeks to see how they were, and offer any help needed, on their terms. After almost a year, through the gradual building of trust and understanding, the brothers asked to be considered for supported housing; with the social worker’s help they improved the state of their house enough to sell it, and moved to a living environment in which practical support could be provided.

**Example 2**

Ms S is a 63 year old woman with mild learning disability. She has always lived with and was cared for by her parents until they both died over the last 5 years. She now lives alone in the former parental home. The house is in disrepair with no windows at the back of the house. The kitchen floor is always wet from the rain. The house is dirty. The house is cluttered with possessions such that it is difficult to walk through the house. Ms S is incontinent, her legs are ulcerated and weeping. Ms S has recently refused to let her sister into her house, but does still allow her GP to come into her house.

The GP has become so concerned he has decided to raise the matter in an MDG. This leads to another meeting involving more agencies that have some knowledge of Ms S. The GP feels Ms S’s capacity to understand the risks may be in question. The Local Authority decided there is reasonable cause to suspect Ms S meets the criteria for s42 enquiry under the Care Act because there is reasonable cause to suspect that Ms S has needs for care and support, is at risk of self-neglect, and there is reasonable cause to suspect Ms S is unable to protect herself from self-neglect or the risk of it.

The enquiries agreed were for the GP, as the person who knows Ms S best, to work with Ms S to understand what her views and wishes are about her care and support needs and to encourage her to accept input and assessment from the Local Authority, and for the Local Authority to undertake a needs assessment. This leads to some care provision and short term nursing input to help her manage her incontinence and keep clean. This also leads to ongoing
involvement with a voluntary sector organisation who are able to link Ms S with a volunteer who identifies some interests she has and links her in with some community activities which she enjoys. Her quality of life, independence and mood dramatically improve over a 6-9 month period as a result of well coordinated actions to improve her situation which started via her GP working with her at her pace and with her consent building on a trusting relationship.

Example 3

Mr M, in his 70s, lives in an upper-floor council flat, and had hoarded over many years: his own possessions, items inherited from his family home, and materials he had collected from skips and building sites in case they came in useful. The material was piled from floor to ceiling in every room, and Mr M lived in a burrow tunnelled through the middle, with no lighting or heating, apart from a gas stove. Finally, after years of hiding in privacy, Mr M had realised that work being carried out on the building would lead to his living conditions being discovered. Mr M himself recounted how hard it had been for him to invite access to his home, how ashamed and scared he was, and how important his hoard was to him, having learnt as a child of the war never to waste anything.

Through working closely together, Mr M, his housing officer and experienced contractors have been able gradually to remove from his flat a very large volume of hoarded material and bring improvements to his home environment. It has taken time and patience, courage and faith, and a strong relationship based on trust. The housing officer has not judged Mr M, and has worked at his pace, positively affirming his progress. Both Mr M and his housing officer acknowledge his low self-esteem, and have connected with his doctor and mental health services. The officer has recognised the need to replace what Mr M is giving up, and has encouraged activities via engagement initially with the health improvement service that reflect his interests. Mr M has valued the officers honesty, kindness and sensitivity, his ability to listen, and the respect and reciprocity in their relationship.

Example 4

Ms T lives alone. She has been diagnosed as having a severe compulsive disorder which manifests itself in hoarding. Ms T experiences high levels of anxiety which impacts on her ability to attend to personal care and eat. There are unopened bags of cooked food that Ms T says she has forgotten to eat. Ms T says she is aware of the risk to her health and environment and has noticed vermin droppings in the kitchen. There is ample evidence of infestation to anyone visiting. She says she does not clean her home as it causes her anxiety to move things and throw things away.

Ms T gathers all her letters but doesn’t open them. Ms T only goes out to familiar places where there are familiar faces.

Her landlord, a social housing organisation received a concern about her property from neighbours. They visited and identified she was at risk of harm through self-neglect. A referral was made to environmental health and also to adult social care. Adult social care checked with GP and mental health services, and found that Ms T had recently seen a psychiatrist. The psychiatrist was contacted and has a clear view that Ms T has full mental capacity to understand these risks, how her mental disorder affects these risks, and to make decisions about her care and support needs.

It turned out there was is no reason to suspect that Ms T is unable to protect herself from self-neglect, but due to the impact of the property on the others
the environmental health and housing officers did have to advise Ms T that he would have to issue proceedings if she did not act to address the vermin issue. Once the issue was put to Ms T in a firm, but understanding way, together with an offer of help to find a reputable company to do the work, Ms T made the necessary arrangements and got her home free of vermin and a reduction in the clutter likely to encourage future infestations.

It was also identified that adult social care had a duty to offer a needs assessment. Ms T agreed to a needs assessment under the influence of the environmental health officer with whom she had struck up a trusting relationship. Ms T expressed a wish to try to continue to manage her needs herself, as she feels this is the best way for her to cope with her mental health in the longer term. The Local Authority provided information and advice on support services and how to access these. Outcomes were feedback to the psychiatrist who will continue to monitor Mr T’s mental health and the housing officer will make occasional contact to see that the property remains adequately clean and free from undue clutter and risk of infestation.
Appendix 5
Salford Agencies: outline of role and services

Greater Manchester Fire Service (GMFRS)

Services provided:

Safe and Well visits
Staff routinely check on individuals lifestyles and both advise and refer based upon following

Hoarding - GMFRS has a comprehensive strategy and action plan based on hoarding which reacts to different levels of hoarding and advice on de-cluttering and fire reduction risks will be addressed

Referral to other agencies such as Housing or in some cases environmental health

Malnutrition - staff will in isolated cases use armbands to determine if an individual is suffering from malnutrition and refer to agencies

Referral to CCG with consent of individual/relative

Social Isolation - Part of the Safe and Well visit incorporates Social Isolation and assistance offered

With the consent of the individual a referral will be made to specialised staff at GMFRS who will visit the individual up to 4 times to offer support and assistance associated with their social isolation needs

Poor Living Conditions - As part of the Safe and Well visit staff will speak to individuals relating to specific conditions witnessed in a household

With the consent of the individual GMFRS will speak on their behalf to RSLs to assist in assisting individuals and also refer onto other agencies if permitted

Physical Appearance - If an individual presents or comes across to staff as not maintaining themselves such as clothing, cleanliness etc advice and offers of assistance are given

With the consent of the individual a referral can be made to other agencies such as AGE UK, or in some cases Adult Safeguarding

Mental Health - As part of a Safe and Well visit staff may offer to contact Mental Health agencies on behalf of the individual

With the consent of the individual GMFRS will refer to Greater Manchester West Mental Health Services or The Sanctuary

Contact/Referral details:

SalfordTraffordsafeguarding@manchesterfire.gov.uk
DSO Safeguarding Leads
0161 609 0212

A dedicated email box is used for all staff including fire fighters and support staff to send in referrals for safeguarding. The email boxes are checked daily by managers and referrals sent to social services.
Salford Health and Social Care  
Salford Royal NHS Foundation Trust (SRFT)

Services provided:

Adult Social Care
Information and signposting to voluntary sector and statutory services as appropriate. Where criteria are:

• Adult Social Care assessments to identify support needs and assess risk
• Assessment for informal carers
• Advocacy support where appropriate

Contact/Referral details:

https://services.salford.gov.uk/contact/SalfordEnquiry/?formtype=HSC_ENQ_PR

Adult Social Care Contact Team Tel 0161 631 4777

NHS Salford Clinical Commissioning Group

Services provided:

The CCG Safeguarding Team provides safeguarding support and advice to all Salford GP practices. This includes dissemination of safeguarding related information as required.

Contact/Referral details:

Safeguarding.nhssalford@nhs.net
The team can be contacted on: 0161 212 4413

Greater Manchester Mental health NHS Foundation Trust

Services provided:

Achieve Salford Recovery Services - confidential services, opportunities, treatments and therapies for people seeking help in tackling their own drug use, or that of a loved one aged 25 and over.

Contact/Referral details:

King Street, Eccles Tel: 0161 787 7343
Acton Square, the Crescent Tel: 0161 745 7227
The Orchard Tel: 0161 358 1530
Greater Manchester Mental health NHS Foundation Trust

Services provided:

Salford Community Engagement Recovery Team
The Community Engagement Recovery Team (CERT) helps to enhance and maintain, service users' role in society, including supporting them into continued employment. Our aim is to improve the quality of mental health and wellbeing of our service users.

Contact/Referral details:
Tel: 0161 607 8280
Fax: 0161 607 8299

Salford Royal Hospital (SRFT)

Services provided:
Acute and Community services.

Contact/Referral details:
0161 206 7373 Various services within SRFT

Housing - Salford City Council

Services provided:
Safeguarding Lead for Housing - offering advice, liaison between services and housing providers/services and signposting where there are issues around housing and safeguarding.

Contact/Referral details:
Lindsay Barrett, 0161 603 4376 lindsay.barrett@salford.gov.uk

Environmental Protection Team (Regulatory Services Salford City Council)

Services provided:
The EP team deals with nuisances under the Environmental Protection Act or issues under the Public Health Act such as filthy and/or verminous properties.
Nuisances can include the following:
• any premises in such a state as to be prejudicial to health or a nuisance;
• smoke
• fumes or gases
• dust, steam, smell or other effluvia arising on industrial, trade or business premises
• any accumulation or deposit
• any animal kept in such a place or manner
any insects emanating from relevant industrial, trade or business premises
artificial light
noise emitted from premises
noise that is prejudicial to health or a nuisance and is emitted from or caused by a vehicle, machinery or equipment in a street

During the investigation of the issues listed above, the team will visit domestic properties, which, on occasions will have children or vulnerable adults present. The team will on occasions find conditions that are either affecting neighbours (nuisance) or that are prejudicial to their own health (self-neglect). Depending on the conditions found, how the individual engages with the officer or the length of time it will take to arrive at the desired outcome, the issues may well be reported and discussed with Social Workers or Mental Health Workers.

If conditions are found that are of concern to those in social care then contact should be made with the team to discuss what actions could be taken. This may involve the use of enforcement notices, and in all cases, any work will need to be recharged to the occupier or to another agency by agreement.

The EP team will deal with issues where the vulnerable person is either the source of the problem and when they are the affected individual.

With regards to the sensitivity of the complainant, the test for determining whether a statutory nuisance exists is an objective one and should be judged according to the standards of the average person, and the courts would not be able to have regard to the sensitivity beyond that of the average person.

Note: action can only be taken where there may be a health effect, and is often more difficult in properties where there is clutter but does not directly affect someone’s health.

Contact/Referral details:

Environmental Health
Innovation House, Chorley Road, Swinton, M27 5FJ
Tel: 0161 925 1097
environmentalhealth@salford.gov.uk

Environmental Crime Team
(Regulatory Services Salford City Council)

Services provided:

The team investigate incidents of illegal dumping/fly-tipping under the Environmental Protection Act 1990.

We also investigate accumulations of litter and debris on land under the Anti-social Behaviour, Crime and Policing Act 2014.

Generally our work is reactive and relates to one offence rather than on-going issues such as the nuisances listed by Environmental Protection.

Similarly to Environmental Protection, we frequently attend domestic and commercial properties and land throughout the city during our investigations and sometimes come into contact with children and vulnerable adults (complainants and alleged offenders).

Again, similarly to Environmental Protection, we sometimes observe conditions that cause us concern.
These conditions include:

- General support needs
- Self neglect
- Alcohol and drugs
- Immigration
- Homelessness

We always liaise with the appropriate Safeguarding Teams when we observe conditions that cause us concern.

Our most common cause of concern relates to children in domestic properties where drugs are present (generally cannabis) closely followed by doorstep crime ‘man in a van’ taking advantage of vulnerable persons through gardening work or rubbish removal.

In the case of alleged offenders, we always work with Safeguarding Teams with a view to implementing behavioural change over enforcement if appropriate.

Contact/Referral details:

Environmental Health
Innovation House, Chorley Road, Swinton, M27 5FJ
Tel: 0161 925 1097
environmentalhealth@salford.gov.uk

Home Improvement Agency (HIA) and Housing Choice (Regulatory Services Salford City Council)

Services provided:

The service aim is to ensure Private sector homes are warm, safe and dry. The HIA receive referrals from owner occupiers regarding their properties condition. The HIA assists clients to seek finance to fund various types of work to support the aims mentioned. Property conditions include; Wiring, Heating and insulation, new doors and windows, Roof repairs, Dampness and timber repairs, Level access showers. The majority of our clients are vulnerable and there is the possibility that some cases are self neglect and there are safeguarding issues. Our priority clients are visited within their home where we are in a prime position to assess the condition of the property and vulnerability of the client. Where appropriate the team will engage with other services and professionals in order to support the client. In some cases this could be a safeguarding referral. In the event of hoarding it would be referred to the Housing Choice service that can support to de-clutter and clean the property should the client meet the criteria. The HIA take self referrals and also professional referrals.

The Housing Choice service receive referrals from all tenures to assist vulnerable residents to move to more appropriate housing where they are unable to do this for themselves. The service receives referrals from health, social care, mental health, hospital and from individuals themselves. The team also take referrals from the hospital and intermediate care where the property is not in a fit state to enable the vulnerable person to be discharged. In the majority of cases it requires a de-clutter and clean, some minor adaptations or a bed moving downstairs.

The assessment process involves visiting the client’s home where we are able to see the condition of the property and the client. There is the potential for us to come across safeguarding issues, most definitely hoarding and potential cases of self neglect.
Where appropriate the team will engage with other services and professionals in order to support the client. For example pest control, helping hands, social worker etc.

**Contact/Referral details:**

[www.salford.gov.uk/salfordhia](http://www.salford.gov.uk/salfordhia)

**Housing Standards (Regulatory Services Salford City Council).**

**Services provided:**

The Housing Standards team proactively and reactively inspect properties to ensure they are free from hazards. We often deal with properties in serious disrepair, where the resident is vulnerable. There is the potential to see signs of self neglect, hoarding and other safeguarding issues. Where appropriate we engage with other professionals/service areas to take a co-ordinated approach especially when the resident is vulnerable.

The team also deal with rogue landlords who often allow the property to get into disrepair and are reluctant to undertake repairs unless we take enforcement action. There is the possibility that staff may see signs of abuse and/or modern slavery as well as a lack of maintenance from landlords. The team are going into properties of the most deprived and vulnerable members of our community who have little choice about where they live and often will not complain about poor condition for fear of eviction.

**Contact/Referral details:**

[www.salford.gov.uk/landlord-standards](http://www.salford.gov.uk/landlord-standards)

**Affordable Warmth (Regulatory Services Salford City Council)**

**Services provided:**

This team works to raise awareness of the help available or to provide support to vulnerable private sector households to prevent vulnerable households from living in fuel poverty. Cold homes can cause cold-related illness and be the cause of Excess Winter Deaths.

The Affordable Warmth team are at the centre of the ‘Warm Salford Referral Network’ which refers residents on to National, Regional and Local schemes to improve energy efficiency and cut fuel bills.

The type of help available includes referrals for grants to repair or replace boilers, fit home insulation and draught-proofing. There are also schemes to make energy tariff switching easier. Referrals are also made to the council’s Welfare Rights team to help maximise household incomes.

It is possible that from visiting homes through this service that cases of self neglect, hoarding or safeguarding are found.

**Contact/Referral details:**

Salford Affordable Warmth Team Tel: 0161 793 2264  
[www.salford.gov.uk/warmsalford](http://www.salford.gov.uk/warmsalford)
Trading Standards Team (Regulatory Services Salford City Council)

Services provided:

The trading standards service could potentially come into contact with vulnerable adults in a number of ways;

- Mass marketing postal scam victims are highlighted to us on a regular basis from the National Scams team. The average age of a scam victim is 75 and many are found to be vulnerable. Most of these victims are visited on a face to face basis at their homes to try to prevent further economic loss to them through these scams.

- Trading Standards has a service level agreement with the Citizens Advice Consumer Service whereby, if they receive a call for advice from a consumer who appears to be a victim of an ongoing doorstep crime where the perpetrators are still at the address or likely to be returning that Trading Standards Officers will attend at the scene to assist the consumer.

- We receive complaint referrals from Citizens Advice Consumer Service, when they deem that a consumer complaint has elements that may require further investigation. When making further enquiries with the consumer, the investigating officer may have concerns that the consumer might be a vulnerable adult and would refer.

- Doorstep crimes involving rogue traders are often reported to Trading Standards by family members after a significant amount of time has elapsed. Often this will involve a very vulnerable person, sometimes with dementia etc. We would offer to visit the victim to discuss what happened and advise on strategies to prevent re-occurrence. We would also liaise with the police crime prevention officer to make sure they are aware of the incident. They would in turn alert PCSOs in that area to be on the lookout for similar instances. We would also liaise with the community safety team to make them aware so that they can look at target hardening of the property to help prevent re-occurrence.

- Where a vulnerable adult is identified as being plagued with unwanted phone calls we can provide them with a free call blocker unit. We would only consider this when it is felt that the consumer or a friend or relative of theirs is competent to understand how the unit works and can set it up correctly.

- Due to the nature of our work we sometimes find ourselves in people’s homes and might inadvertently see something that does not feel quite right. We are always mindful of this and would refer where we feel necessary.

- Part of our role is to conduct business inspections. This could lead to us being in business premises and seeing evidence of modern day slavery. We have been on numerous visits where the border force have accompanied us and identified many illegal workers during the course of the visit but there has been no evidence of modern day slavery to date.

Contact/Referral details:

www.salford.gov.uk/advice-and-support/consumer-advice/

Welfare Rights and Debt Advice Service Salford City Council

Services provided:

Welfare Rights and Debt Advice Service.
**Contact/Referral details:**

Telephone 0800 345 7323 Mondays and Wednesdays between 1pm to 4pm.

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**Care on Call Salford City Council**

**Services provided:**

Equipment is provided to support the individual in their home and tailored to meet their needs. It can be as simple as the basic community alarm service, able to respond in an emergency and provide regular contact by telephone. It can include detectors or monitors such as motion or falls and fire and gas that trigger a warning to a response centre staffed 24 hours a day, 365 days a year. As well as responding to an immediate need, telecare can work in a preventative mode, with services programmed to monitor an individual’s health or well-being.

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**Contact/Referral details:**

Tel: 0161 607 7133

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**Age UK Salford**

**Services provided:**

**Hospital Discharge, Assessment, Aftercare and Reablement Service -**

Arranges support with safe discharge home identifies immediate needs to enable safe discharge home, this can include “dignity on discharge”; meals, clothing, commodes, shopping; in some cases where risk assessments are completed can escort and settle at home to ensure warm and safe discharge.

Undertakes a Safety Check assessment of the home and environment escalating concerns re risk/welfare as appropriate, inter agency working to support the person at risk where appropriate to do so, also completes a personal assessment to determine health and wellbeing support needs including identification of risk to self and others.

Identification of carers at point of referral, i.e. practical immediate needs for a carer to receive treatment and practical support for loved one at home if no formal services in place/support for carers/cared for on discharge to ensure safe at home and be able to continue in caring role (non personal care). Encourages uptake of carer assessments/support from Carer Centre and refers onto these services for future support needs.

Assist individuals with support planning to promote self autonomy, self determination and confidence building Can provide support to individuals (reduce malnutrition/falls risk) up to 6 weeks under a reablement model.

Provides Information and signposting

Provides practical support within the home and support to attend medical appointments

Provides telephone support and support through home visits.

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**Contact/Referral details:**

Different referral routes including self referral and referral by health and social care staff, carers etc.
Anyone living in Salford age 55 years or above.
Operates - 7 days a week including bank holidays
Tel: 0161 206 4607
Email: salford.aftercare@srft.nhs.uk
Situated in the Hope building at Salford Royal, Eccles Old Road. Salford M6 8HD

**Age UK Salford**

**Services provided:**

**Homecare Service -**
Provides experienced help around the home including cleaning, washing, ironing and shopping delivery.

The same person is appointed as a Home Service Assistant which creates consistency, regularity and enhances companionship.

A bond of trust develops creating peace of mind for both service user and relatives knowing that a respected member of Age UK Salford is in regular attendance. This is especially relevant where there are vulnerable adults involved.

The service undertakes a risk assessment of all new customers.

Early detection of deterioration of a person’s health and wellbeing including areas of risk Signposting to other provider services within the Charity.

**Contact/Referral details:**

Self Referral
Paid for service
Any age
Operates Mon to Fri/other times by agreement.
Tel: 0161 788 7300
Email: Homcareservices@ageuksalford.org.uk
108 Church Street, Eccles, M30 0LH

**Age UK Salford - Social Rehabilitation Service**

**Services provided:**

The Social Rehabilitation Service is community based providing outreach support to individuals who have experienced a life changing experience such as bereavement, a fall or a decline in a long term health condition. The focus of the service is to engage with vulnerable people in the community at the point of entry of referral, supporting the person to increase their independence. This includes supporting individuals with a long term medical condition who reside within their home to prevent unscheduled acute hospital admissions; by ensuring support is in place to enable them to effectively manage their condition/situation.

The service also links into the NHS end of life pathway by offering bereavement support; supporting individuals to enhance their quality of life, promoting health and wellbeing by ensuring the individual maintains/regains control of their life whilst maintaining optimum health.
Early detection of deterioration of a person’s health and wellbeing including areas of risk particularly areas of self neglect and potential safeguarding issues.

An integral part of this process includes undertaking an Outcomes Star assessment focusing upon key areas of a person’s life including identification of their support needs;

Providing structured and timely support working with individuals to enhance their lives by enabling them to stay well, keeping in touch, feeling positive, feeling safe and to manage their financial affairs.

The service takes a personalised approach listening to what matters to the individual to promote their health and wellbeing. This focus is upon supporting the person in retaining motivation, enhancing self confidence, rebuilding social networks, optimising quality of life and support with the living environment by making appropriate referrals for aids and adaptations, home improvements etc.

During this process the service aims to match the individual with a volunteer to support them in confidence building and support with social activities thus enabling the person to establish a trusting relationship.

Contact/Referral details:

Different referral routes including self referral and referral by health and social care staff, carers etc.

Anyone living in Salford age 60 years or above.

Operates Mon to Fri, 9am to 5pm

Tel:0161 7887300

Email: Jean.kenyon@ageuksalford.org.uk

108 Church Street, Eccles, M30 0LH

Age UK Salford - Dementia Support Service

Services provided:

For people with memory loss and their carers living in the Salford area.

The Service provides information, advice, practical and emotional support and opportunities for peer networking; supporting people on their dementia journey including support with daily living and to maintain good levels of health and wellbeing.

The service also has a number of peer support groups that operate locally throughout the city for people experiencing memory loss. Carer training is also provided over a 6 week period - 3 times per year

The Service has dedicated staff who specialise in the field of dementia. This includes allocation of an individual case manager empowering and supporting carers/su with advocacy and representation of their needs and rights; support is mainly through individual home visits; carer needs assessments; identification, assessment and management of risk; formulating support plans; mobilising networks of support; making appropriate referrals; interagency working and liaising with other professionals, colleagues and services; responding to situations with a potential for crises; Early detection of potential safeguarding issues; support with POA, `best interest meetings', statutory assessments and reviews; multi agency/disciplinary working.

Contact/Referral details:
Different referral routes including self referral and referral by health and social care staff, carers etc.

Operates: Mon to Fri, 9am to 5pm
Tel: 0161 728 2001
Email: Dssadmin@ageuksalford.org.uk
The Green, Clifton, Swinton, M27 8QL

**Age UK Salford - Neighbourly Connector service**

**Services provided:**

Aim to counteract loneliness and isolation for older people.

Offers practical, social and emotional support through friendly neighbourly volunteers looking out for older neighbours.

All volunteers are DBS checked and are trained to recognise vulnerability and how to respond to Adult Safeguarding.

Each older person has a home based assessment, which identifies any signposting or external referrals. Each older person receives a risk assessment, which considers their living and local environment as well as harm to themselves and or/others.

**Contact/Referral details:**

Different referral routes including self referral and referral by health and social care staff, carers etc.

Operates Mon to Fri, 9am to 5pm
Tel: 0161 788 7300
Email: vanda.groves@ageuksalford.org.uk
108 Church Street, Eccles, M30 0LH

**Age UK Salford**

**Services provided:**

**Humphrey Booth Day Centre** -

Provides a safe and supported environment to older people who require additional support during the day time including a choice of a two course lunch, daily refreshments and a take away service.

HBDC support older people with:

- Learning Disability (mild / Mod)
- Sensory / physical impairments
- Mild/Moderate Dementia
- Social Isolation
- Depression
- Personal care needs, including, bathing, catheter care/ stoma care

**Safeguarding**

HBDC have supported many individuals through the safeguarding process, often
being the instigators for the process and taking an active role in strategy meetings that will arise after the initial SG1 is completed. HBDC also attend “best interest” meetings and regular reviews of individual care packages.

**Sunday Lunches**

During the summer time the Centre hosts Sunday Lunch events every 4/6 wks depending upon demand.

**Risk Assessments**

These are carried out on every individual including those who use the Age UK Salford’s bus; individuals who receive support through HBDC bathing service, have a bathing assessment carried out. Offers a full range of personal care services including:

- Assisted bathing – can be offered as a standalone service or as part of day care services
- Hairdressing and Podiatry service
- A range of relaxing and holistic therapies

Social membership - drop in providing a range of stimulating and fun activities, theme days and evening events, freshly cooked food and refreshments

Activities include Art and Craft, Yoga and Exercise classes

Theme days
Day trips
Entertainment
Indoor bowls/golf
Reminiscence
Baking

**Contact/Referral details:**

Self Referral/GP/DN referral via Social Services

Offers private day care places

Open Mon to Fri 9am to 4pm
Sat 9am to 3pm
Tel: 0161 737 5989/0161 736 8175
Email: humphrey.booth@ageuksalford.org.uk

33 Eccles Old Road, Salford, M6 7AP

**Age UK Salford**

**Services provided:**

**Critchley House Community Hub and Garden Cafe support for older people.**

Offers a social centre, resource hub and garden cafe and can be hired as a venue for meetings, business lunches or social events. The centre also runs fully escorted day trips and calendar events throughout the year.

- Free gardening class
- Creative writing
• Coffee and craft social
• Knitting group
• Social hub club
• Weekly luncheon club

Contact/Referral details:
Self referral - For details of events, booking and cost.
Tel 0161 359 3410
Email Centre Manager:- Age UK Salford
Nichola.swettenham@ageuksalford.org.uk
Critchley House, 75-77, Chorley Rd, Swinton, M27 4AF

Age UK Salford

Services provided:

Information, Advice and signposting -
Free ½ hour legal advice 2nd and 4th Tuesday of the month at head office.
From May 2017 - Free ½ hour legal advice - 3rd Monday of the month,
CAB – Thursdays at head office
landA low level advocacy
Monday and Weds - Head office
Tuesday - Critchley House.
Age UK independent living aids and adaptatations - contact head office.
Wheelchair hire
Provision of Age UK guidance booklets/ leaflets freely available from head office.

Contact/Referral details:
Self referral
Legal advice – bookable appointments only.
CAB - bookable appointments only.
Office hours, Mon – Fri - 9am – 4pm
For appointments contact:
Tel: 0161 788 7300
Email: administrator@ageuksalford.org.uk
108 Church Street, Eccles
Appendix 6 Referral for MDG consideration

Information required
1. Name, DOB and NHS Number (if known)
2. Reasons for referral
3. Concerns and risks
4. Consent gained from patient/service user – if consent cannot be gained, or a referral is being made without consent, please state why.
5. Does the patient/service user have a formal/informal carer?
6. Does the patient/service user have any other professionals involved in their care and support?

Email to mdg.coordinators2@srft.nhs.uk with the subject heading New Referr

If further information required a Referral Form will be emailed to the

Referral declined.
Feedback provided to the referrer

Referral accepted
Feedback to referrer.
Client/service user discussed at MDG.

Referral passed to locality MDG leads to consider referral.
Appendix 7

Multi-Agency Risk Management Meeting Agenda

1. Welcome and introduction
   - Apologies
   - Roles of agencies/professionals/individuals represented

2. Details of the adult at risk of self-neglect
   - Confirm whether adult at risk is aware of safeguarding alert/procedures in place to manage concerns of self-neglect
   - Views (if known) of the adult at risk, and the outcomes that they are seeking.
   - Agency involvement (in place/refused)

3. Confirmation of mental capacity
   - Decision(s) and associated risks and consequences against which mental capacity has been assessed.
   - How capacity assessment was carried out, when and by whom.
   - If mental capacity has been assumed, how has this assumption been reached?
   - Any identified concerns.
   - Is a legal view required?


5. Discussion regarding practical support and strategies to minimise the risks

6. Agree actions to manage risks and identify triggers for review

7. Discuss and agree who is best placed to talk to the adult at risk, empower them to make decisions and to take action

8. Agree strategy to monitor the risks

9. Review - agree timescales for review
Appendix 8 Clutter Image ratings

Clutter image rating: Kitchen

Rooms resembling clutter pictures 1 - 3 would be Level 1
Rooms resembling clutter pictures 4 - 6 would be Level 2
Rooms resembling clutter pictures 7 - 9 would be Level 3
Rooms resembling clutter pictures 1 - 3 would be Level 1
Rooms resembling clutter pictures 4 - 6 would be Level 2
Rooms resembling clutter pictures 7 - 9 would be Level 3
Rooms resembling clutter pictures 1 - 3 would be Level 1
Rooms resembling clutter pictures 4 - 6 would be Level 2
Rooms resembling clutter pictures 7 - 9 would be Level 3
1. **Property structure, services and garden area**
   All entrances and exits, stairways, roof space and windows accessible.
   All services functional and maintained in good working order.
   Garden is accessible, tidy and maintained

2. **Household Functions**
   No excessive clutter, all rooms can be safely used for their intended purpose.
   All rooms are rated 0-3 on the Clutter Rating Scale
   No additional unused household appliances appear in unusual locations around the property
   Property is maintained.
   Property is not at risk of action by Environmental Health.

3. **Health and Safety**
   Property is clean with no odours, (pet or other)
   No rotting food
   No concerning use of candles
   No concern over flies
   Residents managing personal care
   No writing on the walls
   Quantities of medication are within appropriate limits, in date and stored appropriately.

4. **Safeguard of Children and Family members**
   No Concerns for household members

5. **Animals and Pests**
   Any pets at the property are well cared for

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1. **Property structure and services**
   Only one major exit is blocked
   Only one of the services is not fully functional
   Concern that services are not well maintained
   Garden is not accessible due to clutter, or is not maintained
   Evidence of light structural damage including damp
   Interior doors missing or blocked

2. **Household Functions**
   Clutter is causing congestion in the living spaces and is impacting on the use of the rooms for their intended purpose.
   Clutter is causing congestion between the rooms and entrances.
   Some household appliances are not functioning properly and there may be additional units in unusual places.
   Evidence of outdoor items being stored inside

3. **Health and Safety**
   Kitchen and bathroom are not kept clean
   Offensive odour in the property
   Resident is not maintaining safe cooking environment
   Some concern with the quantity of medication, or its storage or expiry dates.
   No rotting food
   Resident trying to manage personal care but struggling

4. **Safeguard of Children and Family members**
   Hoarding on clutter scale 4 - 7 doesn’t automatically constitute a
<table>
<thead>
<tr>
<th>Level 1 clutter image rating 1 - 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>No specialised assistance is needed. If the resident would like some assistance with general housework or feels they are declining towards a higher clutter scale, appropriate referrals can be made.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2 clutter image rating 4 - 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household environment requires professional assistance to resolve the clutter and the maintenance issues in the property.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3 clutter image rating 7 - 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household environment will require a collaborative multi agency approach involving a wide range of professionals. This level constitutes a Safeguarding alert due to the significant risk to health of the householders, surrounding properties and residents.</td>
</tr>
</tbody>
</table>

No pests or infestations at the property

6. Personal Protective Equipment (PPE) Household environment is considered standard.
No PPE required
No visit in pairs required

3. Health and Safety
Human urine and or excrement may be present
Excessive odour in the property, may also be evident from the outside
Rotting food may be present
Evidence of unclean, unused and or buried plates and dishes.
Broken household items not discarded e.g. broken glass or plates
Concern with the integrity of the electrics
Inappropriate use of electrical extension cords or evidence of unqualified work to the electrics.
Concern for declining mental health

4. Safeguard of Children and Family members
Hoarding on clutter scale 7-9 constitutes a Safeguarding Alert.
Please note all additional concerns for householders

5. Animals and Pests
Animals at the property at risk due the level of clutter in the property
Resident may not able to control their animals
Animal’s living area is not maintained and smells
Hoarding of animals at the property
Heavy insect infestation (bed bugs, lice, fleas, cockroaches, ants, silverfish, etc.)
Visible rodent infestation

6. Personal Protective Equipment (PPE)
Latex Gloves, boots or needle stick safe shoes, P3 particle mask, hand sanitizer, insect repellent. Visit in pairs required
For more information about this document contact:
Safeguarding Adults Board Business Manager
by emailing ann.brooking@salford.gov.uk