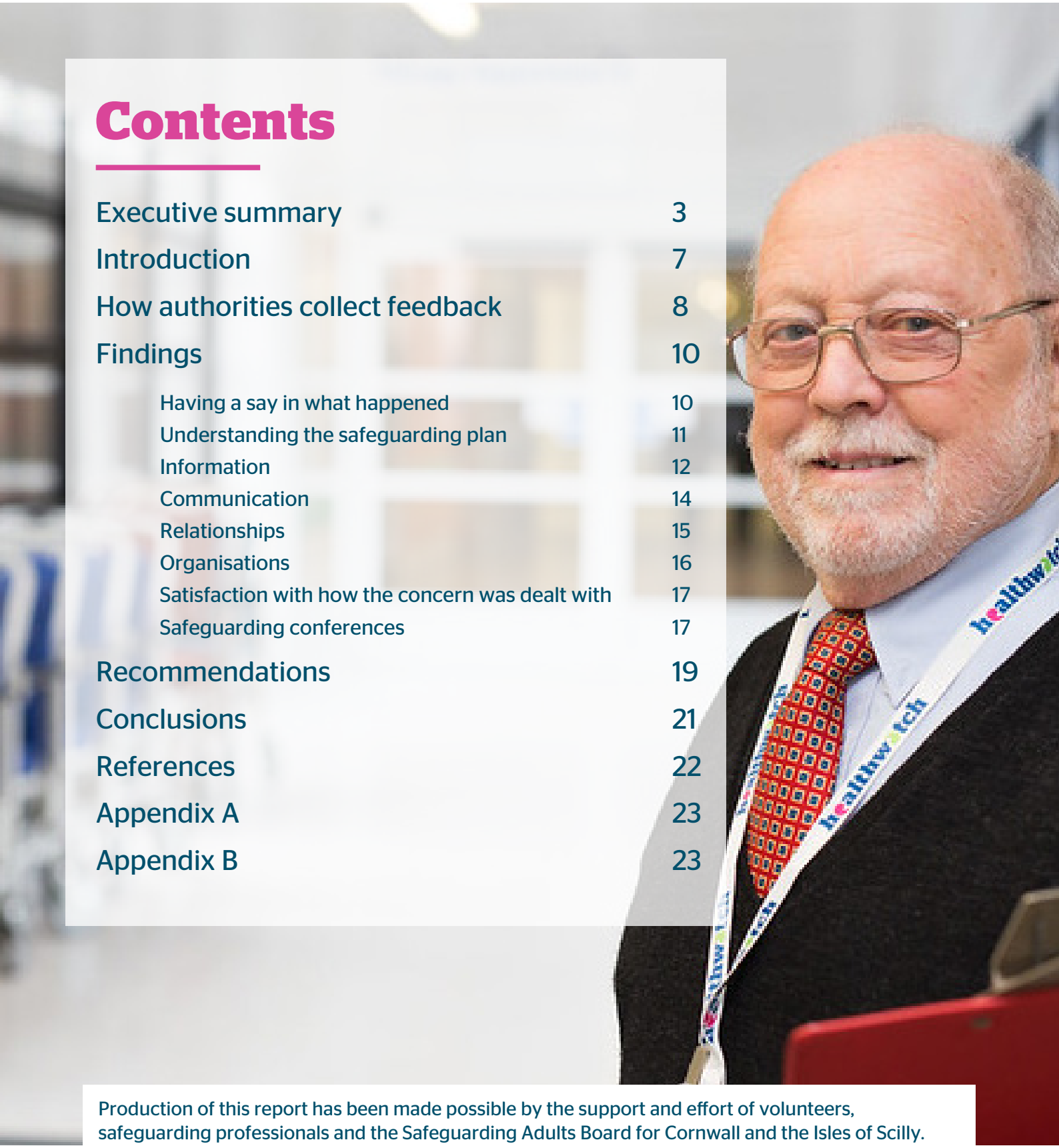
healthwatch Cornwall

People's experiences of adult safeguarding services

A review of services in Cornwall and the UK.

Cornwall and the Isles of Scilly Safeguarding Adults Board

Contents



Production of this report has been made possible by the support and effort of volunteers, safeguarding professionals and the Safeguarding Adults Board for Cornwall and the Isles of Scilly. We would like to thank the service users who were members of the focus group which shaped this research. Their sound advice and opinions informed the research design, ensuring that the right questions were asked in the right way. We would also like to thank everyone who gave their time to participate in the research. Through sharing their experiences, they have enabled us to gain deep insights into the services and their accounts will be instrumental to evidence-based decision making on safeguarding services.

Executive summary

Adult safeguarding services across the UK are undergoing transformation. Over the past 10 years, there has been increasing momentum to place service users firmly at the heart of safeguarding enquiries. The launch of the Making Safeguarding Personal (MSP) Initiative in 2009 proposed a person-led, outcomes focused approach to safeguarding.

Further supported by amendments to the Care Act 2014 which support use of a person-centred approach, there is extensive work being undertaken by authorities to embed this approach. Developing these new methods of practice requires significant service and cultural change. In order to facilitate this service change, the Safeguarding Adults Board (SAB) for Cornwall and the Isles of Scilly has commissioned Healthwatch Cornwall, to undertake research on people's experiences of adult safeguarding services.

This final report fully analyses findings from interviews with 29 service users and the two prior reports that have been published: "Experiences of Adult Safeguarding Services Interim report" and "Peoples' experiences of safeguarding A review of UK findings and recommendations". Understood together, findings from these reports provide an in-depth understanding of services in Cornwall and comprehensive recommendations based on the findings.

The extensive work that has been undertaken by authorities across the UK provides insights into the diverse ways in which MSP can be embedded. We present these insights alongside the rich accounts of services in Cornwall that service users have provided. Together, these findings allow us to understand current experiences of safeguarding services in Cornwall and reflect on opportunities for improvement.

In summary, key findings from this report include:

1. Challenges to attaining people's feedback on their experience of safeguarding are common, in Cornwall and across the UK. This is attributed to the sensitive and often distressing nature of safeguarding enquiries, as well as a significant rise in domestic abuse cases where it may be unsafe to invite people to share feedback.
2. The method of obtaining feedback can significantly affect the quantity and depth of feedback provided. Qualitative methods (semi-structured interviews) allow people to tell their unique stories and results in rich meaningful insights into their unique experiences of the services.
3. Informing people that they are being safeguarded and facilitating their involvement in the case is crucial to delivery of a person-centred approach. In Cornwall just over half of the people interviewed felt they had a say in what happened.
4. Facilitating a good understanding of what safeguarding is and how it can support them allows people to engage with their case and achieve outcomes they are satisfied with. Where people have challenges with their memory or comprehension, they appreciate additional support to understand and engage with their plan.

5. Having the right information on safeguarding at the right time allows people to understand and engage with their case. There is significant good practice in Cornwall. However, there is inconsistency in the type and timeliness of information that people are provided with. For some, insufficient information on their case can be distressing.
6. Good communication between safeguarding professionals and service users is a cornerstone of a good experience of the service. Regular communication and provision of feedback on case progression is highly valued by service users. Influencing many other aspects of how the service is experienced, achieving effective communication with service users is of paramount importance to delivering a person-centred approach.
7. The relationships that people hold with safeguarding professionals exerts a significant influence over how satisfied they are with the service. Furthermore, the quality of these relationships can affect their level of engagement, understanding of the plan and satisfaction with the outcomes.
8. Advocates and the police play an important role in many people's experience of safeguarding. When involved at the wish of the individual, they can support people to achieve their desired goals. In Cornwall there is inconsistency in the circumstances when people are advised they can access these services.
9. There is a high level of variability in how safeguarding services are experienced. This is attributed to variation in service quality, including the quality of relationships that people hold with safeguarding professionals, the information that they are provided with and the extent to which their wishes are taken into consideration.
10. Safeguarding conferences can be distressing for service users who attend them, particularly where they are not consulted on how these are carried out. Where people are given choice on how they are undertaken (e.g. face-to-face, via Zoom or phone) they express increased satisfaction with the conference.

On the basis of these findings it is recommended that:

1. It becomes standardised practice that all service users are informed that a safeguarding enquiry is being undertaken and that they are asked what their wishes are relating to the enquiry.
2. A set of criteria is produced to objectively determine the instances where it is not safe or practicable to inform or engage people in their case.
3. A service user group is formed to assist in development of resources and practices for adult safeguarding.
4. A standardised set of information is developed, to be provided to service users, including details on:
    a. Information about what safeguarding is
    b. The reason for a concern being raised
    c. The objectives of an enquiry
    d. Value of safeguarding
    e. Safeguarding powers
    f. Typical process of safeguarding enquiries
    g. The individual's rights, including the right to request an advocate or involvement of other agencies
    h. Relevant named contacts, job titles and contact details of the safeguarding professional supporting them
    i. An end of enquiry record that includes information on the outcomes
5. A guide is produced for all safeguarding professionals, which documents how the Making Safeguarding Personal approach should be applied in practice.
6. A named safeguarding professional is appointed to each case, to act as the main point of contact and key person who supports the service user through their concern.
7. Service users are asked their preferences for how safeguarding conferences are undertaken, to include location, method of delivery (e.g. face-to-face, via telephone or Zoom) and the people who are present.
8. A minimum level of contact between safeguarding professionals and service users is agreed. E.g. all service users will be offered a meeting at the beginning and end of their enquiry, with minimum once monthly meetings in between.
9. A set of eligibility criteria is developed to determine when people meet the threshold for advocacy support. All service users should be assessed against this eligibility criteria and offered the support where the criteria are met.
10. A library of support service contacts is developed, which service users can be referred to in instances where their support needs (e.g. befriending or advocacy) extends beyond the scope of the safeguarding professional's role.
11. Professional awareness is developed on the importance of relationships and rapport to delivering person-centred services with outcomes that people are satisfied with.
12. Obtaining feedback from service users in the future is undertaken at regular intervals, with a minimum of every 6 months. Feedback is attained by a person or organisation unconnected to their case, to support objectivity and likelihood of honest feedback.
13. There is application of ethical criteria to determine when it is safe to invite people to share feedback (see Appendix A).

Introduction

Across the UK the Making Safeguarding Personal (MSP) initiative is transforming the way that safeguarding services are delivered.

Launched in 2009 the MSP framework now represents the gold standard, against which current adult safeguarding service quality is judged. Adult safeguarding, or the statutory process whereby people and organisations work together to reduce the risk of harm to adults experiencing abuse and neglect, has faced a steep rise in referrals over the past year (Samuel, 2020). It is therefore of immediate importance that we understand how these services are experienced, in order to best meet the needs of the people which safeguarding supports.

The central proposition of MSP is that safeguarding services should place the service user at the heart of its approach. In practice this includes ensuring that the wellbeing of service users, their wishes and needs, are central to the enquiry. This is given weight by the Care Act 2014 which encourages services to adopt a person-centred approach to safeguarding adults. In summary, the Care Act presents six principles by which safeguarding services should be delivered, these being:

1. Empowerment
2. Protection
3. Prevention
4. Proportionality
5. Partnership
6. Accountability

In practice, provision of these principles at the front line is intended to deliver a greater sense of control and satisfaction in service users.

Despite the statutory and advisory framework for delivering safeguarding services using this person-centred model, there remains significant variability in the way in which services are delivered across the UK.

Making Safeguarding Personal is a key strategic priority for Cornwall and the Isles of Scilly's adult safeguarding services. Seeking to embed recommendations for best practice approaches in their service model, the Safeguarding Adults Board (SAB) has commissioned Healthwatch Cornwall to undertake research into people's experiences of the services.

This report presents the culmination of findings from in-depth interviews into people's experiences of the services in Cornwall and broader findings into experiences of safeguarding services from across the UK.

Over the course of a year, 29 service users have been interviewed in Cornwall, providing a deep insight into how services are experienced and the impact they have had on people's lives. These findings are presented in context alongside people's experiences of safeguarding services across 15 of Cornwall's 'nearest neighbour' authorities, which share similar socio-economic characteristics as defined by the Chartered Institute of Public Finance and Accounting (CIPFA). Understanding UK wide findings allows us to make sense of experiences in Cornwall in a broader context, as well as enabling us to draw insights from the actions others have taken to improve services.

It is therefore the aim of this report to assist agencies on decision making related to safeguarding service delivery. We seek to achieve this by drawing out and presenting findings from the totality of this research with practical recommendations made for service development.

How authorities collect feedback

Recent updates to the Care Act (June 2020) recommend that authorities seek feedback from service users. The intention of this update is to enable improved understanding of service provision and evidence-based decision making.

It was important to the authenticity of the project that a person-centred approach was embedded in its design. It was for this reason that a focus group comprising of service users, including parents and carers, was formed. This group co-designed the research questions (see Appendix A) and approach. Held over three sessions, the group considered what comprised a good experience of safeguarding. Good information, relationships with safeguarding professionals and effective communication were just some of the issues they identified. The group further reflected on the MSP Framework, which recommends key indicators by which experiences of safeguarding can be measured. There were many parallels between what service users and the MSP Framework perceive as indicators of a 'good' person centred safeguarding experience. The group also considered the importance of phrasing of questions in relatable language. Each question was considered and refined to produce questions that were meaningful and understandable.

Following development of the research questions a pilot project was launched to test the proposed method of inviting people to feedback and the research design. This process was invaluable to test the proposed method and allowed us to refine the approach prior to its full launch.

The key lesson learned from the pilot project was that gaining referrals for participation was dependent upon having a dedicated person from the safeguarding service, who's role it is to review closed cases via the database (Mosaic) and assess their suitability to participate. The person holding this role also applied a random sampling technique to select participants (every 6th person), to eliminate unconscious bias and selection of favourable participants. Furthermore, the safeguarding professional applied ethical criteria (see Appendix B) to determine where it was safe to invite the person to participate. Application of this process protected the service user's anonymity. In addition, this method benefited from the professional safeguarding expertise of the individual who could accurately apply the ethical criteria. The professional then called the people identified as potential participants and invited them to participate. The professional used a script to standardise the invitation process and gained verbal consent from them that they agreed to participate and be contacted by Healthwatch.

To support delivery of the project, a member of the focus group was trained in delivering interviews. This was a great asset to the project, as they held unique insights and skills that improved the way we engaged with service users.

The project began pre-Covid and in this early phase the research approach design included offering face-to-face interviews. However, with the introduction of social distancing there was a shift to telephone interviews which many people welcomed. With the volunteers' assistance 29 participants were interviewed by telephone, an approach which service users were willing to adopt and offered the additional benefit of flexibility in timing.

There was, however, a limitation of telephone interviews which must be noted. Sharing experiences of safeguarding are very personal and can be emotionally distressing for service users. Telephone interviews limit the

opportunity for building the trust and rapport that is conducive to provision of in-depth responses. As such, there is a requirement for telephone interviewers to build a rapid rapport with the service user and attention must be given to ensuring users feel comfortable and that know that they can stop the interview at any time if they wish.

By adopting the qualitative approach developed with the focus group (see Appendix A), in which service users were asked open-ended questions, rich, in-depth information was elicited. The particular benefit of this approach was that open-ended questions allow service users to provide responses and insights into their experiences that could not have been captured or predicted using a closed-question approach.

Application of this method and testing it in practice demonstrated the significance of the person making initial contact with service users, to the likelihood of service users agreeing to participate. An objective professional, unconnected to their case ensures that service users do not feel unconsciously pressured to participate or provide favourable feedback on the services.

Following application of this process the final numbers of participation in the Cornwall research was 29 service users.

Where people were invited via telephone to participate, there was a high acceptance rate of 97%, compared to rates between 9%-70% in other areas of the country. This high acceptance rate can be attributed to the high skill levels of the individual who made initial contact with service users, who applied a personable approach coupled with extensive experience working in safeguarding. A script was produced to ensure consistency in the way in which people were invited to participate. The final number of people interviewed allows us to elicit distinct themes in people's experiences of the services.

Across the UK there are typically low participation rates in feedback studies (MSP final report, 2018). This is attributed to multiple factors including the often distressing and emotionally sensitive reasons for safeguarding. These factors, combined with the reduction in people who are able to participate following application of ethical criteria (see Appendix A), can interact to significantly reduce the number of people who are willing and able to share their feedback on safeguarding. This trend is reflected in Cornwall, where an initial group of hundreds of service users reduced to 30 potential participants, once application of ethical criteria determined whether it was safe to invite people to participate.

The high rates of cases where it is unsafe to invite to share feedback can be attributed to a range of factors. During Covid-19 there has been an unprecedented rise in domestic abuse cases resulting in safeguarding enquiries. In such cases of domestic violence, the person may be placed at risk of increased harm by inviting them to share feedback. With a high rate of safeguarding cases now relating to domestic abuse, the challenges associated with attaining people's feedback should be factored into any future feedback method design.

Figure 1.0 Method of identifying and inviting people to participate

Findings

Having a say in what happened

One of the central pillars by which MSP judges whether safeguarding is personal, is the extent to which people are engaged in their case (Local Government Association, 2017).

Through the process of being involved, people are able to inform what they want to happen, their desired outcomes and as a consequence gain a greater sense of control over the process. Lord Munby (2017) succinctly explains the reasoning for placing service users at the front and centre of enquiries, when he stated:

"What's the point of making someone safe if in doing so you just make them miserable?"

To understand what a person wants and to avoid situations where safeguarding can cause additional suffering to the individual it is therefore important that all safeguarding enquiries prioritise understanding service users unique wishes and perspectives.

There are many factors that interact to determine people's level of involvement in their case. Across the UK authorities are reporting factors similar to those that we have identified in Cornwall. In particular people's involvement is facilitated by:

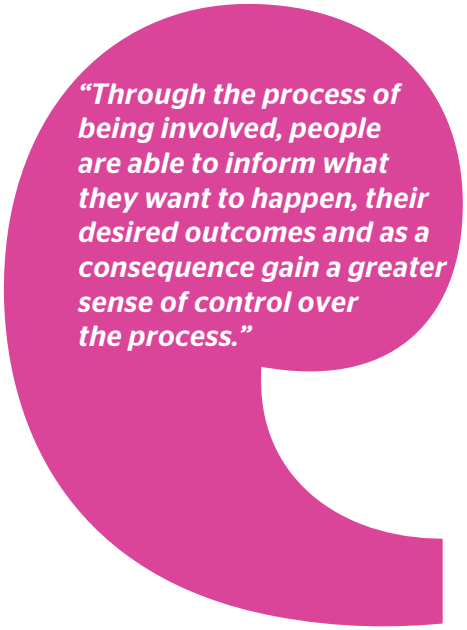
- A consistent approach applied to all safeguarding enquiries
- Sensitivity to carers and the wishes of families
- Offer of an advocate
- Co-development and agreement of safeguarding outcomes, aims and methods
- Flexibility in the safeguarding process, that responds to people's changing wishes
- A personalised approach, that seeks to understand and respond to the particular individual

Providing further insights into how these factors affect people's experiences of safeguarding, just over half of the people we interviewed (16/29) reported being asked what they wanted to happen during their enquiry. Where people were involved, they described how this made them feel engaged and listened to.

However, not everyone felt they had a say in what happened. Family members and carers acting as advocates for the person being safeguarded often reported feeling that they did not have a say in what happened (3/4 carers and family members interviewed). Exemplifying this a participant explained:

"It was difficult to get over what I wanted to say. They only wanted to hear what S said. It made me angry as S felt nothing, but I knew it was a problem. Social workers listened but they only wanted to hear from S" (P14)

Where service users represented themselves and were not asked what they wanted to happen during the enquiry there was a range of causes including the rapid nature of the case, breakdowns in relationships with safeguarding professionals and the case being transferred to a criminal investigation.



The impact of not being asked what they wanted to happen is different for everyone and distressed a number of people interviewed. As one interview put it:

"I got told I was on safeguarding. I wasn't asked [what I wanted]. I would have liked to have been asked. I felt like everyone was watching over my back and safeguarding hasn't helped by PTSD." (P23).

Each safeguarding case is unique and so are the circumstances and feelings of the people that safeguarding intends to support. It is because of this that assumptions of how much or how little an individual wishes to be involved in their own case cannot be made. It is only by asking them what they want to achieve from safeguarding and their wishes surrounding its delivery that we can be sure safeguarding facilitates the improvement of a person's safety and wellbeing.

"Each safeguarding case is unique and so are the circumstances and feelings of the people that safeguarding intends to support."

Understanding the safeguarding plan

Safeguarding is a term commonly used in adult services, including in Local Authorities, hospital and police practices. However, outside of these professional settings interpretations on what safeguarding means are highly diverse.

Disconnect between public and professional perspectives on safeguarding and the threshold for referrals can be problematic. Safeguarding is everybody's responsibility (LGA, 2019). Yet without a clear, accurate public understanding of what safeguarding services are designed to achieve and who they can support, both the public and those being safeguarded may be inhibited from engaging with the service to its full potential.

Findings from across the UK demonstrate that there are many benefits from developing a clear understanding of what safeguarding is and the circumstances in which it applies. Firstly, where people understand what safeguarding is and who it can support they may be more likely to refer people to the service. Furthermore, a clear understanding of what safeguarding is and is not, can narrow the gap between people's expectation of what can be achieved through safeguarding and the reality. This has significant implications for fostering improved satisfaction of safeguarding services, as realistic expectations can help to mitigate disappointment where the two do not necessarily align. Finally, increasing the transparency and comprehension of safeguarding services can assist in improving standards, as it makes it easier to hold professionals accountable for delivering quality services. As one participant in the Surrey study explained, if they do not know they are being safeguarded how can they engage in the process of judging if it is being undertaken well? (Surrey, 2019).

Indicating many areas of good practice, the majority of people interviewed in Cornwall (25/29) stated that they understood what the plan was to keep them safe. However, 4/29 people were not given this opportunity. One person explained:

"I didn't get the chance [to say what I wanted to happen]. I don't know why I didn't. I don't know who was involved." (P13)

It must also be noted that there were multiple instances identified where people did not realise that they had been safeguarded (4/29).

This is problematic, as it is impossible for people to take an active part in an enquiry and influence the outcomes if they do not understand how safeguarding can support them. It also inhibits people's ability to expect a basic level of service quality and make challenges where this is not delivered.

People's accounts of the services suggest that there are certain factors that can inhibit comprehension of safeguarding and personal plans. These include:

- Memory problems. Where a person has memory problems understanding details relating to their safeguarding plan and decision making relating to the case can be facilitated by formal or informal advocates (e.g. friends of family). Written information that documents all aspects of their safeguarding case including key contacts, decisions and objectives can be particularly useful in these circumstances.
- Insufficient communication that a safeguarding enquiry is taking place, the reason for the enquiry and the aims of safeguarding. This can inhibit people's ability to actively engage in their case and have accurate closure over the events surrounding their concern.

Information

Information can be used to enable people to have greater control and influence over their safeguarding case. Where information is provided effectively it can improve people's experiences of the services through assisting them to:

- Know what their rights are
- Understand what they can expect from safeguarding
- Know what 'good' looks like
- Know who to contact
- Take the guesswork out of how safeguarding cases operate and are managed

In particular, service users value written records of:

- Their safeguarding professional's name, job role and contact numbers
- The outcomes which the case was working towards
- The outcomes achieved and the means by which this occurred

Within Cornwall the majority of service users describe how they were provided with information about their case (25/29).

"There was plenty of information and I got everything I needed" (P14)

However, there are certain aspects of the service that many would have liked more information on.

"I didn't understand what the procedure was, so I just went straight to the [care] home and I had to push to get any info. I don't think anything would have happened if I didn't push." (P9)

In 4/29 cases there were reports that service users were reports that service users were not offered an end of enquiry meeting. Where this occurred, service users and their advocates described frustration impacting upon their ability to gain closure on their concern.

"I'm assuming I'm still under safeguarding and I panic like mad and I want to know [whether I'm still being safeguarded] because of that" (P23)

An end of enquiry meeting is a key opportunity to make clear the end of an enquiry and discuss its outcomes. In doing so it can also provide a therapeutic function, by enabling people to make sense of and gain closure to what is for many people a distressing event.

Communication

The quality of information that people receive during their safeguarding case and how satisfied they are with how professionals communicate with them are intrinsically linked.

Moreover, they are both crucial foundations upon which people's engagement with their safeguarding case and subsequent satisfaction with the outcomes rest (see figure 2.0).

'Communication' encapsulates all of the verbal and written exchanges that occur between professionals and service users during the course of their case. In Cornwall, 17/29 service users reported satisfaction with the communication they received. Illustrating the impact of good quality communication on people's experiences of the services, one service user praised their social worker and described how:

"They were very kind and we understood each other. They asked me questions and we all got on very well" (P18).

The benefits of achieving good standards of communication are clear. It can help people gain a sense of control over safeguarding proceedings. On a practical level, regular communication points also provide the opportunity to engage with and influence their case and desired outcomes. Where there is a failure to meet these standards of

Figure 2.0 The Foundations for Service User Experiences

"I may as well have not been there as I felt I wasn't needed and was irrelevant to the equation"

communication safeguarding may have the unintended effect of creating further distress to the individual. Highlighting the importance of achieving consistent standards in communicating with service users, participants described how:

"I may as well have not been there as I felt I wasn't needed and was irrelevant to the equation" (P21)

"There was no feedback [throughout the safeguarding case]. I don't think about it as it's a strain and there's no light at the end of the tunnel" (P25).

Where people were required to "chase" contact with professionals, frustration with the services and a sense of exclusion from their case are also reported.

"Everything was alright apart from once when it took 5 days for them to reach me and I was really worried something bad was going to happen." (P16)

"All I wanted was feedback on the outcome which I got, but it was fed back in the wrong way as I was chasing. I heard nothing back for 2 months and I had to chase and call the safeguarding team. I only had feedback because I was chasing." (P26)

In summary, service users value:

- Safeguarding professionals who contact them at regular intervals to inform them on case progress and discuss concerns, queries and changed wishes.
- Contact from professionals at the beginning and end of the enquiry, to discuss and update on factors including agreed and achieved outcomes.
- Support to comprehend what safeguarding is and what is happening.
- Timely responses to enquiries.
- The use of understandable language and support to understand where this is required.

Relationships

Many different people and organisations play an important part in safeguarding enquiries, affecting not just their experience of the service but their quality of life after the intervention.

Across the UK, as in Cornwall, service users describe how important a sense of rapport with their safeguarding professionals is to achieving a good experience of safeguarding.

Closely related to the quality of relationships that people hold with safeguarding professionals, people also describe how important it is to feel fully listened to. In Cornwall, 19 out of 29 people described feeling listened to. Common factors that influence the quality of relationships and the extent to which they feel heard by safeguarding professionals include:

- Not feeling judged
- Assurances that information is kept confidential
- Helpful, supportive attitude of professionals
- Professionals who take time to get to know the individual
- Are approachable, "kind" and show empathy
- Actively listen and respond to the wishes of the individual

Exemplifying this in practice, service users described how:

"They [the social workers] were really good as I didn't want to go to the police and they listened" (P24).

The opposite aspect of this is where service users feel professionals don't show empathy or respond to their wishes.

"I felt like a number on the page and there was no empathy or support. There was no one to talk to like I wasn't a disaster. I felt like they were trying to put words into my mouth. I wanted someone to talk to me like a friend, to listen. Not act on everything but have a listening ear. There was no compassion, empathy. They were robotic" (P21).

In this case, the importance of establishing rapport with service users so their individual wishes can be responded to is exemplified.

The value of having a safeguarding professional that is the consistent, dependable contact for all matters relating to a person's case is clearly apparent, as it allows trust to be built and their needs to be fully understood.

"They [the social workers] were really good as I didn't want to go to the police and they listened"

Organisations

In Cornwall, as in other areas of the UK, service users describe how important the support of different organisations were to achieving good outcomes from safeguarding. In particular, the police received praise for making an effort to get to know people, take time to understand their case and meet them in their own home.

In certain cases where people would have liked a criminal prosecution but were not aware of their right to request one, they expressed a wish to be informed of their rights at the beginning of their enquiry. As one service user described:

"I wanted the police involved. If they were involved sooner there could have been a criminal case but they were brought in too late and that meant we missed the chance to take it down the criminal route." (P2)

Advocacy services are also valued for helping people engage with their case and achieve the objectives they wanted. In Cornwall and across the UK advocacy services are credited with:

- Helping people understand information and decisions
- Supporting people to have a voice and be heard
- Facilitating improved engagement

All service users within Cornwall who were offered an advocate reported that it had had a positive effect on their case. As one service user described, they felt that the advocate was "someone that was on their side" and it helped to have someone to help them make sense of what was happening (P3).

Despite the benefits of advocacy services the majority of people interviewed were not offered an advocate (23/29 service users). There is a significant opportunity to improve people's experiences of safeguarding, by informing them at the beginning of their safeguarding enquiry of their right to request an advocate and police involvement.

"All service users within Cornwall who were offered an advocate reported that it had had a positive effect on their case."

Satisfaction with how the concern was dealt with

There is extensive diversity in people's experiences of safeguarding services.

Overall, when asked how satisfied they were with how their concern was dealt with the majority (23/29) were satisfied. One service user explained:

"It was really nice to feel they've got your back and I feel very secure." (P18)

However, some service users expressed dissatisfaction with how the concern was dealt with (6/29). The reasons for this were personal to each individual. It was explained:

"I wanted help for my (...) son but he ended up getting arrested as I was told to call the police. They arrested him and he was in prison and that was not what I wanted to happen. I didn't need safeguarding, I needed help with his problems as I'm not in good health myself. I wasn't impressed with what happened, I felt absolutely heartbroken. If he had had help from the mental health team this wouldn't have happened." (P21)

"It didn't improve things. I felt that they were covering things and people disregarded me." (P2)

What these accounts highlight is the importance of the relationship with the safeguarding profession to achieving satisfactory outcomes. Where professionals establish a trusting rapport with the service user, good communication and decision making can flow. Furthermore, it provides the foundation for service users to fully represent their preferences, even when this may be challenging or against what may be anticipated by professionals.

Implementation of the recommendations outlined in this report, including development of consistent standards of communication and a professional awareness of the integral role relationships play in outcomes, can support continued improvement of people's satisfaction of the services.

Safeguarding conferences

Safeguarding conferences are meetings at which multiple organisations and people involved in a person's safeguarding case meet to discuss the concern.

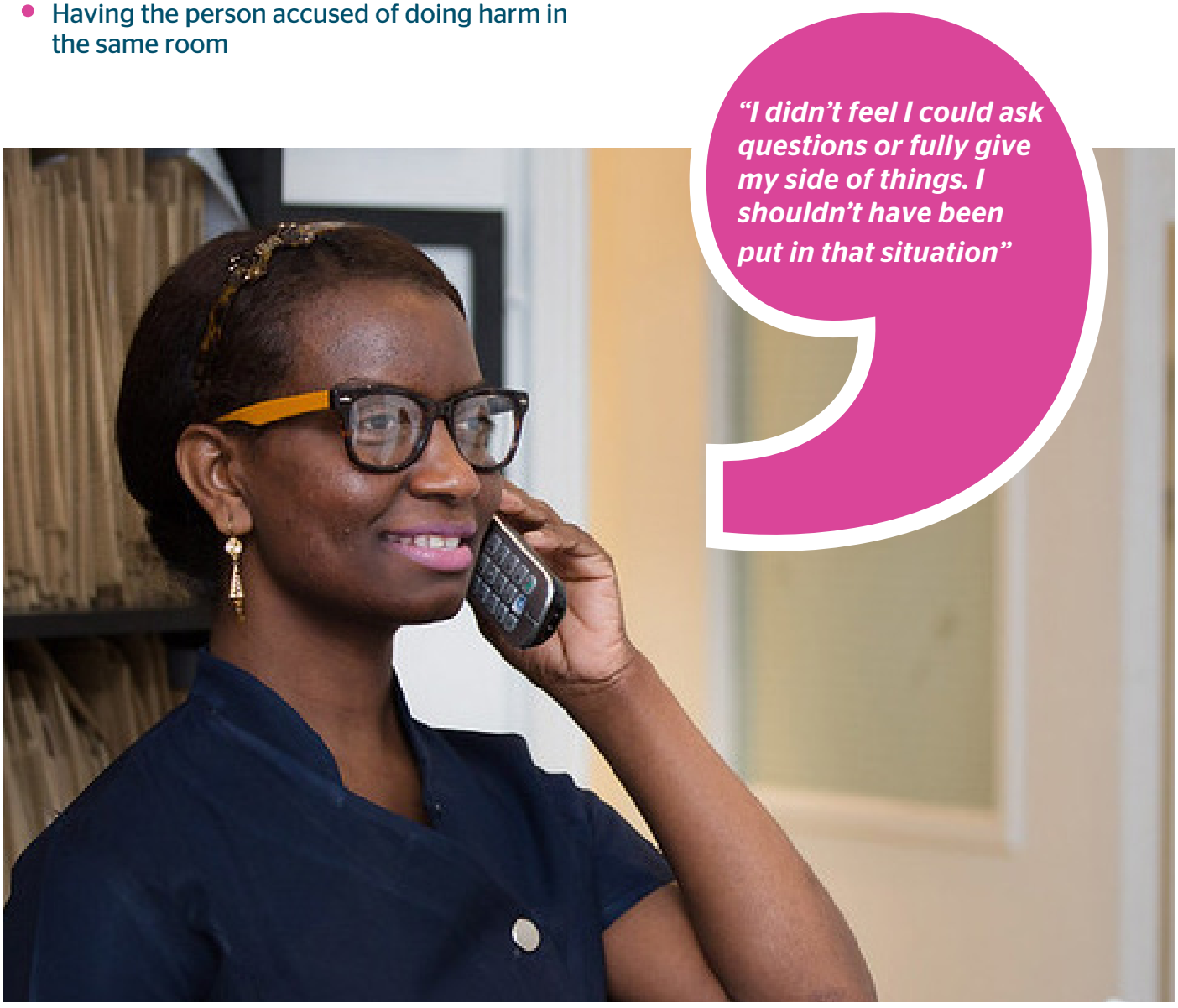
Although not all safeguarding enquiries necessitate a conference, for those who do experience them they can be highly significant events. Furthermore, dependent on how they are managed the conferences can in themselves be distressing experiences. The quotes below illustrates these experiences:

"I didn't feel I could ask questions or fully give my side of things. I shouldn't have been put in that situation. I think that they should listen to the person and not put them in a vulnerable position with the accused in the same meeting as its very intimidating" (P2).

Of the 7/29 participants who had attended a safeguarding conference the majority (5/7) described negative experiences of these events. Particular sources of distress for those who attended the meetings in person (i.e. pre-COVID-19 when conferences were conducted face-face) included:

- Feeling that they were unable to speak freely
- Having the person accused of doing harm in the same room
- Not being invited to the meetings, creating a feeling that they were being excluded
- Feeling that their questions were unwelcome
- Feeling intimidated by the unfamiliar space it was held in and the formal meeting style

For the two individuals who participated in safeguarding meetings during Covid-19 lockdown, meetings were conducted over the phone or via Zoom. The ability to participate from the comfort of home, often with family with them for support was welcomed and the process was felt useful.



Recommendations

Based on these findings it is recommended that:

1. It becomes standardised practice that all service users are informed that a safeguarding enquiry is being undertaken and that they are asked what their wishes are relating to the enquiry.
2. A set of criteria is produced to objectively determine the instances where it is not safe or practicable to inform or engage people in their case.
3. A service user group is formed to assist in development of service user resources and adult safeguarding practices.
4. Development of a standardised set of information to be provided to service users, including details on:
    a. Information about what safeguarding is
    b. The reason for a concern being raised
    c. The objectives of enquiries
    a. The value of safeguarding
    b. Safeguarding's powers
    c. Typical process of safeguarding enquiries
    d. A persons rights, including the right to request an advocate or involvement of other agencies
    e. Relevant named contacts, job titles and contact details of the safeguarding professional supporting them
    f. An end of enquiry record that includes information on the outcomes
5. A guide is produced for all safeguarding professionals, which documents how the Making Safeguarding Personal approach should be applied in practice.
6. A named safeguarding professional is appointed to each case, to act as the main point of contact and key person who supports the service user through their concern.
7. Service users are asked their preferences for how safeguarding conferences are undertaken, to include location, method of delivery (e.g. face-to-face, via telephone or Zoom) and the people who are present.
8. A minimum level of contact between safeguarding professionals and service users is agreed. E.g. all service users will be offered a meeting at the beginning and end of their enquiry, with minimum once monthly meetings in between.
9. A set of eligibility criteria is developed to determine when people meet the threshold for advocacy support. All service users should be assessed against this eligibility criteria and offered the support where the criteria are met.
10. A library of support service contacts is developed, which service users can be referred to in instances where their support needs (e.g. befriending or advocacy) extends beyond the scope of the safeguarding professional's role.
11. Professional awareness is developed on the importance of relationships and rapport to the delivery of MSP and achievement of outcomes that positively affect people's lives.

12. Obtaining feedback from service users in the future is undertaken at regular intervals, with a minimum of every 6 months. Feedback is attained by a person or organisation unconnected to their case, to support objectivity and likelihood of open feedback.
13. A semi-structured methodology is utilised in future feedback design. I.e. open ended questions are used to facilitate indepth accounts of the services.
14. Application of ethical criteria is applied to determine when it is safe to invite people to share feedback (see Appendix B).
15. A Service Users Charter is created which uses 'I statements' to describe what service users can expect from safeguarding services. E.g. "I am given information on safeguarding including why I am being safeguarded", "I am given regular updates on what is happening with my case".
16. An action planning group is formed, to discuss and determine how the recommendations of this report can be applied in service development.

Conclusions

Within the UK there is increasing pressure for local authorities to adopt a person-centred approach to adult safeguarding services. The Making Safeguarding Personal Initiative provides authorities with a framework on how this can be achieved.

By making the wellbeing, wishes and concerns of service users central to the enquiry, safeguarding services are better able to deliver satisfactory outcomes. Delivering services using this approach requires a procedural and cultural shift away from the historically top-down approach taken to safeguarding.

This research into people's experiences of safeguarding services in Cornwall and the broader UK demonstrates that there is a clear will amongst local authorities to understand and improve their services. Assessment of the findings further indicates that there are shared themes between how services are experienced in Cornwall and in other authorities. Through reflecting on the strengths and limitations of current service delivery, informed, evidence-based decision making can be enabled.

Across the UK and Cornwall there are common challenges in recruiting people to participate in sharing feedback on services. The distressing circumstances that cause people to be safeguarded, coupled with ethical considerations affect the range of people who can participate. These are important considerations for the design of future feedback methods.

Allowing people to have a say in what happens during their enquiry is vital to people's wellbeing and the achievement of satisfactory outcomes. Without their engagement, interventions to reduce risk can in fact create additional distress to service users. A clear understanding, both on the part of safeguarding professionals and service users that they should be involved in creating the safeguarding plan can ensure everyone is provided with an equal quality of service.

Safeguarding professionals play a vital role. The relationships that they hold with service users, the extent to which they communicate with them and the support they provide to aid understanding and decision making are closely connected to how satisfied people are with the services. Fostering an understanding of the extent to which these 'soft' skills affect service users can play a significant part in delivering services that truly place service users at their heart.

There is extensive good practice in safeguarding services. However, not all experiences of safeguarding services are equal and there remains a high degree of variability in the support people receive. Moving forward, creating a safeguarding culture and process that gives service users and safeguarding professionals clear expectations on what 'good' looks like is vital to making safeguarding truly personal.

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Appendices

Appendix A: Research questions

1. Were you asked at the beginning of the process what your goals were for feeling safer?
2. Did you get the goals you wanted?
3. Did you get the chance to say what you wanted to happen during the enquiry?
4. Did people feedback to you what was happening with your case?
5. Did people use clear and understandable language?
6. Did you feel that you were listened to?
7. Did you feel people acted on your wishes and views?
8. Were you offered an advocate?
9. Did you know the person who was carrying out the safeguarding enquiry?
10. Did you take part in a safeguarding conference?
    a. If you did, how comfortable did you feel at the conference?
    b. Were the right people present?
    c. Was the meeting held in a way that helped you?
11. Do you feel as safe now as you want to feel?
12. Do you feel happier as a result of the support you received?
13. Do you want to be kept updated with what happens as a result of this project?

Appendix B: Criteria for participation

Participation criteria

The following criteria is to be considered before inviting a person to share their feedback through the safeguarding engagement project. The criteria is based on ethical best practice and has been designed to protect people from further harm.

- Approaching them for feedback would not put them at risk of further harm (e.g. in the case of domestic abuse)
- Do they have Mental Capacity to give feedback about their experience, or a friend, carer or advocate who has knowledge of their case can complete the feedback on their behalf.

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