‘YOU SAID, NEXT STEPS’ Report on Section 42 Adult Safeguarding Experiences in Hounslow

December 2022-December 2024

1.1 Introduction

Your Voice in Health and Social Care (YVHSC)/Healthwatch Hounslow (HWH), commissioned by the London Borough of Hounslow, has facilitated an Adult Safeguarding User Forum to gather feedback from those with lived experience of Section 42 safeguarding.
The forum included three key cohorts:

1. **Lived Experience Representatives** – Individuals who have personally experienced Section 42 safeguarding.
2. **Family, Next of Kin & Friends**– Those who have supported someone through the safeguarding process.
3. **Experts & Professionals** – Individuals with professional knowledge of Section 42 safeguarding who have worked with affected individuals in Hounslow (Voluntary sector professionals/volunteers/Care home and/or extra sheltered house, nursing home managers).

This initiative has provided valuable insights to inform service improvements and contribute to the Quality Assurance reporting schedule.

1.2 Project Intentions Include

- To establish a thriving platform for Hounslow residents with lived experience of Safeguarding (within the last 2 years – indicative) to have their voices heard.
- To allow the groups experiences to help shape ASC DLT strategy, plans, processes.
- To demonstrate the value of listening to those who may be seldom heard and identify impact from the group's involvement
- To feed into the London ADASS group, ensuring Hounslow can influence and benefit from regional plans and developments.
- To feedback to residents/families and carers based on London Borough of Hounslow (LBH) response/action.
- To improve Safeguarding experiences and outcomes

1.3 Actions and Impact of Project

- Quality Assurance & Strategic Influence: Feedback from forum members was integrated into Quality Assurance reporting and presented in pre-meetings with key safeguarding leaders, including the Senior Joint Commissioning Manager and Principal Social Worker.

- Direct Engagement with Leadership: Findings were shared with ASC Directorate Leadership Team (DLT), ensuring lived experiences informed decision-making.
- Comparative Insights: Annual reporting assessed how Hounslow's feedback aligned with broader safeguarding trends across the ASC DLT.
- Commitment to Continuous Improvement: LBH reviewed user feedback to shape ongoing safeguarding improvements, embedding insights into Safeguarding Adults Managers (SAMs) meetings and strategic discussions.

1.4 Reflections on the Journey

This project has experienced many ups and downs, requiring the development of various materials to support its progress. It is not easy for individuals to take part in a forum where they share their lived experiences of Section 42 safeguarding.

To encourage participation, Easy Read leaflets were created, and an informational video explaining the project was produced and widely distributed.

We extend our heartfelt thanks to everyone who has contributed to the success of this initiative, including Healthwatch Hounslow, Adult Safeguarding Hounslow, and Adult Social Care Hounslow. We also appreciate the support of care home managers, extra sheltered housing providers in Hounslow, and the family members and friends who played a vital role in making this project a success. We also thank our partners for providing opportunities to present and distribute information about this project in relevant meetings. Our collaborations included POhWER (Patient Advocacy Group in Hounslow), Homelink Respite Care, Age UK Hounslow, Long-Term Conditions (LTC) Carers Group Meetings, Learning Disability (LD) Carers Group Meetings, Autism Carers Group Meetings, Sheltered Housing, Care Homes, and Nursing Homes, Housing Team – London Borough of Hounslow, Ealing and Hounslow Community and Voluntary Services (EHCVS), Social workers team LBH, HSAB (Hounslow Adult Safeguarding Board)and Community Hubs – London Borough of Hounslow.

To further raise awareness, we set up information stalls at events such as Living Well with Dementia, Health in the Park, and Age UK Hounslow events to disseminate project information.

To enhance recruitment efforts and empower residents with knowledge of Adult Safeguarding, we collaborated with The Recovery College and West

London NHS Trust to establish links with their Adult Safeguarding course. However, due to low attendance, the course was discontinued.

Additionally, we participated in the Local Safeguarding Adults Board (LSAB) conference to share information about our project, ensuring wider engagement and awareness within the safeguarding community.

Limitations- **It is important to note that the feedback gathered from this small group may not fully represent the broader safeguarding landscape in Hounslow. Compared to the insights from Section 42 safeguarding enquiries, which provide a more comprehensive and structured overview, this feedback offers a more limited perspective based on the experiences of a select group.**

However, it is particularly rewarding to note that individuals who have experienced Section 42 safeguarding expressed their appreciation for being asked about their experiences. Many shared that being listened to made them feel valued and recognised, reinforcing the importance of this forum in shaping meaningful change.

We wish we could have done even more, but as a token of appreciation, we rewarded participants who actively took part in the forum with a £25 voucher to thank them for their time and valuable contributions.

1.4.1 Project Participation

This project was initiated with the intention of holding quarterly meetings in a forum setting, bringing together individuals with lived experience of safeguarding, including friends, family members, or those involved in planning the meetings or raising the safeguarding alert, who have engaged with Hounslow Council's Adult Safeguarding Service. Additionally, there was a commitment to return to the forums in the following quarter if needed, particularly for individuals whose Section 42 (S42) cases were still in progress. This approach allowed for further feedback once cases had been closed, providing deeper insights into the safeguarding process and its outcomes. The initial plan aimed to recruit 10–15 panel members through a local campaign, ensuring diversity and representativeness due to the sensitive nature of the project.

However, by December 2024, a total of 34 participants were successfully recruited, comprising:

- 17 participants from Cohort 1 – individuals who had personally experienced Section 42 safeguarding enquiries with Hounslow Council.
- 11 participants from Cohort 2 – family members, friends, or next of kin who had supported individuals undergoing Section 42 safeguarding, particularly those unable to advocate for themselves due to disabilities.
- 6 participants from Cohort 3 – carers, professionals, and managers of care homes, nursing homes, and extra sheltered housing, who had raised safeguarding alerts in Hounslow, with more than four cases progressing to Section 42 enquiries.

Given the sensitive nature of the project, the feedback received highlighted that many participants preferred one-on-one discussions rather than participating in group forums. Many felt uncomfortable sharing their experiences in a group setting, particularly when discussing personal or distressing safeguarding situations involving themselves, their family members, or friends.

2.1 "You Said, Next Steps" – Key Findings, Recommendations, and Responses

The following key findings have been gathered from eight quarterly reports, incorporating feedback from all three cohorts. The "You Said," section highlights the concerns, experiences, and suggestions raised, while the "We Did" section outlines the responses and actions taken by multiple teams within Adult Social Care, London Borough of Hounslow. Healthwatch Hounslow provided several recommendations based on the feedback collected, focusing on improving safeguarding experiences, enhancing communication, strengthening support services, and ensuring greater transparency in decision-making processes. The Adult Social Care team at the London Borough of Hounslow, in collaboration with other relevant teams, reviewed these recommendations and took action to implement changes where possible.

For clarity and better understanding, the findings have been categorised into seven main themes.

Theme-1 Distrust and Communication Issues

'YOU SAID'

- Strong Distrust for Social Workers and Authorities: There is a significant distrust towards social workers and authorities. This distrust affects residents' cooperation and involvement with safeguarding teams.
- Lack of Clarity Between Social Workers and Safeguarding Teams: Participants felt that it wasn't always clear when they were interacting with their social worker versus when they were receiving support from safeguarding adults. This lack of clarity added to their frustration and confusion about the process.

RECOMMENDATIONS

- Enhance Transparency and Communication: Implement regular, clear communication channels between social workers, safeguarding teams, and residents. This could include monthly newsletters, regular updates via email or phone, and dedicated liaison officers to ensure residents are always informed about their cases.
- Training and Awareness Programmes: Conduct refresher training sessions for social workers and safeguarding teams to improve their communication skills and ensure they provide clear, consistent information to residents.

'NEXT STEPS'

- **It is important to note that Social Workers in all our operational community teams lead on Safeguarding there is no distinction between safeguarding and social work interventions.**
- **We do have a leaflet that clearly outlines the safeguarding process - https://www.hounslow.gov.uk/downloads/file/1124/adults_safeguarding_leaflet https://www.hounslow.gov.uk/downloads/file/1121/adult_safeguarding_leaflet_-_easy_read_version**
- **We will review all information and advice we provide on safeguarding to emphasise the role of Social Workers in Safeguarding enquiries**
- **We have requested in our Safeguarding forums that Social Workers do reiterate their role in leading safeguarding enquiries to residents and carers.**
-

Theme- 2 Community and Involvement

'YOU SAID'

- Weak Community in Extra Sheltered Housing: The current social setting in extra care housing was not fostering a strong community, resulting in weakened resilience and empowerment among residents.
- Desire for More Involvement in Planning Meetings: Participants expressed a desire to be more involved in planning meetings and to have more information about adult safeguarding during enquiries so they could have a better understanding of their situation. Several participants mentioned that meetings were scheduled without offering them options for dates. Participants, who also work from cohort two, found it challenging to accommodate safeguarding dates, especially when informed only a few days in advance.
- Need for Better Sharing of Feedback Questionnaires: There was a desire for better sharing of the feedback questionnaire at the end of the safeguarding process.

RECOMMENDATIONS

- Foster Community Engagement: Organise community-building activities and events within extra care housing to strengthen the sense of community and resilience among residents.
- Increase Resident Involvement: Involve residents in planning meetings and decision-making processes. Provide them with detailed information about adult safeguarding during enquiries to empower them to ask informed questions about their situation. Provide participants with options for meeting dates in advance and seek to accommodate their schedules, particularly for those who work, to ensure their availability and active participation in safeguarding meetings.

'NEXT STEPS'

- **We will implement core standards that staff will need to work to in respect of keeping in contact with residents who are being supported through safeguarding. This will also include keeping in contact with people important to the resident. (contact may be affected by our need to respect confidentiality)**
- **In terms of setting meeting dates staff do recognise the importance of ensuring full attendance at meetings but often advance notice is not always**

possible given the risk to residents and the need to put in place urgent protection plans.

Theme-3 Process and Timeliness

'YOU SAID'

- Need for Earlier Intervention: Participants expressed a need for earlier intervention rather than waiting for issues to escalate.
- Lengthy Safeguarding Process: The safeguarding process was perceived as too lengthy. Participants experienced prolonged waiting times and were often not informed about the closure of their cases. They suggested that the process could be faster, considering the importance of ensuring someone's safety. Most forum participants mentioned that it typically takes the Safeguarding (SG) team about 3 days to a week to establish first contact after an SG alert is raised, despite the expectation that this should occur within 24 hours.
- Prolonged Waiting Times and Lack of Updates: Participants conveyed that they experienced prolonged waiting times, and their families had to actively pursue the outcome letter. In many instances, individuals were not informed about the closure of the Section 42 enquiry, leaving them unaware of the conclusion of the process.

RECOMMENDATIONS

- Streamline the Safeguarding Process: Review and optimise the safeguarding process to reduce delays. Implement a tracking system to monitor the progress of cases and ensure timely interventions.
- Annually review adherence to timescales.
- Implement a performance tracking system to monitor response times.
- Review systems in place to flag overdue responses.
- Share regular feedback on outliers with the SG team in internal team meetings, acknowledging their hard work but also emphasising the need to align with the 24-hour contact requirement. This could be followed by periodic reviews to measure improvements.
- Set Clear Timelines: Establish clear timelines for each stage of the safeguarding process and communicate these to residents and their

families. Ensure that residents are informed about the closure of their cases promptly.

'NEXT STEPS'

- **We constantly monitor our safeguarding performance to ensure that is timely, focused and proportionate and hold monthly meetings with Safeguarding Adult Managers.**
- **We are implementing safeguarding clinics to scrutinise safeguarding enquiries and to provide support to staff in dealing with barriers to concluding safeguarding enquiries**
- **We are currently reviewing how technology can reduce the administrative burden of recording resulting from the need to provide statutory returns on our safeguarding activity**
- **We will ensure informing residents and loved ones of the conclusion of safeguarding enquires will be part of our new safeguarding core standards.**
- **While timelines are important, we also need to ensure that enquiries are person centred and take account of the different contexts of enquiries.**

Theme-4 Support during enquiry and Aftercare

'YOU SAID'

- Positive Feedback About Aftercare and Support: Some participants were very positive and appreciative about the aftercare and support from social workers once the case had been closed.
- Most forum participants mentioned that social workers primarily check in with them over the phone (and they call from private number so it gets very hard to chase them), and safeguarding meetings are often held online, citing "other work commitments" as the reason for this approach. Participants expressed concerns that assessing vulnerable individuals over the phone may not fully capture their complexities and unique challenges, potentially affecting the quality of care and support they receive. Many face-to-face interactions would provide a better understanding of their circumstances and needs, as conducting assessments over the phone can be particularly challenging due to their additional health and social care requirements.
- Lack of Involvement of Care Teams in Safeguarding: Concerns were raised about the lack of involvement of care teams in safeguarding when residents are living in care homes/extra sheltered house.

Participants emphasised the importance of the care team being more informed about residents' safeguarding cases.

- Feeling Abandoned After Relocation: Focus group participants conveyed that after being relocated to extra sheltered house, no social workers came to check on their well-being. Some of them expressed feeling abandoned.

RECOMMENDATIONS

- Enhance Aftercare Services: Provide comprehensive aftercare support to residents once their cases are closed. This could include mandatory in person follow-up visits from social workers, regular check-ins, and access to additional support services.
- Give participants a choice
- Adopt a Hybrid Assessment Model: Implement a mix of in-person and virtual assessments. This allows for initial face-to-face evaluations to better understand the complexities of vulnerable individuals, while maintaining the convenience of virtual check-ins for ongoing communication.
- Involve Care Teams: Ensure that care teams in care homes/ extra sheltered house are actively involved in safeguarding cases and are kept informed about the status and progress of these cases.

'NEXT STEPS'

- **We will take action to ensure that Protection Plans following a safeguarding enquiry are better incorporated into our overall annual review of care and support**
- **We do involve care providers in safeguarding enquiries, but we will ensure that this encompasses all providers particularly in respect of Extra Care Schemes. In providing updates we do need to recognise that the Protection Plan is for the individual but where the plan involves actions from providers then we will ensure information is shared.**

Theme-5 Awareness and Education

‘YOU SAID’

- Lack of Awareness About the Safeguarding Process: There is a significant lack of awareness about the safeguarding process, leading to misconceptions about why inquiries are being imposed on them (Participants who have been through S42 Safeguarding).
- Need for Consistent Reminders About the Importance of Safeguarding: Despite the lack of awareness, the council and social workers should consistently remind individuals of the importance of the safeguarding process to ensure they do not perceive it negatively or as something detrimental to them.
- Misconceptions About Inquiries: Misconceptions about why inquiries were being imposed were prevalent among participants.

RECOMMENDATIONS

- Increase Awareness Campaigns: Launch awareness campaigns to educate residents about the safeguarding process and its importance. Use various communication channels such as brochures, workshops, and online resources.
- Consistent Reminders: Regularly remind residents about the safeguarding process and its benefits to ensure they do not perceive it negatively.

‘NEXT STEPS’

- **Hounslow Safeguarding Board is involved in a year long campaign to strengthen awareness across the Borough.**
- **Adult Social Care runs regular pop-up hubs across the borough to share information advice and guidance on how it supports and safeguards residents**

Theme-6 Specific Concerns

'YOU SAID'

- Concerns About Disabilities and Mental Health Issues: The participants raised concerns that when a family member asserted that an individual lacked mental capacity, the person was excluded from participating in decision-making processes.
- Participants Not Being Consulted About Their Preferences: Some individuals, especially those whose families are involved in the safeguarding process, have not been asked about their preferences or desires regarding the inquiry.

RECOMMENDATIONS

- Introduce an independent review process for mental capacity assessments to guarantee objectivity and prevent undue influence. Establish regular re-evaluation mechanisms to uphold individual autonomy in decision-making, ensuring ongoing assessments align with the individual's current circumstances and rights.
- Implement a structured and standardised method to actively involve individuals in the safeguarding process by seeking and considering their preferences and desires. Ensure that this approach is consistently applied, with specific emphasis on including input from individuals whose families are part of the safeguarding process.

'NEXT STEPS'

- **Our policy and procedures make clear that in following statutory guidance in relation to the Mental Capacity Act all staff do need to consider the wishes and feelings of residents who are assessed as not having capacity in making decisions in respect of safeguarding**
- **Our refreshed Carers Plan will focus on ensuring that carers and family members are involved but as we have highlighted throughout our next steps this does need to take into account residents right to privacy and confidentiality.**

Theme-7 Communication and Updates

‘YOU SAID’

- Need for More Frequent Updates and Better Communication: Participants recommended that the council and social workers should consistently provide updates to individuals and families who may not have the background of working in social care, as they may require more frequent communication to stay informed.
- Concerns About Preventive Measures: Participants expressed gratitude towards the safeguarding team and social workers for their efforts in ensuring that at the end they are at a safer place but questioned what actions are being taken to prevent similar incidents in the future, emphasizing the need for proactive measures beyond ensuring immediate safety.
  Comment: "It's always good to see that the council makes sure the person is safe, but how about preventing such events? What are you going to do to make sure this never happens with someone else?"

RECOMMENDATIONS

- Regular Updates and Communication: Implement a system for providing regular updates to residents and their families about the status of their cases. This could include scheduled phone calls, emails, or face-to-face meetings.
- Implement a proactive prevention strategy that includes regular reviews and updates to safeguarding policies, ongoing training for staff and stakeholders, and community education initiatives to raise awareness and prevent similar incidents from occurring in the future.

‘NEXT STEPS’

- **As highlighted above our revised safeguarding core standards will make a requirement for staff to provide updates to residents and their families. These core standards will be monitored on a regular basis and reported into the Safeguarding Board.**
- **Hounslow Safeguarding Board is in the process of revising their strategic plan, prevention will be a key part of the plan which will be shared with Healthwatch for onward distribution.**

2.2 Wider Issues beyond Safeguarding Enquiries and Observations.

1. A recurring concern was identified regarding vulnerable individuals being placed in council accommodation and subsequently becoming victims of crime. In some cases, the police were unable to take action due to a lack of evidence, often advising victims to install CCTV, which many could not afford. Additionally, housing teams were perceived as slow in relocating residents despite ongoing risks of harm.

Recommendations:

- Strengthen collaboration between housing services, the police, and safeguarding teams to ensure a proactive approach to risk assessment before placing vulnerable individuals in accommodation.
- Implement a support fund or alternative security measures for those at risk who cannot afford CCTV or other safety provisions.
- Improve communication between agencies to ensure a quicker response when an individual is identified as being at ongoing risk.

2. It was noted that some care home managers, care leads, and extra sheltered housing managers initiated safeguarding alerts and were involved in enquiry meetings, leading to cases being classified as Section 42 safeguarding matters. However, there was an indication that some managers lacked full awareness of the specific requirements and processes of Section 42 safeguarding, raising concerns about the overall level of safeguarding knowledge within management teams.

Recommendations:

- Provide mandatory safeguarding training, including clear guidance on Section 42 processes, for all care home managers, care leads, and sheltered housing managers.
- Ensure regular refresher training sessions to keep staff up to date with safeguarding policies and procedures. Develop accessible resources (e.g., guidance documents or workshops) to help managers understand their role in safeguarding referrals and enquiry meetings.
- Establish a direct point of contact within Adult Social Care for managers to seek clarification on safeguarding concerns and processes.

By implementing these recommendations, the aim is to enhance safeguarding awareness and responsiveness, ensuring that both vulnerable individuals and professionals working with them feel supported and informed.

2.3 Conclusion

This project has provided valuable feedback from individuals, families, and professionals involved in Section 42 safeguarding enquiries in Hounslow. The engagement of a diverse range of participants has highlighted key areas for improvement, including the need for better safeguarding awareness among professionals, more proactive support for vulnerable individuals, and improved cross-agency collaboration.

While recruitment and forum participation posed challenges due to the sensitive nature of the subject, the feedback collected has been instrumental in identifying key recommendations for improving the safeguarding process. These insights have been shared with relevant teams and will guide future improvements.

It is particularly rewarding to note that individuals with lived experience of Section 42 safeguarding expressed appreciation for being asked about their experiences. Many felt that being listened to made them feel valued and recognised, emphasising the significance of this forum in fostering meaningful change.

Overall, this project has reinforced the importance of continued dialogue, training, and collaboration to ensure a more responsive and effective safeguarding process in Hounslow.