HALTON
BOROUGH COUNCIL

Self-Neglect Policy and Procedure

July 2020

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Acknowledgements

This policy has been developed with reference to the following documents:

Croydon Multi-Agency Safeguarding Adults Board – Self Neglect Dignity and Choice Practice Guidance for Social Services, Partner Agencies, Voluntary and Community Groups, September 2015

Social Care Institute for Excellence – Self Negelct and Practice Key Research Messages, March 2015

West Midlands Adult Self Neglect Best Practice Guidance and Procedure for responding to Self Neglect concerns and enquiries

Sutton Safeguarding Adults Board – Sutton Multi-Agency Self Neglect and Hoarding Protocol, 2015

Kent and Medway Safeguarding Adults Board – Kent and Medway Multi-Agency Policy and Procedures to support people who self-negelct, April 2015

Cheshire East Council Self Neglect Policy April 2015

Self-Neglect Toolkit - Training, Advice, Solutions and Consultancy 2016

Hoarding Disorders UK website

Social Care Institute for Excellence Safeguarding Adults Webinar on Self-Neglect, April 2020

Policy Summary

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POLICY

1.0 Introduction

The Care Act 2014 clarified the relationship between self-neglect and safeguarding and made self-neglect a category of harm about which the Local Authority has a duty to make enquiries and to assess need with the promotion of wellbeing at the heart.

In further clarification received from the Department of Health in June 2015 it states that self-neglect is the responsibility of Safeguarding Adults Boards in terms of ensuring that policies and procedures underpin work around people who self-neglect, balancing self-determination, robust mental capacity assessment, consent and protection. It does not mean that each case of self-neglect must be opened as a Section 42 Enquiry, but that each case must receive an appropriate response.

1.2 Aims and Objectives

The aim of this policy and procedure document is to prevent serious injury or even 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 concerning self-neglect
- There are effective multi-agency working practices in place
- Concerns received regarding self-neglect are prioritised appropriately
- There is a proportionate response to the level of risk to self and others

These aims and objectives can be achieved by:

- Promoting a person-centred approach which supports the right of the individual to be treated with respect, dignity and to be in control of, and as far as possible, to lead an independent life
- Increasing knowledge and awareness of self-neglect including relevant legislation
- Promoting a proportionate response to self-neglect and approach to risk assessment
- Clarification of different agency and practitioner responsibilities in order to aid identification of a lead agency, when required
- Promoting an appropriate level of intervention through a multi-agency approach

1.3 Principles

The following principles should be adhered to in any work regarding self-neglect and the successful implementation of this policy and procedure:

- The most effective approach to hoarding and self-neglect is to use consensual and relationship-based approaches. These may be more effective if carried out by, or in partnership with, non-statutory parties including but not limited to family members; friends; housing associations; charities and voluntary sector organisations
- Hoarding and self-neglect will be approached in the least restrictive manner unless there is evidence that a clear risk of significant harm exists, which may require a non-consensual intervention
- The rights of individuals under the Human Rights Act 1998 will be supported and consensual interventions will be made unless there is evidence that a clear risk of significant harm exists which may require a non-consensual intervention
- Risk of harm should always be considered in terms of harm to the individual and harm to other people, for instance, neighbours
- A lead organisation has to be identified when it is necessary to coordinate interventions across multiple organisations to reduce risk of harm to an individual/community
- Leading and coordinating does not mean taking responsibility for carrying out **all** of the necessary work and interventions

1.4 Definitions of Self-Neglect

The Care and Support Statutory Guidance issued under the Care Act 2014, Department of Health and updated in March 2016, self-neglect has been defined as follows:

> ***"Self-neglect covers a wide range of behaviour, neglecting to care for one's personal hygiene, health or surroundings and included behaviour such as hoarding. It should be noted that self-neglect may not prompt a Section 42 Enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support"***

The definition of what is self-neglect proposed by **Social Care in Excellence (SCIE)** is as follows:

- **Lack of self-care to an extent that it threatens personal health and safety**
- **Neglecting to care for one's personal hygiene, health or surroundings**
- **Inability to avoid self-harm**
- **Failure to seek help or access services to meet health and social care needs**
- **Inability or unwillingness to manage one's personal affairs**
- **Sometimes related to drug and alcohol addiction**
- **Sometimes related to hoarding**

There are also other definitions which are also useful to consider when dealing with cases self-neglect, which are as follows:

Adult at Risk: Safeguarding duties apply to an 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

Care Act Eligibility Criteria: Many of the Care Act eligibility outcomes will feature in self-neglect, for example:

- Manage and maintain nutrition
- Maintain personal hygiene
- Manage toileting needs
- Being appropriately clothes
- Be able to make use of adult's home safely
- Maintain a habitable home environment
- Develop/maintain family and other personal relationships
- Access/engage in work, training, education or volunteering
- Make use of community services
- Carry out caring responsibilities for a child

When taking such factors into consideration in order to determine whether an adult at risk does have care and support needs, the following questions need to be taken into account:

- Do the needs arise from a physical or mental impairment or illness?
- Do these needs mean that the adult is unable to achieve two or more of the listed outcomes?
- Is there consequently a significant impact on the adult's wellbeing?

Significant Harm:

- Is not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health, and the impairment of physical, intellectual, emotional, social or behavioural development

- The individual's life could be or is under threat

- There could be a serious, chronic and/or long lasting impact on the individual's health and physical/emotional/psychological wellbeing

Significant Risk: Indicators of significant risk could include:

- History of crisis incidents with life threatening consequence

- High risk to others

- High level of multi-agency referrals received

- Risk of domestic violence

- Fluctuating capacity, history of safeguarding concerns/exploitation

- Financial hardship, tenancy/home security risk

- Likely fire risk

- Public order issues; anti-social behaviour/hate crime/offences linked to petty crime
- Unpredictable/chronic health conditions
- Significant substance misuse, self-harm
- Network presents high risks
- History of chaotic lifestyle; substance misuse issues
- The individual has little of no choice or control over vital aspects of their life, environmental or financial affairs

Hoarding:

The acquisition of items with associated inability to discard things that have little or no value (in the opinions of others) to the point where it interferes with use of their living space or activities of daily living. Hoarding can include new items that are purchased and hoarded. Also, hoarding can include food items, items of no monetary value, refuse and animals.

Signs of hoarding can include:

- Conditions of extreme clutter, especially where necessary objects in the household, like bathroom facilities, food storage, oven, heating sources and entry and exits are blocked
- Inability to throw things away that may seem like, or actually is, rubbish
- Often times there are empty food containers, or papers stacked up in the living space

It is important to recognise that there are numerous factors that might lead to or exacerbate hoarding and self-neglect, These include sensory deprivation/loss (i.e. loss of hearing or sight and physical disability etc.). Hoarding can also become a comfort to someone especially during times of discomfort or upset. In these cases, relief of or support with these problems may result in an alleviation of self-neglect and hoarding.

Hoarding may become a reason to make safeguarding enquiries when:

- The level of hoard poses a serious health risk to the person or neighbours
- There is a high risk of fire; of infestations by insects or animals; neglect of physical health; lack of adequate nutrition
- Hoarding may be linked to serious cognitive decline and lack of capacity to self-care and care for the environment
- Hoarding is threatening a person's tenancy and they are at risk of being made homeless through closure or possession orders

1.5 Indicators of Self-Neglect

A failure to engage with individuals 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 wellbeing. It may also impact on the individual's family and the local community.

Indicators of self-neglect can broadly be categorised into two domains – neglect of self and neglect of environment. Possible indicators under these two domains are as follows:

Neglect of Self:

- **Either unable or unwilling to provide adequate care for themselves**
- **Not engaging with a network of support**
- **Unable or unwilling to obtain necessary care to meet their needs**
- **Portraying eccentric behaviour/lifestyles leading to harm**
- **Poor diet and nutrition and personal hygiene**
- **Declining or refusing prescribed medication and/or other community healthcare support**
- **Refusing to allow access to health and/or social care staff in relation to personal hygiene and care needs**
- **Repeated episodes of anti-social behaviour – either as a victim or perpetrator**
- **Dirty/inappropriate clothing (e.g. clothing not appropriate to season)**
- **Alcohol/substance misuse**
- **Social isolation**
- **Poor financial management leading to unpaid bills**
- **Situations where there is evidence that a child is suffering or is at risk of suffering significant harm due to self-neglect by an adult**

Neglect of Environment:

- **Neglecting household maintenance and therefore creating hazards within and surrounding the property**
- **Obsessive hoarding**
- **Refusing to allow access to other organisations with an interest in the property, for example, utility companies or housing association**
- **Unsanitary, untidy or dirty conditions which create hazardous conditions that could cause physical harm to the individual or others**
- **Fire risk**
- **Lack of heating**
- **No running water/sanitation**
- **Issues with vermin**

1.6 Causes of Self-Neglect

Self-Neglect can be a result of:

- **A person's brain injury, dementia or other mental disorder**
- **Obsessive Compulsive Disorder or hoarding disorder**
- **Physical illness which has an effect on abilities, energy levels, attention span, organisational skills or motivation**
- **Reduced motivation as a side effect of medication**
- **Traumatic life change**
- **Dependency on drugs/alcohol**
- **It can also be unexplained**

(Source: SCIE Safeguarding Adults Webinar on Self-Neglect)

Risk Factors

Self-neglect most often occurs in the elderly, especially in people over the age of 75. It can also affect individuals with mental health problems like dementia and long standing alcohol abuse. Self-neglect occurs more with social isolation and certain personality characteristics. Self-neglect has no preference for religion and it is not yet known if it is hereditary. ***Research undertaken by Lauder & Roxburgh (2012);***

Lee & LoGuudice (2012); Clark, Mankikar & Gray (1975); Macmllan & Shaw (1966)

The following are risk factors for self-neglect:

The following table provides more detail about some of the important risk factors commonly describing self-neglect:

Risk Factors for Self-Neglect

Feature	Comment
Chronic Diseases	Long standing medical conditions worsen when neglected
Dementia	Memory loss, poor judgement
Depression	Low self-worth, not enjoying pleasurable activities, lack of motivation and energy
Alcoholism	Malnutrition, dehydration, slow healing injuries, ulcers, dementia
Phobia & Anxiety	Phobias may delay seeking medical care
Delusions/Schizophrenia	Suspiciousness, poor social networking, care refusal
Obsessive Compulsive Disorder	Hoarding can cause fire hazards and infestations
Personality Problems	Limits social networking, leading to isolation and depression
Disorders that influence Cognition & Behaviours	May cause delirium and impaired judgement
Sensory impairments	Poor vision and hearing can lead to social isolation and increase risk of falls
Physical disabilities	Limits the ability to seek care and maintain the environment
Social Isolation	Poor social network, separation, divorce, living alone, bereavement and fear all can promote behaviours such as hoarding
Low Education	Uniformed lifestyle choices
Adverse Life Events	Includes physical, financial or emotional hardship
Independence	Persistent fear of losing one's independence or privacy or being the subject of harm

(Day & Leahy-Warren (2008)

Mental Capacity

The 5 fundamental principles of the Mental Capacity Act are as follows:

Assume Capacity: A person must be assumed to have capacity unless it is established that they lack capacity

Maximise Capacity: A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success

Unwise Decisions: A person is not to be treated as unable to make a decision merely because s/he makes an unwise decision

Best Interests: An act done, or decision made under the Act for or on behalf of a person who lacks capacity must be done or made in their best interests

Least Restrictive Option: Regard to whether the purpose can be effectively achieved in a way that is less restrictive of the person's rights and freedoms

Making Decisions with Capacity

The Mental Capacity Act says that a person is unable to make their own decision if they cannot do one or more of the following four things:

Understand information given to them

Retain that information long enough to be able to make the decision

Weigh Up the information available to make the decision

Communicate their decision – this could be talking; using sign language or even simple muscle movements such as blinking an eye or squeezing a hand

Mental capacity consists of two distinct components, which are as follows:

Decisional Capacity: the ability to make a decision themselves or to pass that decision on to another person if impaired

Executive Capacity: the process of putting that decision into effect alone or by delegating another person **but** someone who does not, for whatever reason, execute what they have decided or agreed cannot be considered to lack capacity for that reason.

When an adult refuses to engage and appears to be at risk of serious harm, a detailed and specific capacity assessment of both decision making and executive functioning skills is critical in helping to determine how best to intervene. Capacity assessment in these circumstances is not a one off event, but a series of repeated assessments to build an understanding of a person's ability to make informed decisions and to carry out these decisions. If the person refuses initial contact, it is

important not to close the case whilst uncertainty remains about the level of risk and the person's capacity to make informed decisions about their circumstances and need for support.

1.7 Addressing Self-Neglect

It is essential for an assessment to be carried out to address needs and risks that is both appropriate and proportionate for the individual in question. The assessment should be informed by the views of carers and/or relatives as well as by the views of the individual themselves, wherever this is possible. Where there are concerns that the individual may lack the mental capacity to fully understand the risks related to their behaviour and their need for care and support, a mental capacity assessment should be considered in relation to their ability to make informed choices.

(*Source: SCIE Safeguarding Adults Webinar on Self-Neglect)*

An assessment of self-neglect should include the following elements:

- A detailed social and medical history
- Activities of daily living
- Environmental assessment
- Details of the extent of self-neglect
- Individual's perspective of their situation and needs
- Willingness of the individual to accept help
- Views of family members, healthcare professionals, other relevant professionals/individuals
- Whether there are any children at risk of harm as a consequence of the adult's behaviour

Organisations that were found to be most successful in supporting work regarding self-neglect were found to have:

- A clear location for strategic responsibility for self-neglect – usually found to be the Local Safeguarding Adults Board
- Shared understanding of how self-neglect might be defined
- Joined-up systems to ensure coordination between agencies
- Time allocations that allow for longer term supportive involvement
- Data collection on self-neglect referrals and outcomes
- Training and practice development around the ethical challenges, legal options and skills involved in working with adults who self-neglect

Research undertaken by SCIE concluded that self-neglect practice is a complex balance of knowing, being and doing:

Knowing: in the sense of understanding the person, their history and the significance of their self-neglect, along with all the knowledge resources that underpin professional practice

Being: in the sense of showing personal and professional qualities of respect, empathy, honesty, reliability, care, being present, staying alongside and keeping company

Doing: in the sense of balancing hands-on and hands-off approaches, seeking the tiny opportunity for agreement, doing things that will make a small difference while negotiating for the bigger things and deciding with others when the risks are so great that some intervention must take place.

The emotional impact of self-neglect must also be taken into account. Individuals who self-neglect can often report a sense of worthlessness and reduced motivation to improve their lives. Many individuals, though not all, were worried about how they would be perceived by others and in some instances would try and "cover up" their self-neglect. This was sometimes due to embarrassment or stigma, but could sometimes be due to fear of eviction or clearing of possessions.

Practitioners dealing with cases of self-neglect can also experience some form of emotional impact. Supervision is extremely valuable in such circumstances, to give practitioners the opportunity to reflect and receive appropriate support.

Information Sharing

Information gathering will aim to build an understanding of:

- Any previous successful engagement with the individual
- Approaches that appeared to disengage the individual
- An insight into the individual's wishes and feelings
- The views of anyone who has contact with the individual including relatives and neighbours

When working with individual's who may be reluctant to engage, the risk of miscommunication between agencies is greater than usual. It is important to ensure that all relevant information is available to those who undertake any assessments. Responses to self-neglect from a range of organisations is likely to be more effective than a single agency response. Sharing information between organisations will usually require the person's consent and each organisation will have to consider when, if at all, it is appropriate to share information without the individual's consent, for example, if it is in the public interest.

Information will only be shared on a "need to know" basis when it is in the best interests of the adult:

- Confidentiality must not be confused with secrecy
- Informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement; and

- It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk

- Where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing and wherever possible the Caldicott Guardian should be involved

- Decisions about who needs to know and what needs to be known should be taken on a case by case basis, within agency policies and the constraints of the legal framework

- Principles of confidentiality designed to safeguard and promote the interests of an adult should not be confused with those designed to protect the management interests of an organisation. These have a legitimate role but must never be allowed to conflict with the welfare of an adult. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of the adult, then a duty arises to make full disclosure in the public interest

The decisions about what information is shared and with who will be taken on a case by case basis. Whether information is shared and with or without the adult at risk's consent. The information shared should be:

- **Necessary for the purpose for which it is being shared**
- **Shared only with those who have a need for it**
- **Be accurate and up to date**
- **Be shared in a timely fashion**
- **Be shared accurately**
- **Be recorded proportionally demonstrating why a course of action was chosen**
- **Be shared securely**

(Self-Neglect Toolkit – Training, Advice, Solutions &

Risk Assessment

It is the responsibility of all involved practitioners to conduct and record a risk assessment and to review and share this when appropriate.

The risk assessment should include the following:

- Whether the person is refusing medical treatment/medication
- Whether there is adequate heating, sanitation, water in the home
- Whether there are signs of the client being malnourished
- The condition of their environment
- Whether there is evidence of hoarding/obsessive compulsive disorder
- Whether there are serious concerns over level of personal or environmental hygiene
- Whether the person may be suffering from untreated illness, injury or disease, physically unable to care for themselves or may be suffering from depression
- Whether the adult has serious problems with memory or decision making, signs of confusion or dementia rendering them unable to care for themselves
- Whether there are associated risks to children
- Seek to establish the individual's life history including any major losses or traumas in order to aid understanding of their current situations

Effective Multi-Agency Working

It is likely that these individuals will not clearly meet the criteria for any one or a number of different agencies or organisations. Previous attempts to engage the individual may have proved unsuccessful. Self-neglect should be viewed as a multi-agency priority and thereby there is an expectation that:

- All partner agencies will engage when this is requested by the lead agency as appropriate or required, and
- Where an agency is the lead agency, then take responsibility for coordinating multi-agency partnership working

There are often a number of practitioners who are involved in self-neglect cases, they can include:

- General Practitioners
- District Nurses
- Community Matrons
- Psychiatrists
- Community Nurses
- Drug and Alcohol Services
- Psychologists
- Physiotherapists
- Occupational Therapists
- Community Chiropodists
- Dentists
- Pharmacists
- Community Physicians
- Ambulance Crew
- Police
- Solicitors
- Advocates
- Social Landlords
- Voluntary Organisations
- Housing Associations/Organisations
- Environmental Health
- Fire and Rescue Service
- Welfare Benefits
- Animal Welfare

Self-neglect work can be well coordinated when there is clarity and flexibility regarding the role of the practitioners involved, with clear goals agreed by all concerned. It is beneficial to agree a common approach, ensuring consistency of the messages received by the individual concerned. Case conferences, team discussions or multi-agency risk panels have generally been found to be positive from research undertaken. They were found to confirm a sense of direction for each case and helped form agreement on the most appropriate actions to be taken, and by which agency.

1.8 Advocacy

The Care Act 2014, requires that a 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 community care assessment, where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate individual to help them. There is a difference between people who do not lack capacity and have substantial difficulty and people who lack capacity who by the nature of their cognitive impairment will have substantial difficulty.

People who self-neglect or hoard may not agree to engage with an advocate any more than they may agree to engage with any other professional. However, the need for advocacy should be considered and kept in mind. This is especially true of the person who's situation may lead to sanctions, for example, if the landlord is seeking a possession order due to the unsafe state of the property.

2.0 PROCEDURES

2.1 Procedure for Managing Self-Neglect Cases

The following sets out the procedure for the management of cases involving individuals who are at high risk of severe injury and/or death due to lifestyle; self-neglect and refusal of services.

Please note: This procedure is intended for use where there is **NO** perpetrator – the risk arises from the individual's refusal to engage with services and/or their high level of self-neglect puts them at risk of severe injury and possible death. It is essential that the referrer/professional establishes that the individual is not an adult at risk suffering from abuse from another party before this procedure is implemented.

In the majority of cases the care management approach of assessment, care planning and review will be the most appropriate and suitable route to provide intervention in self-neglect. This will respect the person's right to make unwise decisions/choices where they are deemed to have capacity.

- Concerns regarding self-neglect will be made via the same route as all other safeguarding concerns and reported in via the Halton Borough Council Contact Centre using the Adult Social Care telephone number **0151 907 8306,** or by using the online referral form which can be completed and will be sent directly to the Integrated Adults Safeguarding Unit: https://adult.haltonsafeguarding.co.uk/what-is-abuse/

- The concerns will be triaged by the Duty Social Worker in the Integrated Adults Safeguarding Unit and a decision will be made as to the most appropriate team to try and coordinate efforts to engage with the adult at risk.

- Once the alert has been allocated to either the Initial Assessment Team; Mental Health Team or Complex Care Runcorn or Widnes Team, the safeguarding alert will be moved onto the Risk Assessment stage on Carefirst.

- The allocated worker within the team who has been assigned the case, will then attempt to coordinate a multi-agency approach to resolve the issues, which will need to be evidenced.

- The Risk Assessment form should identify what providers/stakeholders will be referred to and highlight the support currently in place for the person. This could be family members; domiciliary care; GP; Housing Tenancy Support etc.

- The involvement of other providers/stakeholders does **not** transfer the responsibility of the case, it still remains the responsibility of the allocated social worker

- The Risk Assessment form will then be closed on Carefirst, when there are agreed actions and clear direction for the case and requires care management involvement for ongoing support.

- For cases where the allocated social worker has not been able to achieve any form of engagement with the adult at risk, or where there is difficulty in establishing connections with other providers/stakeholders, a multi-disciplinary team meeting will need to be arranged. Those providers/stakeholders who could be involved in the multi-disciplinary meeting may include the following (this is not an exhaustive list):

    - Police
    - Fire and Rescue Service
    - Primary/Secondary Health Care Providers
    - Environmental Health
    - Family members

- The multi-disciplinary team meeting will be organised by the allocated social worker may be chaired by the Principal or Practice Manager of the Integrated Adults Safeguarding Unit/or by the Care Management teams themselves. The purpose of the meeting will be to ensure all parties are up to date with the details and background of the case; identify what the current barriers are to the case; formulate and agree an action plan to achieve engagement with the adult at risk; identify realistic timescales and lead/responsible officers for each action and set a date for review of the agreed action plan.

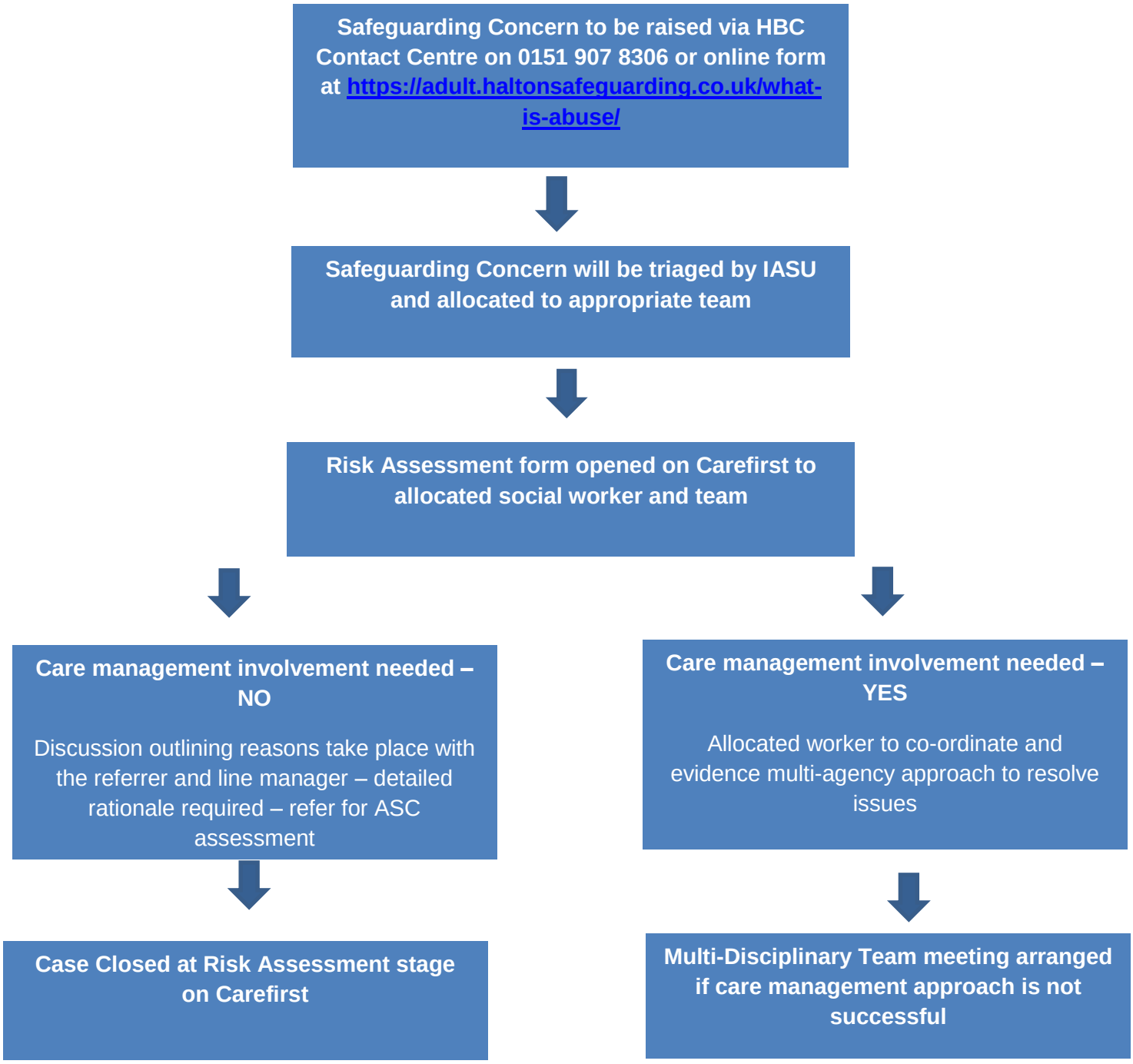
- As self-neglect cases are usually complex by its very nature there will be requirements for numerous multi-disciplinary team meetings to take place, in order to discuss progress of the case; agree next steps or where a new course of action may be need to be agreed upon

- Minutes from the multi-disciplinary meeting will be taken by the Administrative Officer for the Integrated Adults Safeguarding Unit (for meetings chaired by the Principal or Practice Manager of the Integrated Adults Safeguarding Unit) or by Care Management teams and will be circulated to all attendees. Each agency will be responsible for the secure storage of these minutes on their relevant organisation's databases.

- The Integrated Adults Safeguarding Unit/or Care Management teams will keep an up to date version of the agreed action plan following each meeting, which will identify lead/responsible officers and an agreed timescale for each action. The responsibility to take appropriate actions rests with the individual agencies, it is not transferred to the Integrated Adults Safeguarding Unit, nor will the Unit resume care management of the case.

- A multi-disciplinary meeting should not be called for cases where the lack of engagement with the adult at risk is merely sporadic or intermittent. As research shows that full engagement only develops over a period of time with some people, where efforts to engage with them are sustained and a relationship is established.

Procedure Flow Chart



Appendices

Appendix no. and file attachment	Name	Date of last update
1  Communicating with someone who	**Communicating with someone who hoards**	2016
2  Questions to ask about Hoarding+Se	**Questions to ask about hoarding and self-neglect**	2015
3  clutter-image-ratings.pdf	**Clutter image ratings (Hoarding Disorders UK)**	N/A
4  Key Pieces of Legislation.docx	**Key Pieces of Legislation regarding self-neglect**	Various

Appendix no. and file attachment	Name	Date of last update
5  Best Interests Checklist.docx	**Best Interests Checklist**	2005
6  HCPC Standards of Conduct Performanc	**Health & Care Professionals Council Standards of Conduct, Performance & Ethics**	June 2018
7  nmc-code.pdf	**Nursing and Midwifery Council: The Code – Professional Standards of Practice and Behaviour for Nurses and Midwives**	October 2018
8  Strategy Meeting Agenda Template.dc	**Strategy Meeting Agenda Template**	April 2020
9  Sign in Sheet.docx	**Sign In Sheet**	April 2020

Appendix no. and file attachment	Name	Date of last update
10  Strategy Meeting Minutes Template.d	**Strategy Meeting Minutes Template**	April 2020
10  Staying Safe Protection Plan Revi	**Staying Safe Protection Plan Review Meeting Template**	April 2020