

# Making Safeguarding Personal: *hearing the voice of the service user*



**A report to the Redbridge Safeguarding  
Adults Board (RSAB)**

20 April 2022

## Introduction

The project aims to hear the voice of service users with experience of the process of being part of a safeguarding review, either directly or as a family member, or as an advocate working closely with the service user.

Recommendations are presented to the Board as part of a qualitative analysis via a series of themes, and centre around the **timing and nature of communication** during a safeguarding enquiry.

## Background

In April 2021, the Redbridge Safeguarding Adults Board (RSAB) published its priorities for [2021-2022](#). The RSAB identified a specific action to ensure the voice of service users is heard and to seek assurances that Making Safeguarding Personal<sup>1</sup> (MSP) is embedded within the London Borough of Redbridge and across the wider safeguarding partnership.

Healthwatch Redbridge (HWR) was commissioned as an independent organisation, to conduct the interviews and make recommendations to the board.

## Project

The project was initially scheduled to be completed and presented to the RSAB at the January 2022 meeting; however, we were unable to complete the initial interviews as we had not received any interest from potential participants via social worker or care team assistance. Due to the poor response, a working group meeting was held in October to review how we might adjust the project to seek wider engagement with service users.

We provided an online presentation to the RSAB Policy and Practice Subgroup meeting, enabling attendees to ask questions and understand the basis of the project. Assistance was also obtained through the Safeguarding Adults Network meeting with local voluntary and community sector groups. These included Age UK Barking, Redbridge, and Havering, Voiceability, and Jewish Care. Staff from these organisations are currently working with service users who have been through safeguarding reviews.

Given the vulnerable nature of many service users in these contexts, the project sought access to interviews through personal recommendation of core staff from these organisations. In some cases, the interviews were conducted by those staff most closely connected to service users. Interview tools were agreed and shared for this purpose.

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<sup>1</sup> <https://www.redbridgesab.org.uk/for-professionals/making-safeguarding-personal-msp/>

## Research objectives

The RSAB is seeking to develop effective ways of hearing, understanding, and acting on the voice of participants who experience safeguarding interventions.

This project will test the Redbridge approach to Making Safeguarding Personal by talking to those people who have direct experience of safeguarding arrangements in the Borough or are relatives or friends of those who have done so.

The aim of the project is:

- To get a snapshot of adults (and their families) experiences of safeguarding systems in Redbridge.
- To understand what is working/what is not working in terms of current safeguarding practice, from the perspective of the ‘service user’ (which we suggest could and should include carers and family members).
- To understand how advocacy services are used in relation to safeguarding.
- To identify gaps, strengths, and deficiencies in current safeguarding practice.
- To shape and improve professional practice (where necessary), and to ensure that safeguarding is (wherever possible) truly ‘personal’.
- To inform future resource allocation, as appropriate.
- To identify and recommend how participants could be further involved in the ongoing audit of safeguarding to improve the service.

## Interviews - sample size

The data set for the project comprises 5 anonymised service user interviews, and 3 anonymised interviews with safeguarding leads of large community and voluntary organisations.

One service user interview was 2 hours in length; another took place over 4 different occasions, at the request of the interviewee, due to the sensitive and traumatic nature of the issues being discussed.

Several interviews required multiple conversations by telephone to explain the project, and to deal with concerns about how the data would be used and with whom. This was particularly pertinent where service

users felt that existing care arrangements could be under threat if difficulties were expressed.

Our independence as a local Healthwatch was a great asset in negotiating these matters with service users. Although this part of the project involves a small sample size, rich recent data is presented which illuminates the lived experience of having a safeguarding enquiry in Redbridge involving immediate family members.

The second section of the data has a wider reach. Safeguarding leads were able to discuss multiple safeguarding enquiries, spanning many years, due to their extensive experience working with vulnerable service users.

Their interviews drew on combined advocacy experience in varying contexts and with different forms of abuse or neglect, and drew on embedded local knowledge and insight.

These interviews were approximately an hour in length and were given a high priority by interviewees. We are extremely grateful for the time taken and their willingness to offer support to the Project.

### Context of a safeguarding issue

By their very nature, situations involving a safeguarding enquiry are distressing, confusing, and at times terrifying for relatives and service users. Three of the five service user interviews carried out within this study involve uncertainty as to the intentions of those caring for extremely vulnerable persons.

There are many more examples given in three further interviews by those walking closely with service users. The interviewees spoke of their sense of shock and trauma that those they had trusted with their precious loved ones instead may have perpetrated injury, through direct trauma or neglect.

Three interviewees felt they had been lied to by the health professionals involved, in order to evade detection.

At times, the trauma involved was disabling to the extent that interviewees felt they were not able to hear or understand what was being said to them. In this context, there is a need for clear, compassionate, and person-centred communication, which is at the heart of Making Safeguarding Personal.

This is not an easy task, and our current health and social care climate adds further complexity. The impact of pandemic restrictions has led to

increased referrals, and current illness is affecting staffing throughout the NHS and social care. Whilst giving the following themes and recommendations it is vital that this context is also appreciated.

Our findings appear to support previous reviews of safeguarding experiences. For example, in 2016, Healthwatch Wolverhampton published a report<sup>2</sup> into the same issue, which found many similar themes, including:

- *A lack of awareness of safeguarding systems.*
- *A general mistrust of professionals who were sometimes seen as unhelpful.*
- *Advocacy appeared to assist participants to better access the help they needed in a timely manner.*
- *Satisfaction with the process was inconsistent and mainly due to a lack of consistency with a follow-up review process, or the feeling of not being able to influence the outcome.*

*Similar themes were found in the Healthwatch Essex's 555 Safeguarding Review<sup>3</sup>, and further interviews they have conducted<sup>4</sup>.*

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<sup>2</sup> [https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/reports-library/20160915\\_Wolverhampton\\_Safeguarding%20Experiences.pdf](https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/reports-library/20160915_Wolverhampton_Safeguarding%20Experiences.pdf)

<sup>3</sup> [Resources – Healthwatch Essex](#)

<sup>4</sup> <https://healthwatchessex.org.uk/2019/11/mother-shares-her-experience-of-safeguarding-in-heartbreaking-story-of-crisis-while-caring-for-her-son/>

## Our Findings

### Raising a safeguarding concern: communication at the beginning and end of safeguarding reviews

Many service users felt unsupported in the reporting of a safeguarding issue. Community organisation Leads also identified this issue from a different perspective.

In one situation, we were able to speak to both the relative and a member of the safeguarding team in a community organisation whom she had approached for help. The relative quotes first, concerning their adult son in a Care Home:

*'I was trying to tell someone there was something wrong for my son's care for about a year. I kept on going to the Manager and then the overall Manager. I rang and left messages. I saw her come and look in on my son, but she never spoke to me. I knew they had received the information, but they didn't want to see me. I then got ill.*

*It was not until I got in touch with Angela<sup>5</sup> that we were able to raise a safeguarding and get him moved.'*

In a corresponding interview the community organisation Safeguarding Lead, identified the need for her professional knowledge to raise and pursue a safeguarding referral:

*'I don't think the service user would have been able to escalate as quickly as I would, I don't think they would...I followed up as a tenacious professional: would a service user do this?'*

Other Safeguarding Leads identified the absence of feedback to a referral:

*'There was a silence after the referral. The process is very lax. There is no sense of urgency. This process has made me sad.'*

Service users also felt that there was significant delay in response, generating additional concerns of being unable to access support:

*'The safeguarding referral was not dealt with as a matter of urgency.'*

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<sup>5</sup> Angela (not real name) was the safeguarding Lead within the community organisation.

There can also be perceptions of being disbelieved, and that the process is a chore rather than a core activity:

*'You're made to feel like you are a liar. You are made to feel bad for raising this, like it's too much effort...they are hoping you will go away and give up.'*

For other service users, where a safeguarding concern had been raised independently, the situation itself was overwhelming and the use of the word safeguarding was not meaningful. It was hard for service users to understand the nature of the actions that would then be taken:

*'The person [health professional] told me they were raising this as a safeguarding. I had never heard of a safeguarding. I never heard anything else about safeguarding until after my Dad had died.'*

Community safeguarding leads also spoke of their concern that vulnerable service users often did not understand the nature of a safeguarding review. They may have made the referral as a third party, but due to GDPR and confidentiality, the call about the safeguarding issue would be made to the service user. This could present difficulties in the ongoing care of the vulnerable person:

*'The service user often doesn't understand what a safeguarding issue is because they are extremely vulnerable. They don't know who has called, or what is happening in the situation. We often don't know they have been called. The process then stalls.'*

There seems to be considerable difficulty caused by not having confirmation that a safeguarding referral has been received, and the plan of action that will follow. Safeguarding leads also spoke of difficulties in accessing appropriate professionals, with out of office replies from June 2021 in one instance, and mistakes in the telephone numbers provided.

These difficulties, in urgent situations, led to escalations of referrals and the making of complaints. It was only at this point that leads felt that the referral had been appropriately registered and acknowledged:

*'The referral was not picked up; it was not read - I was told this. The situation was only dealt with, immediately and quickly, when I contacted seniors by name. This prompted a call to the unit.'*

Service users echoed this theme, feeling that the review never took hold because they did not hear back:

*'One safeguarding issue never got progressed. Nothing really happened with that. We had a terrible time with that.'*

## Communication at the conclusion of a safeguarding issue

A strong theme from both the service user and community safeguarding leads data was the difficulty in hearing when the review had reached a conclusion, and the nature of actions to follow. This leads to a sense of being removed from the process, without a voice:

*'No information was given. [At the conclusion of the review] I have not seen the final notes. I feel totally disregarded.'*

Community safeguarding leads felt that it was directly harmful to the ongoing care of their vulnerable service users to not know when a review had been completed:

*'Our involvement doesn't end when I've made the safeguarding referral. We have a level of responsibility, a duty of care to report the outcome. We never have this information...we have a lot to give, a lot of resources we can use. We could be part of improving the outcome for the service user.'*

Other service users felt that after not hearing about the process of the review, they were presented with formal reports or meetings for which they were unprepared. One service user was asked to attend a 'virtual' Zoom meeting at the conclusion of a review into the care of a parent:

*'I had to go into a safeguarding meeting blind, on my own. I didn't even know who would be there or why. Faces kept popping up on the screen and I had no idea. No documents were given in advance of the meeting. There was no agenda. Forms were sent during the meeting on a platform we could not open, and we never got to see them...'*

The lack of appropriate communication meant that the conclusion of the review did not bring about a clearer understanding of what had happened, and what would be done as a result.

The context of safeguarding reviews can affect the way in which communication is received, with the acknowledgement that some calls may have not been heard appropriately. Service users were aware that they might not always be in a position to grasp information being provided:

*'I didn't get enough help. I was on my own. Nobody got in touch from safeguarding. I didn't follow up though. It might have gone in one ear and out the other. Everything was piling up in my brain and my heart and I didn't know which way to look. After they passed away, I didn't want to know any of this rubbish.'*



## Nature of communication throughout the review - explanation of purpose and timescale

Many service users felt alienated and confused during the safeguarding review. Service users felt at the mercy of processes and plans that were not explained, evidenced or representative of the rapidly changing situation affecting their relative. Central to this was their perception of a lack of adequate and timely information:

*‘The process was not explained. We kept asking. We were begging for information.’*

During the review, many service users identified distrust in the process which led to the sense that all the responsibility fell to them:

*‘There is a total lack of communication. Nothing gets reported: you have to do all the follow up. It is not joined up in any way.’*

There was concern amongst service users in particular, that the communication between professionals was not clear and effective. This led to further distrust in the process:

*‘Two Social Workers had an argument in front of us about whether we were having a meeting. One asked the other to be quiet. The meeting did not go ahead.’*

This led to a wider distrust in the system of social care:

*‘The system is totally broken. Totally disjointed. People are just doing their own thing. The system is just not there.’*

The nature of communication was often found to be abrupt and on occasions, discourteous during engagement with vulnerable people and situations:

*‘There is a basic lack of understanding. This is a person. You are not a statistic. We were spoken to rudely, with bullying and intimidation. They lose track of a person’s life having any quality to it.’*

Safeguarding leads in community organisations also felt that communication could be discourteous and rude, even in professional dialogue. The concern was then how a vulnerable person would engage with communication delivered in this way.

A further aspect of communication was raised by safeguarding leads, about the complexity and inaccessibility of language used in safeguarding reviews. They felt that at times, this could alarm vulnerable service users and could lead to some withdrawing their cry for help, and a missed opportunity to prevent further harm.

## Recommendations

Each service user was asked for their recommendations. We have presented un-themed quotes followed by recommendations from all the interviews:

*'I am grieving and hurt. Make sure the family know whatever is going on. Send it - write it - so they can read and understand it.'*

*'Please may there be proper co-ordination between teams of professionals.'*

*'Please listen to the family.'*

*'Please work with the voluntary sector. We have a lot to give, and we can make a difference.'*

*'Please stay in touch with third party referrers. Please let us know when you have been in touch with the service user so that we can follow up'*

*'Communication must be clear.'*

*'There must be a response to a referral.'*

## Timing of Communication: recommendations

- All safeguarding reviews must receive a clear and timely acknowledgement.<sup>6</sup>
- That referrals are triaged by an accountable person who makes provision for their absence on leave;
- That at initial referral safeguarding is explained by a person to the person at the centre of the review, in language that refers to the features of the actual situation at hand;
- That the person at the centre of the review is told what to expect, a timescale and what to do if they do not hear within that timescale
- That at the closure of a safeguarding review, the outcome is explained by a person to the person at the centre of the review, with their advocate present, if needed. This would be before any formal outcome measures, such as final reports of final meetings
- Communication with third-party referrers about the closure of the review and outcome, possibly via template letter

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<sup>6</sup> Note: Whilst it is advised that a safeguarding referral receives an acknowledgment as part of the process; there have been incidents identified by partners where acknowledgements have not been received.

## Nature of communication: recommendations

- Clear, non-technical explanations
- At the beginning and end of the review, the service user perspective should be sought and recorded
- Compassionate, respectful engagement should take place, addressing the service user or carer's circumstances and vulnerabilities
- Regular updates throughout the review in person-centred language
- Timescales given and contact details for one person who can remain in contact throughout the review

## Conclusion

Many of the service users and carers found these interviews extremely difficult to give. One lady asked me to ring back on four separate occasions as she found it so painful to discuss the care of her son who she felt had been at extreme risk.

Each interviewee expressed their desire only to improve the experience for others. They stopped me before ending the call to say thank you to me for listening, and that they felt this had been therapeutic.

It is clear that these findings are influenced by systemic issues and that communication during a period of trauma is exceptionally sensitive work.

We need to be clear that the pressures on Social Workers, and other practitioners and support staff are intense. However, the experiences highlighted above are troubling in their genuine pain and feeling of disempowerment.

Clear timings of communication intervention, and a consistent attempt to personalise the information given, would be a supportive ongoing structure within which to address these concerns.

Ongoing review of these matters would also give comfort to the interviewees.

We recommend this report to the Board.

## Acknowledgements

Healthwatch Redbridge would like to thank everyone who contributed to the information contained in this report and to our community sector colleagues who helped with some of the interviews.

We also wish to express our gratitude to the service users and their families who spoke at length about their personal experiences in order to improve services for future users.

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