TIME TO SEW-UP THE HOLES IN THIS SAFETY NET

A report on safeguarding in West Sussex October 2016

Healthwatch West Sussex has produced this report presenting how the principles of the Care Act are being realised for individuals in West Sussex, specifically looking at whether person-centred approaches are being applied in safeguarding as set out in the Care Act 2014 and the level of participation of those who find themselves at the centre of a concern.

To inform this report, we worked with Independent Lives who facilitated conversations capturing the experiences of local people living in West Sussex who shared their own safeguarding journeys. We are grateful to the individuals who entrusted us with their experiences.

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It's fundamental to high-quality health and social care. (Care Quality Commission, April 2016)

My family has tried to find the positives all the way through.

We have met some very caring people along the way, and will be eternally grateful that dad had a wonderful, happy, worry free life; he had never been in hospital before and didn't need any medication.

However, there will always be that question of why someone of his generation, who served our country in the war, had his life ended in such an undignified way.

Independent lives

healthwatch West Sussex

Acknowledgement
Healthwatch West Sussex and Independent Lives would like to thank everyone who has contributed to this work and, in particular, the people who have entrusted us with their personal stories.

Executive summary

As a result of the independent discussions we had with people who have experienced the safeguarding process Healthwatch West Sussex makes the following recommendations to help statutory and other investigating bodies to make the safeguarding process better and more personal for the people at risk and their families.

Recommendations

- Professionals involved in a safeguarding enquiry should have a short biography of the person concerned, to help them humanise the process, to enable them to obtain and retain a sense of who the person was or is. Where a person offers a photo of the adult at the centre of the concern, this should be included as a visual prompt. This section of the safeguarding enquiry should include the person's desired outcome(s) and wishes.
- The safeguarding process should include time for Enquiry Officers or Managers to explain the process and procedures and what people can expect, which should be backed-up with a simple information leaflet explaining how people can choose to be involved (including an easy read version.)
- Enquiry Officers or Managers should be given/or make time to check their written communications to make sure peoples' names are right, and to have time to read casefiles, so they are able to give assurances to people that their story is known and understood, and that the enquiry conclusions are robust.
- West Sussex County Council to ensure that systems are in place to monitor that Making Safeguarding Personal (MSP) forms an integral part of the enquiry process (enquiries under section 42 of the Care Act), and forms part of the Council's annual safeguarding reporting process.
- All future Safeguarding Adult Board audits should start with a review of how the process has put the person at the centre of the enquiry by asking:
  - how the person's wishes were obtained and considered throughout the process
  - how the process sought to offer access to people being involved
  - how the person was communicated with and the quality of this communication.

Introduction

The introduction of the Care Act in May 2014 fundamentally changed the approach to adult safeguarding. It sets out that safeguarding actions need to have a personalised approach, with the emphasis on wellbeing, empowerment and putting the individual at the centre of the safeguarding process.

In West Sussex, safeguarding enquiries are audited and reviews of safeguarding processes are carried out by West Sussex Safeguarding Adults Board. The views of people who are at risk form only a small part of these processes and there is no specific process in place to examine or respond to the individual experiences of the people involved and their families.

Since the launch of 'What good looks like', West Sussex Safeguarding Adults Board's campaign to raise public awareness of 'what good looks like' in terms of safeguarding, in 2014, there has been a great increase in people coming forward with safeguarding concerns.

As the local consumer champion, Healthwatch West Sussex is well placed to capture and report on experiences of local people and their safeguarding journeys. This report looks at a small sample of people who have experience of the safeguarding process.

Making safeguarding personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

(14.15 p. 233 Care Act Guidance 2014)

We have also worked with Independent Lives, the user-led disability organisation which has day to day contact with a wide range of people with care needs, to facilitate detailed, one to one conversations with a number of people who have direct, lived experience of safeguarding situations to explore their views and feelings about how the processes can be made to work better for them.

By doing so, we can contribute to the process development and delivery of work undertaken by the West Sussex Safeguarding Adult Board, with the ultimate aim of supporting organisations and Enquiry Officers involved in safeguarding alerts and investigations to engage with people in a person-centred, outcomes-focused way.

This report tells the stories of how the safeguarding processes in West Sussex have been experienced by eight local people or their families.

Is this about me?

When sharing their stories, whether as individuals or family members, most people that we talked with started with a personal history, explaining who they are and their backgrounds. Some chose to share a photo of the individual.

During our conversations, examples of names being misspelled were provided and there was a clear shared sentiment that this simple oversight can be frustrating but also interpreted as a lack of caring or interest.

None of the people who shared their experiences could recall being asked what they wanted from the safeguarding process. They also did not feel involved in and remained unaware of the outcome of the enquiry. But when asked, people were able to say what they wanted to gain from the safeguarding process. Most wanted to ensure that what happened to them or to their relative could never happen again or happen to someone else. As desired outcomes and wishes may change through the process, especially when people feel unheard or ill informed, we recommend that the outcomes are identified and discussed at the beginning of the process.

Recommendation

Professionals involved in a safeguarding enquiry should have a short biography of the person concerned, to help them humanise the process, to enable them to obtain and retain a sense of who the person was or is. Where a person offers a photo of the adult at risk, or at the centre of the concern, this should be included as a visual prompt. This section of the safeguarding enquiry should include the person's desired outcome(s) and wishes.

The personal accounts also suggested that an individual's previous experiences of care and support planning influenced their expectations and determined their overall feelings about the safeguarding process.

> **Hindsight is cruel because just going over the story again I find myself wishing I'd done certain things, made objections, put my foot down, but we felt we were in a 'bubble' and we put all our trust in those we thought were professionals.**

People described their feelings about the safeguarding process as:

made to feel guilty

no-choice

passed on

A number

misinformed

Pressurised

Humiliated

> **No way were my wishes considered.**

Many people had little or no previous understanding or experience of the care system, and felt disempowered by the complexities within the system.

> **We never knew who or where to talk to, with so much time spent 'on hold', answerphones or waiting for phones to be answered, we had to email on many occasions just to try and provoke a response from someone, anyone.**

Am I involved?

In order to realise the aspiration of '*safeguarding is everyone's business*' people need to have confidence in the safeguarding process. This can only come from people feeling they are a respected and involved part of the process and understanding how it is progressing.

> **They (social services) want you to report incidents but then they do nothing with it. They are really poor communicators.**

People talked about the barriers they encountered in the enquiry process. For example: being told they could not attend the local authority's initial meeting because of '*data protection*' but then later receiving information that contradicted this. In answer to a question of whether the person attended the safeguarding review when it took place, they answered "*I would have done had I known there had been one!*"

Other people felt their comments were ignored and excluded during the process, but others appreciated that safeguarding officers were pleasant and nice to deal with.

One participant was less concerned about their lack of involvement as the end result was what they felt was needed, and she "*has chosen to not dwell on it*".

> **I don't think social services kept us informed enough but did deal with us nicely. I was given a brief overview in writing which contained inaccurate information… There has still been no outcome since... They have sent two letters to say they haven't been able to contact me which isn't true.**
>
> (This account is from someone who is visually impaired, with a known preference for telephone communication)

The use of jargon and abbreviations is unintentionally excluding people who are not familiar with language used in health and social care. We observed examples of this in reports sent to individuals that detailed the outcome of the safeguarding process.

Not understanding abbreviations or terminology can lead to assumptions and create unnecessary concern about what has happened.

> **There is a lot of jargon used that doesn't necessarily make sense**

We heard from two people with learning disabilities, who shared their feelings that there were too many people involved in the process and that there wasn't enough time set aside for them to help them to understand the process and overall timeframes.

Recommendation

The safeguarding process should include time for Enquiry Officers or Managers to explain the process and procedures and what people can expect, which should be backed-up with a simple information leaflet explaining how people can choose to be involved (including an easy read version.)

Are you communicating with me?

All of those we spoke with felt there had been a lack of communication and a lack of information as a result. One individual said that "*If they had actually got back to me when they said they would and if they had got back to me at all the situation would be different.*"

The personal accounts portray a very real sense of people lacking confidence in the existing protection system and, in some cases, a lack of information having a considerable impact on the quality of the individuals' lives. Some shared that they were left with a feeling of mistrust and others felt '*insulted*' by the way professionals had communicated with them.

Recommendation

Enquiry Officers or Managers should be given/or make time to check their written communications to make sure peoples' names are right, and to have time to read casefiles, so they are able to give assurances to people that their story is known and understood, and that the enquiry conclusions are robust.

Some of these feelings can be attributed to a lack of understanding of the individual and, in other cases, to poor attention to detail from the local authority. For example, in a letter received by one of the families, a conclusion drawn by the person leading the safeguarding enquiry was based on something the person was physically unable to achieve. This did not inspire confidence in the system or the processes.

Two people stated that, in their view, there was only a reaction from the Enquiry team once there had been a prompt from a Member of Parliament or another advocate acting on behalf of the person. When an advocate was involved there was a still a lack of response for one person: "*the advocate sent a letter to the council* [over eight months ago] *requesting data on the bullying but nothing has happened.*"

> ***I asked for my case notes and I have not been given them, they may have lost them apparently.***
>
> ***There has been no letter, or phone calls from social services to let us (the person and their advocate) know what has happened.***

Jasmine* explained how delays in information sharing between different agencies involved in her care have meant she still feels vulnerable as other organisations cannot progress with an action plan for removing her from the situation she is in. She told us that the process had made her feel more afraid, as she is worried about the repercussions and outcomes from the enquiry.

Everyone has empathy towards someone who has recently lost a relative and can recognise that this would become more distressing where there is a reason, or reasons, to suspect abuse or neglect. But the systems have led to a feeling of depersonalisation with a failure to reflect empathy.

Mary* told us how the receipt of an invoice from the council, addressed to her father - who the council knew had passed away a month earlier and was known to be subject to a safeguarding enquiry - had left her and her family '*fuming*'.

Mary felt upset that the council had considered charging a small amount for the care which was under investigation. Her distress was compounded when she sought to raise this issue and she was given numerous different local authority department numbers to call. On calling, she experienced being cut-off, only getting through to an answerphone message, and also being told there was no one in the office who could deal with the matter.

Mary resorted to emailing the council asking for an explanation of the invoice and also for some feedback on the safeguarding enquiry. "*Two weeks later I had still not received a reply, so emailed again, this time to the complaints team.*"

Mary received a reply from the complaints team within 24 hours of her email giving assurance that her concerns had been passed to the relevant department.

The complaints team also stated she would not be informed about the enquiry whilst it was ongoing, as all details were confidential. She was given a copy of the letter that the finance team had said was sent but which had not been received. Mary shared that she had found the letter to be "*condescending, explain[ing] breakdown of costs but not apologising for the insensitivity of it.*"

Mary pointed out she was not questioning the charge but asking for the payment to be at least deferred until the outcome of the safeguarding enquiry. This suggestion was later accepted.

Mary has been waiting over six months since the safeguarding enquiry was launched and has yet to hear the outcome, having not received anything in writing to either acknowledge the complaint or about the investigation, the procedure, or what to expect.

Are safeguarding officers applying the insight safeguarding enquiries can provide?

Throughout the process of gathering evidence for this report, people have shared insights that could support other people, families and services to identify risks and potential concerns. As this work did not look at the way in which professionals evaluate enquiries, it is unknown if such opportunities are used or go unused.

> **We seemed to be constantly airing our concerns and amazingly still believed the manager and nurse when they assured us he would be fine.**

The personal accounts shared in this report offer a rich insight into a relative's experience, from which there is much to be gained:

- If you visit and see someone at different times of the day this may alert you to any issues with their wellbeing sooner.

- Loose fitting dentures, food in the mouth, untouched/cold tea or drinks out of reach, and staff not being able to tell you when the person last had food or a drink, should not be ignored.

- Not knowing your rights or what you are responsible for - "*only leaflets supplied related to financial side, with people often wanting to talk about finance*" - one person described this as creating a "*terrifying nightmare*".

In conclusion

From these eight accounts we have not been able to identify a personalised safeguarding system that involves and communicates effectively with adults at risk and their families.

The eight accounts were unable to identify how the current safeguarding system added value for these eight individuals and/or their families.

At a basic but fundamental level, a lack of attention to detail has caused distress and a sense of not being important or taken seriously.

It's time to sew-up the holes in this safety net!

Recommendation

West Sussex County Council to ensure that systems are in place to monitor that Making Safeguarding Personal (MSP) forms an integral part of the enquiry process (enquiries under section 42 of the Care Act), and forms part of the Councils annual safeguarding reporting process.

Recommendation

All future Safeguarding Adult Board audits should start with a review of how the process has put the person at the centre of the enquiry by showing:

- how the person's wishes were obtained and considered throughout the process
- how the process sought to offer access to people being involved
- how the person was communicated with and the quality of this communication.

Methodology

*As this work reflects and focuses on the experience of local people, we have used alternative names, so we can keep a sense of personal perspectives throughout. Great care has been taken to make sure any identifiable information has made removed.

As part of this assurance work, a draft of this document was shared with the staff who carried out the one to one interviews, our quality assurance team and Board. As a final assurance before publication we sought assurance through West Sussex County Council's quality team and a draft copy was received by the Chair and Business Manager of the Safeguarding Adults Board.

The preparation for this work has been evaluated through a research governance process carried out by West Sussex County Council.

This work has been designed and conducted by Healthwatch West Sussex working in partnership with Independent Lives, with the aim of broadening the range of people represented and involved in the report. Independent Lives was able to provide direct support to people during and after their interviews, and facilitated these discussions.

The question guide used was discussed and agreed with participating organisations with input from the local authority's Head of Adult Social Care and Principal Social Worker.

Interviewers received training and support throughout and full written consent was received from the people involved.

In writing this, we have sought to identify the common features of peoples' experiences and the interviewers have been asked to reflect upon what people shared with them, and to note any questions or thoughts arising from what was said.

Statement from the Independent Chair of West Sussex Safeguarding Adults Board

A major theme in Making Safeguarding Personal (MSP) has always been to ensure that the person's voice is heard, and as such I welcome this report from Healthwatch West Sussex (forwarded to me on the 21st October).

Firstly I am sorry to hear that the safeguarding process caused distress, and a sense of not being important or taken seriously, for the eight individuals and/or their families outlined in the report; this is not acceptable and shows we need to improve safeguarding practice.

As I indicated in the introduction to the West Sussex Safeguarding Adult Board's Annual report in September, the demands over the past two years in implementing the broad requirements of the Care Act 2014, competing work pressures, and the challenges of extending the profile of personalisation across a range of differing organisations, has meant that there is still much to do in embedding MSP across the wider range of partner agencies which now comprise the Safeguarding Adults Board.

That said there has and continues to be good progress, with Healthwatch West Sussex providing a very active voice at the Safeguarding Adults Board on behalf of people needing support and advice, we have reviewed our safeguarding policies and procedures to take account of Making Safeguarding Personal requirements, and have established a sub group of the board to provide focused local user engagement, and I am pleased to announce that the board will be undertaking an audit of Making Safeguarding Personal in November 2016, and this will be published in due course.

I will ensure that this report is presented to our next board meeting in December, and will advise you in writing of the outcome of this discussion.

I am confident that if we work together we can ensure that the person s voice is heard, and that we are placing the individual at the centre of the safeguarding process.

David Cooper
Independent Chair of West Sussex Safeguarding Adults Board

25th October 2016