Recommendations Review of Adult Safeguarding Report

An overview of our future work

The following briefing sets out our plan of action to review the recommendations made in our report into Adult Safeguarding published in October 2016.

This briefing outlines what we have done since publishing and what we plan to do to understand any changes in experience since our recommendations were made.

Since publishing the 2016 report, we understand the demand for safeguarding enquiries has risen significantly.

*Approx. figures**	2016-17	2017-2018
Number of concerns	6000	8000
Number of enquiries	1000	3000

* We await the full data set to confirm these figures.
The conversion rate of concerns resulting in safeguarding enquiries in West Sussex is 35%, compared to 42% nationally.

What have people already told us?

Back in 2016 people told us their experiences of the adult safeguarding process in West Sussex felt impersonal, that they felt excluded or had a sense of being ignored. We reported that at a basic and fundamental level, the lack of attention to detail caused distress and resulted in the experience of feeling unimportant and not taken seriously.

2016 Healthwatch recommendations

Using the evidence from peoples' personal accounts, we made the following recommendations:

1. 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.

2. 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.)
3. 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.
4. West Sussex County Council (WSCC) 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.
5. 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.

Steps being taken to improve support locally

The report was presented to the Safeguarding Adult Board and we asked for a follow up to the recommendations to be included in the minutes. However, despite raising it at the two following meetings there was insufficient clear action.

Healthwatch observed some Safeguarding Adult Board audits in 2017 to assess the impact the recommendations have made to the way audit members considered cases. We noted that following some recommendations has enabled team managers to provide positive feedback where due, as well as an evidence base, to support enquiry officers and managers to understand the impact their work has on individuals (positively and negatively.)

In the present (September 2018) Healthwatch West Sussex still believe that our recommendations and concerns have not been fully addressed and we formally request that an action tracker is reintroduced to the Safeguarding Adults Board.

We have also, more recently, raised concerns to the NHS officers currently undertaking a safeguarding process review, over the lack quantitative evidence to support continuous improvement.

Promoting the value of gaining feedback

Since reporting, we have been pushing for a formal process of seeking feedback from the person and/or their family and friend carers at the centre of safeguarding enquiries, to help inform practice. There has been slow progress but WSCC Safeguarding Adults team has now accepted responsibility to provide user feedback. 50 service users will be contacted by phone, as an initial trial. It is expected the results will be reviewed and then the process fully implemented.

There appears to be no evidence that recommendation 4 was implemented in the annual report. However, the Healthwatch representative is currently inputting into to the next annual report and will again ask the question about how this report shows the outcome from this recommendation and what has improved.

What we intend to do

In November/December 2018, we plan to meet with the local adult social care teams, who are now responsible for enquiries relating to safeguarding concerns that meet the section 42 criteria, to understand from enquiry officers and managers the changes and challenges they work in. This should enable us to see if the first three recommendations have been fully realised.

We will be putting a call out for evidence via local support organisations in November 2018 to seek to hear from people who have experienced the safeguarding process in the last 12 months.

We will formally report findings to the independent Safeguarding Adults Board and nationally, at the end of the year.

About us

Healthwatch West Sussex is the independent champion for people who use health and social care services. We exist to ensure that people are at the heart of care. We are represented at Safeguarding Adult Board meetings but, in order to retain our independence, we are not statutory members with voting rights.

There is a local Healthwatch in every area of England. We provide information and advice about publicly-funded health and care services. We also go out into communities and hear from local people about what they think and experience of local care. We share what people like and what could be improved with those commissioning and operating services. We share feedback with Healthwatch England so that they can identify patterns in people's experiences and ensure that people's voices are heard at a national level.

We have the power to ensure that people's voices are heard by the Government, Local Authorities and those running services. As well as seeking the public's views ourselves, we also encourage services to involve people in decisions that affect them. We are extremely mindful of the realities and strains that our national health and care organisations and professionals are working under. Our sole purpose is to help make care better for people and therefore we endeavour to work as a "critical friend" wherever possible to raise awareness, influence and support positive change.