

555

Making Safeguarding Personal

'I can't understand
why things can't get
done without the word
safeguarding.'

555 participant

Daniel Potts
Sophie Blythe

May 2018

Contents

Introduction	1
Foreword	2
Methodology	3
Key Findings	4
Recommendations	6
Our main findings	7
Awareness and understanding of safeguarding	7
Trust in professionals and the system	11
Working in partnership	15
Feedback and communication	19
Conclusions - what should happen now?	23
About Healthwatch Essex and the partners	24

Acknowledgements

We are really grateful to the participants who gave up their time to attend the 555 focus groups, and in particular, the individuals who shared their own lived experience.

By sharing your experiences of the safeguarding system in Essex you have already made a difference.

Thank you to ECL Sensory Service, Essex Carers Support, Braintree Mencap, PARC, and Mind in West Essex who hosted our focus groups and gave us access to their service users and clients. Thank you also to our Healthwatch Essex Carer Ambassadors and Essex County Fire and Rescue Service.

Please note that names have been changed to protect identities.

Introduction

Healthwatch Essex's award-winning '555' model of engagement has been recognised both locally and nationally as an innovative, yet simple, means of capturing the lived experience of people in Essex – giving them the opportunity to share their stories, face-to-face, with the professionals who deliver care in Essex and beyond.

The Care Act (2014) put in place a clear legal framework for how local authorities and other agencies should protect adults at risk of abuse or neglect. In Essex, during 2016-17, there were more than 12,500 safeguarding concerns of abuse raised to Essex County Council; an average of around 34 each day. In Essex there were 5,175 Section 42 enquiries started that year. The conversion rate for this is 41 per cent; this means that for every 10 concerns raised, approximately four enquiries were started. The most common types of risk in Section 42 enquiries related to neglect and acts of omission, physical abuse, and psychological abuse.¹

'Making Safeguarding Personal' (MSP) is a sector-led initiative that aims to develop an outcomes focus to safeguarding work, and a range of responses to support people improving or resolving their circumstances.² This report provides a snapshot of people's experiences of safeguarding, and whilst not conclusive, we hope it goes some way in testing Essex's approach to 'Making Safeguarding Personal'.

Between February and April 2018, Healthwatch Essex worked with a range of partner organisations across Essex in order to access, listen to and gather information on the experience of safeguarding from the perspective of the service user, their families/carers and support workers involved in the process.

This report is directed at professionals responsible for designing, commissioning and delivering safeguarding services in Essex. It highlights our findings by bringing together the voices of ordinary people in Essex, offering their experiences, how they felt, what worked well and what could be improved. Our report also provides a better understanding of the strengths and weaknesses in current safeguarding practice and the gaps from a service user or carer's perspective.

On 24th May 2018, we invited professionals in Essex to listen to the lived experience of some of the individuals we engaged with. We believe that listening to people's lived experience is the first step to shaping services that are fit for purpose, financially sustainable and, above all, in the best interests of service users.

It is hoped that the recommendations in this report will ultimately help shape and improve professional practice where necessary to ensure that safeguarding is, wherever possible, truly personal.

Dr David Sollis

Chief Executive Officer, Healthwatch Essex

¹ Safeguarding Adults Collection, NHS Digital 2018

² Making Safeguarding Personal, Local Government Association 2018

Foreword

The Essex Safeguarding Adults Board (ESAB) is committed to understanding individuals' experience of the adult safeguarding system. Whilst it is relatively simple for us to hear the views of professionals, it is challenging to reach out to users, carers and their families to get a better understanding of their experiences. We have therefore been very pleased to work with Healthwatch Essex in carrying out this engagement and producing this report.

ESAB's core responsibility is to help and protect adults with care and support needs by coordinating and ensuring the effectiveness of its partners' work to keep vulnerable people safe. Such safeguarding work is about protecting individuals in a way which recognises that everyone has different preferences, histories, circumstances and lifestyles. The national programme, 'Making Safeguarding Personal' emphasises that safeguarding arrangements should be fitted to the needs and desires of each person and focused on outcomes agreed with them. This should involve a conversation about how best to respond to their particular situation in a way that enhances people's choice and control.

This report provides a really useful test of how well the 'Making Safeguarding Personal' approach is working in Essex. We will use it to develop our plans for improving safeguarding services in the future and checking out how well we are doing. I particularly recognise how difficult it can be for someone to talk about their experiences of abuse, either personal or in supporting others. I would like to thank everyone who has come forward to share their stories and experiences to enable this work to take place.

Phil Picton

Independent Chair for the Essex Safeguarding Adult Board (ESAB)

www.essexsab.org.uk

Methodology

Using the 555 model, Healthwatch Essex worked with ECL Sensory Service, Essex Carers Support, Braintree Mencap, Play and Resource Centre (PARC) and Mind in West Essex to host a series of focus groups and individual interviews across Essex. We also spoke with Essex County Fire and Rescue Service. The aim was to listen to views on safeguarding and their understanding of the processes in place to support people if they had a safeguarding concern.

These organisations were able to give us direct access to vulnerable people and the staff who support them. They provide services and support for people who have additional needs; a learning, sensory or physical disability; those with mental health problems, and people who are elderly or are carers.

Victim Support and Castle Point Association of Voluntary Services (CAVS) were involved in the initial formulation of the project but were unable to directly participate in the engagement process due to work-related circumstances.

Healthwatch Essex did not have access to a referral system, or anyone who had consented to be contacted about their safeguarding review. Therefore we approached this project by firstly facilitating five focus groups with support workers and advocates who, as part of their role, may have to help their clients through the safeguarding process. These participants understood the service users' experience, as well as common dilemmas around policy and practice. They were also able to give examples of what worked well, and what didn't.

Secondly, we conducted more structured interviews with individuals who have been through a safeguarding review (either for themselves, or someone they care for) to understand their experiences. These interviewees were identified through the focus groups or partner organisations, or had responded to our calls for participation. In total we spoke to 36 participants and 6 interviewees.

These focus groups and interviews took place between February and April 2018 and were hosted at partner organisation's premises, Healthwatch Essex's office or individuals' homes. All participants and interviewees were adults who consented to taking part and for their responses to be shared. By working with partners we ensured that the contributors had appropriate support in place to participate fully.

It should be noted that going through a safeguarding review can be very stressful, and sharing personal information about painful or difficult experiences is not easy.

It is also important to note that we did not interview any social workers or social care professionals, so their feedback is not captured in this report.

Key findings

Although our engagement covered a broad spectrum of safeguarding concerns, recurring issues emerged that seemed consistent with all vulnerable adults in their safeguarding referral/review. We summarise these below.

Awareness and understanding of safeguarding

From our conversations we discovered that, in general, individuals had little or no understanding of the term 'safeguarding' and consequently had no awareness of the systems and people in place to protect and support them.

Our conversations also showed that participants were not clear on where to go for help, or what services were available to support them either through the safeguarding process, or to prevent a concern being raised.

Participants from partner organisations reported feeling well trained, understood the actions to take, and felt supported by their organisation should they need to make a referral.

Trust in professionals and the system

Both participants and interviewees expressed concern over the process feeling judgemental and potentially causing individuals to feel criminalised. They also lacked confidence that matters would be dealt with appropriately or in a timely fashion.

One concern that was raised frequently was the perceived lack of confidentiality, in particular how their information was being shared with other organisations. Some told us they didn't feel in control of the situation.

The role of advocates, or people to support the individual/family, was considered extremely important.

Working in partnership

Participants found that cases were resolved faster and with better outcomes for people when organisations and agencies worked together. Working in partnership and sharing information was seen as key to dealing with a safeguarding referral, or preventing one from being made.

However, we also uncovered confusion around where responsibility ultimately lies, particularly when a safeguarding need is not found but where there is still concern about an individual or family.

Participants acknowledged the police were not always the most appropriate service to contact, but that they were often the only ones to respond.

Feedback and communication

From the point where a safeguarding concern was raised to the time when an outcome was reached, two key issues emerged from the interviews and focus groups. These were understanding the process and being kept updated.

Participants rarely received acknowledgment that their referral was being dealt with and individuals were not given clear information on the process, timelines or what was going to happen next. In these instances, not being kept updated could have a detrimental impact on their emotional wellbeing.

What people valued

Participants and interviewees alike told us that they valued the following:

- Being listened to and feeling believed
- Keeping a focus on the person at the centre
- Not being made to feel like a criminal or perpetrator
- Being told about options available and choices they have
- Transparency from being informed, involved in decisions and kept in the loop
- Professionals being sensitive to families' or carers wishes
- Reassurance that something will be done quickly

What people wanted

- Proactive services that are there to help people and prevent situations from escalating
- A named person to talk to about their case
- A forum for support workers to discuss ideas, or a Frequently Asked Questions document to refer to before raising a safeguarding concern
- Flexibility in the system to cater for the individual needs of carers and families
- Continuity from the same person to work on a case from beginning to end
- Someone independent
- Better communication and information sharing between social care and other organisations

Recommendations

Reflecting on the findings of this report, we offer the following recommendations:

Raising awareness of 'Safeguarding'

- A multi-agency approach to a campaign raising awareness of what safeguarding is, and is not.
- Clear and accessible information for the public and a wide range of vulnerable groups.

Improving joint working

- A committed long-term engagement of social care staff, service users and partners to feedback valuable insight of the safeguarding journey and share best practice.

Engaging with service users

- Involvement of people who have been through a safeguarding review to provide 'lived experience' to help shape and improve safeguarding practice.

Reviewing of communication with service users

- Development of a standardised way of communicating with service users about their review and outcomes.

Our main findings

Between February and April 2018, Healthwatch Essex worked with a range of partner organisations across Essex to access, listen to and gather information on the experience of safeguarding from the perspective of the service user, their families/carers and staff from organisations who support them.

The organisations we worked with supported a wide range of vulnerable people and their carers including the elderly; those with a learning, sensory or physical disability and people living with mental health conditions. We spoke to individuals who had experienced instances of emotional abuse, financial abuse, neglect and/or domestic abuse.

Our findings from the conversations with groups and individuals have been summarised under four headings.

1. Awareness and understanding of safeguarding

During the interviews and focus groups, participants shared their understanding of safeguarding as individuals and professionals, and the services in place to support them.

In our conversations we discovered that, in general, individuals had little or no understanding of the term 'safeguarding' and consequently had no awareness of the systems and people in place to protect them.

Information available to the public

Participants involved in an advocacy role told us that sometimes issues raised as safeguarding concerns were simply things that a carer or family member had always done, and they therefore could not understand how their behaviour might be considered inappropriate. The advocates felt that it seemed to be their job to explain the process to them, and that this had to be done delicately.

"We know it's a safeguarding issue because it's flagged up, but when we ring people they don't have a clue. They say, 'what dear?, I think you've got the wrong number?'"

Other participants found that individuals didn't seem to understand the importance or seriousness of the term.

"Sometimes when you mention safeguarding to adults, they say, 'Well they're not going to kill me'. You say, 'I know, but you are still in danger!'"

One interviewee was concerned about the handover when her elderly mother was discharged from hospital into a care home. She was unaware of the safeguarding process but felt that what her mother experienced at the care home was neglect due to there being a lack of communication between the organisations.

'Safeguarding' was often referred to as a daunting process particularly when reporting a concern as an individual.

"The word itself can be terrifying, as it's like they are being accused."

"I didn't know about safeguarding. I was in a panic as I always did my best for my son and now I'm being punished for it, and I felt like a criminal."

It was evident from our discussions that there was a lack of information or documentation about the safeguarding process, and who to talk to about a case. One interviewee had resorted to Google – but only found information on how to raise a concern.

"It was a good thing it was there to protect us, but I wasn't given any information about who this safeguarding team was, who was involved and how our information was being transferred."

"I thought a big team would come in, but it's not, it's just a social worker. I didn't realise that."

Services and choice

Our conversations also uncovered the fact that people were not clear on where to go for help, or what services were available to support them either through the safeguarding process or to prevent a concern being raised.

One participant reported receiving no information to support the decision to move her mother into a care home, or any other options.

"Never being in that position, I would have liked to have been told 'this is the support we offer you due to your mother's situation'".

Two interviewees reported a constant struggle to get support, and felt they had to reach crisis before any help would be put into place.

"We did get access eventually, by which time I'm on my knees crying on the phone for help."

Some participants commented on the workload of social services and felt they were so busy that it was difficult to speak to someone to start the process, or that staff moved on frequently so there was no continuity. Another participant suggested that there needed to be another service so that people didn't automatically call the police.

"I don't know what it is but we need something for when we need to 'press that button'. It's not the police and it's not the social worker, but in between."

Essex County Fire and Rescue Service echoed this and highlighted that there was no layer between 'no support' and 'referral to social care', which was frightening for people. Having a role in between, like a health visitor, that doesn't have an enforcement duty would help with prevention, rather than always reaching crisis before anything is done.

Understanding of safeguarding by service providers

All participants felt that they had undertaken a high standard of training and had excellent support in place, often provided by individuals with many years of experience dealing with safeguarding issues. One organisation supplemented their regular training sessions with scenario-based training, which made it realistic.

“[The training] gives you the structure. When it comes to the crunch you need the support system.”

Most of the focus group participants reported that, although they did not deal with safeguarding issues on a regular basis, they felt well supported by their safeguarding lead and they understood the actions to take. That said, the initial decision to raise a safeguarding concern or not was never taken lightly. It was noted that although the course of action was clear cut for cases that dealt with immediate danger, there were also many grey areas.

The decision to raise a safeguard was particularly difficult when people were living with a condition related to sensory impairment, and experienced hallucinations or paranoia. These individuals could, for example, report of people breaking into their house or stealing money. In these instances it became complicated, and staff would need to unpick the situation, investigate and discuss whether or not to raise a safeguard.

“We can't assume. We have to follow a process and make sure we don't make assumptions and leave people at risk.”

Unfortunately, one participant had a negative experience of raising a safeguarding concern as an individual. She had been made to feel that she was interfering and causing trouble, which had put her off doing it again.

Case study

Rachel's mother, Anita, had a stroke when she was 78. Rachel described Anita as 'a very young 78' who read two to three books a week. After the stroke, Anita could only communicate using four words and could no longer walk, read or write. At the hospital Rachel was told there wasn't much hope for Anita due to her age and the type of stroke she'd had.

“It's sad that so much is against you. Not only could she no longer talk or walk, she's not going to be respected - told she's on the heap and she's not going to last.”

Without explanation, Anita was placed on medication that made her drowsy, and given a catheter that she did not need. Rachel tried to advocate for her mother but described a 'hierarchy' in the hospital that caused her to feel belittled.

After three months in hospital, staff decided Anita was ready to be discharged. While Rachel wanted to care for Anita at home in Clacton, hospital staff told her she would not be able to cope with Anita's needs and advised that Anita be discharged to a nursing home.

"I would have liked the option...I would have liked to have been told 'this is the support we offer due to your mum's situation.'"

Rachel found that the handover of Anita's care, from hospital to nursing home, did not address Anita's needs. At the nursing home, Anita's meals were liquidised and she was repeatedly given catheters, despite not needing these measures. Rachel recalled Anita's drink being left on the wrong side of her body, where she could not reach it, and Anita would be left to sit in a soiled pad.

Again, Rachel tried to have her mother taken off the medication that made her drowsy, but staff were unwilling to do so. Rachel suspected that staff were reluctant to take residents off this medication as it made them quiet and compliant.

Eventually Rachel arranged to care for Anita at home, as she had originally wanted; a time Rachel described as 'joyful'. Rachel and Anita were able to visit the seafront and Stroke Association every day, and Anita could eat suitable food. When Rachel stopped the medication that had been making her mother drowsy, Anita's alertness returned.

Rachel firmly felt that Anita's needs should have been thoroughly assessed and agreed upon before she was discharged from hospital, which could have prevented the inappropriate treatment she received at the nursing home.

"I would say to be careful when the hospital feels you're ready to go. Be very careful. I don't believe she was ready to go with a catheter, with all those pills and with her food not sorted...Get the right people in to look at medication, food, catheter... If they can't talk, what place shall they go to? What's needed on the other end?"

Rachel said that as Anita couldn't talk she had to be her mother's voice. She expressed concern for others who were not in the same position as Rachel to visit a relative in hospital or a nursing home every day and advocate on their behalf. Even with her ability to do this, Rachel's concerns were frequently dismissed, and she felt bullied by professionals who treated her concerns as an annoyance.

Anita died 18 months after she had the stroke.

Since Anita's death, the nursing home has been closed down.

2. Trust in professionals and the system

The length of time it took for professionals to take action that would lead to meaningful change could leave people vulnerable. There was also some distrust of professionals, who were sometimes considered to be dismissive or obstructive.

Concerns about confidentiality and control

There was general concern amongst interviewees about a lack of confidentiality, particularly about how their information was being used and shared with hospitals and other care providers. Many felt that this had not been addressed in the initial meeting and the process often left people feeling as though they had done something to harm their loved one.

“It leaves me feeling vulnerable – that if I take my son to A&E they look at me thinking ‘what has she done to him?’”

Some interviewees felt they had lost faith in care organisations when a safeguard had been raised, as it left them feeling paranoid. This could break down a lot of trust between both parties.

It was also noted by participants that unless an individual was in agreement for a safeguard to be raised, nothing could be implemented, which again left parties feeling frustrated.

A couple of the interviewees reported that they didn’t feel in control of their situation, causing stress and distrust. One interviewee was put on a waiting list and, despite constantly phoning the service, eventually found she had been taken off the list.

“The system makes you feel more vulnerable, not less vulnerable.”

Will something actually happen?

Some interviewees and participants spoke about a lack of confidence that matters would be dealt with appropriately and in a timely fashion, if at all.

“I reported to the key worker and she said ‘you realise this is a safeguarding issue?’ I said ‘yes, that’s why I’m telling you’ and nothing happened. It’s a fact it’s a safeguarding issue but nothing happens.”

One interviewee talked about a time when she had asked all available services for help and felt she could not carry on. She rang the ECC safeguarding number to ask if they could help, as she was concerned that she and her family were now putting her daughter at risk, but found them to be unhelpful and dismissive.

“They just said ‘it’s not really a safeguarding issue, it’s more of a health issue’. So they also didn’t seem to care. It’s almost like – ‘you’re an alcoholic, nobody cares.’”

Participants also highlighted the fact that complaints sometimes seemed to go 'round and round' with no resolution. There were several experiences of a lack of staff continuity within social services. One participant spoke of a time when she contacted the social care team at ECC to ask for an update on a particular safeguarding case and was told that "the social worker no longer works here!"

The role of a trusted intermediary

Some advocates spoke of the process feeling very judgemental.

From a carer's point of view it was sometimes felt that the social worker wasn't doing a very good job and hadn't followed a duty of care. Often, in these instances, the person given the job of investigating an issue, is the same person who has allegedly been ineffective as a social worker. It was suggested that there should be an independent officer within the safeguarding team to allocate jobs and take control.

"It's never person-centred. There's a breakdown in the relationship between the carer and the social worker. The carer doesn't get heard and it's very one sided. The carer is portrayed as the baddie."

Another advocate spoke of a case where a social worker was quick to make a judgement about a gentleman's perceived lack of care towards his wife, when in fact it was a choice this couple had made together. The social worker hadn't taken into consideration that the gentleman knew his wife best and had her best interests at heart.

Focus group participants highlighted the importance of individuals being supported at the safeguarding multi-agency meetings. This could be a frightening experience and could seem that professionals are 'arranged against you'. In participants' experience, it was often the case that professionals would meet beforehand to discuss the case without the individual or family present.

"It's almost like a court of law, the way it's run. Nobody has actually raised with the person being accused what they are actually being accused of."

It was also reported that not all professionals involved in raising the safeguarding concern seemed able to follow them through and didn't always turn up to the meetings. This was particularly the case with paramedics, where many meetings had no outcome.

"That individual is left with the turmoil of it being raised against them and they think people don't think they look after others properly; there's no empathy for their situation".

Members of the public seemed to trust the fire service because they are not seen as part of the 'establishment'. This enables the service's Community Builders to gain access into homes and identify safeguarding issues, as people are less concerned about there being repercussions.

"There is no enforcement. They are seen as member of the community who will rescue you in your hour of need...The biggest frustration is we have around 130 cases we are still waiting for an answer on."

Being listened to and being taken seriously

Several participants spoke about their positive working relationships with social workers and how important this was when a safeguarding concern was raised.

“I was impressed with how quickly they responded – but I think it’d been highlighted before, so they were aware of the family”.

Another interviewee reported on the way a new social worker had been proactive. This social worker took time to familiarise herself with the situation and was surprised at the way the family had been able to manage up to this point.

“She was really on the ball and then she said – ‘what about you?’ That’s the first time anyone ever said that to me”.

Both participants and interviewees spoke highly of the police in responding to safeguarding alerts, even though they knew they shouldn’t have to be the service to respond. One interviewee was forced to rely on the police, out of sheer desperation, when her daughter’s self-neglect was at its worst. A lady walking her dog in the woods had found her daughter unconscious in a ditch.

“You get to the point where you haven’t got anything left to give. I said, ‘perhaps can you call the police?’, because I just couldn’t do it anymore.”

Unfortunately, some participants from two of the organisations we spoke to felt de-valued by the attitudes demonstrated by some social workers.

“Social workers think we are way below them.”

“Sometimes other social workers talk to us like we know nothing – we are from the voluntary sector.”

Case study

For most of the six years she experienced alcohol-dependency, Sarah’s daughter Jessica lived in the family home in Harlow. Sarah described getting any support for Jessica as a ‘battle’, despite requests for support being made to the police, children’s services, 111, A&E, the crisis team, the drugs and alcohol team and the safeguarding board.

Sarah felt that risks associated with addiction were often viewed by services as self-inflicted and not taken seriously as a safeguarding issue:

“She would say she’s going to drink herself to death, and she would be serious about it, but the hospital wasn’t really bothered. It was like ‘come back when you’re sober’.”

Even though Jessica faced violence, financial abuse, self-harm, suicidal ideation and being found unconscious in public, Sarah felt that services treated Jessica as though she was able to manage her own safety. For example, when Jessica's partner was violent toward her the police took no further action as she declined to press charges, and Sarah could not speak to the drugs and alcohol service about the risks Jessica faced because of confidentiality protocol.

"What I really wanted more than anything was somebody to work with us as a family, not just focussing on her. [She] says 'I don't care, I'm not at risk' because she isn't with it enough to identify the risks. I feel they almost deliberately exclude the families because they don't want to know what the risks are."

The small amount of support that was accessible seemed focussed on the short-term and did not consider the broader impact of Jessica's alcoholism. For example, A&E would stabilise Jessica's body fluids and then discharge her without any other care in place. On one occasion, Jessica tried to become sober to be seen by a crisis worker. By the time she was seen, she was experiencing severe withdrawal, and because she wanted to leave hospital to buy drink she was no longer deemed as suicidal and was discharged to find her own way home.

"I think for people with addiction issues the system doesn't work. And especially for carers it doesn't work, because we've still got capacity and it's up to us whether we put up with what we're doing or not. But I was crying out for help."

As the family struggled to cope with Jessica's behaviour and the damaging impact it had on their lives, Sarah contacted the safeguarding board, concerned that aggression towards Jessica could escalate.

"I said 'we cannot carry on like this, she is at risk from us, as well as anyone else out there she might meet, can you help?' and they just said 'it's not really a safeguarding issue, it's more of a health issue.'"

When a safeguarding concern was finally raised by children's services it was because Jessica was deemed as being at risk from Sarah, who they said was 'too controlling' for having saved her daughter when she was found unconscious. After children's services spoke to the drug and alcohol team they decided there was no safeguarding issue.

On another occasion, Jessica called Sarah when she found herself in danger while drunk in public. Sarah recalls:

"I reported to the key worker and she said 'you realise this is a safeguarding issue?' I said 'yes, that's why I'm telling you' and nothing happened. It's a fact that it's a safeguarding issue but nothing happens. Over and over again."

3. Working in partnership

Participants discussed the issues they encountered when working with other agencies on safeguarding concerns, and the fact that relevant information was not always shared in a timely fashion, if at all, between the parties concerned. Participants also expressed their frustration with situations that needed to be resolved, but were not seen as a safeguarding concern. Where would the responsibility lie to address it?

Information sharing between services

It was clear from discussion that good working relationships with social workers and other agencies were beneficial. Sometimes incidents didn't need to be raised as safeguarding concerns as people already acknowledged the situation and were dealing with it.

“I always say we are part of a jigsaw and if we don't put our piece in then, even if it isn't a safeguarding issue, we make sure we case note it or contact the social worker.”

The general consensus was that agencies who work closely together meant situations could be resolved quickly. This was evident with a domestic abuse case. The support worker worked alongside Safer Places and the police to keep the individual safe and move him to new accommodation.

“It works well if people talk to each other and it comes back to sharing information.”

Information sharing was fundamental in protecting staff who provided services for vulnerable people, in particular, the sharing of case history. Two participants explained that this was needed to protect their own staff against allegations or complaints.

“When we flag it up as a concern, people tell us that they were already aware of this. Therefore the local authority could have been dealing with another case.”

Another issue raised was data protection, and how in some cases it could hinder progress. One participant recounted that a meeting had been cancelled and she'd been asked to call to reschedule.

“People get so hung up around data protection. I had a missed call from a withheld number and a message from a social worker. I rang the office and they said they can't give out information as it's data protection.”

Some participants commented on the fact that children and adult services still operate separately in terms of safeguarding and did not understand why the two did not work more closely together.

“It doesn't make sense. People exist in families and communities, not separately. Information sharing between adult and children services is so important.”

Frustration was expressed by everyone we engaged with, that many safeguards could have been prevented if support had been in place sooner, either because people were unaware of support and services, or unable to access them. Participants and interviewees felt that people often had to reach crisis before being given help.

“I couldn’t cope anymore and I said ‘I’m going to kill myself and kill my son’ because that’s how I felt and that’s when the safeguarding came in.”

“As soon as you hear ‘safeguarding’ everything gets done and I can’t understand why things can’t get done without the word ‘safeguarding’.”

Which service and who is responsible?

It was highlighted by participants that the police were often contacted as a last resort, and that they frequently responded to issues that other agencies could be taking responsibility for.

One participant described her frustration trying to access help for her alcohol-dependant daughter.

“Even when I called 111 to speak to the crisis team they asked to speak to my daughter and, on that occasion, she walked into the room and she said ‘I feel like killing somebody’ so they sent the police round. She wasn’t actually about to kill somebody. Agencies usually reply along the lines of: ‘I’m in an emergency! Well, call the police’.”

Another participant had a similar experience where the social worker had advised her to call the police to deal with a situation involving her disabled godson.

“He would have been locked up, which he didn’t need. He needed support which eventually he did get, but after a massive battle.”

The majority of participants agreed that incidents should not involve the police, but it appeared that some agencies ‘passed the buck’. Sometimes it was not clear which agency was going to take control of the situation.

“She has great things to say about the police because they are the only ones listening.”

One participant confirmed this to be the case when discussing an incident involving a mother and daughter. The daughter had a learning disability and had been talking to people on social media and meeting up with them, which could leave her extremely vulnerable. The mother raised a safeguarding concern about her daughter’s safety and the police raised 17, but nothing happened. The response from the social worker has always been ‘she’s got capacity; she can make her own decisions even if they are unwise ones’.

One interviewee explained her ongoing frustration with a lack of support and ownership from services for her daughter.

“I felt there was a lot of institutional neglect in the sense that she would be suicidal and self-harming, saying she will drink herself to death and she would be serious about it. But the hospital wasn’t really bothered. It was like ‘come back when you are sober’.”

“She would sober up and return but then they would discharge her with severe withdrawal symptoms, to find her own way home, without being aware of any risks to her safety.”

It could also be confusing when situations involved children and adults. One case involved safeguarding the parents from their child. Essex Safeguarding Adults Board rejected the case and said there was nothing they could do.

“They suggested we do a children safeguarding. They didn’t get the concept we were trying to safeguard both adults from physical and mental abuse, but because the perpetrator was a child, that became very difficult.”

We heard how it often took one professional to go the ‘extra mile’ to join things up and make things work. One interviewee spoke highly of a social worker and how well she managed a safeguarding situation involving her family, whilst caring for her daughter.

“I would say she knew her stuff and she’s bringing in other agencies to help. Boy what a difference that would have made in the early days!”

Case study

Deborah is the sole carer for her son, James, who has autism and catatonia that inhibits his ability to move or communicate.

When James turned 17, Deborah helped him learn to type. He used this ability to tell Deborah he was depressed and did not want to live. Deborah had struggled to find support for James. He was treated at a London hospital over 18 months, but as James could not move or sit down, getting him to London was difficult. Because James was able to type, Deborah was told he did not have a learning disability and so James had to join the waiting list for mainstream mental health support.

Deborah also described asking social services for help:

“I’m on my knees, crying on the phone, asking social services for help for years. You never get to see a social worker because they’re so busy.”

At the same time, Deborah had been caring for her mum, and when both of her parents died she had been responsible for putting everything in order. Deborah did not have time to grieve for her parents, was exhausted from the constant care she had to provide and felt hopeless from the lack of support from mental health services, social services, the learning disability services and an autism service.

Deborah felt increasingly depressed, and her doctor recommended she self-refer to a mental health service. Deborah remembers waiting for someone to contact her for a long time, and ultimately felt she had been forgotten about. Eventually, Deborah experienced mental health crisis and told a nurse that she felt like killing herself and, because there would be no one left to care for him, James too. Following this a safeguarding case was opened and the much-needed support was quickly put in place.

Deborah felt hurt that help only came after she had reached crisis and felt the safeguarding case could have been prevented if she'd had more support. She had received no documentation about the case and was therefore not informed on how her situation was described, or who it had been shared with.

“The system makes you feel more vulnerable rather than less vulnerable.”

The only consent Deborah had given for information about the case to be shared was to an autism service, but she had since found out that information had also been shared with a hospital.

“It was shared with a different trust, so information was spread without our consent and with no documentation. That’s really hurtful, because he hasn’t been abused. It’s just a situation. I don’t know that if I took him into hospital with a broken arm what will come up on their system. Whether it says ‘this person is not safe at home’ which leaves us very vulnerable.”

Deborah was told that the safeguarding case was closed, but other services told her they believed it was still ongoing. Deborah has been unable to find out the status of the case, as no one has responded to her queries about it.

“The safeguarding was in our best interests, but when it’s closed it needs to be closed. You need to feel it’s over.”

Deborah wanted families to be informed about the status of their case, what had been documented and what had been shared. She felt that the safeguarding case had criminalised her for experiencing mental health crisis, but felt that had some support been provided sooner, the situation could have been avoided altogether.

4. Feedback and communication

Two key issues that everyone felt very strongly about were understanding the process and being kept updated.

Reporting Safeguarding Concerns

None of the interviewees had been given any information explaining the safeguarding process, but the majority reported that things seemed to start happening quickly, once the safeguard had been reported. One interviewee reported being called back within an hour by the safeguarding team. It was suggested that an information leaflet with contact details would have made people feel more reassured.

One interviewee who raised a concern herself knew the safeguarding was in place for her and her son but received no information or documentation about what was going to happen next, and who she could talk to.

“What would have been really good is if someone from the safeguarding team would have come along and told me what will happen, ‘these are your rights’.”

Several participants had experienced difficulties in raising a referral, in particular when calling the safeguarding team and LADO (Local Authority Designated Officer for allegations against members of the workforce).

“I understand people are busy, but if they provide a service then people need to be on the other end of the phone. In the training course they stress it’s important to do it straight away.”

We heard several times from participants that the person reporting a concern wasn’t given information as to what happened, or even an acknowledgment that the referral had been received.

“If it comes back that ‘this is not an action for us but we have referred to the police or social services’, then at least you feel someone’s taken it up.”

Participants appreciated acknowledgement that a referral had been received by the safeguarding team, even if it didn’t go any further, as this meant that somebody had actioned it and their concern didn’t just ‘disappear’.

“The easiest way to deal with this is really simple. They just need to send you a receipt on your email saying that it’s been received. That’s all it needs.”

Others felt confident with the process, as they had access to a shared database which kept them informed.

However, some other participants expressed frustration that they were often brought into someone’s safeguarding process at short notice, and not given information prior to this, which made things difficult to manage.

“All of a sudden you get these documents from county council with all this history from six months and we had never been made aware.”

Another participant highlighted that sometimes urgent information about a client would be requested at very short notice. One received an email alert from social services safeguarding asking her to phone to gain the password to the document. No one was answering, and when she finally received the password it left little time to process the request.

“They requested information at 4pm on a Friday within 24 hours – we aren’t open weekends or out of hours!”

Safeguarding was taken seriously by all of the organisations who participated, and many of the participants reported that occasionally a staff member would make a referral only to be told that one had already been raised by another party, but not shared. Sharing safeguarding history was considered vital in ensuring the right support was in place for the service user and staff, potential situations avoided and time not wasted.

“It can be easy to miss one thing, then another care place has to flag it.”

Managing Safeguarding Concerns

Some of the individuals agreed that eventually their wishes were listened to throughout the safeguarding enquiry, but that it had been a struggle to get to that point. Although they were not entirely sure that they had been involved in all of the decisions that were made at every stage, upon reflection, this could have been due to the fact they knew little about the safeguarding process in the first place.

One interviewee stated that the safeguarding officer had listened carefully to his concerns about his father and stepmother’s care agency. He also was involved in the decision made to resolve the situation, but was not kept updated with how it was progressing.

Everyone we spoke to emphasised the importance of being kept up-to-date about the progress of a safeguarding concern. For support workers this meant they had an overview of what was being done, and could chase if necessary.

For the individual in particular, being kept informed had a massive impact on their own emotional wellbeing. One interviewee felt very strongly about consenting to her information being shared between agencies, and knowing exactly what had been said about her situation.

“I didn’t know what information had been shared. I didn’t know whether they said ‘this mum wasn’t a perpetrator’, or whether ‘the safeguard had been opened on this person’, I didn’t know!”

It was also noted that the service user needed a timeline of dates to work to (even though participants reported that dates were not ‘stuck to’, particularly where health and social care were both involved). Liaison between organisations was therefore very important.

Frequently at meetings it seemed information had not been circulated in advance, and time was wasted whilst professionals read the case details. This proved a particular problem for carers who had to make arrangements for someone to look after their loved one. It seemed that these circumstances are not taken into consideration when arranging times, and in some cases, venues for meetings.

Most participants reported having to chase the safeguarding team for updates, rather than receive them automatically. Some reported they never received feedback.

“We have to keep ourselves in the loop and ask questions.”

Outcomes of Safeguarding Concern

As previously mentioned, most participants who made referrals never received acknowledgement, let alone any update of the outcome unless they were directly involved with the individual/family. Many reported it would be nice to be informed of the outcome, or given acknowledgement that referral had been received, or was being dealt with.

Four of the interviewees believed the professionals had worked in their best interest. One reported that he was satisfied with the outcome, which was communicated to him by telephone. There had been two incidents with medication mix-ups for his parents, who have different neurological conditions and are cared for in their own home. The care staff involved in the incident had been given more training, and two safes had been purchased for each patient’s medication.

“You don’t want to get rid of the company who have made two mistakes, but have built up relationships with my dad and stepmother – it’s sometimes better the devil you know!”

However, another interviewee felt she hadn’t had closure for her safeguarding concern. She believed the safeguarding was in her and her son’s best interests and that the support was ‘miraculous’, but her case still seemed to be open and she received no communication confirming the problem was now resolved.

“You need an end to it, as I feel my crisis is still carrying on.”

Case study

Anthony's father has Parkinson's disease and his step-mother has Multiple Sclerosis. They both live together in their own home and a domiciliary care organisation provides staff, who visit four times a day to attend to their personal care. His step-mother, Beryl, is bedbound and his father, Jack, is beginning to become quite frail. Anthony visits on a regular basis and does all their shopping.

Last year, Anthony was contacted by the manager of the care organisation who alerted him to an incident that had happened regarding a mix-up of medication. The carers had accidentally given the MS medication to his father, and the Parkinson's medication to his step-mother. A call to the GP confirmed that this was not too serious, but that his father should be monitored for the rest of the day, just in case there were any adverse effects. The care organisation agreed that they would tighten up their procedures and make sure the staff involved were given some more training.

Unfortunately, a couple of months later, a similar situation occurred. This time his father was given his night-time medication in the morning. This was more serious than the previous incident as it made him drowsy and impaired his mobility.

"I couldn't believe it had happened again – how could it happen?"

Anthony was extremely concerned it had happened a second time, and upon speaking to the manager, was not reassured that it wouldn't happen again. He rang the Essex County Council Safeguarding number and spoke to a duty officer who took the details and said he would pass it on. Anthony was called back within an hour and the safeguarding officer listened to his concerns at length and said they would initiate an investigation. Anthony was not given any details about this process, or how long it would take, but was given a name and contact number of the person dealing with it.

After about a week, Anthony was contacted again by the safeguarding officer to discuss the findings and decide on the best course of action. Anthony was asked if he would like to change care providers, but he felt that they had built up a good relationship with his parents, and knowledge of their conditions, so he didn't want them to have to start again with new carers. Together, they agreed that a drugs safe for each patient would be the best option, and some more training for the care staff.

"You don't want to get rid of the company who have made two mistakes, but have built up relationships with my dad and stepmother – it's sometimes better the devil you know!"

Anthony would have preferred to have received something in writing about his case and the outcome, but was pleased that changes were implemented swiftly.

Conclusions – what should happen now?

Often people find themselves in complex situations that don't always have clear-cut solutions. This makes safeguarding, in some cases, a complex process. A safeguard is often raised as a last resort when people have reached crisis, perhaps because of a lack of awareness, or lack of available services.

What came across from our discussions is that information is paramount; people need to know where to go for support and what services are available. Individuals who are going through the safeguarding process need to understand the process, and know who to contact about their case. People feel more in control when they know what is happening, and why.

To provide meaningful outcomes people must be listened to and involved in decision-making. Organisations working together to support individuals/families, and sharing information where possible, is key.

Making Safeguarding Personal

This report provides a snapshot of the experiences of a small number of people's journeys through safeguarding. In order to better understand how to remove barriers to person-centred, outcomes focussed practice, more engagement with a larger cross-section of people and social care professionals would need to take place.

In this process we have been able to highlight a number of strengths and weaknesses of current safeguarding practice. Key strengths include existing working relationships between some support organisations and individual social workers which meant that issues could be proactively managed and resolved quickly, and in some cases, situations prevented. Staff providing services for vulnerable groups felt well-trained in safeguarding, and confident with the process of raising and dealing with a concern.

There were, however, inconsistencies in the quality of experiences for individuals. The provision of clear and accessible information right from the start of the process, through to the end, was not always evident. Communication between agencies was another weakness in current practice, along with the process not being flexible and accommodating to peoples' needs.

General awareness of what safeguarding is, and peoples' rights in relation to safeguarding, was also identified as a current weakness.

By listening to the voices of this report, and recognising the impact the issues above have on individuals and families, we hope to encourage changes to everyday practice.

About Healthwatch Essex and the partners

Healthwatch Essex

Healthwatch Essex is an independent voice for the people of Essex. We're here to understand the lived experiences of people who use health and social care services in the county and to make sure their voices are heard. We also provide an Information Service to help people access, understand, and navigate the health and social care system.

The Information Service can be contacted on **0300 500 1895**

www.healthwatchessex.org.uk

ECL Sensory Service

We are a team of sensory specialists delivering services across Essex and beyond. Our aim is to ensure that people can access the correct information, advice and support at the right time, in the right place and in the right way.

www.eclsensoryservice.org

Essex Carers Support

Essex Carers Support was established in 1992 in North Essex, and has grown to cover large parts of the county. We have a Board of Trustees that are made up of people that include carers themselves, keeping carers at the heart of everything we do. We have a team of skilled and qualified people working across the county to deliver the best quality service possible

www.essexcarerssupport.org.uk

PARC (Essex)

PARC (Essex) is a short break centre for children and young adults with disabilities and additional needs. All the children, young adults and families who access PARC are attending because they already have a diagnosis or the family already know their child has an additional need. Children and young adults do not need a formal diagnosis to access PARC and we are able to meet the varying and individual needs of all children and young adults with SEND (Special educational needs and disabilities).

We as a team are not just here for the children, we are also here to help and support the family as a whole unit.

www.parc-essex.co.uk

Braintree Mencap

Braintree Mencap is the voice of learning disability for the Braintree District. We cover Braintree Town, Witham, Halstead and the surrounding rural villages.

We offer a wide range of services for people with a learning disability, their families and carers. We are unique to the District in that we offer support and activities for people with a learning disability from the age of 5 years throughout adulthood. We also offer a helpline support service, as well as information coffee mornings for families and carers.

www.essexcarerssupport.org.uk

Mind in West Essex

We're Mind in West Essex, your expert mental health partner. Our network across England and Wales provide services that are practical and rooted in the reality of people's lives. We provide information and support to anyone who is affected by mental health problems, primarily in West Essex.

www.mindinwestessex.org.uk





Find out more



www.healthwatchesessex.org.uk



@HWEssex



/healthwatchesessex



enquiries@healthwatchesessex.org.uk



01376 572829



RCCE House, Threshelfords Business Park,
Inworth Road, Feering, Essex CO5 9SE

Information Service

We can answer your questions about health and social care services

Call
0300 500 1895

Monday to Friday 9am to 5pm
for the cost of a local call

Healthwatch Essex is a registered charity in England and Wales (no. 1158356) and a company limited by guarantee and registered in England (no. 8360699). Registered office: RCCE House, Threshelfords Business Park, Inworth Road, Feering, Essex, CO5 9SE