Essex Safeguarding Adults Board

healthwatch Essex

Making Safeguarding Personal

Phase 2

April 2019

Introduction and background

Healthwatch Essex (HWE) 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.

Part 1

In early 2018, HWE worked in collaboration with the Essex Safeguarding Adults Board (ESAB) to help them better understand individuals' experience of the adult safeguarding system.

Between February and April 2018, HWE engaged with a range of partner organisations across Essex in order to access, listen to and gather information on what the experience of safeguarding is like from the perspective of the service user, their families/carers and staff involved in the process.

HWE worked with ECL Sensory Service, Essex Carers Support, Braintree Mencap, PARC and Mind in West Essex, to host a series of focus groups and individual interviews across Essex. The aim was to listen to participants' 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.

HWE 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 help their clients through the safeguarding process. They understood the service users' experience, as well as some of the dilemmas around policy and practice. They were also able to give us examples of situations that worked well, and ones that hadn't.

Secondly, we conducted some more structured interviews with individuals who have been through a safeguarding review (either themselves, or someone they care for). These individuals were identified through the focus groups or partner organisations, or they had responded to our calls for participation, directly. In total, we spoke to 36 support workers and advocates and 6 service users.

We produced a '555 Making Safeguarding Personal' report in May 2018, which contained our findings and recommendations.

Part 2: methodology

The next stage of the project commenced in June 2018 with the aim of gaining a deeper understanding of the safeguarding system from the perspective of the service user. ESAB identified a sample of 100 people on their client record system and wrote to them to ask if they would consent to being interviewed about their experience. Their details would then be forwarded to HWE to make contact.

In September 2018, two names were forwarded to HWE and contact was made. Unfortunately, one of the candidates was very disgruntled and abusive, and was consequently removed from the list. An interview took place with the other candidate.

The process was repeated a couple of times from October to January 2019, and a few more names came forward. Unfortunately, several of the candidates were very confused and unwilling to talk to us and one has remained uncontactable.

It was not possible for ESAB to give us any further details on each client, other than a name and phone number. We did not know the nature of the safeguarding concern, what other agencies were involved or the outcome, in advance.

In total, HWE were able to visit 11 individuals who consented to be interviewed. In the first instance, contact was made by phone to explain the project and to try to establish the nature of their experience. An interview then took place which was carried out at a time and location of their choice.

The interviews varied from just one hour in length, to three hours. Many of the individuals were accompanied by a friend or relative, who were able to talk about the experience in more detail. In some cases, the individual gave a name of a friend or relative, and an interview was arranged with them later as well.

Although the experiences captured from the interviewees cover different circumstances, all participants were able to explain reasons as to why they needed care or support in relation to their health and well-being.

Two individuals had been living in unsuitable accommodation and had been discharged from hospital into new accommodation. One participant, after having a fall, returned home with apparatus put in place through social services. Three interviewees explained how they were provided with equipment for their home after a series of falls, but were unclear as to how this had been arranged, and by whom. Others had experienced problems with carers or a care home.

It is important to note that this report only reflects the experiences from their point of view and not of a social worker or any other professional involved in their case.

Making Safeguarding Personal

The Making Safeguarding Personal (MSP) programme emphasises that safeguarding adults should be person centred and outcome focused.

For us to ascertain whether the components of MSP had been put in place, it was largely dependent on the individual having understood what had happened to them and being able to recall the details.

Although all the interviewees had been through the process, many of them were unaware of the term ‘safeguarding’ and didn’t in fact, realise or understand that they, or their relative, had been safeguarded at all. This made it difficult to draw conclusions from their experience about how personalised the process was. Nevertheless, their accounts provide some useful insight into what they felt worked well, and what didn’t.

Five of the individuals (or their carers), however, were able to give us valuable information about their experience of the safeguarding process and we have produced case studies below.

During the interviews we asked questions that addressed:

- Their understanding of why they were being safeguarded
- Whether the process that followed was explained to them
- Whether conversations took place to discuss what they wanted to happen
- Whether they felt well informed and involved in the process
- And to what extent their desired outcome was achieved.

NB. All names in this report have been changed to protect identities.

Case Study: Silvia and Joan

Silvia experienced issues with coordination, speech and mobility following a stroke. She received assistance from carers with personal care, meal preparation and accessing the community.

Silvia's friend Joan, who has Power of Attorney, told us that the reliability of the care Silvia received had deteriorated, explaining that Silvia was not informed when carers were going to be late or miss a visit. These delays caused Silvia to miss doses of her medication or going without food and drink.

Joan began visiting Silvia to help with these needs, but was unable to care for Silvia alone, particularly with tasks that required Silvia to be lifted. The situation continued to deteriorate, with Joan saying visits were delayed or missed on a weekly basis. Joan said that after a series of incidents in which carers left Silvia's front door, windows and freezer open she resorted to leaving a checklist for the carers to try to prevent poor care.

Joan and Silvia's ex-husband grew increasingly concerned about the risk to Silvia. Silvia's ex-husband raised a safeguarding concern with social services, and a social worker was promptly assigned to the case.

Social services arranged for a different company to take over Silvia's care, and Joan has been impressed with the improved quality of care. Joan and Silvia's ex-husband were therefore pleased with the outcome of Silvia's case, and Joan was pleased with the progress updates social services had supplied them with throughout, including a letter at the end of the case saying the review had been closed.

Joan believed Silvia was still vulnerable living alone in her flat and felt that social services could have helped find a more suitable placement.

Joan continues to search for a place providing on-site care that Silvia could be moved to. Since Silvia will fund her own care, Joan has received limited support with this, apart from an email with some website links from the social worker.

> "They leave it for us to do, but I'm not really any the wiser as to how to go about it."

Key MSP points:

- Silvia's ex-husband, upon discussion with Joan, knew what to do and raised the safeguarding concern with social services.

- Joan felt the concern was taken very seriously and someone was allocated to the case very quickly. A conversation took place with that person and Joan was asked what she would like to happen which was a new care company to be appointed.

- Things happened very quickly and efficiently, and Joan was kept informed by email on a regular basis. She remembers receiving a letter when the case was closed. She is very satisfied with the outcome but is still concerned about her friend's situation.

Case Study: Maria

Maria had Chronic Fatigue Syndrome, mobility issues, Emotionally Unstable Personality Disorder and Psychosis. Maria lived in [sheltered accommodation] where carers supported her with day to day routines such as taking medication, living a healthy lifestyle and other aspects of personal care.

Prior to her involvement with the safeguarding process Maria had experienced personal belongings such as money and her bank card going missing. When she reported these incidents to the care company, she was told she must have lost these items and theft was unlikely.

However, one evening Maria noticed a box of her medication was missing, even though she had seen it in her medication bag earlier that day, before her carer came round. Maria reported this to the care company's manager who again told her she must have lost her medication, and there was no proof of theft. Maria felt she was repeatedly being stolen from, but that no one was taking her concerns seriously.

> "[The manager] was completely adamant that it was me, that I must have mislaid it. Basically, they didn't believe me."

The manager who Maria had reported to asked the carer Maria suspected of stealing the medication to come to Maria's flat and look for the medication. This was concerning because Maria would be alone in her flat with the carer she had accused of stealing from her.

> "The manager should have told the [care company] owner there and then, then cancelled my lunchtime carer who was the one who had stolen the meds. So, you're gonna one, inform her that they know the medication was stolen; two, get her to "help" me find the medication; and three, you're not safeguarding me."

Both the carer and Maria's cleaner looked for the medication, but it was not found. Maria went without her medication for two weeks, and experienced withdrawal symptoms that negatively affected her physical and mental health.

Maria felt increasingly worried about her care and contacted the Care Quality Commission (CQC) to explain her concerns. The CQC informed her that they would raise a safeguarding concern. Social Services, responding to the safeguarding concern, contacted Maria and told her the matter would be investigated when the social worker working on her case came back from holiday.

> "It's a safeguarding issue. Surely you would pass that onto somebody who was on shift?"

The care company was not informed by Social Services that a safeguarding review would be taking place which caused further delays. Maria said it was eight weeks in total before the investigation began. During this time Maria had to interact with the carer in question daily.

The social worker spoke to the care company about Maria's concerns and the care company told the social worker they had made attempts to look for the medication and did not think it had been stolen. The social worker relayed this to Maria's, and no further action was taken. Maria said this felt like another agency who disbelieved her, and her mental health deteriorated.

Following the safeguarding investigation, Maria said the care company staff could be verbally abusive and unsupportive toward her.

> “I should be supported, and I wasn’t."

The safeguarding process continued as social services tried to find another company to takeover her care, but Maria said that she was never contacted about the safeguarding again. She received no apology from the care company, and the disruption to her care routine caused her mental health to reach crisis. (She had been temporarily placed with a care company that social services deemed too expensive, and was therefore in the process of changing company once again). Maria had since been informed that the carer had been dismissed for theft from other clients.

Maria said the experience could have been better if she felt believed by the services safeguarding her, and appropriate action was taken – such as making sure she was not cared for by the staff member who she believed was stealing from her. She felt that it should not have taken eight weeks for her to be spoken to and felt that 7-10 days would have been more reasonable, with a resolution being found within 14 days.

> “What should have happened is it should have been passed to someone who wasn’t going on holiday for several weeks. Erm, it should’ve been, erm, passed over to someone who would then contact me ASAP.”

Key MSP points:

- Maria was aware of safeguarding, but the safeguard was raised by the CQC after she had made a complaint about her carers. She was given a name of someone who would deal with the case, but unfortunately, he was on holiday.

- No contact was made with Maria for several weeks and her situation continued, making her feel increasingly vulnerable and distressed. Maria felt that she wasn’t believed in the first instance and that her concern wasn’t taken seriously, or indeed that she was treated with respect. Maria started to research new care companies herself.

- Maria did not feel in control and received no communication or support from a social worker for 8 weeks. The process made Maria feel disempowered. She would have liked someone to have visited her straight away to assess the risk so that the situation could have been dealt with more promptly.

Case Study: Lily and Veronica

Veronica is in her late 80's and lives on her own. Carers visit every day to assist with housework and personal care, as Veronica has limited mobility.

Veronica told us that she had requested that one of her carers stopped visiting her after causing Veronica pain when tending to her legs. Her daughter, Lily, felt this situation could have been resolved in-house, simply by ensuring the carer treated Veronica more delicately in future. The manager of the care company visited Veronica in an attempt to resolve the situation. However, Veronica said the care manager became aggressive, shouting at her and causing her to feel afraid.

When the care manager left, Veronica phoned her daughter, Lily, who told us:

> "She phoned me after this and was really shaky. She said [the manager] shouted 'everybody hates and dreads coming to this house' and 'you ought to know better.'"

Veronica became increasingly worried about the manager coming round again, and Lily felt the care company was not dealing with the situation. Therefore, Lily decided to phone a care charity for advice, who suggested she reported the situation to the safeguarding team.

Lily described the process of calling the safeguarding team as taking an "emotional toll," as her call was diverted to a number of professionals, each time requiring her to repeat Veronica's situation again. Veronica saw the impact this had on her daughter, telling us:

> "She had to speak to about five or six people, giving them all the details of what terrible things had gone on. She said 'by the time I got to the end of the last one I felt so ill.'"

Lily felt this need for repetition could have been avoided if the system allowed call-handlers to enter notes about her case that could be shared with other call-handlers.

Three weeks later, Lily had not received any updates and so called the safeguarding team again. This time, a social worker was assigned to Veronica's case and investigated the incident. Veronica told the social worker that she did not want the carer, or the care manager, to be able to come into her home again, but Lily was unsure if this had been formally actioned.

Lily told us that she had to contact social services herself if she wanted to be updated on Veronica's care, receiving no updates otherwise. Lily did not know if the safeguarding case had even been closed, or if it was still open, stressing the importance of "closing that feedback loop,":

> "I assume that it's all been taken forward, but obviously I haven't been party to any outcomes or anything. I don't actually know what happens now, if anything."

Overall, Lily and Veronica both felt relieved that Veronica was no longer being visited by the carer or care manager involved in the incident. Lily felt grateful that there was a system in place could intervene in such cases, allowing Veronica to feel protected:

> "I felt it was really positive that there was a number I could call, that I could talk about what had happened, and that there were steps in place to make decisions about whether that had wider repercussions."

Key MSP points:

- Lily was comforted by the fact that she knew about safeguarding and that there were people to talk to about the situation and a process in place to make decisions. Unfortunately she had to ring the number several times as the situation was not deemed to be an emergency, and consequently spoke to different people each time.

- Lily found it hard to repeat her story each time, but felt she was listened to, taken seriously and the desired outcome agreed upon. However, Lily felt 'forgotten about' after three weeks as she had received no further communication from the initial conversation.

- Lily had to chase to be allocated a social worker and was then informed that it was down to the social workers to decide what would happen next.

- Lily feels the actual conversations and interactions she had with the social workers were really positive and helpful, but that it would have been useful to have the occasional update, or at least some expectation management about when she would be likely to hear from them.

- She is reassured that her mother's situation seems to have been resolved but has not received any official confirmation of that.

Case Study: Brenda and Lindsey

Brenda lived alone on a boat in cramped conditions. The boat did not have showering or laundry facilities, and Brenda only had room to sleep upright, in a chair. Brenda's daughter, Lindsey, was concerned about her mother's living environment and the negative impact this had on her health, as Brenda had sustained several injuries and infections from the boat.

When Brenda was admitted to hospital, Lindsey hoped the social care team would prevent her returning to the boat, but this did not happen.

> "I felt that taking her back there was not conducive to her getting better…I feel like the hospital let her down, because it was irresponsible…if she's having to go there and be patched up, surely that tells you something about her situation."

Lindsey contacted the safeguarding team as she continued to be concerned about Brenda's wellbeing, but said they were dismissive. She spoke to another three professionals from social services, explaining Brenda's situation, before deciding she would try to find Brenda accommodation by herself.

The social care team told Lindsey that Brenda did not meet their criteria for support, and recommended social services took over Brenda's care. Lindsey said:

> "There's failings there, because if anyone had seen the situation they would be in agreement [that she needed social care support]."

Lindsey felt there had been missed opportunities that could have prevented Brenda's health and wellbeing from deteriorating. She was frustrated that no one from the various services she had spoken to had come to view Brenda's living environment but felt that if they had Brenda could have been helped much sooner.

> "A lot of it was desk-based. You would explain a situation on the phone when, actually, you need someone to come and see it. So, it was quite a long time between us reporting it and someone coming to see the situation…it's like we weren't taken seriously."

A month after first contacting the safeguarding team, a social worker and occupational therapist agreed to come and assess Brenda and the boat. They concluded that Brenda needed to be moved from the boat as soon as possible, but Lindsey received no further assistance.

> "It wasn't like we said 'She needs to get out,' and they took care of it. It was me and my sister, chasing people."

Lindsey felt that services were unclear on what help they could provide, and who was responsible, which made accessing support complicated:

> "It's confusing, knowing who's in charge of what. If that was clearer then I would have been banging on the right doors, but instead I was banging on *all* the doors… Everybody involved kept passing the buck."

Lindsey arranged for Brenda to be moved into ambulatory care and continued to contact the assigned social worker to update her on the growing urgency of her mother's situation, and the steps Lindsey was taking liaising with the GP and contacting the council about sheltered accommodation.

Brenda was admitted to hospital once more while Lindsey was still trying to arrange alternative accommodation. Lindsey told us the hospital were eager to discharge Brenda and told her that as long as she had a bed to return to, she would be released. Lindsey had a bed delivered to the accommodation, collected Brenda from the hospital and moved her in.

> "They kept phoning me up to come and get her. They were very pushy about getting her out of hospital. If you can bear in mind she's moved from a boat to a flat – she had zero, there was nothing. We had to arrange furniture and they said as long as she had a bed they would discharge her. No fridge, no cooker, just a bed and nothing else."

From when Lindsey first contacted the safeguarding team, to when she moved Brenda into her new accommodation, took four months. Lindsey reflected:

> "It just needs to be different so that people are listened to straight away, and their concerns are dealt with...Nothing was actually being done, it was only because we kept badgering and badgering that anything got done."

Brenda was happy in her new home and her health had improved, but she said that without Lindsey's help she would probably have remained on the boat. Lindsey is pleased that Brenda is happy and safe but feels that if she had been listened to and taken seriously from the beginning, Brenda could have been helped much sooner.

Key MSP points:

- Brenda's daughter was initially unclear about who to contact about her mother's situation. She rang the safeguarding team to ask if they could come and visit, but found them quite dismissive in the first instance. It took a long time to persuade them to come and visit.

- Lindsey felt that the professionals kept passing the buck between different agencies, making her feel that the case wasn't being taken seriously. She felt that the onus was on her to make all the arrangements.

- Lindsey was pleased that her mum is now happy and safe but feels that if she had been listened to and taken seriously from the beginning, Brenda could have been helped much sooner. She expressed concerns about other vulnerable people without a family member to help them. Both would have liked more input from social services.

Case Study: Cheryl and Ethel

Cheryl is the main carer for her mother, Ethel, who has dementia.

Social services had found Ethel an apartment that provided on-site care. Cheryl told care staff there that she wanted to remain a key part of Ethel's care, and feel included in the decisions made.

However, Cheryl found there was often some 'resistance' to the involvement she had in Ethel's care. For example, Ethel often benefitted from paracetamol if she had a cold or an injury. Cheryl was informed she was only allowed to give Ethel paracetamol if it had been prescribed by a doctor. Therefore, Cheryl arranged a GP to visit Ethel and he agreed to prescribe paracetamol as required.

> "I specified 'Please would you write on the prescription 'as required?'' The first time, he didn't do that so I wrote on it 'as required,' and then I got pulled in front of the care manager who said 'You must not do this.' So I then had to go back to the chemist to ask 'Please can you write on here 'as required?'"

Cheryl also told us Ethel would always decline the paracetamol, even when it was needed.

> "You can't ask her if she wants paracetamol because she will always say no. If you give her a reason, she will remember the reason and respond to it. She's not stupid, she's just got dementia."

Cheryl told us she later discovered that Ethel was being offered paracetamol four times a day, every day, even when she was not in pain, or didn't have a cold.

> "I spoke to the manager and said 'Please don't offer it to her, because she doesn't need it."

Cheryl was also concerned about the likelihood of Ethel choking on paracetamol, as she had difficult swallowing tablets. Cheryl asked staff if they could cut the paracetamol in half to make them easier for Ethel to swallow but was told that by law they could not tamper with the integrity of the tablets.

Cheryl received an email from Ethel's social worker saying that the care manager had raised a safeguarding concern about Cheryl's attitude toward the paracetamol. She said she could not comprehend how she could be perceived as being a risk to her mother's safety, especially as staff had never spoken to her about this.

The safeguarding investigation was resolved by prescribing Ethel liquid paracetamol to eliminate any risk of her choking, which Cheryl is satisfied with, but would have preferred if the member of staff who raised the safeguarding concern had spoken to Cheryl to ascertain the concern was valid.

> "If you know that somebody is there frequently because they care for their relative, then they shouldn't be regarded with suspicion."

Key MSP points:

- Cheryl didn't understand why what she had done or said would have been cause for a safeguarding concern and thought it was unnecessary.

- But both Cheryl and her mother had a very good relationship with the social workers who they found very supportive and helpful in working towards their desired outcome.

- The social workers kept Cheryl informed on a regular basis and the desired outcome, a change in her mother's medication regime, was achieved quite quickly.

- Cheryl however, does feel that if the care home had listened to her concerns and suggestions from the start, the safeguarding could have been avoided.

Key Themes

Many of the key themes emerging from our last MSP report were also evident in this round of engagement. We were able to use information from the experiences of all the participants and these have been summarised under the following headings:

1. Awareness and understanding of Safeguarding

From our conversations with all the participants interviewed, we discovered that half of them had little or no understanding of the term 'safeguarding' and consequently had no awareness of the systems and people in place to protect them.

Several didn't realise that a safeguard had been raised and one didn't know anything about it until they received the letter inviting them to take part in this project.

None of the participants can recall being given any information about 'safeguarding' or the process that would follow.

Of those who understood that they had gone through a safeguarding review, or had raised the concern themselves, only some were allocated a named professional straight away, or given the contact details of someone.

2. Trust in professionals and the system

Again, what came across strongly during this round of interviews, was the length of time it took for professionals to respond, who would be responsible for what and whether any action would be taken at all.

A couple of interviewees reported that they didn't feel in control of their situation and this caused them a lot of stress and distrust. One interviewee was left in a vulnerable situation for 8 weeks before any action was taken, which left them feeling disempowered and deflated.

However, several interviewees commented on how helpful and friendly their social workers had been and how they had 'gone the extra mile' and that they felt that the services had worked in their best interest.

> 'I am incredibly grateful for their support because sometimes I think it's gone over above and beyond'

Feeling as if they are being listened to and believed is a very important component of the whole safeguarding experience.

> 'Instead of working with her to understand the outcomes she wanted, the social worker made her cry.'

Unfortunately, some participants didn't feel confident that progress was being made and still felt that they had to do a lot of the chasing and contacting other agencies, themselves.

3. Working in partnership

Many of the participants again felt that there was a lack of partnership working between agencies. Some felt that services, such as hospitals, social services and care companies, could work more effectively together and share information between each other in a more timely manner.

> 'I just feel like each group of people were meant to be there to help. The left hand doesn't know what the right hand is doing. They're not in contact with each other'.

One participant felt that there was a lot of 'passing the buck' and no one taking overall responsibility for the concern.

4. Communication and feedback

Everyone we spoke to emphasised the importance of being kept in the loop about the progress of a safeguarding case – as often this was a very worrying and stressful time for them.

Although many interviewees reported that they hadn't heard back from their social worker or had received no follow-up, some received regular phone calls and updates about their case which made them feel reassured.

> 'They check – it's lovely'

One interviewee described having to repeat her story every time she spoke to a different member of the safeguarding team. There appeared to be no sharing of information internally.

> 'I know some of its system limited and some of it may be data protection but I would have expected there to at least have been a note on the system that I had called before. That was one thing that really struck me.'

> 'It just takes an emotional toll each time you have to re-explain it. Also each time you re-explain it, it might get embellished.'

Some were left feeling that they had to constantly chase for an update once a safeguarding concern was raised and many felt there was an unnecessary length of time before they heard back from anyone.

> 'Yeah we had to call her a lot. I mean she did on occasion keep us in the loop but not really, a lot of it was us getting off our own backs and doing bits and pieces.'

Many felt that they hadn't been given enough information about the process they were going through and that it would have been useful to be provided with some sort of document explaining the safeguarding process, and who to contact when they had a question.

Others thought that it would be beneficial to use the initial conversation to manage expectations, have a timeline of dates to work towards and for individuals to receive official notification of when a safeguard has been lifted or the case closed.

> 'It would have been nice if possible if there had just been an occasional update or at least some expectation management or just something like that just to reassure.'

5. Needing the help of a relative or friend

During the phase two interviews, we also discovered that participants were concerned about what would have happened if they hadn't been there to make contact, or chase for updates. They were unsure if, without their input, any action would have taken place or the situation resolved.

> 'I feel like we're quite fortunate and it scares me to think that other people in similar situations who didn't have family would stay like that you know.'

One interviewee felt she was completely on her own and didn't feel confident communicating with services due to fear of not being taken seriously.

> 'They don't take notice of you. Our age group, we need someone to speak for us.'

6. Speaking up to create a positive change for others

Some interviewees felt it important to voice their opinions to influence positive change.

> 'I thought I was being constructive, not just for her benefit but for other people'.

It was also considered important for people who had gone through the process to be given an opportunity to be able to evaluate the service or at least give their opinion on how well they thought it had gone and how satisfied they were with the outcome.

Conclusion

Many safeguarding cases are a negative experience for the individual as they are vulnerable, at risk and it is often the last resort to try and improve their situation. In many cases, the individual has experienced significant distress and problems before they get to this stage.

Unfortunately, some of the individuals were not able to recall details about their safeguarding review, but what they did tend to remember is how friendly and helpful a professional has been and whether things were dealt with in a timely fashion.

In line with our first report, what came across from the interviews was that information is paramount. Individuals who are going through the safeguarding process need to understand the process and to know who to contact about their case. People feel more in control when they are kept informed, know what is happening, and when. Similarly, people feel more empowered when they have information about what the options are and the implications of these, so that they are able to make informed decisions.

All of the participants we interviewed valued the following:

- Being listened to and taken seriously
- Being informed about what was happening and kept in the loop
- Being contacted in a timely fashion
- Reassurance that action would be taken

Whilst this report is only based on the experiences of a few individuals, and is by no means conclusive, we hope it goes some way in helping to test Essex's approach to 'Making Safeguarding Personal'. It would be a useful exercise to compare the information we have captured on each case, to the information held by ESAB.

Recommendations

Reflecting on the findings of this report, and the original 555 Making Safeguarding Personal report, we offer the following recommendations:

Raising awareness of 'Safeguarding'

- A multi-agency approach to a campaign around 'what is safeguarding'.
- Information that is clear and accessible for the public and a wide range of vulnerable groups.

Improving joint working

- A committed long-term engagement of 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 in planning and shaping safeguarding services.

Review of communication with service users

- Developing a standardised way of communicating with service users about their safeguarding review and outcomes, including information on the process, contact details and a 'timeline' to help manage expectations.

Evaluation of the process

- Build in an opportunity for the individual to review their experience of the process and whether their desired outcome was achieved. This would best be conducted by an independent organisation, soon after the case has been closed.