Healthwatch Together

Safeguarding Voices

Making Safeguarding Personal in Blackburn with Darwen, Blackpool and Lancashire

Contents

Glossary

Safeguarding: The protection of a persons' health, wellbeing, and human rights, and enabling them to live free from harm, abuse, and neglect.

Safeguarding Adults: Protecting an adult's right to live a life free from abuse and neglect.

Section 42 safeguarding enquiry: Section 42 of the Care Act 2014 places duty on Local Authorities to respond to concerns of abuse or neglect of an adult with care and support needs, whether the local authority is meeting those needs or not.

Making Safeguarding Personal: Defined by the Care Act 2014, Making Safeguarding Personal are six key principles which should underpin all safeguarding adults work. These principles are in place to ensure organisations deliver an outcome focused and person-centred safeguarding process and include empowerment, prevention, proportionality, protection, partnership, and accountability.

Safeguarding Adult Board: Every Local Authority has a multi-agency Safeguarding Adult Board which is a strategic board with a duty to co-ordinate and review the actions of all partner organisations to prevent and respond to abuse and neglect. Partnership organisations include the local authority, health, Police, and Probation. Safeguarding Adult Boards have three main duties:

- Develop and publish a strategic plan
- Publish an annual report
- Commission safeguarding adults reviews (SARs)

More 'safeguarding adults' information can be found by visiting: Care Act 2014 (legislation.gov.uk)

Chairs of local Safeguarding Adult Board Foreword

Within our Safeguarding Adult teams in Blackburn with Darwen, Blackpool and Lancashire, we aim to ensure that peoples voices are at the heart of every enquiry.

Our teams work to ensure that people feel heard, involved, and valued, to make every contact with Adult Social Care feel personal. We recognise that people receive the best possible outcomes when they are truly involved within any enquiry made.

The Safeguarding Voices project has been a fantastic opportunity for our Safeguarding Adult Boards to evaluate the section 42 Safeguarding process and assess whether Making Safeguarding Personal principles are being applied to every person we support.

By listening to recent experiences of individuals, family members and carers, at what may already be a challenging time in their lives, has been a unique opportunity to achieve an insightful evaluation of the process.

Experiences shared within this report are powerful and we would like to take this opportunity to thank each individual who has contributed to this invaluable piece of work.

We are committed to shaping the section 42 safeguarding process to reflect recommendations made within this report.

Dr Henri Giller, Chair of Blackburn with Darwen Safeguarding Adult Board

Stephen Chapman, Chair of Blackpool Safeguarding Adult Board & Lancashire Safeguarding Adult Board

Introduction

The Care Act 2014 provides the legislative framework for Safeguarding Adults and emphasises a personalised approach that is led by the individual, not by the process. Approaches to adult safeguarding should be person-led and outcome focused with the individuals' feelings, wishes, values and beliefs central to the process. It is vital that the adult feels that they are the focus, they have control, and their desired outcomes are respected.

Making Safeguarding Personal, defined by the Care Act 2014, are key principles in place to support agencies including Local Authorities, Health, Police, and their partners to deliver an outcome focused and person-centred safeguarding process. The six key principles are:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability.

The Local Authorities with the statutory responsibility for Safeguarding Adults which form part of the Pan-Lancashire Safeguarding arrangements are:

- Blackpool Council
- Blackburn with Darwen Borough Council
- Lancashire County Council

Healthwatch Together delivered a robust engagement project to independently review the effectiveness of the section 42 Safeguarding case management for Blackburn with Darwen, Blackpool and Lancashire Safeguarding Adults Boards. A section 42 Safeguarding enquiry is part of the Care Act which gives Local Authorities the primary duty to respond to a concern of abuse or neglect of an individual.

The involvement of people within the safeguarding process was investigated, looking at whether people felt involved, supported and valued. The project explored the experiences of the individual, the carer (where applicable) and the professional involved in a section 42 safeguarding enquiry. The findings of this engagement have formulated recommendations for the Safeguarding Adults Boards to independently support them to review their safeguarding process, celebrate good practice and make improvements where required.

About Healthwatch Together

Healthwatch was established under the Health and Social Care Act 2012 as an independent consumer champion to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

There are over 150 local Healthwatch across England. The role of a local Healthwatch is to:

- Listen to people, especially those who are most vulnerable, to understand their experiences and what matters most to them
- Influence those who have the power to change services so that they better meet people's needs now and into the future
- Empower and inform people to get the most from their health and social care services and encourage other organisations to do the same

Healthwatch Together (HWT) is the collaboration of five Healthwatch across the Lancashire and South Cumbria Integrated Care System (ICS). HWT works in partnership to effectively operate over the whole footprint and consists of Healthwatch Blackburn with Darwen, Healthwatch Blackpool, Healthwatch Cumberland, Healthwatch Lancashire, and Healthwatch Westmorland and Furness. Each Healthwatch organisation works in their own local authority area and is their own unique entity, providing a local approach to community engagement.

Methodology

Healthwatch Together engaged with individuals and carers involved in a section 42 safeguarding enquiry, to investigate whether people felt their voice was heard and whether they felt informed in the safeguarding process.

Healthwatch Together also set up an online survey to gain the experiences of multi-agency professionals who have raised a safeguarding concern and experienced the section 42 safeguarding enquiry, to understand what is working well, what could be improved and any barriers to real inclusion. This survey was circulated on social media and through an e-newsletter to existing professional contacts. Contacts included partner agencies on local Safeguarding Adults Boards, professionals from safeguarding teams within the Lancashire and South Cumbria Integrated Care Board, NHS staff, the probation service, Borough and City councils and third sector organisations.

Healthwatch Together engaged with **258** individuals in total. Engagement ran from 1st July 2023 to 2nd October 2023 and this was conducted through one-to-one interviews to provide rich qualitative data. Feedback collected gave an insight into lived experience, as well as highlighting good practice and areas for improvement within the safeguarding process.

The engagement target for each local authority area was determined using safeguarding closure data, gathered by the Local Authorities, which was compared with population sizes for each area. The target for each Healthwatch to engage with is detailed below:

Local Healthwatch	Engagement target
Blackburn with Darwen	30
Blackpool	28
Lancashire	90

A methodological approach was devised to allow for an independent examination of the roles and practices of social workers within the adult social services sector in Blackburn with Darwen, Blackpool and Lancashire. The combination of qualitative insights from interviews and observations contributes to a well-rounded picture that in turn can be scaled for future independent understanding.

Online Consent Forms:

Social workers employed by each local authority were engaged in the initial phase of data collection. A consent form was distributed to refer residents keen to give independent feedback. This survey was designed to gather essential information. Data sharing agreements were in place between each local authority and their local Healthwatch.

One-to-One Interviews:

Participants were contacted for more in-depth exploration of their interactions and experiences with the safeguarding process. One-to-one interviews were conducted either in person or via telephone, based on individual preference. These interviews were tailored to understand interactions with each Councils' safeguarding processes.

Understanding Unsent Referrals:

Healthwatch Together had regular conversations with adult social care leads who had performed an analysis of the reasons behind referrals that were not sent. This was incredibly helpful and provided insight into the complexities of some safeguarding enquiries.

Meeting with Adult Social Leads:

Healthwatch Together had regular meetings with adult social care leads to discuss progress and shape engagement. This was really helpful to understand perspectives and challenges within the teams.

Attending Team Meetings:

In addition to the above after experiencing a delay in referrals from the local authority, Healthwatch Blackpool attended social work team meetings to further promote the project including highlighting the purpose of the work and the positives of having independent conversations on experience.

Healthwatch Together engaged with 258 people (59 individuals, 90 carers and 109 multi-agency professionals). The following table shows a breakdown of feedback source.

Local Authority area	Individuals	Carers	Multi-agency professionals
Blackburn with Darwen	20	10	2
Blackpool	13	16	27
Lancashire	26	64	59
Across multiple local authorities/not stated	-	-	18 across multiple local authorities 3 not stated

The findings of each Safeguarding Adult Board have been analysed and comparisons have been made between the experiences of individuals and carers involved in the safeguarding enquiry. Analysis has discovered differences between areas and the experiences of individuals and carers.

Safeguarding Voices in Blackburn with Darwen

Executive Summary

This executive summary offers a comprehensive overview of the key themes and findings from the responses of individuals and carers involved in safeguarding enquiries living in Blackburn with Darwen. It highlights the diverse experiences and emphasises the importance of clear communication, involvement, and support throughout the safeguarding process.

These findings can serve as valuable insights for further refinement of the Making Safeguarding Personal agenda in Blackburn with Darwen, to better meet the needs of individuals and carers involved in safeguarding enquiries.

Lack of explanation and understanding: More than half of the people we spoke with told us that they were not told what a safeguarding enquiry was and over half were not told that they were subject to a safeguarding enquiry.

Support: The majority of people we spoke with felt that it was easy to contact the safeguarding team if they needed to speak with them.

Over half of the individuals were asked what support they needed, with some not needing any further intervention from the team but some stated that they had not been asked.

Planning for the future: Feedback about the support received was generally positive. Just under half of the individuals we spoke with who had been through the safeguarding process had been given support to plan for the future, however it was clear from talking with the others that this was not needed and was not perceived to be a gap in support.

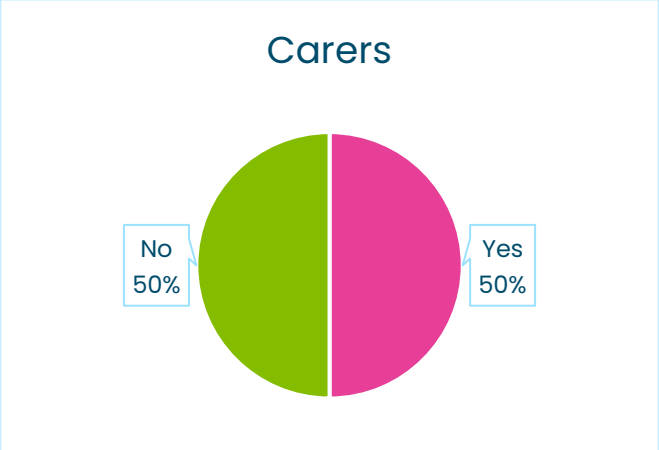
Similarly, not all of the carers we spoke with had been asked what support they needed as a carer.

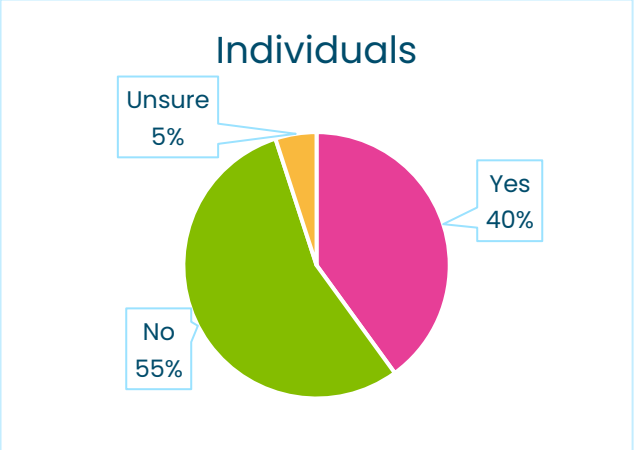
Involvement and feeling heard: The majority of individuals and carers felt that they were involved in decisions made through the process and felt listened to. However, a few people did not feel involved at all.

Findings

Explanation and understanding

Were you informed what a safeguarding enquiry is?





Feedback was mixed, with the majority of individuals stating that they were not informed. Responses from people included:

"Yes, it's something about people looking after you"

"No, I don't understand what this means"

No but it's about protecting people from danger"

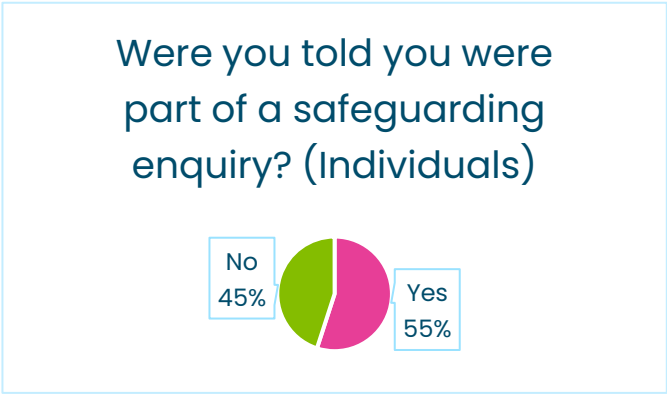
"Nobody told me, but I get what it means"

Only half understood why they were part of a safeguarding enquiry and this was clear from our discussions with them.

"Yes because of the situation with my friends when I was paying for things for them"

"Yes it was financial abuse"

However, it was clear for others that the process was not as well explained and there was a lack of understanding of the role of the safeguarding team.



"No, they didn't use the word safeguarding and didn't want to go into too much detail with me but my social prescriber kept me informed about what was happening."

When someone came to talk to you about safeguarding, did the person/s involved introduce themselves, explain what their role is and why they were involved?

27 of the 30 people felt that the safeguarding team had explained who they were and why they were involved, with one individual reporting a very positive experience.

"She explained and introduced herself and was very polite and calm and friendly. I didn't know at that point why she was involved. She acted like a counsellor and told me that she was looking after the whole situation I was in."

However, 2 people we spoke with felt that they had not explained who they were when they came out to visit and a third person felt unclear.

3 people we spoke to felt that they wished that it had been a face-to-face initial meeting rather than over the phone, "but they did explain everything".

Support

Was it easy to contact the person involved if you had any questions?

17 out of 20 of the individuals we spoke with who were part of a safeguarding enquiry reported that it was easy to contact the safeguarding social worker if needed.

"I agreed for all contact to go through my social prescriber, and she talked to the safeguarding social worker. The social worker was really good and approachable though."

"She was the only person in the contacts in my phone at the time."

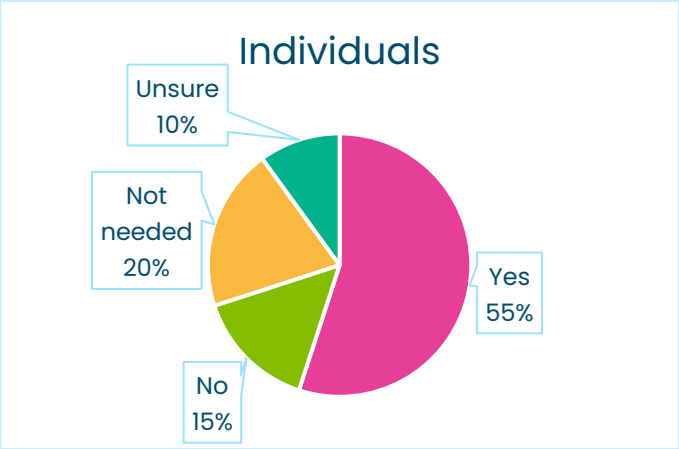
However, 3 stated that it was not easy including one person who stated "they didn't leave a number."

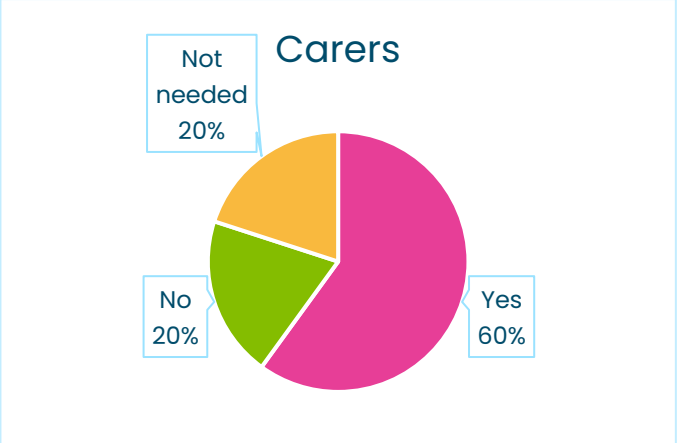
9 out of the 10 carers engaged with found it easy to contact a member of the safeguarding team, although some of them felt that there was no further need for contact because they were being supported by other social workers.
One person spoke highly of the support:
"Yes, it was and the whole thing didn't take long – I was surprised how quickly my concerns were addressed."

However, one carer's experience was not as positive:

"The person seemed to keep changing from one person to another but I didn't actually need to speak to them in person. It would have been preferable to have a consistent email address so that you can have an email trail of correspondence."

Did the person tell you what would happen and when?





The majority of people engaged with felt that they were kept informed by their safeguarding social worker.

"She did say that everything was going to be ok. She didn't tell me all the details at the time because I was so paranoid so maybe she just chose to tell me nice things."

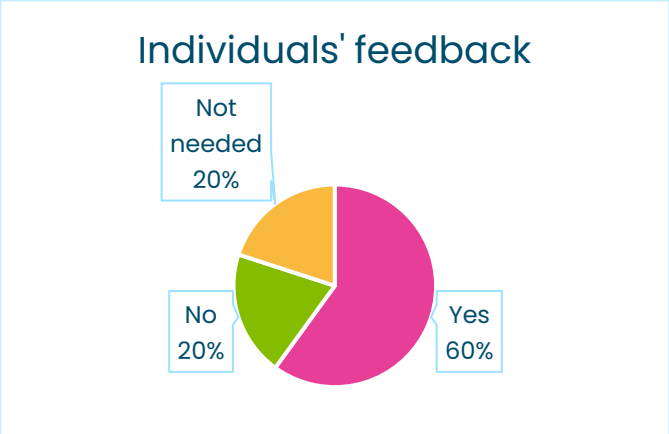
"Yes they explained the process and how they would have to investigate. They said that they would keep coming back to me throughout the process to keep me informed."

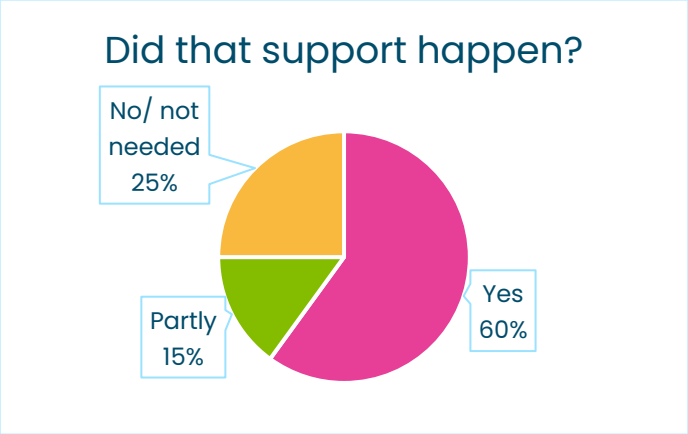
Where people stated that it was not needed, this was due to the enquiry only requiring an initial meeting to establish the level of risk for the individual or carer and no further actions required.

Negative feedback received included:
"I don't know what they were on about really. They were just talking about my son. Nothing has changed."

"I feel like I don't know what they're doing and I didn't know they had even closed my case."
"Not really no – I didn't have any further contact with them that week, it was the following week."

Were you asked what support you needed?





There were some great examples of personalised care provided by the team to individuals we spoke with.

"She supported me with getting sheltered housing, medical appointments and a care worker. She set up a bank account for me and the card is held in a safe at their office."

Personal story: From surviving to thriving

"It's taken me three years to get to where I am today. I didn't want help initially but it was clear I wasn't living in a place that was healthy for me. Although I didn't like moving back in with my mum for a bit, I've now got my own flat. I can't read or write so they've helped me sort out my bills on direct debit. I didn't know I was diabetic until they started helping me and I've now stopped both drinking and smoking."

Jack

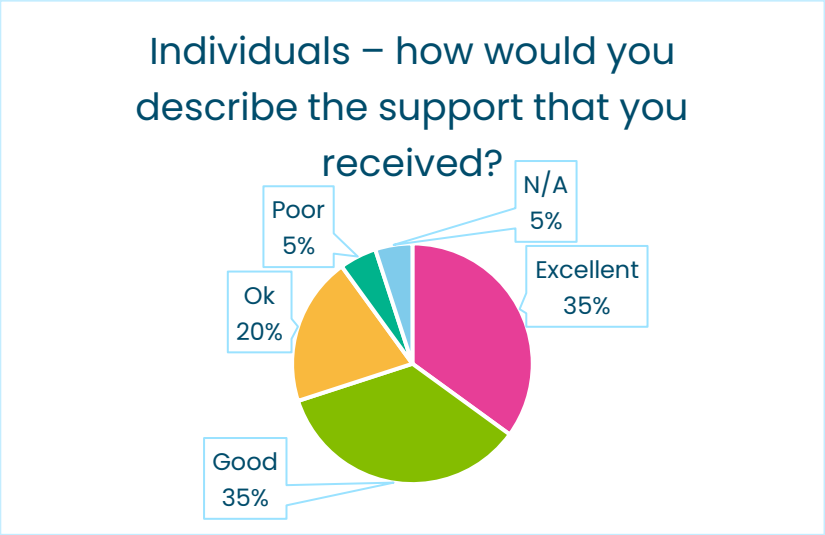
Similarly, feedback about the support received by individuals through the safeguarding process was also generally positive.

"She's a really nice person and I could talk to her. One of the best social workers I've had and understood me really well and my problems."

"I got a lot of support – I was on the phone with my safeguarding social worker a lot. I was glad there someone to talk to about it."

"I understood everything that was going on."

"Nice to actually feel heard for once. I felt heard and a weight had been lifted off my chest



"They liaised with the management of this place and everyone joined together. I felt like there was a team around me. I felt really supported."

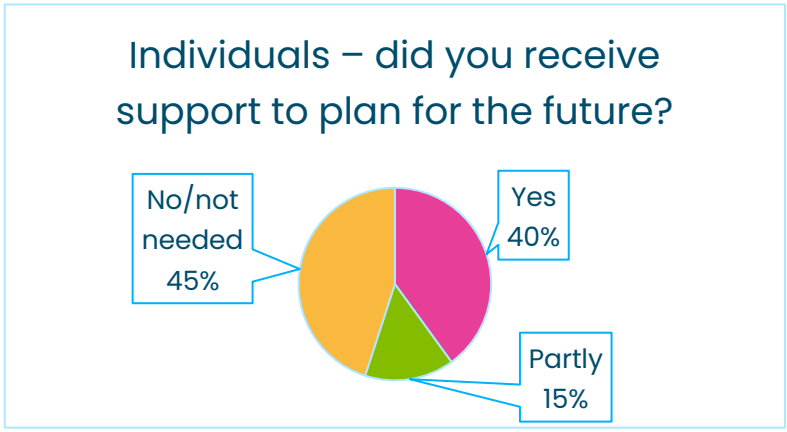
One person who recorded the support as 'ok' wished that the meetings had been held face to face rather than over the telephone and also wished that they had had a few more meetings with the team before the case was closed.

However, one person did not have a good experience of support and felt ignored throughout the process.

"It was a 2 minute conversation then he left. I wasn't involved in it. No-one asked me what I wanted."

Individuals were asked whether they were asked if they had received support to plan for the future.

"Yes I'm now getting mental health support and my money is held in a safe for me to access."

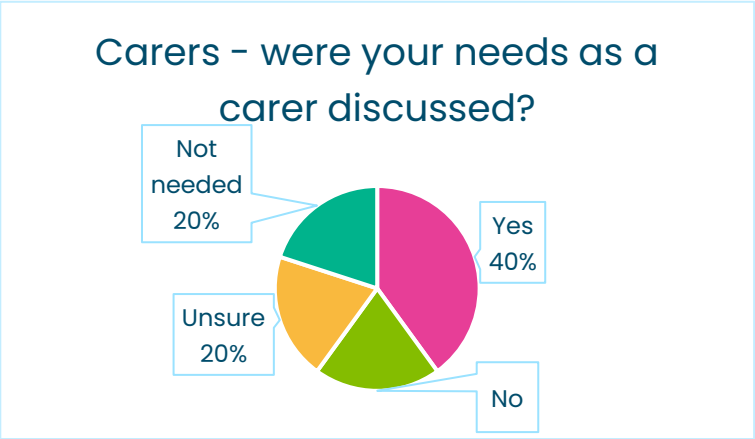


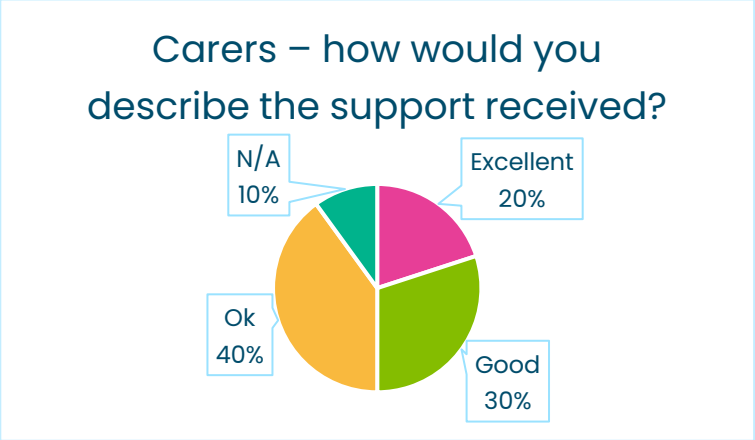
Feedback about support for carers was mixed, although even those who said their needs were discussed, preferred the focus to be on supporting their loved one.

Feedback from those who said that their needs were not discussed was:

"No but I talked about it with my social worker and they talked about it between themselves."

"No but they didn't suggest putting my daughter back with me so I guess they thought about my needs?"





"In some respects yes but not really in the detail – I've been left with being controlled by what my brother in law said. I think the safeguarding team listened to me and I've gone through social services to get on to the police about him."

Feedback from carers was generally positive about the support they received from the team.

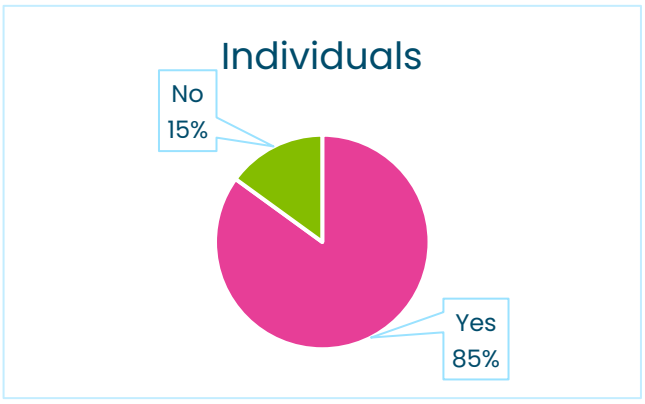
"I was very well supported"

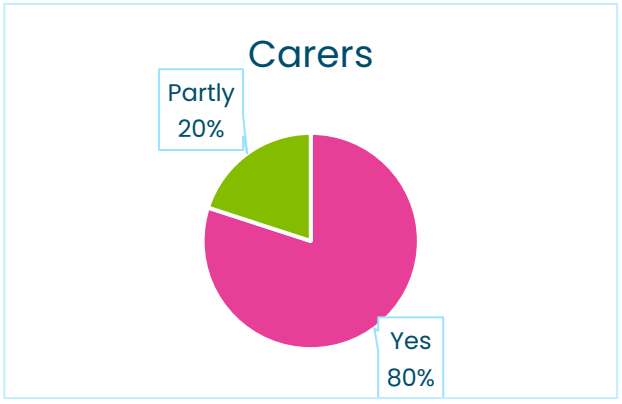
"10 out of 10"

"It was received in bits as and when we needed it and because the situation kept changing around us."

Involvement and feeling heard

Did you receive all information in a way that was easy to understand?





Overall, people felt that they understood the information they received.

"They were very patient with me"

"I had a stroke so things are a bit harder for me to understand and adjust to and get my head around. I felt like they were there and they wanted me to make the right decisions."

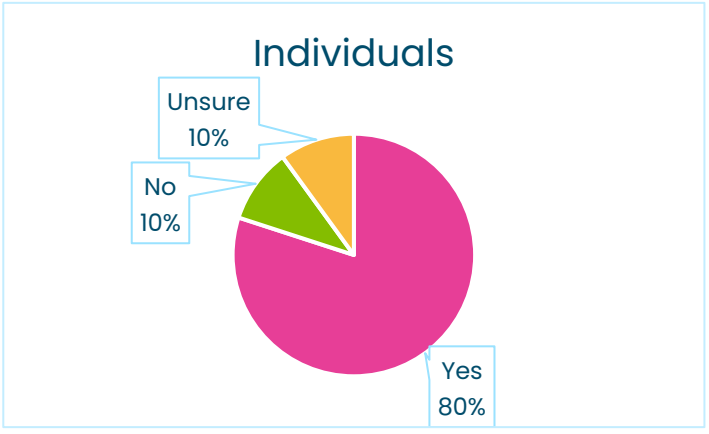
However, some people did not feel listened to or communicated well with throughout the process.

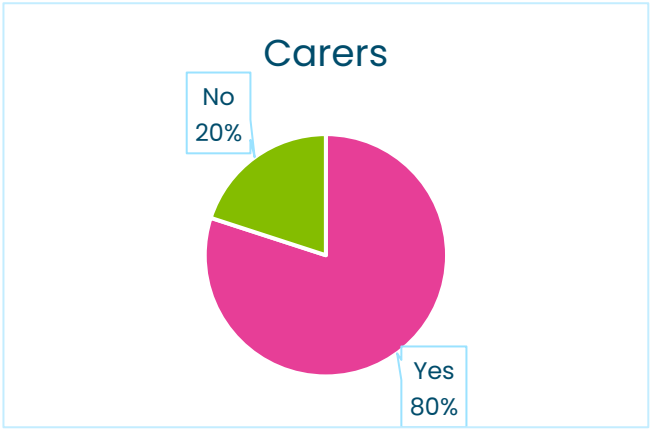
"I've not had any information about anything."

"I felt like I didn't have a choice and felt bullied into the situation. I felt it was done badly."

"I felt that her attitude was that she didn't want me on her caseload."

Did you feel involved in decisions?





Very similar feedback was received regarding involvement in decision making, with the majority of people feeling that they had been appropriately involved.

Positive feedback received included:

"I felt understood by the social worker. They knew where I was coming from."

"I felt at the centre of it all and I felt validated and my opinions mattered."

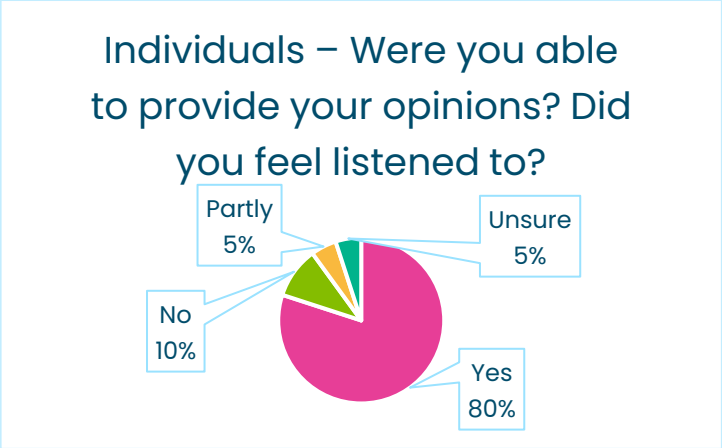
"They told me that they would keep me safe which is what I wanted and felt involved in that decision."

One person felt that they had been involved in decision making but still felt that they would have preferred more regular face to face meetings with the safeguarding social worker.

Negative feedback included:

"There weren't any decisions made it was a vague short call really."

"I felt railroaded and pushed into a decision"



Again, feedback was generally positive with comments received from individuals involved in the safeguarding process:

"Yes I felt like they were listening and the advice I was getting was spot on really. There were no half measures. I felt like I wasn't on my own."

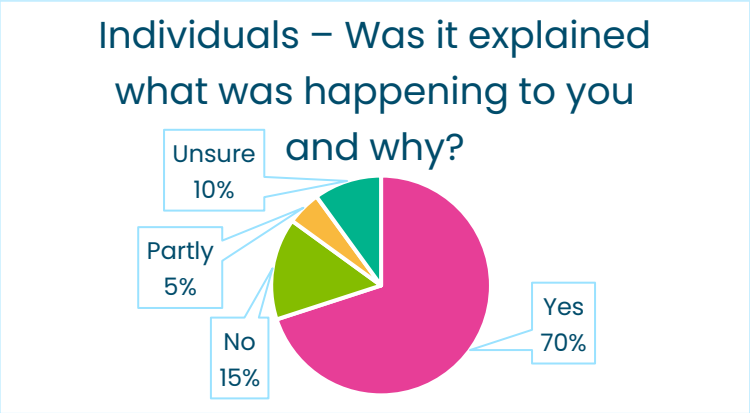
"Yes they were understanding and listened to me. I felt comfortable with my social worker and felt more confident with her involved."

However, this unfortunately was not consistent for all individuals we spoke with:

"I didn't feel like I was listened to at all"

"I put my views across but I got one word answers. I didn't feel listened to. I felt like I was the problem and thus was disregarded."

Over half of individuals we spoke with felt that the safeguarding team explained to them what was happening as part of the safeguarding enquiry and why, however 6 people did not feel as well supported.

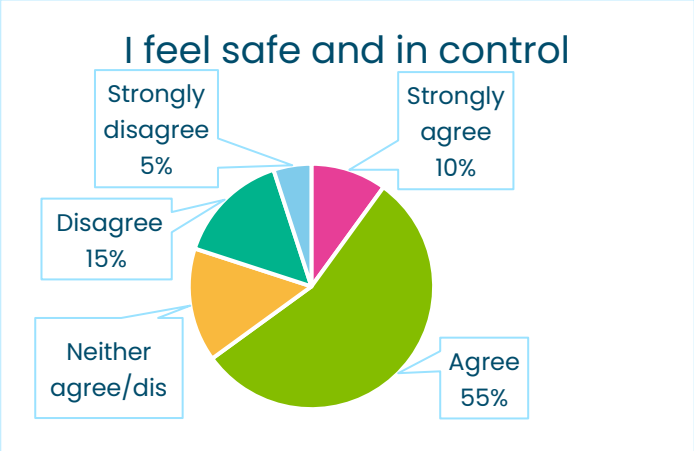


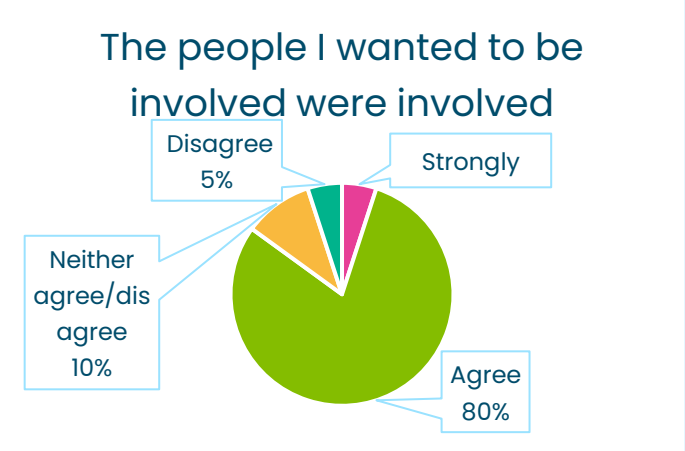
"Some bits were ok and some bits I just didn't understand"

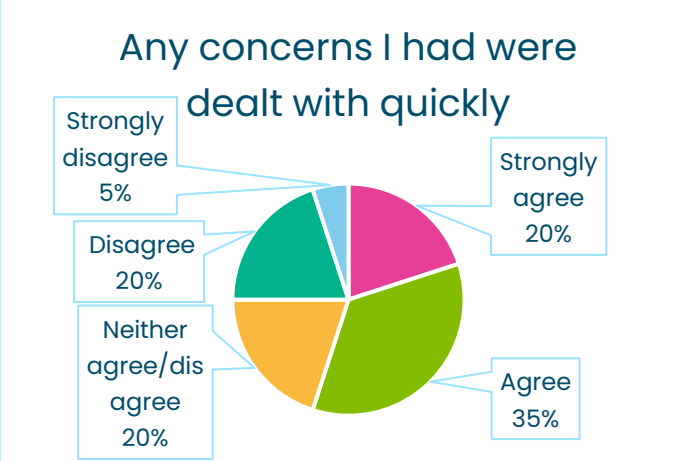
"They came to see my mother and didn't talk to me about it."

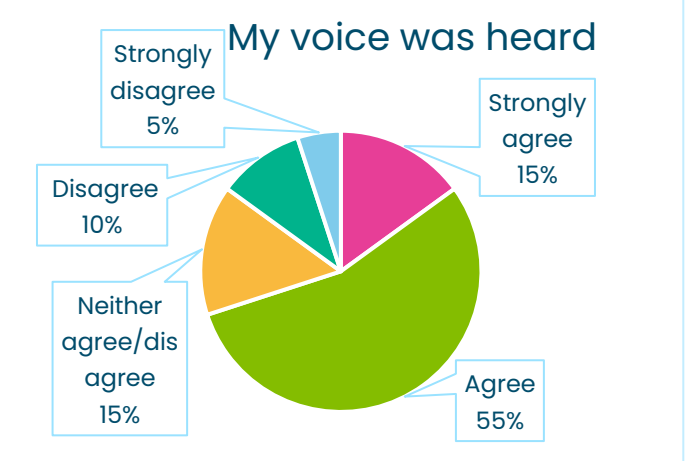
"No nothing at all."

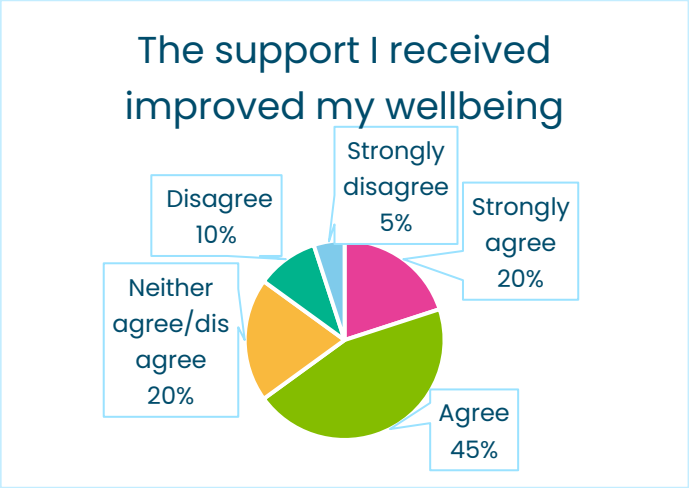
Individuals were asked how much they agreed or disagreed with the following statements:











Is there anything else you would like to share about your experience?

Below are comments left by respondents.

Positive

6

"I just want it all to be sorted and I've got a cancer appointment next week which I'm worried about. Thanks for taking the time to listen to me today, most people just hang up."

"I was diabetic and didn't know until my safeguarding social worker started supporting me. I've since also given up smoking and drinking."

"Overall the support from the team was really good."

"It was left to me to make my own decision – they gave advice but ultimately it was left to me, I wasn't pushed into anything and I can still ring them."

"I turn up every day at Duke Street to chat with them!"

"I felt understood and supported and I knew that there were no half measures and they did everything at the time that needed to be done and I wasn't on my own."

"I could always contact them if needed. I've been happy with the support I've had."

"I'm just glad it's all worked out and things are much better for my son."

"They were sympathetic. It took a while and the process is still ongoing but the safeguarding team have done everything they can as part of that process."

"The social workers really put me at ease – when they got involved I really felt like I could get somewhere. They dealt with everything really quickly and I'm happy with how things are going – just now need to find somewhere good for my husband."

"It was ok really but it was hard when I was made to feel like the guilty party."

Negative

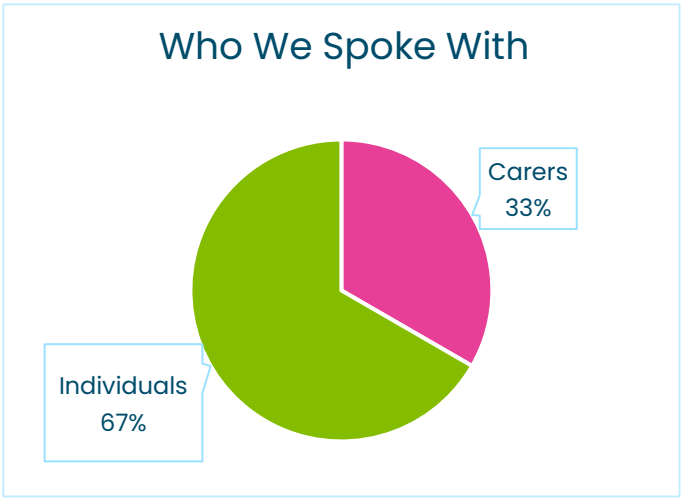
"I don't even know why I had to be put through it. It was stupid. I'm fully mentally competent so I should have a choice of making my own decision."

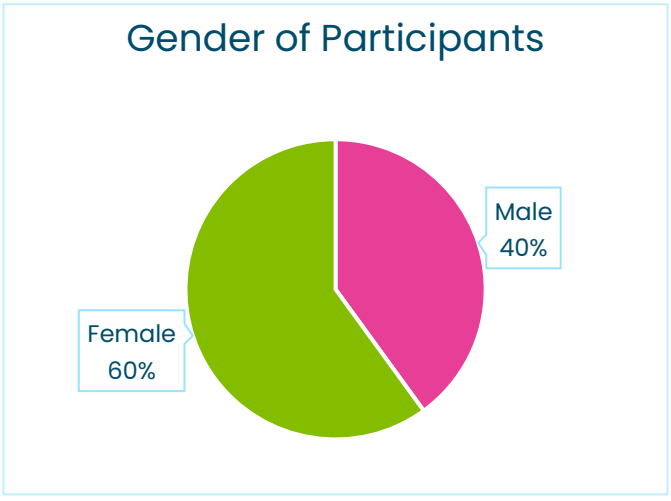
"I just feel completely disregarded, ignored and I didn't know my case had been closed. I haven't heard anything from the police at all."

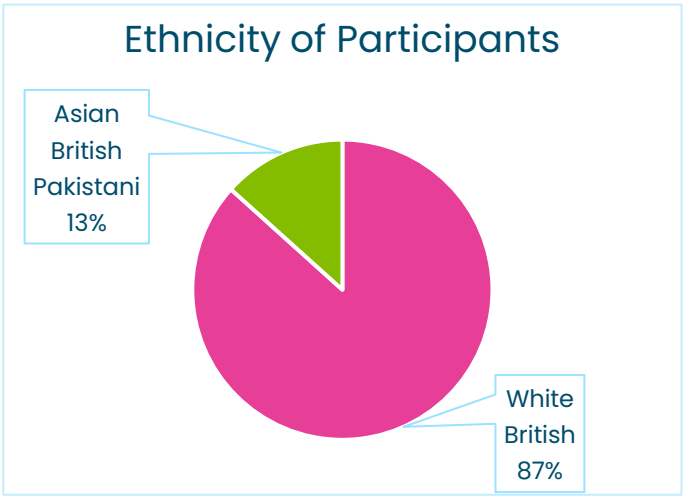
"I just don't feel safe still and if I've got problems I want to have someone to talk to. I don't want to suffer from being bullied again and I don't want to be fobbed off. I struggle with my learning difficulties and schizophrenia and would just like someone to talk to."

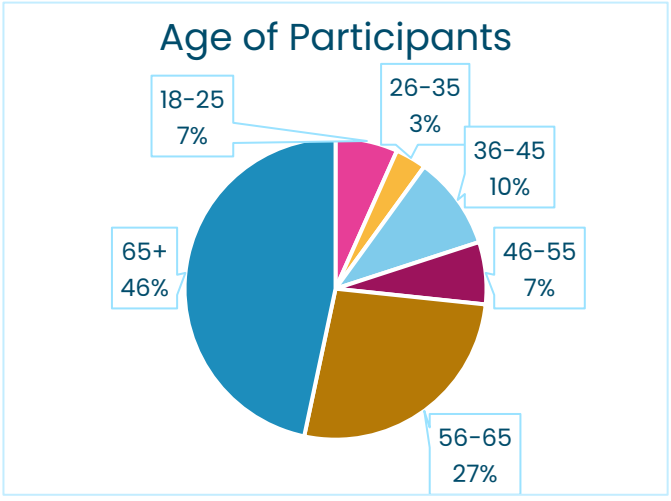
"I just didn't understand where it had come from. My mother-in-law had hurt herself a month earlier but no one contacted me but because she broke her hip someone from the home told me social care would be contacting me. That said they acted on it in the week."

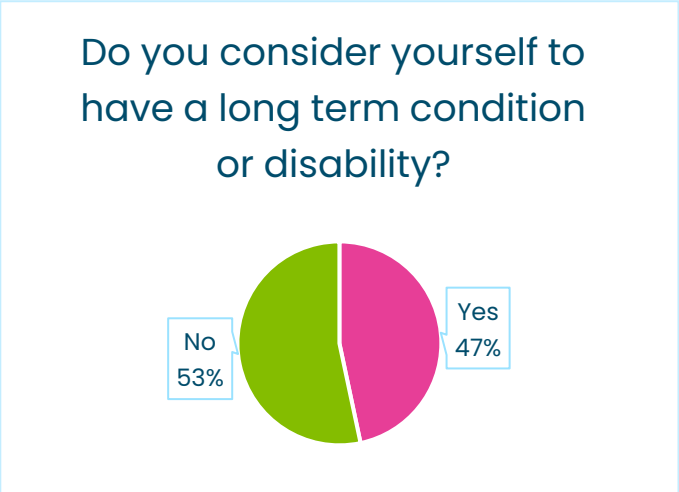
Demographics











Conclusion

Overall, feedback has highlighted good working practices, however, there are some areas for improvement. The majority of individuals and carers felt involved in the enquiry and felt that they were listened to. Most respondents felt that it was easy to get in contact with the safeguarding team and over half were asked what support they needed. However, negative experiences included not being informed they were part of a safeguarding enquiry, carers not being asked what support they needed and not feeling involved in the enquiry.

Recommendations have been formulated based off feedback received.

Recommendations

In addition to the overall recommendations, Healthwatch Blackburn with Darwen have made the following 'Blackburn with Darwen' specific recommendations:

1. Aim to close the feedback loop with those involved in a safeguarding enquiry before closing the case or stopping contact, to ensure individuals are not left wondering what the outcome is. Communication is key.
2. Develop a consistent approach to supporting individuals across the safeguarding team, and ensure they have a good understanding of the situation throughout, to help ensure that some people do not feel ignored through the process. Clear communication and listening to people's needs and preferences is essential to making safeguarding personal.

Blackburn with Darwen Safeguarding Adult Board (BwDSAB) Formal Response to Recommendations

Following the publication of the report, the BwDSAB will take the following steps:

- The BwDSAB will welcome Healthwatch representation to present findings at the next BwDSAB meeting in December 2023. The Partnership will be encouraged to discuss the findings and or recommendations, on both a Blackburn with Darwen and Pan Lancashire footprint.

- All recommendations will then feed into the BwDSAB 'Promote subgroup' where the recommendations will be broken down into effective actions and work plans.
- Updates made on actions and work plans will be periodically reported to the Board in order to provide assurance.
- The work undertaken on Healthwatch recommendations will be featured and reflected in the BwDSAB 2023/24 Annual report.

Safeguarding Voices in Blackpool

Executive Summary

This executive summary offers a comprehensive overview of the key themes and findings from the responses of individuals and carers involved in safeguarding enquiries living in Blackpool. It highlights the diverse experiences and emphasises the importance of clear communication, involvement, and support throughout the safeguarding process.

These findings can serve as valuable insights for further refinement of the Making Safeguarding Personal agenda in Blackpool, to better meet the needs of individuals and carers involved in safeguarding enquiries.

Varied explanation and understanding: The understanding of what a safeguarding enquiry entails varies among individuals and carers. Some reported clear explanations, particularly those with previous experience in the health and social care sector or through external agencies. However, an equal number did not receive any explanation, resulting in uncertainty and confusion.

Listening and involvement: A substantial proportion of individuals and carers expressed that they felt listened to and involved in the safeguarding process. They emphasised the importance of their opinions being considered and regular involvement in meetings.

Conversely, some participants reported not feeling heard or being actively involved, citing poor communication, lack of empathy, and inconsistent approaches as barriers to effective participation.

Support and future planning: Experiences with the support provided during the safeguarding process were mixed. Several participants praised the support received, describing it as "excellent," "brilliant," and "outstanding." They highlighted effective practice, clear explanations, and a caring approach.

Others expressed negative experiences, noting that support was often hindered by stretched resources, inconsistency, and a lack of information. Some reported feeling unsupported and left to handle issues themselves.

Receiving relevant information and clarity: Most participants reported that they received relevant information that was easy to understand. Effective communication and clarity were appreciated.

However, a few individuals noted a lack of information following their interaction with adult social care, leading to frustration and confusion.

Involvement in decision-making: A majority of participants felt involved in the decisions made during the safeguarding process, with their opinions considered and valued. They found this to be crucial for the success of the process.

However, some individuals reported limited or no involvement, attributing this to inconsistent decision-making and poor communication.

Planning for the future: Approximately half of the participants reported having a plan for the future, which was facilitated by social care, external agencies, or their own initiative. This planning was seen as essential for ensuring the well-being and safety of the individuals involved.

On the other hand, some participants had not received any support for future planning, while a few did not believe it was necessary.

Additional comments: Several participants provided additional comments related to their experiences with the safeguarding process. These comments covered both positive and negative aspects, emphasising the need for better communication, reassurance, and feedback.

Recommendations were made to improve practice, including regular updates, spot checks in care homes, and providing additional reassurance to individuals and carers to ease the emotional impact of the process.

Findings

When asked whether it was explained to the individual or carer what a safeguarding enquiry meant, responses were mixed, with some people having a greater understanding than others. Having previous employment experience within the health and social care sector contributed to a greater understanding.

11 individuals or carers stated that it was explained what a safeguarding enquiry meant.

"Yes somebody explained. A social worker explained that she would be going over this safeguarding issue."

"Yes it was explained to me really well. The social worker let me know that dad's occupational therapist had expressed concerns with regards to his mattress and his bed sores. He wasn't always sat up properly in bed when eating she explained that it might be a choking hazard."

"Yes, the learning disability nurse explained to us and she goes to all the meetings. I deal with her in terms of the safeguarding enquiry. That's my choice."

"It was explained to me but not my mum. She has dementia... A lady from the DOLS team called me and I mentioned the falls, then the next thing, the lady from social services rang me to say she'd had a conversation with the lady from the DOLS team and said the home hadn't reported mum's falls correctly. The lady from social services explained everything and did a full investigation."

Despite this, the meaning of a safeguarding enquiry was not explained to 11 individuals or carers, with an additional 3 people being unsure.

"No. I phoned up Social Services so the incident of physical abuse towards me was entered on his record, but nothing was explained to me about safeguarding."

"No I don't think so."

"Not really."

"I wouldn't say it was explained. They told me something had happened and they were looking into it."

"No. I have had no communication from Blackpool Borough Council at all about the issue. I only interacted with the care home staff about the incident."

4 individuals or carers had a greater understanding of what a safeguarding enquiry meant, due to working within the health and social care sector.

"I didn't need it - I am a retired district nurse so it wasn't something new to me."

"Not really but I do work in the industry so I know what this means, it was me that originally raised the safeguarding so I knew what to expect. I explained it to my Mum and Dad and told social care I would do that. They rely on me to be their voice anyway."

"I already know this information from processing safeguarding's in my previous roles."

2 individual's or carers had an understanding of what a safeguarding enquiry meant through being informed via an external agency.

"The agency that worked with him (my son) at the time, reported it and they briefed me about it."

"It was the care worker who got in touch with the social worker... District nurses were sorting it out, but care workers don't understand the situation with my wife's leg, which weeps sometimes, and they thought it was a safeguarding concern."

Were you told that you were involved in a safeguarding enquiry?

For 17 individuals or carers, they were informed that they were involved in a safeguarding enquiry, usually via a telephone call or being told by the manager of a social care provision. An additional 3 participants mentioned they were the person who raised the safeguarding enquiry in the first instance. In contrast to this, 4 participants are unsure as to whether they were told they were involved in a safeguarding enquiry, typically due to the length of time since the event. For 5 people, they were not told they were involved in a safeguarding enquiry until activity started to happen. Quotes illustrating these themes are displayed below.

Yes:

"The manager informed me yes. The nurse said my sister or I would be receiving a call."

"Yes we were. We had a meeting with me, a lady from the council and three people from the home to discuss the council's findings. My mum has had a couple of issues since and these have been resolved."

"Yes they let myself and dad know from the very beginning. [Social Worker] went above and beyond and really exceeded what she really needed to do. She ticked every box."

"I was contacted on both occasions by the care provider to inform me a Safeguarding concern had been raised regarding my son but no further information was offered."

"Yes, I received a phone call and someone came for a visit. The incident happened in March, but I didn't have a visit from anyone until August."

No:

"I thought it was something about my brother that was being looked into initially, as he he has a learning disability and is vulnerable himself. I wasn't informed it was about concerns over my brother taking advantage of my Grandad financially."

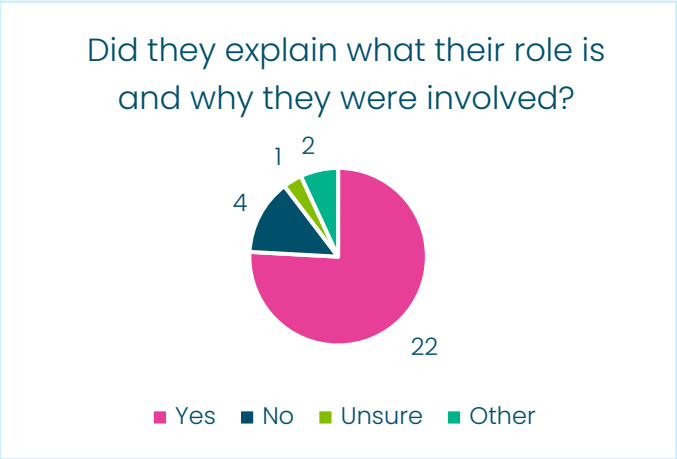
"No, it seemed all a fuss about nothing all of a sudden and I was confused because I have the concerns all the time."

"No, I didn't have any correspondence from Blackpool Borough Council. I was just told by the care home staff that my Mum had had a fall."

Unsure:

"I don't think so, not that I can remember but my memory is bad at the moment, i'm having problems with my short term memory. I know I've had a problem with my daughter taking money out of my bank."

"I'm not sure, they were asking me several things, [Social Worker] and her supervisor were asking me questions about the friend I've got who was draining my finances."



Was it easy to contact the person/s involved if you had any questions?

Participants were asked how easy it was to contact the person involved, and their responses varied. Sixteen participants said that it was easy to contact their key person, and some said that they were given multiple contact numbers and that if their calls were missed, they were always called back.

"Yes, we had a mobile number and also the admin number from the Council, they always called back."

"They gave me their contact details and showed me their identification. He wrote his number down and I was going to phone him recently, but haven't done yet. The main woman locally gave me her phone number as well."

Nine participants said that it was not easy to contact the person involved and gave reasons such as "They never got back to me or followed it through" or "I wasn't allocated anyone to deal with it." One participant said that they only received an introduction to a key contact after "constant emailing to find out what was happening."

"I'm not sure because initially I spoke to two or three people from Lancashire, so it was a bit confusing. There wasn't much continuity and I struggled a little with this, not knowing who was helping with what."

"On the second safeguarding incident, due to my constant emailing to find out what was happening a Safeguarding Officer did call me and introduce themselves to reassure me of her involvement and that my son had come to no harm. I was not given her contact details for if I had any further queries."

Two responses were mixed, with one participant stating "Yes it was fairly ok, I had to leave the message and wait for a reply back, the second time it was quick but the first time it got lost." One respondent stated that they had never contacted the person involved.

Did the person/s tell you what would happen and when?

When asked if an explanation was given regarding what would happen next and when, experiences were mixed, with some individuals and carers feeling greater clarity from adult social care than others.

16 individuals or carers stated that the next steps were explained to them by a member of staff within adult social care.

"Yes it was explained and kept me updated. She rang me on a regular basis."

"She explained that she was changing all my banks over and setting up new accounts so she told me when that had all happened."

"Yes - she did everything for me. She was brilliant I just wouldn't have known how to do it."

"She did and explained what would be put in place. She handled it really well."

"Yes she explain what goes on with the safeguarding enquiry and any outcomes."

In contrast, next steps in relation to the safeguarding enquiry were not explained to 7 individuals or carers, with an additional 2 people requiring no further action

"Not really to be honest, but I think they relied on the fact that I would know anyway. It took me quite a long time for me to find out what was going on but I knew they would be doing work behind the scenes. It would have been a bit better being kept more up to date but I understand it was difficult because we were both struggling to keep in touch sometimes with clashing work hours. Sometimes I can't have my phone at work so we'd miss each other.

CQC were good at keeping in touch and got back to me straight away. I had raised some concerns beforehand and these hadn't been dealt with yet. They didn't have a care plan so I wrote a rough one myself and pinned it to the wall. I'd sent all this information through to the company but they hadn't provided the carers with any of this information. I stopped the care immediately when my Dad was eating raw chicken out of the fridge because he was starving. They were really at risk and I was so concerned about my parents."

"No there was no breakdown of events and when things would happen, appointments were just set at certain times and I found things out then."

"No one from social care spoke to me about what would happen. The staff working with my daughter suggested splitting the staff up who were involved in the enquiry, but I don't know what that would have done. At first they were going round the houses not making decisions. The manager contacted the head office in the end and raised my concerns, and it eventually all got resolved."

"No one came out to me, it's quite confusing."

"No, they only needed to come for one visit and there were no further concerns."

Additionally, 1 carer had been informed what would happen next, however this has still not been implemented.

"They said they will send a written report of the outcome but we haven't seen this yet."

Were you asked what support you needed?

The responses to this question were evenly spread, with 9 respondents being asked what support they would benefit from and 10 not being asked this question. As well as this, an additional 5 participants were offered further support, but decided not to take this.

Yes:

"Yes they asked me what I needed but I wasn't really sure."

"Yes - the safeguarding lead was very supportive and kept in touch via email."

"Yes, they made a referral and got me in the Phoenix Centre pretty quick."

Yes, but I didn't take it:

"Yes, we were offered support, but we didn't accept the support."

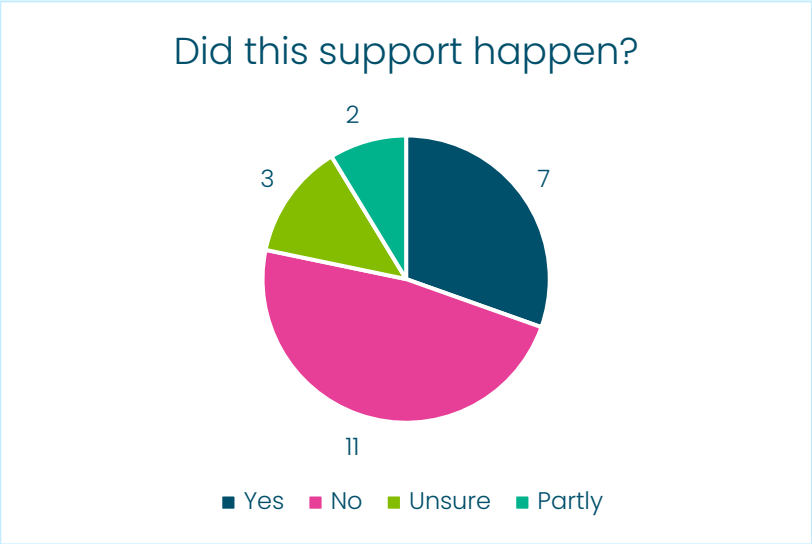
"Yes - X identified that respite was needed. They arranged it but I never used it."

No:

"No, very limited. I was redirected/signposted to other services for support."

"No. Although I'd already addressed the concerns and didn't want any other support. There was no need for them to ask me this."

"I asked for certain support but they didn't have the funding or capabilities to do it. The resources just weren't there, but they tried their best."



48% did not receive support they asked for.

If you are a carer, were your needs discussed?

Carer's were asked whether their needs were discussed during the safeguarding process. Eight carers felt that their needs were discussed, however some felt they did not require any additional support "They did mention something, but I was alright. I didn't need it." One participant stated "My needs were always considered" and another said that they were still in the process of arranging additional support.

A further seven carers felt as though their needs were not discussed.

> "I want to be welcome when I come and see my daughter. They weren't very nice with me. Other than that, I didn't have any and just got on with it, sorting things myself."

Seven carer's responded "not applicable" or their responses were unrelated to the question asked.

Did you receive all the information that you needed in a way that was easy for you to understand?

When asked if all the relevant information needed was received in a way that was easy to understand, 18 individuals or carers answered yes, with 5 of these emphasising how well information had been explained.

"Everything is easy to understand when the staff member explained it to me."

"It was ok to understand and she chased people for me."

"Yes - I understood it clearly and received it via email as promised and I understood it."

"Yes - I got all the paper work and it was explained to me what support I could have."

In contrast, 5 individuals or carers did not receive any information following their interaction with adult social care.

"I never received any information. It was a phone call and then a meeting. I was given opportunities to ask questions at the meeting."

"I didn't receive any information, they don't get back to me with anything."

2 carers required no further information.

“They didn't even give me the process, I just informed them to update their records. No further contact was needed.”

“There wasn't that much actually to go through, everything was communicated verbally and one or two texts.”

Were you able to provide your opinions and let people know what was important to you? Did you feel that you were listened to?

For 18 individuals or carers, they felt as though their feelings were considered and listened to. In contrast, 5 participants did not feel heard or as though their opinions were taken into account. 4 others had mixed experiences, with some professionals listening to what was important to them more than others.

Yes:

“Yes and these were also acted on. They got the person who owns the home and resolved a lot of the issues.”

“Yes. The main thing was they needed it on record, they understood why I'd made the call and listened to my concerns.”

“Yes I explained my concerns with my wife’s safety and this was the first time they’d ever listened to me”

No:

“No one really listens to me, I do share my opinions but not many people listen.”

“Not too much. Nothing to do with the social worker, just Blackpool Council, they were not very helpful.”

“I asked them about one particular thing about her falling out of bed but it happened again so I don't think it's been sorted.”

Mixed:

“I do feel listened to by the care home and they do understand, I don't know if safeguarding understand this because they don't say much or feedback to you, they just listen and then I'm assuming come to conclusion. I don't think it's a lack of empathy, I think it's just horrendously hard and a struggle to run a home and keep people safe.”

"Yes within limits, they tried to guide the process a certain direction when realistically it should have been different."

"Well it was very difficult for me to say because the circumstances were being told to me. Other than is she ok, what happened. They told me what they knew."

Was it explained to you what was happening and why?

When asked this question, sixteen participants answered 'yes', with further comments including "informed throughout" and "They explained their concerns with my wife". One participant highlighted good practice after their experience of the professional ringing first to arrange a time and then being on time for the visit. Another participant stated how the process of assessment for a new home was explained well to her.

Three participants described negative experiences of being informed about what was happening and why, with one stating:

"I was asked for all the information I had and then at the end they've done a lessons learnt but there wasn't really a conclusion as such. Once I got told they were contacting the contracts manager but didn't hear what happened after that".

Did you feel involved in any decisions that were made?

When asked if individuals or carers felt involved in the decisions that were made, 16 people answered yes, stressing the importance of feeling listened to and regular involvement in meetings.

"Yes I feel like I was involved and they allowed me time to talk and advocate on my wife's behalf"

"My brother was involved but his decisions were based on finances. There were some face to face meetings at the care home that we all attended together."

"Yes and they listened to us. The home have more staff now and the lounge is monitored all the time, whereas no one used to sit in there beforehand. we have a residents meeting one every six months and I raise stuff then. I'm going to raise next time that they need more staff."

"Yes entirely. I was very direct within knowing my mum the best and getting that communicated in meetings."

"Yes - I didn't feel shut out at all."

"Yes definitely. I can't fault the way staff handled it. She was very supportive of both of us (me and dad)."

"I was aware of everything that going on at the time and I was listened to. I felt like my opinions mattered."

In contrast, 6 individuals or carers felt they had no or limited involvement. Particular emphasis was given to poor communication and not feeling heard.

"We don't sit down with anyone and discuss decisions, the communication here and with social care is poor. I nearly cried this morning because they ignore me."

"A lot of people were on annual leave at the council and I was trying to contact people but there wasn't anyone there at this time, so I did most of it myself. I think they left me to it a lot of the time because I know so much from my job."

"I felt like I was done to a little bit."

For 3 carers, no further decisions were required. An additional 1 carer felt comfortable with social care staff advocating on their behalf, rather than being involved in decision making directly.

"I didn't have to be because they phoned me after the event. So no not really. They told me what they had done. There wasn't much more they could have done."

"I just let social care go into meetings because I don't feel like I'm listened to. They already make the decisions before you go at the harbour so we just leave them to it. I don't think they follow up on what she needs anyway."

Did you receive any support to plan for the future?

There were 11 individuals or carers who stated they have a plan for the future, whether that be through social care offering support with this, signposted to the appropriate place or organising it themselves. However, 9 people did not receive any support to plan for the future. An additional 4 respondents felt this was not required.

Yes:

"Yes - this is ongoing. Mum continues to receive 1-1 support and this has been reviewed in the last couple of weeks. I was given advice and updates after the safeguarding's were closed."

"Yes, they're coming round next week to discuss a night time support worker which I suggested to keep her safe."

"I did most of the planning for the future myself, I've raised 2 additional safeguardings in the past few weeks and haven't had much support for that. My parents are deteriorating now and they've come out to assess but it's really difficult not having one of us there. I've still not had an update from that. I want to know what they need me to do and what they can offer us to help. They haven't offered us help to find another PA."

No:

"No, they never referred me to a social worker either (which I wanted and asked for during the visit)."

"Not yet, I've got cancer so I'm not really worried about the future."

"I don't have a plan for the future."

How would you describe the support you received?

Eleven participant's responses to this question were positive, with participants describing their experiences as "Excellent", "brilliant" and "outstanding". Reasons for these responses were due to experiences of effective practice, communication, clear explanations without the use of jargon, and a kind and caring approach to support. Many stated that their issues were resolved, with some professionals going "above and beyond, giving advice on many other issues and offering future contact".

Conversely, six participants described negative experiences. Some issues with support included staff being "too thinly spread" and therefore being unable to dedicate the necessary time to their case. Inconsistencies in a proactive approach is cited by two participants.

"Sometimes they say we'll get this and that plan in order and then it works for a bit but then it drops off and I feel like I'm back to square one. I get my hopes up each time so it's hard when the surface disappears".

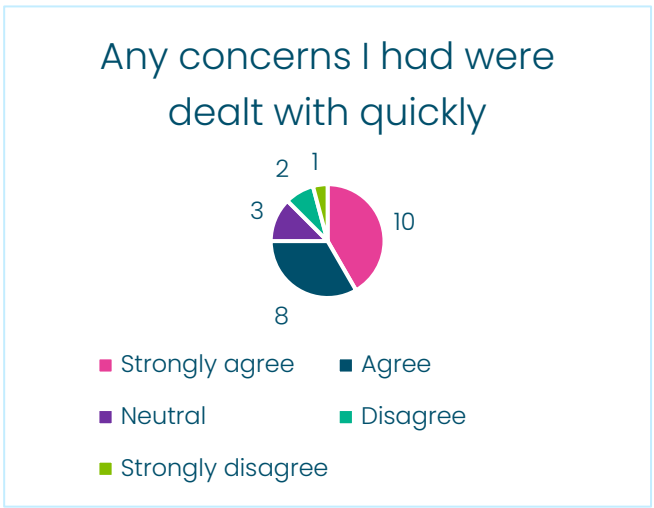
"I don't think enough was done".

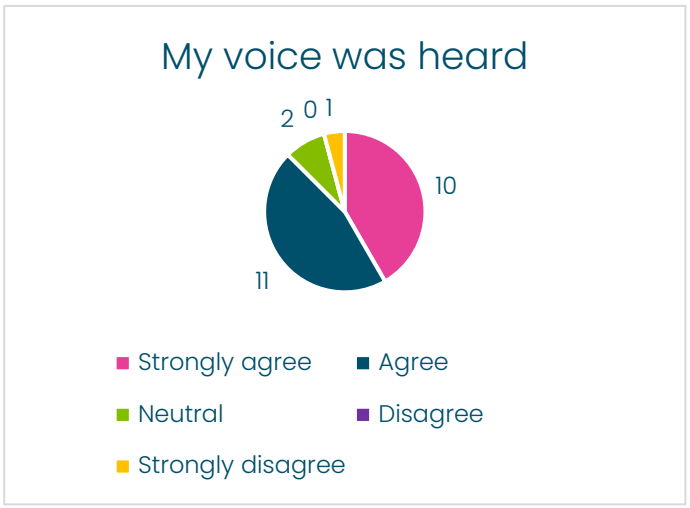
Another participant described their experience as follows:

"The support I needed was information, honesty and openness of which I received none".

Three participant's responses were either not applicable or mixed in nature, with one stating:

"Just being kept in the loop is all I ask really. I think I was mostly, although it must have been difficult for the council as I live at distance. I believe everything was done in her best interest."





Is there anything else you would like to share about your experience?

In response to this question, seven participants wished to share further details about their positive experience with the safeguarding process:

"The council were approachable and it was good."

"Just very reassuring."

"Social services have been pretty good to me. They have all been helpful and done whatever they can. I know it's not easy for them, but they've all been so supportive, I can't thank them enough."

Equally, another six participants wished to share further details about their negative experience with the safeguarding process.

"I've done a complaint to social care. Nothing has been done. It was disgusting and we told them. This went on for weeks and we kept saying she needs this tablet. Finally after weeks and weeks she got the tablet. It cleared up within a week. This is why parents and carers don't get involved because we don't have a voice."
"There were bruises to prove my abuse, so I had evidence, but more people need to be listened to and believed."

One participant described the emotional impact the safeguarding process had on them as a carer:

"Please feel free to call and discuss. On two occasions my son has been the centre of Safeguarding concerns. The care provider has called to inform me of them but no further information was offered. As a parent, thousands of miles away to be told their child is involved in a safeguarding incident, not to worry, they have come to no harm but we can't give you any details until months down the line and even then not a full account was very difficult. After both of these incidents were over and the 3 staff concerned allowed to leave their caring role. No further action was taken and they were all free to go and work for other local care providers with no record of these incidents against them. 2 of the 3 have seen my son in the community since and blame him for 'having to leave their job' when it was their actions that led them to leave their job."

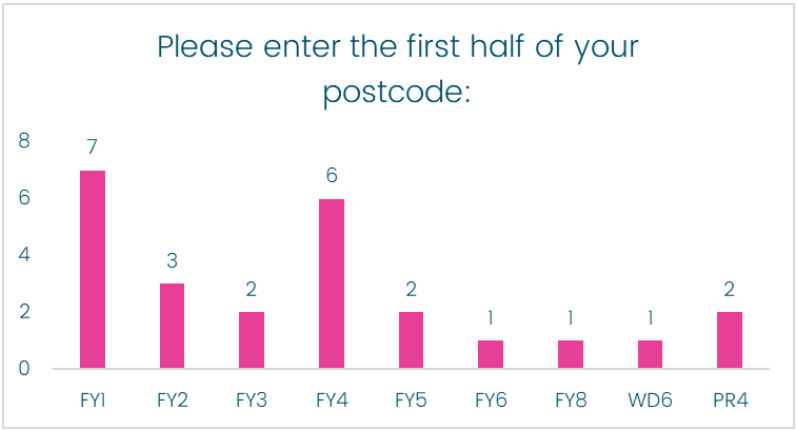
Five participants wished to offer recommendations for better practice based on their experiences. One participant stated that their experience would have been better had they been "updated more on a regular basis" with another stating "Someone to do spot checks in the home would be really beneficial".

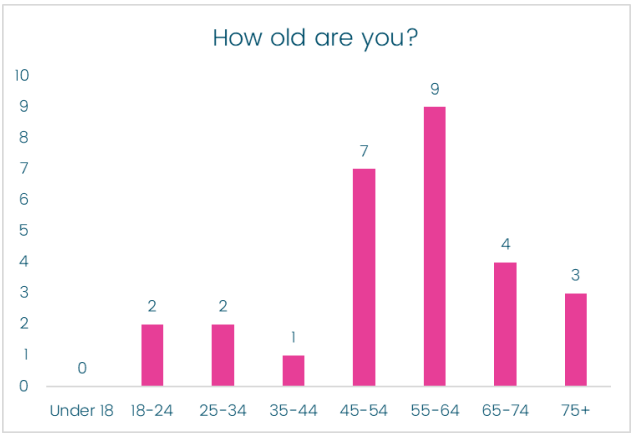
Two participants made suggestions regarding how better communication would have provided more reassurance and impacted positively on their wellbeing:

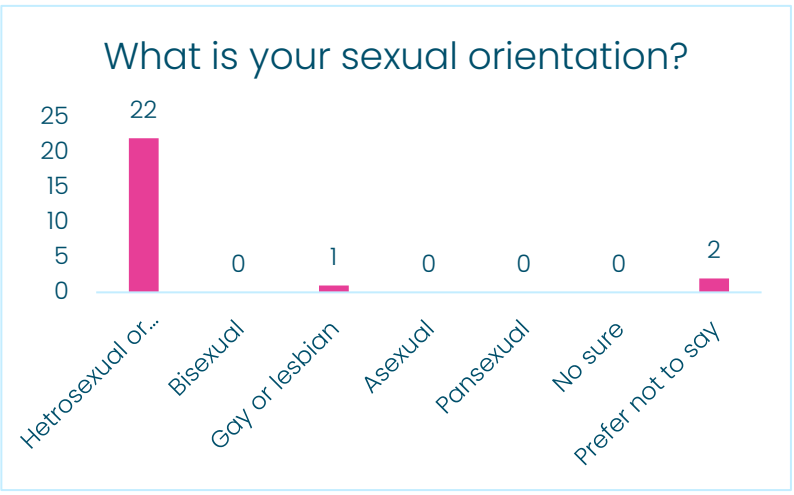
"They never informed me of the outcome, I was only made aware of the police investigation. I discovered the staff member was sacked, but through hearsay. It would have helped my mental wellbeing and helped put my mind at rest knowing it had been resolved. This really would have made all the difference."

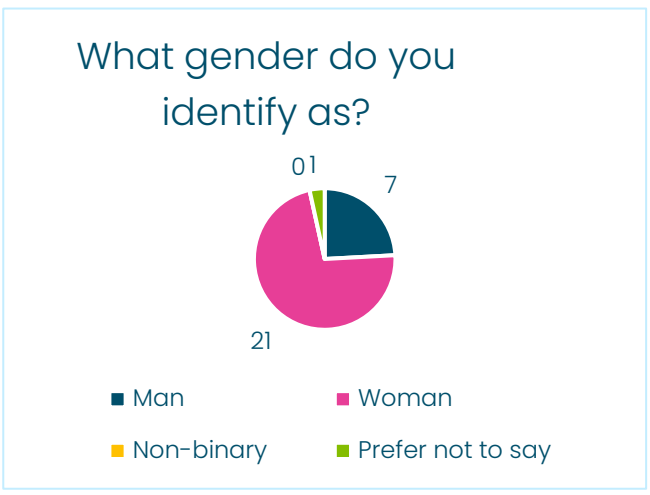
"I think sometimes you could do with that extra bit of being told that you're doing the right thing, so some reassurance would have been appreciated. This could help others in the future if they were given some reassurance by the professionals, as it's not easy making that call, especially about a family member."

Demographics









Conclusion

Overall, individual and carer experiences of the safeguarding process were extremely varied, with some having a positive interaction with the process and others struggling. Particular areas to celebrate included staff providing timely information that was easy to understand. Staff listened to the needs of those involved in the safeguarding enquiry and implemented proactive action plans going forward. Despite this, there are inconsistencies with people's experience, as some recalled receiving little communication, struggling to understand what was happening with the safeguarding process and not having their voices heard.

The following recommendations aim to address the variations in experience described throughout this report.

Recommendations

In addition to the overall recommendations, Healthwatch Blackpool have made the following 'Blackpool' recommendations:

1. Aim to contact individuals and carers early in the safeguarding process to remove confusion and gain involvement from those involved at the earliest opportunity. It is crucial that communication is initiated in a clear and concise manner from the outset to avoid confusion.

2. Allocate a designated Safeguarding Officer to each enquiry where possible, to foster positive rapport and consistency. Each individual or carer should be made aware of the most appropriate method to make contact with this worker should they encounter any difficulties or have any further questions.

3. Ensure communication is followed through in a timely manner, particularly when an individual is informed they will receive a further telephone call or visit. It may not always be required to have additional contact with an individual or carer, but this should be explained in order to manage expectations and create a trusting relationship. The next steps in an enquiry should always be explicitly clear for those involved, where possible.

4. Aim to close the feedback loop with those involved in a safeguarding enquiry before closing the case or stopping contact, to ensure individuals are not left wondering what the outcome is. Communication is key.

Blackpool Safeguarding Adult Board (BSAB) Formal Response to Recommendations

The Blackpool Safeguarding Adult Boards (BSAB) extend their appreciation to all participants who engaged with the 'Safeguarding Voices Project' led by Healthwatch Lancashire. The engagement has been vital in providing an insight into the lived experiences of the residents of Blackpool involved in the safeguarding processes.

Following the publication of the report, the BSAB will take the following steps:

- The BSAB will welcome Healthwatch representation to present findings at the next BSAB meeting in January 2024. The Partnership will be encouraged to discuss the findings and or recommendations, on both a Blackpool and Pan Lancashire footprint.
- All recommendations will then feed into the BSAB 'Making Safeguarding Personal Subgroup' (MSP) where the recommendations will be broken down into effective actions and work plans
- Updates made on actions and work plans will be periodically reported to the Board in order to provide assurance.
- The work undertaken on Healthwatch recommendations will be featured and reflected in the BSAB 2023/24 Annual report

Safeguarding Voices in Lancashire

Executive Summary

This executive summary offers a comprehensive overview of the key themes and findings from the responses of individuals and carers involved in safeguarding enquiries. It highlights the diverse experiences and emphasises the importance of clear communication, involvement and support within the safeguarding enquiry process.

These findings can serve as valuable insights for further refinement of the Making Safeguarding Personal agenda in Lancashire.

Explanation and understanding: A higher proportion of carers compared to individuals shared that it was explained that they were involved in a safeguarding enquiry. For those it was not explained to, this left people feeling confused and unsure what was happening. There was mixed feedback from individuals and carers regarding whether staff introduced themselves, explained their role and why they were involved. Some respondents shared that they were not always contacted by the same professional which they would have preferred during a distressing time.

Receiving relevant information and clarity: Only half of individuals shared that they were clear on actions being taken along with timeframes, with a slightly higher proportion of carers having this understanding.

Communication: Feedback has revealed that there is an inconsistent approach regarding communication between professionals and individuals/carers involved in a safeguarding enquiry, with some being provided a direct contact number and others being provided a main office number.

Support for individuals: 61% of individuals were asked what support they needed but only 40% of these said that they received this support. Four individuals shared that they were Autistic and/or had a learning disability and relied on their key workers for support.

Satisfaction rates for support received by individuals was varied and there was mixed feedback from individuals about whether the support put in place improved their wellbeing. Less than half of individuals received support to plan for the future.

Support for carers: Only 35% of carers were asked what support they needed and although most carers shared, they were focused on the support needed for the individual, feedback suggests that some carers did not feel supported regarding their own wellbeing.

Praise for social workers: Positive feedback was given about social workers, with comments made about their empathy, professionalism and offering of personalised care.

Accessible information: Satisfaction rates were fairly high regarding the format in which information about the enquiry was presented to them, however, suggestions were made to make information accessible.

Involvement and feeling heard: Feedback from individuals and carers was mixed regarding whether they felt listened to, with a lower proportion of individuals feeling involved in decisions. Feedback from individuals indicated that many felt they had to 'push' for what they wanted, or decisions had already been made by the time they were informed, which made individuals not feel involved in the process.

Findings

Explanation and understanding

Respondents were asked if it was explained to them what the term 'safeguarding' means and findings show that this appeared to be explained to carers but not as often to individuals, with 73% of carers saying it was explained, compared to only 46% of individuals.

Individuals' feedback showed that many felt confused and not sure what was happening, whereas carers shared that a social worker contacted them and explained there was a safeguarding enquiry and what was going to be investigated. Despite this, there was still a large proportion of people who did not understand what was happening and who was involved. Feedback also indicated that both individuals and carers were told the issue was being investigated but the term 'safeguarding' was not used.

> To be honest I would have liked for them to provide me with more information. We have heard horror stories in the past related to Safeguarding and we didn't really get the detail about what the process would entail. Everyone was very keen to get the process completed and we felt that a little more information would have helped us as lay-people understand the ins and outs of what it meant. We know there was an issue reported and that there were things put in place immediately but I am still awaiting some other details - *carer.*

"I had a real job to understand what was happening as the person who called me was not very clear when speaking to me on the phone" – *individual*
"The social worker rang and said that he would call me back. He explained that they were investigating my brothers care, I cannot remember if they used the term 'safeguarding' but I understand what the conversation was about" – *carer*

There was mixed feedback from individuals and carers regarding whether staff introduced themselves, explained their role and why they were involved. 65% of individuals said that this was explained to them which helped with the process. In comparison, this was explained to 75% of carers who shared that the social worker was professional and enabled them to talk about the situation.

Of those who said this was not explained, feedback described how they were contacted by multiple people and they would have preferred to have contact with the same professional and when professionals did not introduce themselves, this made an already distressing event, confusing.

"They [staff] did [introduce themselves and why they were involved] but because a lot was going on, I didn't really take on what was going on. My mind switched off at the time so I found it very confusing" – *individual*

"It was a different person every time which was confusing. I have so far spoken with three different people. It would be nice to have a bit of familiarity with one person" – *carer*

To investigate how much respondents understood the safeguarding process and how well this was explained, respondents were asked if they had been told by a professional what was happening along with timeframes. 50% of individuals shared that this was not explained to them. This left individual feeling confused and unaware of what the next steps were. However, there were individuals who understood the process due to professionals explaining what steps were being put in place and why.

"They decided for me and in the beginning, I felt that decisions were being made without talking to me" - *individual*

A higher proportion of carers appeared to have a clear understanding than individuals on actions being taken within the safeguarding enquiry. 52% of carers said that this was explained to them, and a further 11% said that it was explained what was happening but clear timeframes were not provided. 4 carers explained that this was not necessary as the enquiry was opened and closed either on the same day or within 48 hours. 2 individuals shared that their loved ones care home informed them of actions being taken but not the safeguarding team. 22% of carers shared that they were not told what was happening which left them feeling like they were not up to date. Two carers shared that they felt like the safeguarding team were keeping information from them intentionally.

"They told me everything at each stage and they also told me that if there was a delay in contacts it was because they were finding out information. They kept me up to date and the findings were clearly explained along with what they were going to do next with the information" – *carer*

"They said that they would contact me at the end of the day but I haven't had any contact since. I sent them an email but I didn't receive any correspondence to the email" - *carer*

Support

Respondents were asked how easy it was to contact the professionals involved if they had any questions. 54% of individuals said that it was easy as they were provided with a contact number which they could contact. 23% of individuals said that it was difficult and this was either because they were not provided with a contact number (5), they did not know who to contact or there was no answer when they did ring.

"Yes I have two names and contact numbers for both. I can contact them when I need to and speak with them regularly" - *individual*

26 carers shared that they did not need to contact anyone about the enquiry. Of the 36 who did, 54% had a positive experience and 43% shared that they struggled to get in contact with the person involved. Many of these shared that they had to speak to multiple people before they were transferred to the correct person.

43% of carers found it difficult to get in contact with professionals

I found it difficult to get back to the safeguarding team there was no direct number for me to use. I had to go through 4 or 5 switches before I could speak to the person that I needed to speak to. They always had to ring me back – *carer*

Feedback has revealed that there is an inconsistent approach regarding communication between professionals and individuals/carers involved in a safeguarding enquiry, with some being provided a direct contact number and others being provided a main office number.

"I had the full name of the person. There is an option when contacting adult social services, to provide the full name of the person that you want to speak to and the phone line will connect you to that person directly. I found this service really helpful, rather than being passed around to different people when you call" - *carer*

Individuals were asked whether professionals asked them what support they needed. 61% of individuals said that they were asked what support they needed, but only 40% said that this support was put in place for them. 40% of individuals were unsure whether the support they asked for had been put in place, with many still waiting to hear from support services.

"I didn't feel supported at all, only when victim support got involved that I felt heard" - *individual*

"They said they refer me to other services but I'm still waiting to hear from them" - *individual*

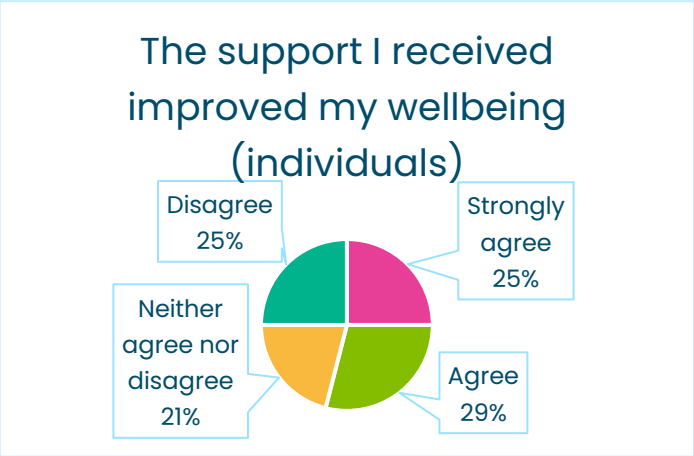
A common theme which emerged was that for those who had Autism and/or a learning disability, they relied heavily on their key/support workers for support rather than the safeguarding team.

"I told her that I had Autism but I didn't have any extra help or support" - *individual*

Individuals were also asked if they had received any support to help plan for the future. Only 46% of individuals shared that they had, with 2 of these individuals sharing that the support was from their key/support staff.

When asked how they would describe the support received, feedback from individuals was mixed with positive and negative comments received.

Positive feedback received from individuals about the support received was mainly praise for the staff, particularly social workers who were supportive and provided guidance.



"It was good, they listened to me, allowed me to speak for myself and helped sort things really quickly" - *individual*

Five negative comments were received from individuals which included a lack of support leaving the individual feeling that nothing was being done, not feeling involved and/or not know what was happening as well as actions being decided which went against what the individual wished for.

"I have had no explanations or evidence to suggest that something is being done to help" - *individuals*

38% of carers shared that they did not need support or did not think it was necessary, with most sharing that they were more focussed on getting the required support for their loved ones. 35% of carers shared that they were asked what support they needed and most of these carers shared that they asked for specific support to be put in place for their loved ones.

"They made sure that I was happy with the new care home and that it worked well for me not just my [parent]" - *carer*

Of the 25% of carers who were not asked what support they needed, feedback identified that carers felt that they were not supported despite the safeguarding enquiry impacting them.

"No, no one asked how we were. There was a lot of input at the start of the process but we have had no follow up or discussion about what we felt we needed. I must add though that at the time of the issue, we were more focused on the incident than ourselves as our relative was more important than us. It is only with retrospect that we can say that nobody checked in on us." - *carer*

The majority of feedback from carers about the support received was highly positive. There was high praise for social workers, particularly around their professionalism, understanding, explanation, support, personalisation, communication and prompt response.

> [Social worker] throughout the process which is still ongoing, has taken the weight and the worry away from us so we can start a new chapter without having to worry about the baggage which was destroying [relative] as a person. Fantastic job. I wouldn't have known where to start but their help and guidance has helped us get to where we need to be and without them I don't know where we would be - *carer*

Six people had negative feedback about the support they received. Four people felt they did not receive any support, one carer shared that there was a lack of clear communication about timescales as well as poor communication between services and a further carer shared that they did not feel listened to.

Satisfaction rates were fairly high regarding the format in which information about the enquiry was presented to them. 65% of individuals and 73% of carers received information in a way that was easy for them to understand, including phone calls and emails. However, feedback shows that when some respondents asked for information in another format, or for a follow-up email after a phone call, this was not always put in place.

"What would have been good is after the phone call we receive a link or an email to explain the conversation that's just happened" – carer

"They said they would keep me updated. they rang me to let me know what was going on. I did ask for letter form but I never received a letter, I was told I would receive emails but I don't have access to my emails" – *carer*

Involvement and feeling heard

Respondents were asked if they were able to provide their opinions and whether they felt listened to. 65% of individuals expressed that they felt listened to and

that they were asked about their opinion and what they would like to happen. They felt informed due to the information received from professionals.

Despite this, only 58% of individuals felt involved in decisions which were made. 3 individuals shared that they felt heard to a degree and this was due to either having to "push" for what they wanted or not feeling like they were updated regularly by the professional to know whether their opinions had been listened to.

"Yes I was really listened to and felt very heard. They always asked me my opinion and what I would like to see happen" -*individual*

"I was not listened to. I was only given one call where I was told what was happening" – *individual*

Similarly, 64% of carers shared that they felt listened to as they were asked what they wanted to happen and this was taken into account.

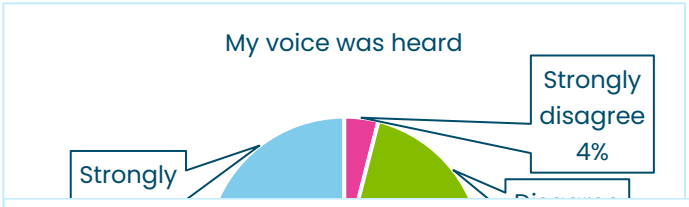
"Yes, they could see where I was coming from, I felt very listened to and the social worker was very emphatic. I felt that my worries were understood and was told if I had any concerns in he future I just needed to contact them" - *carer*

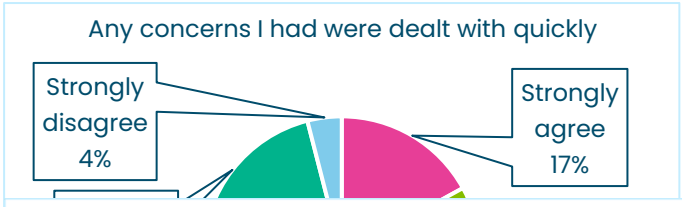
"I was able to have my say. I cannot thank the council and safeguarding team enough" – *carer*

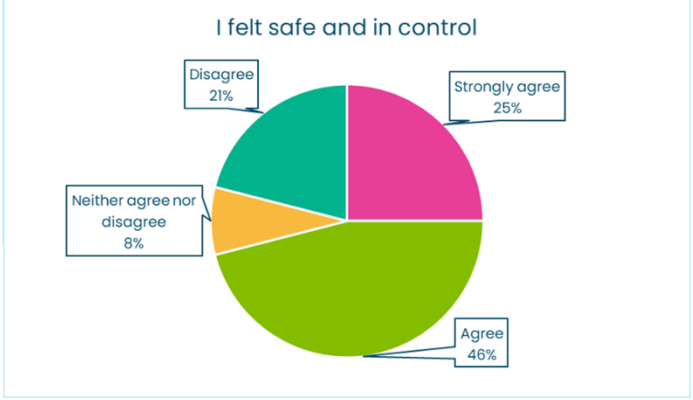
However, an additional 9% of carers shared that although they were asked what they would like to happen, this did not always happen and their wishes were not put in place leaving carers feeling like they were not fully involved.

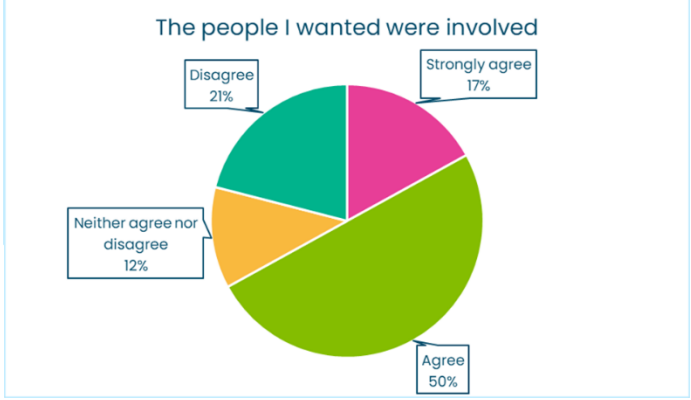
"They investigated the issues but I felt that I wanted a bit more input into the enquiry and how the care was designed. I had evidence to support the investigation that I think could have been used better" - *carer*

Individuals were asked how much they agreed or disagreed with the following statements:









Conclusion

Overall, experiences were varied between and within individuals and carers. Good working practice is evident but not consistent. Areas of good working practice to celebrate includes supportive and empathetic social workers, information being accessible to individuals/carers in most cases and some being provided with a direct point of contact should they have any enquiries or updates to share.

However, this good working practice was not always evident. Some individuals and carers shared that they were not aware they were involved in a safeguarding enquiry, they were not asked what support they needed and they did not feel involved in the process.

Recommendations have been formulated based off these findings.

Recommendations

In addition to the overall recommendations, Healthwatch Lancashire have made the following 'Lancashire' specific recommendations:

1. Provide a more detailed and clear explanation of actions being taken as part of the enquiry to the individual and/or carers, including next steps and any proposed timeframes.
2. Involve individuals and carers in decisions though regular communication (agreed at the beginning of the enquiry) and work closely to put actions in place in agreement with individuals to ensure full involvement throughout the safeguarding enquiry.

Lancashire Safeguarding Adult Board (LSAB) Formal Response to Recommendations

The Lancashire Safeguarding Adult Boards (LSAB) extend their appreciation to all participants who engaged with the 'Safeguarding Voices Project' led by Healthwatch Together. The engagement has been vital in providing an insight into the lived experiences of the residents of Lancashire involved in the safeguarding processes.

Following the publication of the report, the LSAB will take the following steps:

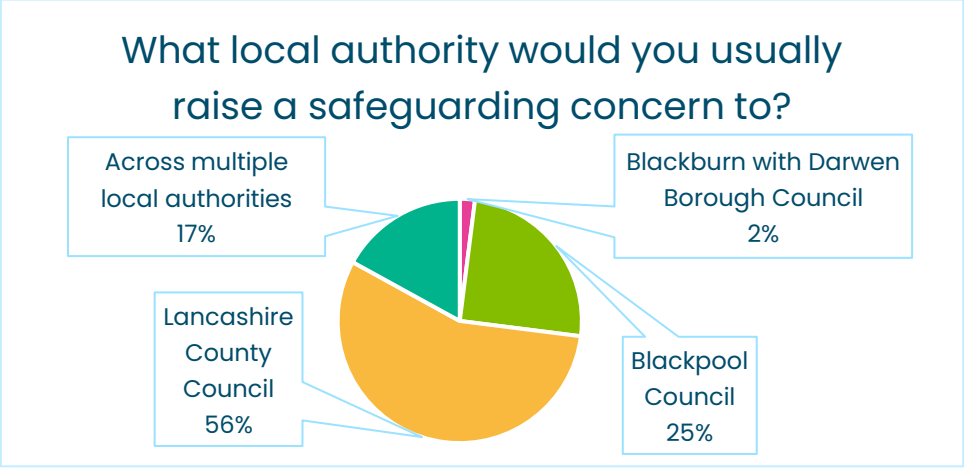
- The LSAB will welcome Healthwatch representation to present findings at the next LSAB meeting in January 2024. The Partnership will be encouraged to discuss the findings and or recommendations, on both a Lancashire and Pan Lancashire footprint.
- All recommendations will then feed into the LSAB 'Listening, Learning and Delivery subgroup' (LLD) where the recommendations will be broken down into effective actions and work plans

- Updates made on actions and work plans will be periodically reported to the Board in order to provide assurance.
- The work undertaken on Healthwatch recommendations will be featured and reflected in the LSAB 2023/24 Annual report

Multi-agency professionals' experiences of section 42 safeguarding enquiries

Findings

Healthwatch Together received **109** responses to the survey from a wide range of professionals, 77% of these had raised a safeguarding concern in the last 12 months. Findings have been analysed per question, as well as identifying any themes within each Local Authority.



Of the 109 who responded, 17% of professionals raised safeguarding concerns to multiple local authorities pan-Lancashire.

The below table displays the sector and professional roles of the respondents to the online multi-professional survey:

Profession	Number of respondents
Local Authority	30
Independent Advocate	19
NHS staff (frontline practitioner)	17
Care provider	16
Voluntary, Community, Faith, Social Enterprise	10
Other NHS staff	7
Police	5

Respondents were asked to rate how much they agree or disagree with the following statements. Graphs of this data can be found in appendix 1.

The process of raising a safeguarding concern was simple to follow

The majority of respondents agreed that the process of raising a safeguarding concern was easy to follow. 92% of those who either strongly disagreed or disagreed that the process of raising a safeguarding was simple to follow would usually raise a safeguarding to Lancashire County Council. Of these respondents, 42% worked for the Local Authority and 33% worked within the VCFSE sector.

The staff member who took my concern had to knowledge and skills to enable them to respond appropriately

Overall, the majority of respondents agreed that the staff member who took their concern had the knowledge and skills to enable them to respond appropriately. Of those who strongly agreed or agreed, 53% would report to Lancashire County Council, 18% across multiple local authorities and 29% to Blackpool Council. Of those who strongly disagreed or disagreed, 73% would raise a concern to Lancashire County Council, 20% would raise a concern across multiple authorities and 1 individual would raise a concern to Blackpool Council.

I was clearly informed of what would happen with my concern within an agreed timeframes

Feedback was mixed from professionals about whether they were clearly informed of what would happen with their concern within an agreed timeframe. Of those who strongly disagreed or disagreed, 59% would report to Lancashire County Council, 21% would report to Blackpool Council, 18% would report across multiple local authorities and 3% would report to Blackburn with Darwen Borough Council. Further, of those who disagreed with this statement, 29% were independent advocates and 24% were NHS frontline workers.

I am confident that my safeguarding concern was responded to in a timely manner

Over half of respondents agreed that their safeguarding concern was responded to in a timely manner. Of those who strongly disagreed or disagreed, 58% would

report to Lancashire County Council, 21% across multiple local authorities, 17% to Blackburn Council and 4% to Blackburn with Darwen Borough Council.

I was given an explanation for any delay/s that occurred

The majority of respondents neither agreed nor disagreed that they were given an explanation for any delay/s that occurred. This may indicate that professionals did not experience any delays and so did not require an explanation. Of those who strongly agreed or agreed, 50% would report to Lancashire County Council, 42% to Blackpool Council and 8% across multiple local authorities. Of those who strongly disagreed or disagreed, 53% would report to Lancashire County Council. 26% across multiple local authorities, 15% to Blackpool Council and 6% Blackburn with Darwen Borough Council.

The outcome of the decision was shared with me

The majority of respondents did not agree or disagree that the outcome of the decision was shared with them. However, of those who strongly agreed or agreed, 56% would report to Lancashire County Council, 22% to Blackpool Council, 19% across multiple local authorities and 3% to Blackburn with Darwen Borough Council. Of those who strongly disagreed or disagreed, 58% would report to Lancashire County Council, 19% across local authorities, 19% to Blackpool Council and 3% to Blackburn with Darwen Borough Council.

If dissatisfied with the response, I know how to challenge the decision made

The majority of respondents knew how to challenge a decision made if they were dissatisfied. Of those who strongly agreed or agreed, 46% would report to Lancashire County Council, 26% to Blackpool Council, 24% across multiple local authorities and 3% to Blackburn with Darwen Borough Council. Of those who strongly disagreed or disagreed, 82% reported to Lancashire County Council. 9% across multiple local authorities and 9% to Blackpool Council

I was involved throughout the safeguarding enquiry

There was mixed feedback regarding the experiences of professionals feeling involved throughout the safeguarding enquiry. Of those who strongly agreed or agreed, 65% would report to Lancashire County Council, 17% to Blackpool Council, 17% across multiple local authorities. Of those who strongly disagreed or disagreed, 48% would report to Lancashire County Council, 24% across multiple local authorities, 20% to Blackpool Council and 8% to Blackburn with Darwen Borough Council.

I was provided with a point of contact if I had any questions or updates to share

Feedback was also mixed regarding whether professionals were provided with a point of contact if they had any questions or updates to share, with 27 professionals strongly agreeing or agreeing and 28 professionals strongly disagreeing or disagreeing. Of those who strongly agreed or agreed, 70% would report to Lancashire County Council, 15% across multiple local authorities, 11% to Blackpool Council and 4% to Blackburn with Darwen Borough Council. Of those who strongly disagreed or disagreed, 46% would report to Lancashire County Council, 29% to Blackpool Council, 21% across local authorities and 4% to Blackburn with Darwen Borough Council. 29% of these were independent advocates.

I was able to provide an input in relation to the safeguarding enquiry

The majority of professionals agreed that they were able to provide an input in relation to the safeguarding enquiry. Of those who strongly disagreed or disagreed, 53% reported to Lancashire County Council, 26% to Blackpool Council, 16% across multiple local authorities and 5% to Blackburn with Darwen Borough Council.

I was made to feel that my contribution to the safeguarding enquiry was valued

The majority of professionals shared that they did feel their contribution to the safeguarding enquiry was valued. Of those who strongly agreed or agreed, 63% would report to Lancashire County Council, 22% across multiple local authorities and 15% to Blackpool Council. Of those who strongly disagreed or disagreed, 55% reported to Lancashire County Council, 22% to Blackpool Council, 17% across multiple local authorities and 6% to Blackburn with Darwen Borough Council. 28% of these were independent advocates.

I was kept up to date of progress throughout the safeguarding enquiry

Feedback was mixed regarding whether professionals were kept up to date of progress throughout the safeguarding enquiry. Of those who strongly disagreed or disagreed, 47% reported to Lancashire County Council, 30% to Blackpool Council, 20% across multiple authorities and 3% to Blackburn with Darwen Borough Council.

Information I received was provided in a timely manner, this includes meeting minutes

The majority of respondents did not agree that the information they received was provided in a timely manner. Of those who strongly disagreed or disagreed, 63% reported to Lancashire County Council, 20% to Blackpool Council, 11% across multiple authorities and 6% to Blackburn with Darwen Borough Council.

I was informed about the outcome of the safeguarding enquiry and action that has been taken

Feedback was mixed regarding whether professionals felt informed about the outcome of the safeguarding enquiry and action that had been taken. Of those who strongly agreed or disagreed, 57% reported to Lancashire County Council, 24% to Blackpool Council and 19% across multiple local authorities. Of those who strongly disagreed or disagreed, 58% reported to Lancashire County Council, 23% to Blackpool Council, 15% across multiple authorities and 4% to Blackburn with Darwen Borough Council.

The feelings, wishes, values and beliefs of the person and their family/carer involved in the enquiry were listened to and respected

45% of respondents did not agree or disagree whether the feelings, wishes, values and beliefs of the family/carer involved in the enquiry were listened to and respected. It could be inferred that professionals were not informed about whether family/carers were involved and whether their feelings. wishes, values, and beliefs were listened to and respected. However, of those who strongly agreed or agreed, 65% would report to Lancashire County Council, 18% to Blackpool Council and 18% across multiple local authorities. Of those who

strongly disagreed or disagreed, 45% reported to Lancashire County Council, 33% to Blackpool Council and 22% across multiple authorities.

The needs of the person involved in the safeguarding enquiry were met with adjustments made accordingly

Similarly, a large proportion of professionals did not agree or disagree about whether the needs of the person involved were met with adjustments made accordingly, which could suggest that they were not involved heavily to receive this information. Of those who agreed or strongly agreed, 52% would report to Lancashire County Council, 26% across multiple local authorities and 22% to Blackpool Council. Of those who strongly disagreed or disagreed, 46% reported to Lancashire County Council, 27% to Blackpool Council, 18% across multiple authorities and 9% to Blackburn with Darwen Borough Council.

The outcome of the enquiry reduced/prevented risk of harm to the person involved in the safeguarding enquiry

The majority of professionals did not agree or disagree about whether the outcome of the enquiry reduced or prevented risk of harm to the person involved in the safeguarding enquiry. Considering these findings with those from individuals and carers, it is clear that next steps are not always arranged or discussed. This could explain why the majority of professionals do not think that the outcome of the enquiry reduced or prevented risk of harm to individuals involved in a safeguarding enquiry.

Of those who strongly agreed or agreed, 57% would report to Lancashire County Council, 29% to Blackpool Council and 14% across multiple local authorities. Of those who strongly disagreed or disagreed, 67% reported to Lancashire County Council, 22% across multiple authorities and 11% to Blackburn with Darwen Borough Council.

Summary of feedback from multi-agency professionals

Blackburn with Darwen

Two professionals completed the online survey.

Both professionals shared that they were not given an explanation for any delay/s that occurred, they did not feel involved in the safeguarding enquiry, and they did not think they were provided in a timely manner. One professional also shared that there is a staffing shortage within the safeguarding team which can lead to delays. One of the professionals however, did share that the process of raising a safeguarding concern was simple to follow, the outcome of decision was shared with them, they knew how to challenge a decision if they were dissatisfied with the outcome, they were provided with a point of contact and they were able to provide an input in relation to the safeguarding enquiry.

Blackpool

Respondents were asked to leave their feedback about what is currently working well about the safeguarding process. 8 comments were received and positive feedback was mentioned about the easiness of raising the safeguarding concern (3), good multi-agency working (2), being informed of the outcome of

the enquiry (1), praise for social workers (1) and acknowledgement that the safeguarding concern has been received and passed on for investigation (1).

The most positive ratings/feedback from Blackpool professionals related to the process of raising a safeguarding concern being simple to follow, with 81% of respondents strongly agreeing or agreeing. Other areas which received positive feedback were that 69% of respondents felt that the staff member who took the concern had the knowledge and skills to enable them to respond appropriately. Also 63% of respondents knew how to challenge a decision if they were dissatisfied with the response.

Respondents were also asked what could be improved about the safeguarding process. The most common answer given related to better communication (particularly being given regular updates) with 9 people sharing this view. 2 people shared the need for better training for raising a safeguarding concern across professionals. One respondent shared that there should be communication with the professional who raised a concern about why a specific circumstance would not meet the criteria for a safeguarding enquiry to be opened and the reason for this.

The most negative rating/feedback from Blackpool professionals related to being kept up to date of progress throughout the safeguarding enquiry, with 69% sharing that they did not feel up to date. Closely, 62% of respondents were not given a point of contact if they had any questions or updates to share.

Other comments made about the Blackpool safeguarding process captured:

"It would be good if there was better communication across all involved to get the best outcomes for people involved"

Lancashire

The most positive ratings/feedback from Lancashire professionals related to the process of raising a safeguarding concern being simple to follow, with 63% of respondents strongly agreeing or agreeing. Other areas which received positive feedback was that 58% of respondents were given a point of contact if they had any questions or updates to share. Also, 58% of respondents were able to provide an input in relation to the safeguarding concern.

Respondents were asked to leave their feedback about what is currently working well about the safeguarding process. The most mentioned area was the ease of reporting a concern through the online reporting system, with 9 people leaving this feedback. Other feedback received was about the professionalism of staff (3), partnership working (2), being provided with a point of contact (2) and quick triage of concerns (1).

Respondents were also asked what could be improved about the safeguarding process. Most feedback was about the need for better communication including being given a point of contact (9), receiving acknowledgement once a referral has been received (4), more prompt responses from the safeguarding team (3), providing professionals with updates on the enquiry (3) and explanations on why a concern has not been eligible for a full investigation (2). Other suggestions for improvement made included having more variety of meeting venues with a mix of online and face to face (2) the online form being more flexible with less

prescriptive questions (1), training on Making Safeguarding Personal (1), more regular progression meetings for multi-agency professionals (1) and better communication and processes for professionals working across both Lancashire and Cumbria (1).

The most negative rating/feedback from Lancashire professionals related to information not being provided in a timely manner (including meeting minutes), with 67% of respondents leaving this feedback. Further, 51% of respondents either strongly disagreed or disagreed that they were clearly informed of what would happen with their concern within an agreed timeframe.

Other comments made about the Lancashire safeguarding process captured:

"The knowledge of some staff particularly regarding the impact of multiple deprivation, inequality, trauma and safeguarding within the community is lacking."

"Please encourage the safeguarding team to link in with NHS Safeguarding teams."

"My experiences with safeguarding over the past twelve months have been varied. I have found that some safeguarding concerns have been investigated and closed without the person of concern receiving a visit from a safeguarding Social Worker. Some of the safeguarding social workers will keep me up to date and will involve me in the alert, where other social workers have not kept me updated and I have to chase them."

"The limited contact we have does tend to impact on building relationships with key individuals to ultimately support service users in safeguarding processes."

Conclusion

To conclude, Healthwatch Together have had the privilege of hearing about excellent working practice with the key principles of Making Safeguarding Principles applied. These included socials workers showing real kindness, empathy and personalisation throughout the safeguarding enquiry when people are potentially at some of their most vulnerable times. However, there are clear inconsistencies with the approach being taken by social workers within the three local authority areas covered by this project, as well as the experiences of individuals and carers.

There have been examples of individuals and/or carers being provided with a point of contact, receiving regular updates and feeling involved in decisions made. On the other hand, some individuals/carers do not know they are involved in a safeguarding enquiry, do not have a named professional to contact when they have an enquiry and do not feel involved in decisions made.

Recommendations made are focused around improving communication, providing tailored support to individuals' and carers' needs, providing accessible information and supporting individuals to plan for the future. These recommendations have been made to improve working practice in line with the six key principles of Making Safeguarding Personal, ensuring each Safeguarding Adult Board is providing an outcome-focused and person-centres safeguarding process.

Good practice is evident in some areas and by some professionals, and this should be celebrated and applied across all areas.

Recommendations

Healthwatch Together have formulated the following recommendations in response to feedback received which include overall recommendations and local recommendations for each local authority. These recommendations are in line with Making Safeguarding Personal principles.

Empowerment: People being supported and encouraged to make their own decisions and give informed consent.

1. Embed a consistent approach to explaining what a safeguarding enquiry entails and why there is an investigation. Ensure all staff are relaying the same message to individuals and carers, regardless of their prior knowledge. This explanation should be done at the earliest opportunity. We recommend that all individuals and carers involved in an enquiry should be given a document (also available in an Easy Read version) explaining the safeguarding enquiry process including their rights.
2. Consult with individuals and carers to understand how they would like to receive information and strive to make sure each person receives information in a way that is accessible for them. Reduce inconsistencies

with the information shared to individuals involved in a safeguarding enquiry, and strive to make sure each person receives information in a way that is accessible for them.

3. Aim to contact individuals and carers early in the safeguarding process to remove confusion and gain involvement from those involved at the earliest opportunity. It is crucial that communication is initiated in a clear and concise manner from the outset to avoid confusion (Blackpool specific)

4. Involve individuals and carers in decisions though regular communication (agreed at the beginning of the enquiry) working in partnership to put agreed actions in place to ensure full involvement throughout the safeguarding enquiry (Lancashire specific)

Prevention: It is better to take action before harm occurs.

5. Consider future plans and the sustainability of the approach taken when finalising the safeguarding enquiry, to hopefully prevent the situation from arising in the future. Involve the individuals and carers in discussions about the future to ensure this is embedded into an action plan.

6. Provide a more detailed and clear explanation of actions being taken as part of the enquiry to the individual and/or carers, including next steps and any proposed timeframes (Lancashire specific)

Proportionality: The least intrusive response appropriate to the risk presented.

7. Implement a model or communication framework that includes asking the individual and carers what support they need to make people feel more comfortable through the safeguarding process and ensure that everyone's needs are met appropriately. Feelings, views and experiences should be at the heart of decision-making.

Protection: Support and representation for those in greatest need.

8. Develop a consistent approach to supporting individuals across the safeguarding team, and ensure they have a good understanding of the situation throughout, to help ensure that some people do not feel ignored through the process. Clear communication and listening to people's needs and preferences is essential to making safeguarding personal. (Blackburn specific)

Partnership: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

9. Celebrate the positive feedback and best practice highlighted within the findings, to encourage a cohesive and progressive approach across the team. There is some excellent work happening and this should be recognised.

10. Consult with more multi-agency professionals from Blackburn to gain a more representative overview of experiences. Healthwatch Blackburn will conduct a second phase of engagement with multi-agency professionals

through an online survey to collect a wider range of feedback (Blackburn specific)

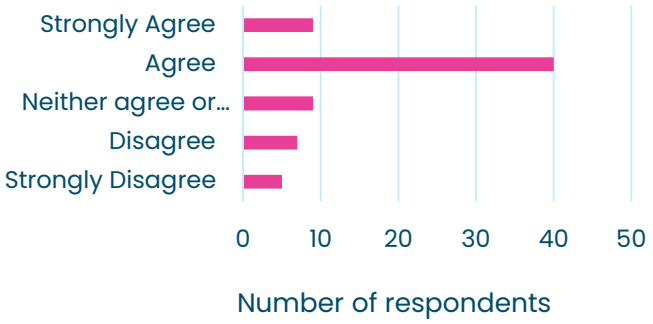
Accountability: Accountability and transparency in delivering safeguarding.

11. Ensure there is a consistent approach across teams by providing all individuals and carers with a direct point of contact, to foster positive rapport and consistency.
12. Aim to close the feedback loop with those involved in a safeguarding enquiry before closing the case or stopping contact, to ensure individuals are not left wondering what the outcome is. Communication is key. (Blackburn and Blackpool specific)
13. Allocate a designated Safeguarding Officer to each enquiry, to foster positive rapport and consistency. Each individual or carer should be made aware of the most appropriate method to make contact with this worker should they encounter any difficulties or have any further questions (Blackpool specific)
14. Ensure communication is followed through in a timely manner, particularly when an individual is informed they will receive a further telephone call or visit. It may not always be required to have additional contact with an individual or carer, but this should be explained in order to manage expectations and create a trusting relationship. The next steps in an enquiry should always be explicitly clear for those involved, where possible (Blackpool specific)

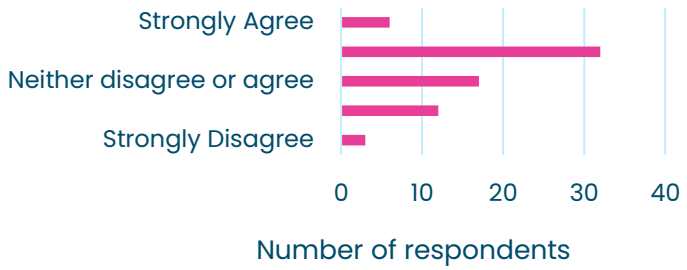
Appendix

Multi-agency professional data

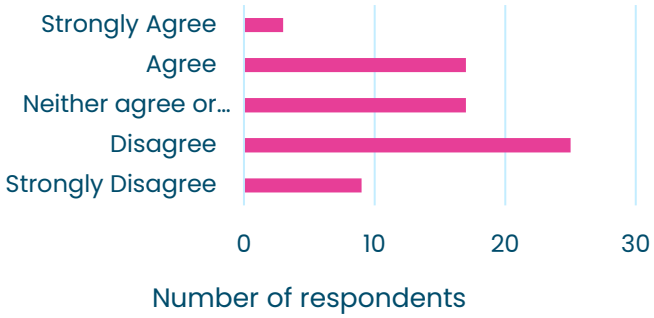
The process of raising a safeguarding concern was simple to follow



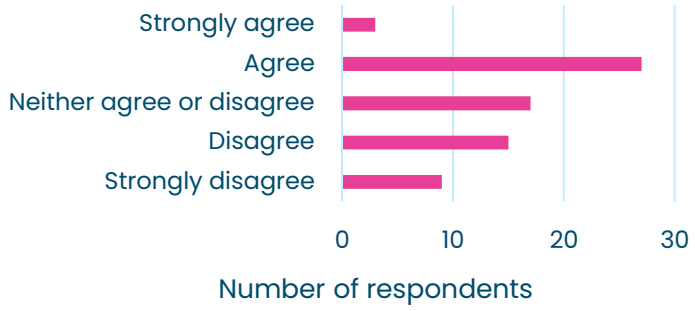
The staff member who took my concern had to knowledge and skills to enable them to respond appropriately



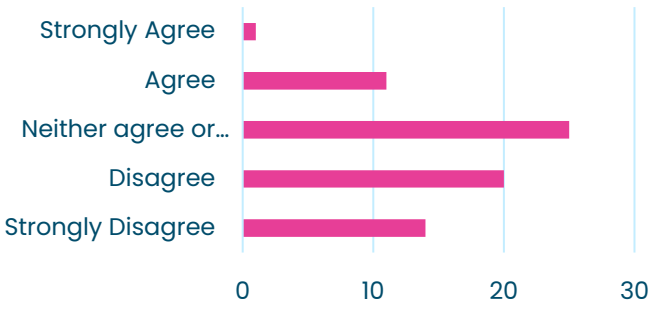
I was clearly informed of what would happen with my concern within an agreed timeframe



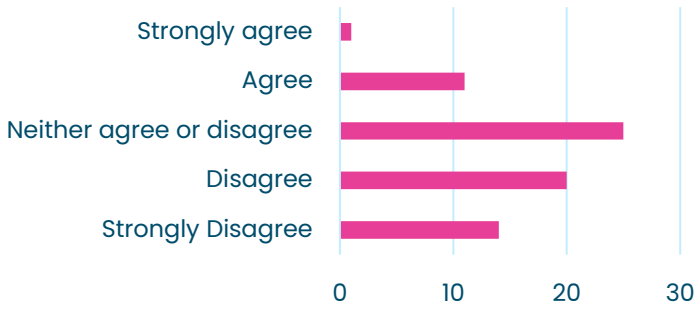
I am confident that my safeguarding concern was responded to in a timely manner



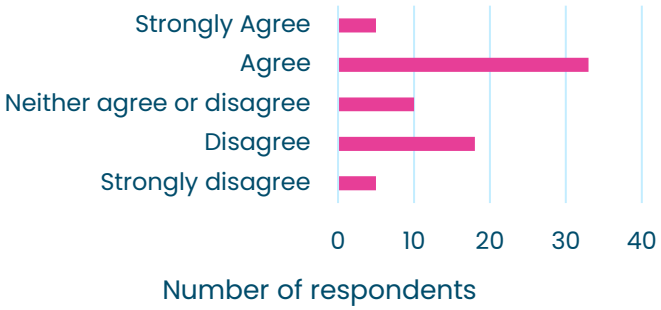
I was given an explanation for any delay/s that occured



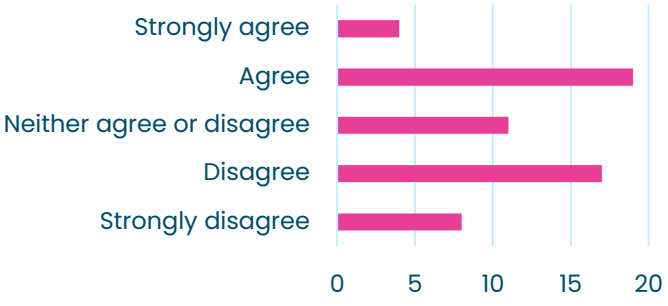
The outcome of the decision was shared with me



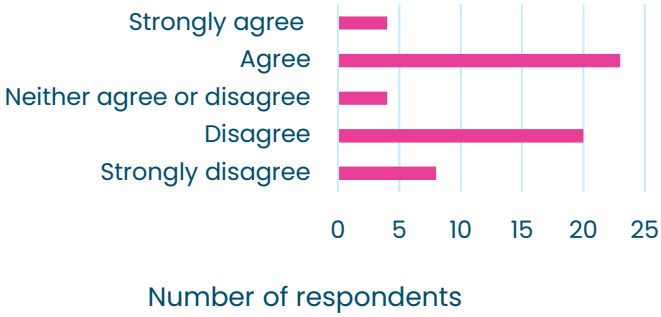
If dissatisfied with the response, I know how to challenge the decision made



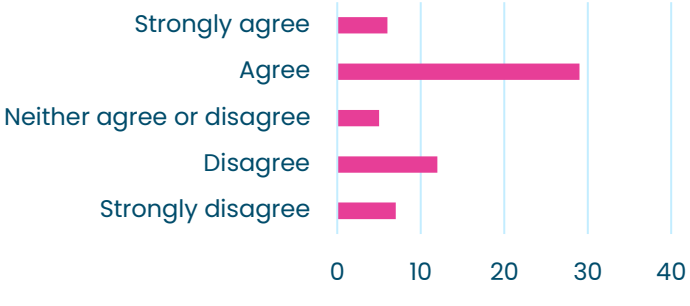
I was involved throughout the safeguarding enquiry



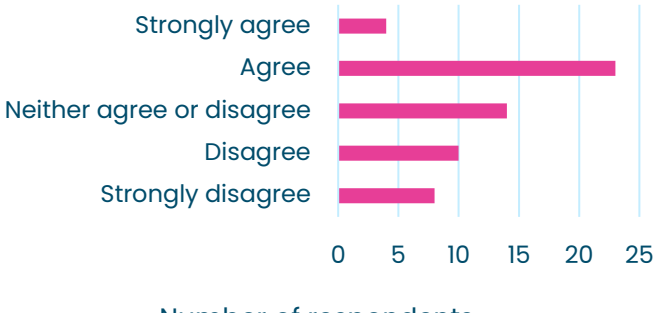
I was provided with a point of contact if I had any questions or updates to share



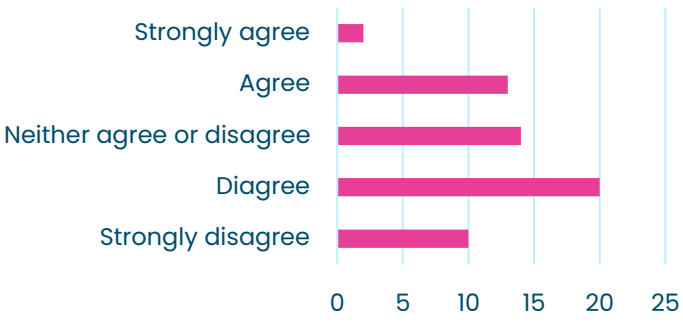
I was able to provide an input in relation to the safeguarding enquiry



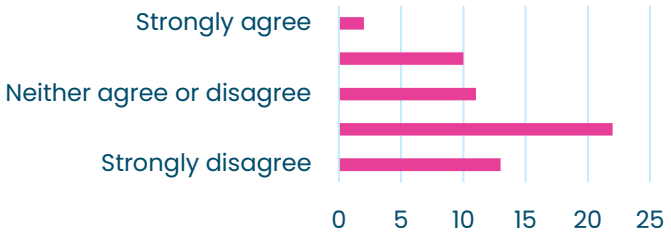
I was made to feel that my contribution to the safeguarding enquiry was valued



I was kept up to date of progress throughout the safeguarding enquiry

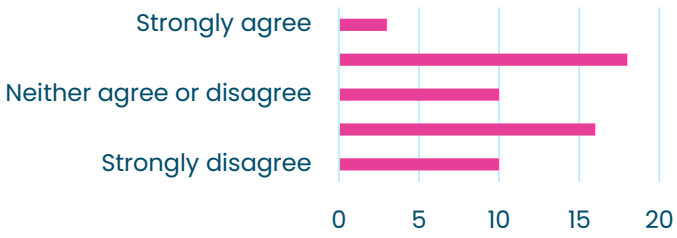


Information I recieved was provided in a timely manner, this includes meeting minutes



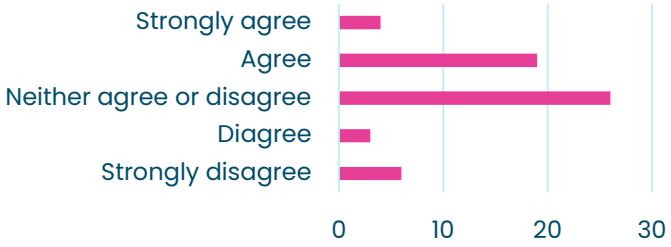
Number of respondents

I was informed about the outcome of the safeguarding enquiry and action that has been taken



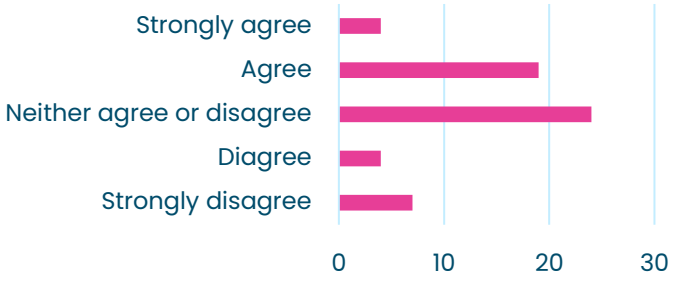
Number of respondents

The feelings, wishes, values and beliefs of the person and their family/carer involved in the enquiry were listened to and respected



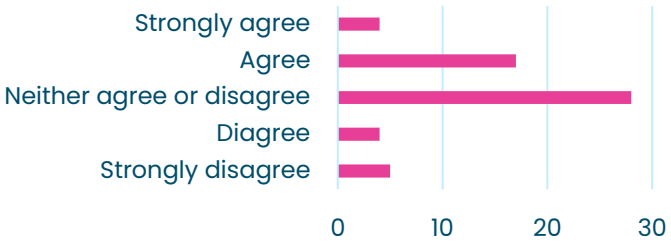
Number of respondents

The needs of the person involved in the safeguarding enquiry were met with adjustments made accordingly



Number of respondents

The outcome of the enquiry reduced/prevented risk of harm to the person involved in the safeguarding enquiry



Number of respondents

Healthwatch Together

Email: info@healthwatchlancashire.co.uk