Northern Ireland Adult Safeguarding Partnership

KING'S College LONDON

SOCIAL CARE WORKFORCE RESEARCH UNIT

HSC Public Health Agency

HSC Health and Social Care Board

10,000 TEN THOUSAND MORE VOICES

Experience of Adult Safeguarding

The service user, carer and professional perspectives

November 2018

Contents/Index

Contents	Page number
Foreword	3
Summary document	4
1.0 Introduction	11
2.0 Methodology	12
3.0 Results and Analysis	13
4.0 Regional Recommendations	33
5.0 Trust Actions	35
6.0 Conclusion	37
Appendices	38

Foreword

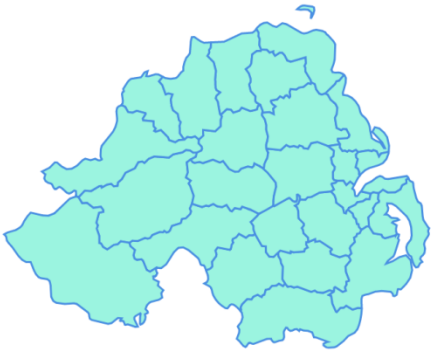
I am pleased to present the regional report on the findings in relation to Experience of Adult Safeguarding process. This is one of a number of work streams on the 10,000 More Voices work plan for 2017/2018.

The 10,000 More Voices Initiative is commissioned and funded by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) to introduce a more person centred approach to shaping the way services are delivered and commissioned. It is based on the principles of Experience Led Co-Design, which have been adapted into a robust and systematic model, through which patients, clients, family members, carers and staff describe their experience of receiving and delivering health and social care in Northern Ireland. This is in line with the processes for co-production as outlined in DoH (2018) "Co-Production Guide. Connecting and Realising Value through People". This guide highlights the importance of partnership with service users, carers and staff to support transformational change.

The Bengoa Expert Panel Report, Systems Not Structures (2016), recognizes the unique skills of people who use services along with the importance for increased emphasis on listening to the experience, taking co-production to 'a new level'. Similarly, the Ministers 10 year vision for Health and Wellbeing, Delivering Together (2016) outlines the importance of a "new culture of partnership, involvement and listening" within a quality health and social care system. Using the 10,000 More voices methodology is one of the ways in which we can begin to embrace this new culture of partnership and collaborative working by integrating the information we receive into shaping and delivering services for the future. When a service user engages with the adult safeguarding process we want to ensure that we are providing safe and effective care which is focused on the safety of the individual. I wish to acknowledge and say thank you to the people who took the time to submit their experience through this 10,000 More Voices project. Each individual story is important to the work we do through the 10,000 More Voices Initiative.

Mary Hinds, Director of Nursing and Allied Health Professionals, Public Health Agency

Demographic information



Trusts

167 respondents to survey with 99% response (165) on completion of signifiers. 37 from BHSCT, 29 NHSCT, 18 SEHSCT, 54 SHSCT, 28 WHSCT, 1 PSNI

Gender

107 respondents were female and 55 were male. 1 respondent was transgender and 4 preferred not to comment. 1 respondent did not answer the question.

Nationality

151 respondents were born in N.Ireland, 3 from England, 1 from Scotland, 1 from Wales and 5 were from outside the United Kingdom. 6 respondents did not answer the question.

Disability

131 respondents considered themselves to have a disability. 9 preferred not to say. 27 respondents did not answer the question.

Programme of care

35 Adult learning disability, 10 Adult mental health, 50 Primary care & older people, 33 Physical & Sensory disability, 39 Unknown

Analysis of surveys

Recommendations highlighted in the report reflect the key messages from the following data sources contained in the surveys

167 stories were shared. 112 told by the service user, 15 on behalf of the service user, 33 by a carer or relative, 4 by an other. 3 respondents did not specify their relation to the story.

Data findings from patient stories using SenseMaker

COGNITIVE EDGE

*Percentages are reflective of cluster responses only and do not account for all responses scattered in the signifier.

1 To what extent did you feel listened to during meeting and conversations?

- I felt I was listened to in a respectful way — 64%
- I felt I was being judged — 4%
- I felt listened to but my views didnt affect the decisions — 11%

2 To what extent did you feel satisfied with how the SAFEGUARDING INVESTIGATION was carried out?

- The process dragged on — 5%
- I was supported to work things through — 59%
- I didnt know what was happening — 9.6%

3 To what extent were you able to understand the information given to you DURING the safeguarding investigation

- The information was clear and easily understood — 41%
- Someone helped me understand the information — 31%
- I didn't understand it — 4.8%

4 To what extent were you given the information you needed at the right time during the safeguarding investigation

- I was not kept up to date — 9%
- I got the right information when I needed it — 67%
- I found it hard to make sense of the information — 8.4%

5 To what extent were you satisfied with the outcome of the investigation?

- I didnt know what the outcome was — 5.4%
- I felt more could have been done — 11.5%
- People worked together to make things better — 65%

6 Do you feel that you are safer now as a result of the safeguarding investigation?

- I feel that I am not at all safer now — 6%
- I feel that I am not much safer now — 10%
- I feel that I am quite a bit safer now — 47%
- I feel that I am completely safe now — 37%

What was said

The following is an example of statements across the spectrum of strongly positive to strongly negative stories by patients and carers.

I felt that people in the meeting listened to me and heard what I wanted to happen. They agreed with me and did what I wanted.

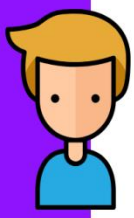
The process run on far too long to be called reasonable because as long as the matter loomed over us, we all as a family were affected.

I felt I had options and support, things are a lot better now.

I found it very helpful. I found the 10,000 Voices had a good approach. I was upset by the whole thing.

My experience was one of frustration, anger, sporadic communications, not being made aware of incidents at the time and having to draw attention to adult safeguarding issues myself regarding my relative. I am still waiting on closure

The social worker/investigation officer couldn't have been nicer... they were really caring and easy to talk to. They really listened to me and didn't pity me



Service User Stories -Key themes

Key messages in Staff Experience

Staff reflected that they needed more one - to - one time with service users and families.

Competing demands with paperwork and prioritizing adult safeguarding work within workload allocation and management

Need to share learning from investigations to prevent further abuse, exploitation and neglect to adults

Collaborative working to spread experience across different service areas and settings, creating opportunity to develop skills, knowledge across various types of abuse, exploitation and neglect

Importance of staff support from DAPO and safeguarding teams. A need for ongoing quality training and best practice in safeguarding develops

Recommendations

The regional recommendations have been identified by key members of the Northern Ireland Adult Safeguarding Partnership including an external agency, Police Service of Northern Ireland, who have reviewed experinced and formulated their agency recommendations.

For Trusts

- Develop key worker role to strengthen protection plan and grow safely.
- Person centered engagement with service users and carers on how they prefer to be engaged throughout the process.
- Agreed timescales for feedback and updates to service users.
- Review of use of easy read leaflets.
- Collaborative working between Trusts, PSNI and regulatory bodies.
- Trusts to proactively advocate on behalf of service users and carers to seek a timely outcome from judical process.
- 10,000 MORE Voices tool opportunity for meaningful therapeutic intervention post investigation.

HSCB/ Commissioning

- Consideration to the resourcing of adult protect interventions.
- Ensure the structures for delivering adult safeguarding servicees across HSC Trusts and PSNI support and develop a competent and confident workforce.
- 10,000 more voices survey will be part of the closure stage of Regional Adult Protection procedures.
- Consider the potential development of an 'Always Event' under Quality 2020.

For PSNI

- Open and transparent communication about the investigation and time it may take to reach an outcome.
- Ongoing engagement with service user to clarify understanding of information given, manage expectationas and share outcomes

1.0 Introduction

The 10,000 MORE Voices Initiative has been commissioned and funded by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) to provide a more person centred approach to improving and influencing experience of health and social care services. The initiative is integrated into the patient and client focus element of Quality 2020 (DoH) which states that all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

To date a number of work streams have been progressed across a range of service areas. It was agreed by the regional Patient and Client Experience steering group that capturing the experience of people in relation to adult safeguarding processes would be carried forward in the 2017/2018 work plan. The purpose of the 10,000 More Voices Adult Safeguarding project was to provide rich data about the real experiences of service users and their carers and to identify how the adult safeguarding process can be improved to ensure the service users experience is rights based, empowering, consent driven and as person centred as possible. This is achieved by adopting the partnership approach which has been successfully applied in the 10,000 More Voices Initiative, using a blend of qualitative and quantitative data through the use of Sensemaker® methodology. The project was also developed in consultation with Kings College London, Social Care Workforce Research Unit to inform the design. Using six cognitively tested questions (which have been previously developed to define adult safeguarding measures in England) this partnership provided valuable insight into the key concepts of the design

This report has been written by members of NIASP and presents the findings received from patients/relatives/carers/staff in relation to their experience of adult safeguarding from January 2017 – March 2018. In total 167 stories were received from patients/family members/carers during this period. 10,000 More Voices is underpinned by the principles of Experience Led Co-Design, of which partnership working between those who use and deliver healthcare services is a key element. Staff members were also encouraged to submit their stories in relation to the adult safeguarding process. Twenty seven staff shared their story and the key themes integrated into the report.

2.0 Methodology

2.1 The context of the Project

The project included adults who had experience of the adult protection process from the point of strategy planning and were closed to all protective interventions during the period January 2017 – March 2018.

2.2 Aims of the Project

The aim of the project was to identify how the adult safeguarding process can be improved to ensure the service users experience is

- rights based
- empowering
- consent driven and
- as person centred as possible

2.3 Development of the tool

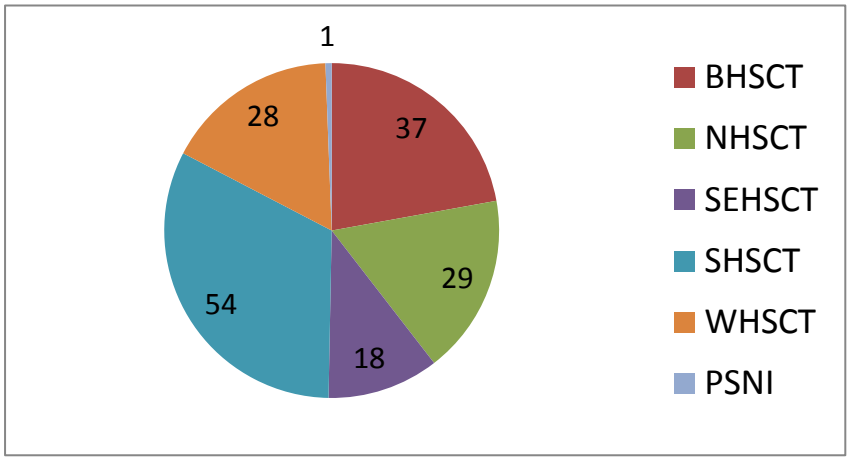
In keeping with the principles of the 10,000 More Voices approach to improving experience of people who use our services, a tool for the project was developed in collaboration with the key stakeholders. Two workshops were held to ensure engagement with and contribution from the stakeholders was achieved. The SenseMaker survey tool was designed, in partnership with Kings College London Social Care Workforce Research Unit and key stakeholders during a series of workshops. Following these workshops the tool was agreed.

3.0 Results and Analysis

3.1 Context

The project took place across all Trusts. It also engaged with PSNI as key stakeholders in the Northern Ireland Adult Safeguarding Partnership (NIASP). In total 167 surveys were received from clients who had experience the process of Adult Safeguarding. In total there were 165 responses to the signifier questions, representing a response rate of 99%. The breakdown of respondents across the Trusts is illustrated in Chart 1.

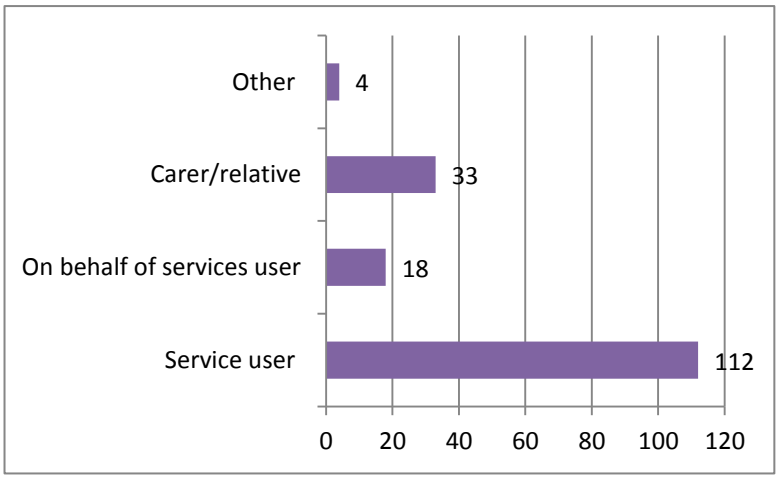
Chart 1 Returns by Trusts



There are a number of reasons for the variation in uptake across the Trusts. For example, service users and carers may have declined due to the timing of events; staffing capacity challenges to engage fully with the project

The majority of surveys were completed by the service user; however carers and relatives also provided valuable insight into the lived experience of the adult safeguarding process. Surveys were also complete on behalf of the service user where they have shared their story with a third party for the purpose of 10,000 More Voices. This is illustrated in Chart 2.

Chart 2 Returns by who completed the survey



It is also important to acknowledge the respondents represented a range of programmes of care. The breakdown analysis for each programme is summarised in Appendix 2 and integrated into the main body of the report*.

Chart 3 Returns by programme of care

Adult Learning disability	35
Adult Mental Health	10
Primary care and older people	50
Physical and sensory disability	33
Not known	39

**Further analysis can be requested on each programme of care through the 10,000 More Voice Regional Lead*

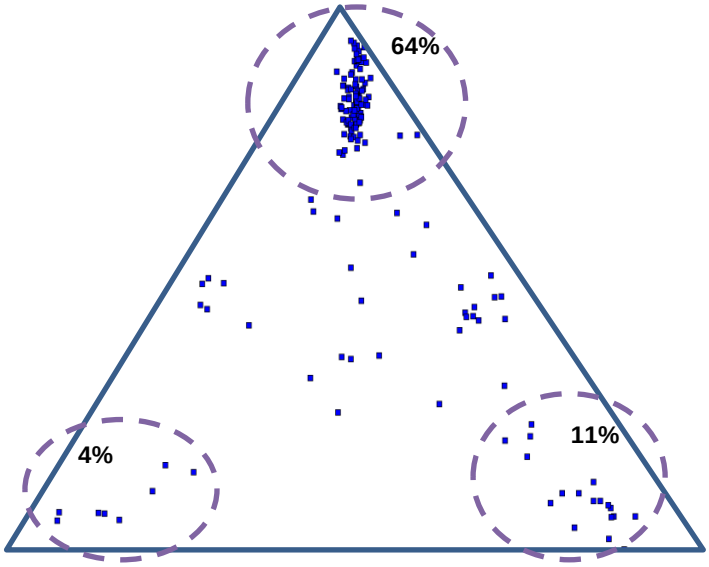
A summary of all demographics is included in Appendix 1.

3.2 Responses to signifiers

Question 1: To what extent did you feel listened to during meetings and conversations?

I felt I was listened to in a respectful way

165 responses



I felt I was being judged

I felt listened to but my views didn't affect the decisions

Discussion/interpretation

In total there were 165 responses to this question, representing a response rate of 99%. The cluster at the top of the triangle refers to a 63% majority of respondents who "felt they were listened to in a respected way". (106 out of a total of 165 experiences) A further 11% felt they were listened to but for some their views didn't affect the decisions. This may reflect the complex nature of decision making within adult safeguarding and highlights the importance of understanding the experience behind the 'dot'. For example the preferred outcomes of some of the service users / carers reflected situations where professional decision making required decisions to be made to safeguard others; or where best interest's decisions were required due to the individual's capacity to consent to a decision.

From a service improvement perspective the narrative behind the 'dots' at the point of the triangle "I felt I was being judged" is of significance. 4% of the survey reflected

this as their experience. None of these respondents were from Mental Health Services. 3 out of 5 of these experiences related to the criminal justice process and outcomes and the other 2 related to experiences involving incidents relating to care staff. This illustrates the importance of supporting individuals to consider their desired outcomes at the beginning of the process and provide appropriate support throughout and after the outcomes of both a judicial and internal HSC safeguarding process.

From the written narratives collected from the study there was evidence that individuals felt it was a positive experience to be listened to, stories contained words such as *relief, helpful and taken seriously* when describing their feelings of being listened to.

The value of ensuring individuals feel listened to is something to be reinforced with all professionals so that in every case each person can say they were listened to in a jargon free and respectful way. The service user / carer analysis workshops highlighted the importance of both verbal and non-verbal communication from professionals when an adult is communicating their experience. This reinforces the view that the service user / carer's experience is being believed.

Communication and the importance of ongoing contact with individuals and carers remains an area for improvement, including explaining the processes better, potential outcomes and regular updates to support adults understand their desired expectations. An individual did comment that even though they attended the meetings they didn't understand all that was being said.

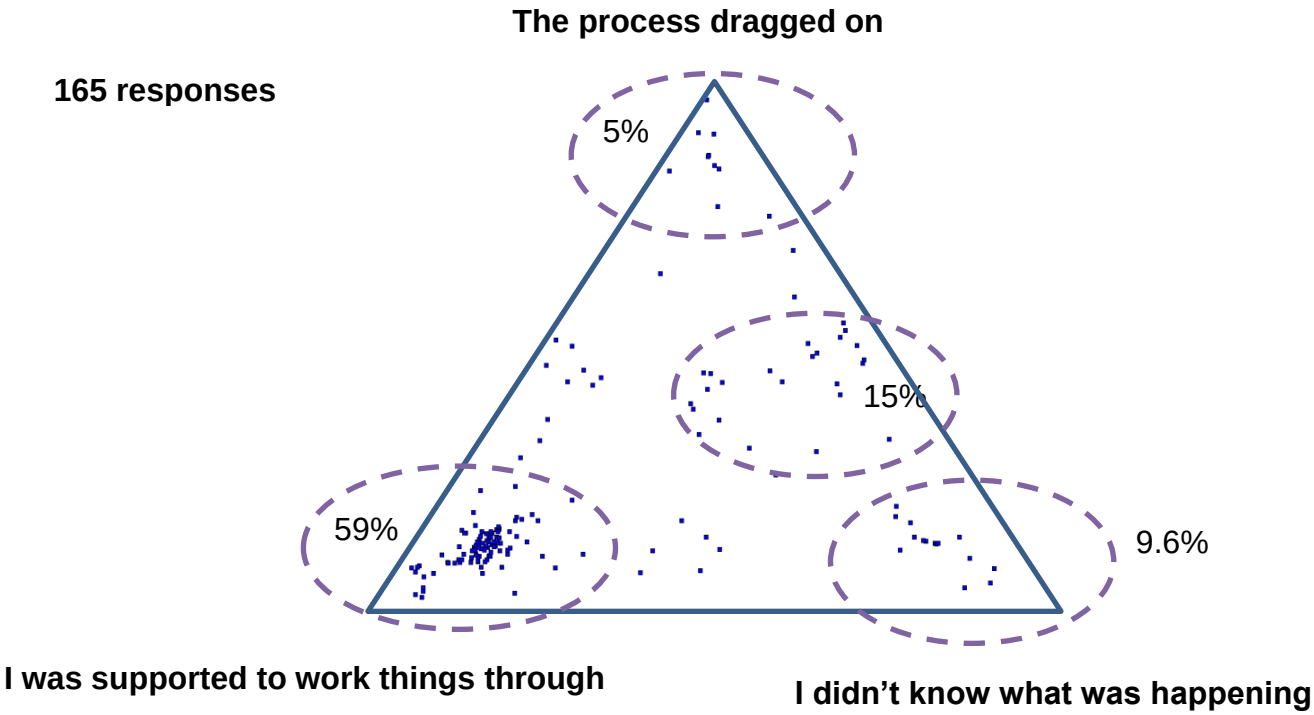
Extracts from Experiences

"I was happy that someone was listening to me."

"The social worker couldn't have been nicer… They really listened and didn't pity me. They know I was going through a hard time."

"I actually don't know if the person speaking with the team explained what my concerns were as a carer."

Question 2: To what extent did you feel satisfied with how the SAFEGUARDING INVESTIGATION was carried out?



Discussion/interpretation

In total there were 165 responses to this question, representing a response rate of 99%. There is a 60% cluster of respondents who felt that they were supported to work things through as reflected in the bottom left corner of the triangle. 54% of adults with a learning disability felt they were supported to work things through as compared to 58% of older people.

Reflecting on feedback from stakeholder workshops professionals had anticipated that service users and carers would have responded in this question by indicating that the "process dragged on" however only 5% reflected the length of time the process took in their experience. There were indications throughout the narratives that individuals recognised that the investigation process took time but respondents highlighted they understood the reasons behind this and did not reflect this as a negative experience. However, 15% of the respondents placed their experience between the points "The process dragged on" and "I didn't know what was happening". This reflects the need for ongoing effective communication with and inclusion of service users and carers throughout the safeguarding process. This not only provides information but also enables service users and carers to respond to

the investigation progress made, preparing themselves for potential outcomes and also to develop personal resilience to strengthen their own safety.

It is of note that 9.6% of the respondents felt they "didn't know what was happening" during the investigation. For example, *"I was not given any additional information and do not feel I was kept up to date."*

Whilst again the majority of respondents report a positive experience improvements could be made regarding the investigation and a number of suggestions have been collected from the respondents, such as increased support to understand the process especially for those with a cognitive impairment, communication with individuals throughout the process to provide regular updates. Consideration should be given to the amount of information provided at any given time to enable service users and carers to process and reflect on the options available. Consideration of the benefits of an independent advocate is noted in service user feedback from the stakeholder workshops.

In terms of investigations involving other agencies, individuals proposed that there was a need for liaison; that there was frustration when agencies did not share updates or co-operate fully, for example due to PSNI processes or staff investigations. Some felt that there were too many involved and that this impacted on them regarding confidentiality of their information.

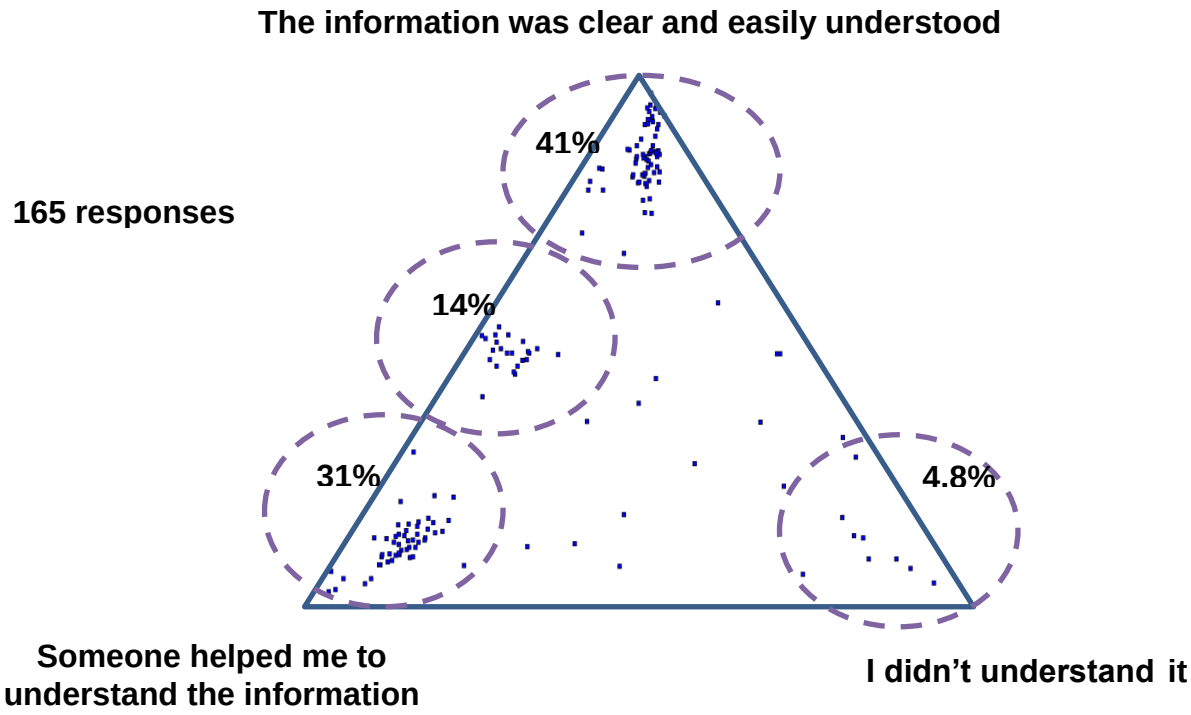
Additional feedback from service user and carer's at the workshops highlighted the importance of professionals discussing potential outcomes at each stage of the process in order to manage the expectations of the individuals. This will improve engagement and communication with service users and carers throughout the process to ensure support meets the individual need and is person centred.

Extracts from Experiences

"I did not realise that there were so many departments that worked 'hand in hand' on these matters"

"This lady felt the safeguarding team made her feel that they were on her side but gave her the time/space to make her own choices."

Question 3: To what extent were you able to understand the information given to you DURING the safeguarding investigation?



Discussion/interpretation

In total there were 165 responses to this question; representing a response rate of 99%. It is encouraging that 86% of the respondents felt that "the information was clear and easily understood" or that "someone had helped them to understand the information." 12% of those respondents who felt someone helped them understand were from the Learning Disability Programme of Care. 0.2% of adults with Learning Disability felt they didn't understand the information. It has been suggested that learning from the positive experiences of these 86% respondents should encourage professionals to further support the 4.8% who did not understand the information.

A small number of experiences reflected that they didn't understand the information during the investigation. The narratives in these 9 experiences reflect the importance of working at the pace of the service user / carer and reflecting with them to check that they understand the content of the information provided and are able to make informed and timely decisions regarding the choices available to them. In one experience a carer reflected that they were so distraught at the time because of what had happened that she could not take in anything and therefore on reflection she felt she did not fully understand what was happening. Another service user discussed

feeling “fuddled” and could not think straight. They needed time to work through the information. Easy read leaflets are available to provide to service users. These can be taken home and reflected upon or worked through with staff / family support. The use of Registered Intermediaries in the joint investigations should be pursued for individuals who require support to understand all the information during the safeguarding process.

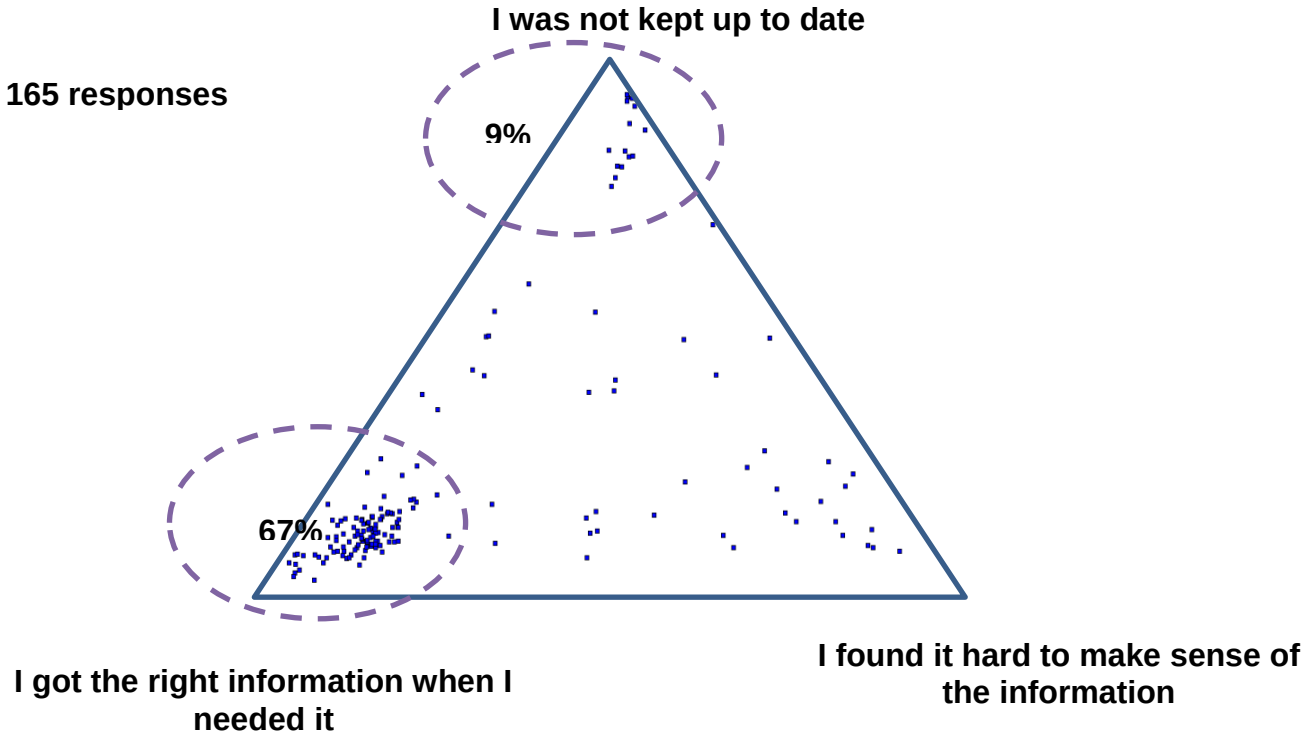
Additional feedback from service user and carer’s at the workshops suggested the importance of professionals communicating clearly the expected sequence and timing of actions throughout the process to enable service users and carers to understand what to expect.

Extracts from Experiences

“During the investigation process family members continued to obtain information updates (primarily via email and telephone calls) from the Adult Safeguarding Team to obtain feedback on the current status of the investigation. Upon receipt of emails from family members for feedback, the Adult Safeguarding Team responded with answers.”

“I was not given any additional information and do not feel that I was kept up to date.”

Question 4: To what extent were you given the information you needed at the RIGHT TIME during the safeguarding investigation?



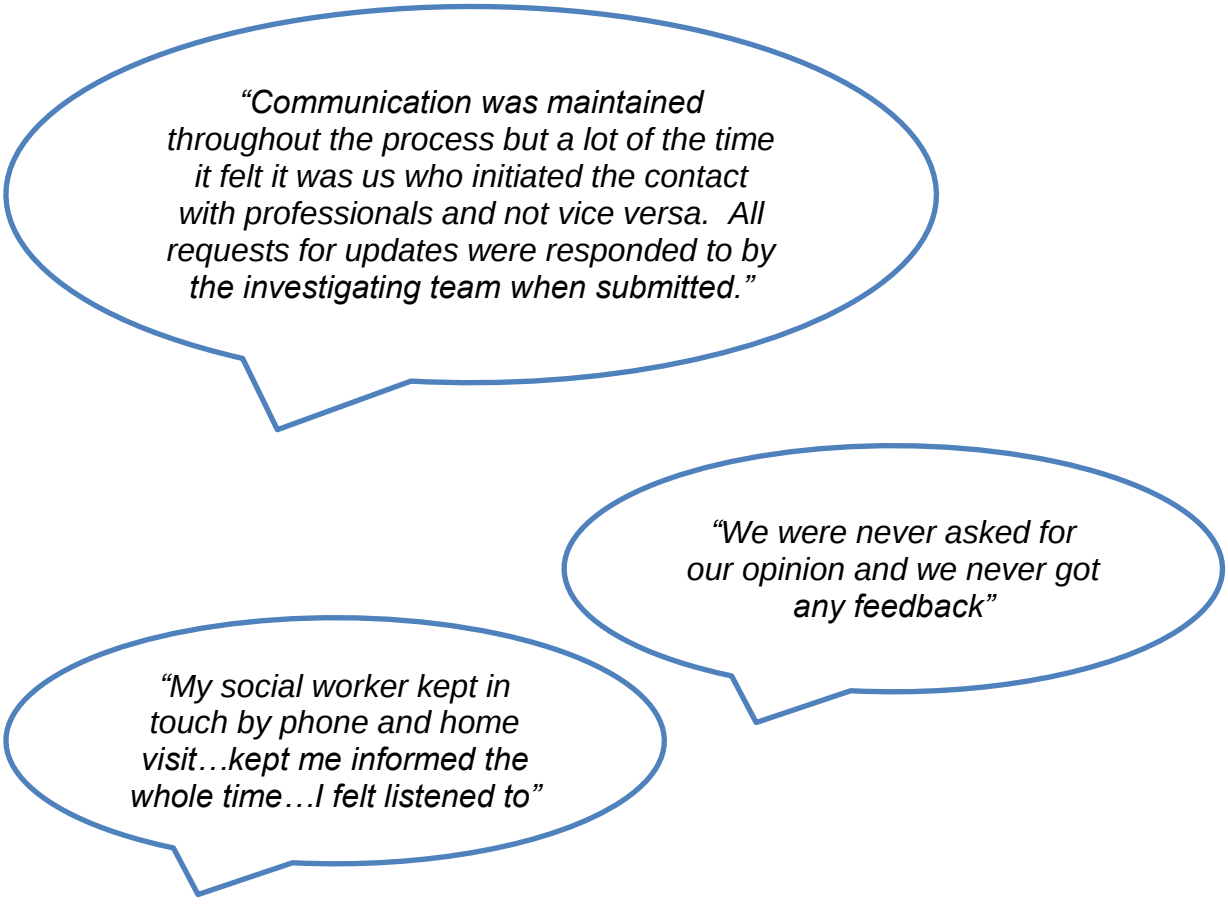
Discussion/interpretation

In total there were 165 responses to this question, representing a response rate of 99%.The cluster in this triangle clearly indicated that 67% of respondents felt that they had the right information at the right time. However, the cluster at the point of the triangle which highlights “I was not kept up to date” requires further explanation. Of these 15 experiences, 5 reflected in the previous question that the information given by professionals was clear and easily understood DURING the investigation, however, they stated that they didn’t get the information that would have helped them understand better at the right time. A further 2 of these individuals reflected that someone had helped them understand the professional information during the investigation but again reflected that the information was not given at the correct time. This reinforces the importance of timing when providing person centred responses during the safeguarding process. Professionals must allow time to clarify the service user understanding of information and to allow the service user to reflect on the information and ask questions. This evidences the importance of working at

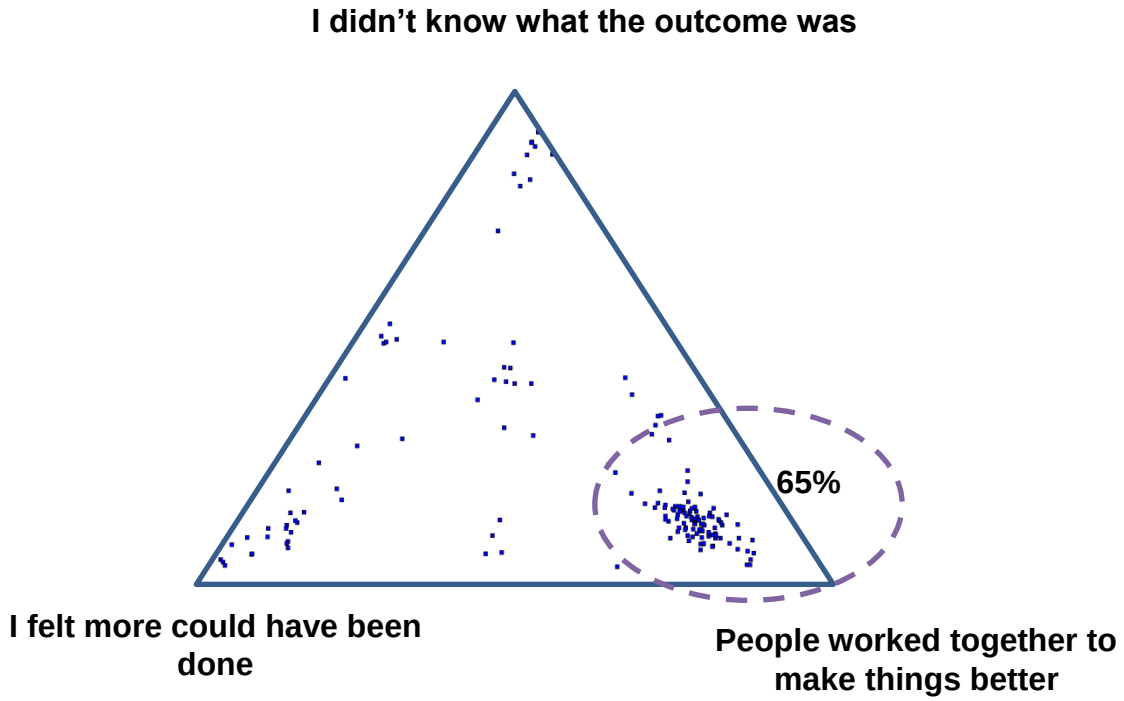
the pace of the service user / carer to support them through a traumatic experience and a complex system of choices to be made to respond to what has happened.

A number of carers have also reflected on the importance of investigation focusing on "the real issue". For example in this story the family member reflected on how the investigation did not consider the mechanism of injury "*The investigation took a long time and only looked at what happened after the carer got her up. The fall itself was never investigated and this I feel was the real issue as mum has now no mobility and potentially the fall has shortened her life."*

Extracts from Experiences



Question 5: To what extent were you satisfied with the outcome of the investigation?



Discussion/interpretation

In total there were 164 responses to this question, representing a response rate of 98%.It is encouraging to see that the majority (65%) of experiences reflected that "people worked together to make things better" encompassing the spirit of the new adult safeguarding policy and procedures. Interestingly, 95% of those who felt people worked together to make things better reported that they felt either quite a bit safer or completely safe following the outcome of the safeguarding process (as reflected in Question 6. This supports the view that better collaborative working delivers improved outcomes from a user perspective.

However, it is of concern that 6% of respondents "did not know what the outcome was" and none of these individuals felt completely safe as reflected in question 6. It is interesting to note that only one of these experiences relates to criminal justice outcomes; the majority relate to experiences where there has been a change in practice and the harm has ceased. In these stories the service user / carer has felt that they did not experience "closure" on the safeguarding concerns due to recommendations from investigations not being implemented. Examples given were no communication from agencies to reflect learning and actions taken to improve systems and no actions taken to improve quality of service provision. This was

particularly reflected in the experiences of carers of individuals who had a diagnosis of dementia and had complex comorbidities.

Of those 24 respondents who felt more could have been done a carer reflected *"Unfortunately the findings were inconclusive. If the care home had admitted what had happened I would have been much more satisfied."*

Extracts from Experiences

"Perhaps more involvement by Adult Safeguarding and advising families that they exist with contact details when admitted to care homes to have a point of contact during incidents…Too much going unnoticed, swept under the carpet, families need somewhere to vent."

"This is a true story…As far as i am concerned there was no investigation. The last i heard the police took a statement from the nurse in charge who was on duty that night. I haven't been advised of any outcome, this incident took place in November 2015"

Question 6: Do you feel that you are safer now as a result of the safeguarding investigation?

I feel that I am not at all safer now	10
I feel that I am not much safer now	17
I feel that I am quite a bit safer now	78
I feel that I am completely safe now	62

This perhaps is the most important question in the survey and asks the service user / carer to give their views on how safe they feel after the safeguarding investigation has been completed. 140 out of 167 people felt either quite a bit safer or completely safe. Those whose experience reflected that they did not feel safer or not much safer frequently were situations where service users choose to remain in the relationship where the harm was alleged to have occurred. Many of these were relating to situations of domestic abuse. Of the 10 adults who felt that they were not at all safer now, 5 reported experiences where PSNI and PPS were involved in the investigation and 3 related to care settings. This is further explained through the following cross referencing.

Cross referencing the questions using the sensemaker software analysis shows an association between the following.

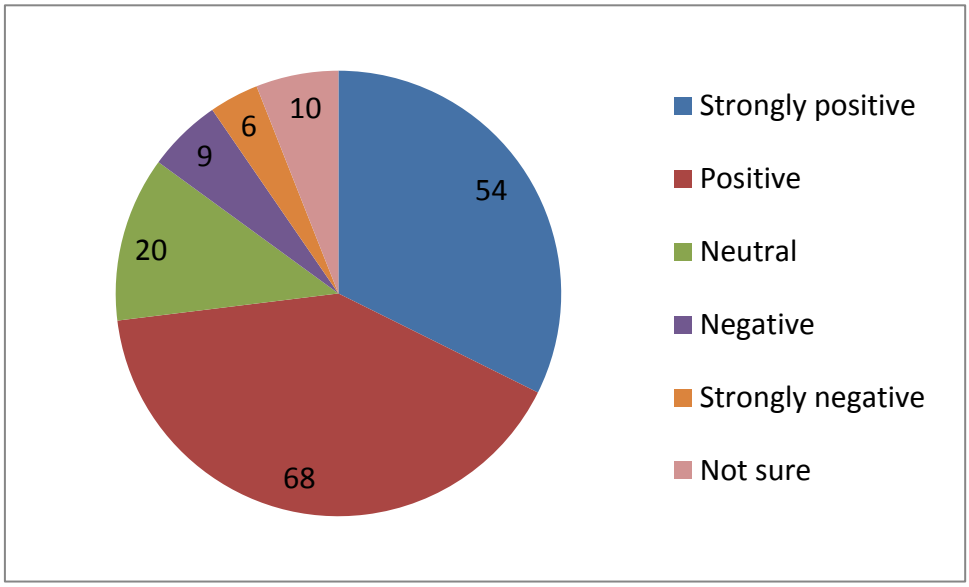
- There is a positive association between being listened to and knowing what the outcome of the investigation was.
- Of the 15 who rated the experience as negative or strongly negative 9 felt that they were not much or not at all safer following the investigation. (60%) This is significant as a further 6 individuals felt safer as a result of the investigation even though they rated their experience as negative / strongly negative.
- Of the 122 who rated their experience as positive or strongly positive, 93% of these individuals reflected that they felt safer as a result of the investigation.
- For people who didn't know what the outcome was there is an association with the experience that the process dragged on.

- For people who felt listened to but felt their views didn't affect the decisions there is a positive association with a view that they did not know what was happening and the process dragged on.
- People who reflected that they felt they were not kept up to date are strongly positively associated with those who did not understand the information.

Chart 4 illustrates the overall rating of the adult safeguarding process. With 73% rating the process strongly positive or positive it is important to explore the emerging themes from the narrative of these stories

3.3 Emerging Themes of Positive Experiences from the client stories

Chart 4: Question 7 Overall how would you rate your experience?



1. **Feeling Safe**

The responses overall would note that the safeguarding process has been perceived by service users and carers as a positive experience. The majority of the respondents (85%) note that they feel safer after the process. This is a significant indicator of success in terms of meeting the desired outcomes of the service user.

2. **Being listened to and believed**

One service user reported experiencing "*a feeling of despair, then hope and eventually light*". Another reflected that "*People believed me*." Experiences commonly reflected the sense of being listened to in a confidential way and being provided with information to support service users and carers to make decisions about what they wanted to happen next.

3. **Being supported through the process**

Importantly, service users and carers felt that they were supported sensitively, respectfully and empathically throughout their experience. The role of the social worker to support, and provide clear concise information is key to continuous improvement and is acknowledged as being helpful and beneficial to the service user experience of safeguarding.

> "*I felt that people in the meeting listened to me and heard what I wanted to happen. They agreed with me and did what I wanted."*

Another carer commented, *"I felt I had options and support, things are a lot better now."*

4. **Access to information**

89% of service users and carers felt that they understood the information provided to them about the safeguarding process. This included being supported to understand the information.

5. **Collaborative Working**

The project has highlighted the benefits from a service user and carer perspective on the importance of collaborative working through the joint protocol process. Some comments included;

> "*The social worker/investigating officer couldn't have been nicer….they were really caring and easy to talk to. They really listened to me and didn't pity me."*

"Both PSNI and Adult safeguarding excellent. PSNI more than helpful and understanding."

"Everyone tried to help and only for the police I wouldn't have gone through with any of it and wouldn't have been able to go back to my home."

Furthermore there were emerging patterns where 68% of the narratives reflected the partnership working across various agencies and disciplines where service users and carers reflected that working together improved their experience. This included references to *"GP's"; "nursing home staff"; "medical hospital staff"; "day care staff" and "domiciliary care staff"; "Alzheimer's Society".*

"Two social workers visited me and my brother at home and they found us somewhere to live which was warm and had loads of food. I went to the doctor in hospital and my toe is now better. I am happy and safe now."

3.4 Emerging Themes for Service Improvement

Exploring the narrative also highlights themes for service improvement and informs the recommendations in this report.

1. **Communication and being kept informed**

The importance of ongoing communication with service users and carers remains an area for improvement. While it is acknowledged that this was not the experience of the majority of service users and carers the learning from the experiences where this was not positive provides good evidence of the impact that poor communication has on the outcomes for individuals. This theme was repeated particularly in the Joint Protocol cases. One service user / carer stated

"*Disappointed by the police feedback and lack of conviction. Police left me in limbo."*

Comparatively, those who noted they were kept informed throughout the investigation and in a timely way reported an overall more satisfactory outcome.

Some recommendations for improvement from service users and carers include

"Explaining things a wee bit better" "Asking do you understand? Asking them to repeat the information"

"I wanted to be told exactly what was reported to the safeguarding team and I believed it was minimised by the staff member"

"Better and more frequent updates of action being taken. More positive reassurance"

"More one to one time with my social worker"

2. Professional Endings

Outcomes that lead to endings of interventions are important to service users and carers. This was further highlighted throughout the study by the response to the completion of the survey as a post investigation intervention.

"I found it very helpful. I found the 10,000 Voices had a good approach. I was upset by the whole thing."

The added value of engagement and completion of professional endings to support the individual to process and respond to the outcome of their investigation is evident in the responses.

3. Timeliness

The length of time an investigation took has been noted as a common theme across all the Trusts. However, only 5% of respondents felt "*the process dragged on*". Therefore it is important to understand the context and complexity of the concerns in these situations. One carer reported "*Time delays but I understand it can take time."*

"*My experience was one of frustration, anger, sporadic communications, not being made aware of incidents at the time and having to draw attention to adult safeguarding issues myself regarding my relative. I am still waiting closure…"*

Another

"The process run on far too long to be called reasonable because as long as the matter loomed over us, we all as a family were affected"

Others reported they *"found the experience lengthy."*

4. Resilience of service uses and carers

There is an emerging theme which identified the resilience of service users and carers in responding to their circumstances. One service user commented that an area of improvement would be

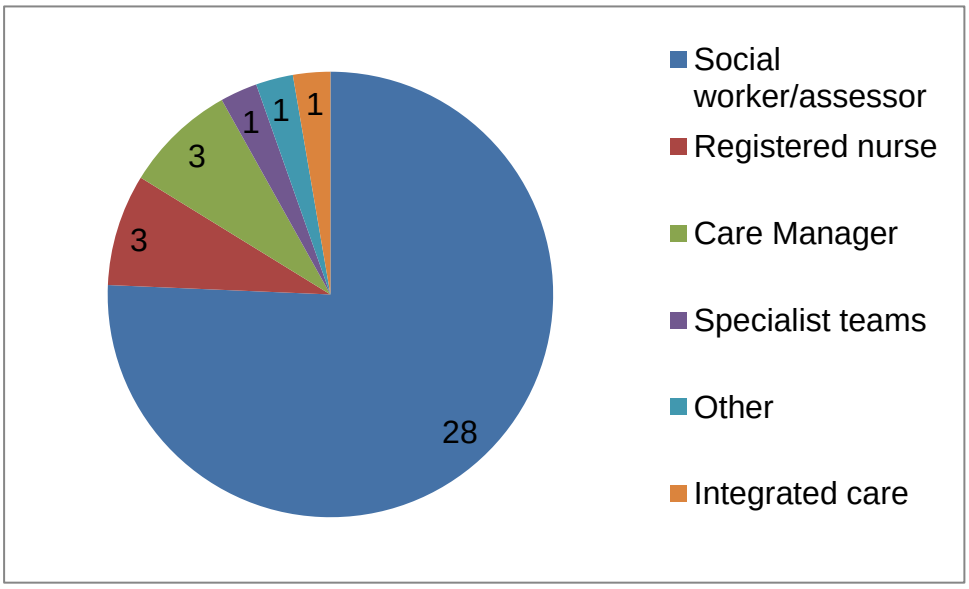
"Help to understand what I could do to keep myself safe"

Many carers reflected actions in seeking out information to support them through the safeguarding process and also prevent harm reoccurring. Using *"google", "Age NI", "Alzheimer's Society", "Carers NI"* and the safeguarding teams to provide advice and support was a recurring theme. There is an opportunity to strengthen protection planning, by building on strengths and resilience of service users and carers through the coproduction of protection plans and ongoing social work interventions to support and grow safety.

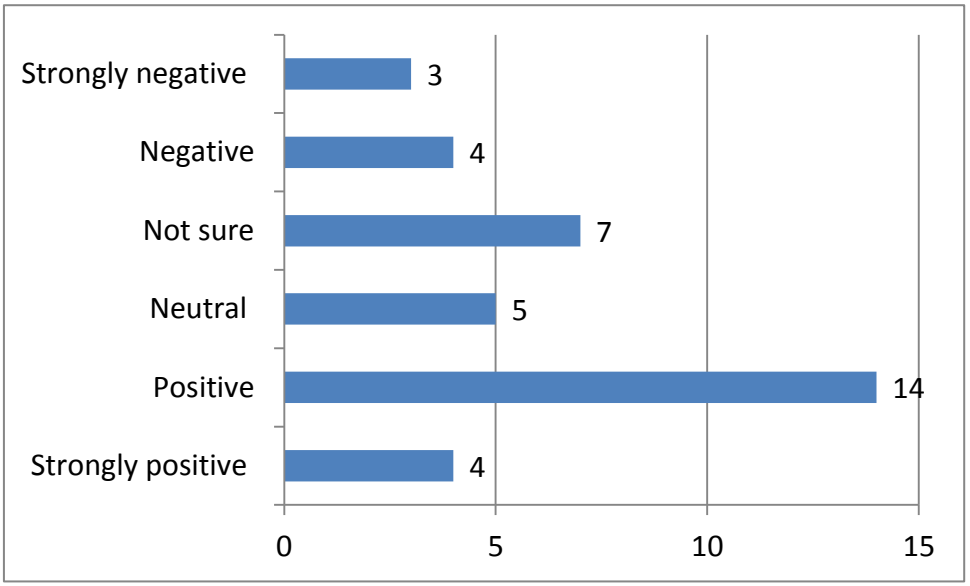
3.5 Staff experiences

In keeping with the principles of experience based co-design which underpin the 10,000 More Voices Initiative, staff who work within Adult Safeguarding services were also encouraged to describe their experience.

In total **37** staff stories were received from the following staff:



How staff rated their stories



Key messages in the staff experiences

From the staff stories recorded 56% reported their experience of the adult safeguarding process to have been positive or strongly positive. 19% reflected that the professional experience was either negative or strongly negative with a further 25% being unsure or neutral in their comment.

There are a number of key themes that can be identified across the experiences. The strongest comment relates to the desire for social workers to have more 1 to 1 time with service users to support them through direct therapeutic work throughout and after the safeguarding investigation. It was also strongly suggested that the reduction of the paperwork would improve this; however, the more frequent comment was for management to reflect the priority of adult safeguarding work within the workload allocation and management. Competing demands within Health and Social Care impact on the quality of the service staff feel able to provide with limited resource.

There was a common message of the importance of staff support from the Designated Adult Protection Officer (DAPO) and safeguarding teams. This was further reflected in comments regarding the need for ongoing quality training as best practice in safeguarding develops and emerges. Other points include the challenges regarding the length of time a complex investigation can take, particularly in the criminal processes and the legislation gap for the protection of adults was also reflected.

Interestingly, a number of staff commented on the benefits of spreading their experience across different service areas and settings, creating opportunity to develop skills, knowledge across the various types of abuse, exploitation and neglect. This was strongly reiterated in a comment stating that professionals needed to stop working in silos and work collaboratively.

Finally, a very important point was made regarding the need to share learning from investigations to prevent further abuse, exploitation and neglect to adults. Consideration should be given to developing a mechanism for taking systemic learning and sharing this appropriately across the system.

4.0 Regional Recommendations

10,000 More Voices Adult Safeguarding has been promoted widely across the region throughout the year. The response is regionally consistent in terms of the benefits of the project however; uptake remains regionally lower than expected. The Executive Directors of Social Work have given their support to the project and have encouraged uptake throughout their respective Trusts. The Regional recommendations have been identified by key members of NIASP, including an external agency, Police Service Northern Ireland who have reviewed experiences and formulated their agency recommendations.

4.1 Recommendations for commissioning

- There is evidence from the project that workload pressures and competing demands on keyworkers impact on the time staff are able to spend "listening" to service users and carers. This has impacted directly on the experience and how seriously they perceive their experience to be treated. Consideration therefore should be made to the resourcing of adult protection interventions.
- Commissioners should ensure the structures for delivering adult safeguarding services across HSC Trusts and PSNI support and develop a confident and competent workforce to enable service users and carers feel safer
- 10,000 More Voices Adult Safeguarding should be included in the closure stage of the Regional Adult Protection Procedures.
- Learning from 10,000 More Voices Adult Safeguarding should be explored through the development of an 'Always Event' under Quality 2020.

4.2 Recommendations for Service Improvement by Trusts

- There is strong evidence to suggest that service users and carers value the relationship with the keyworker. This creates an opportunity to strengthen protection planning, by building on strengths and resilience of service users and carers through the coproduction of protection plans and ongoing social work interventions to support and grow safety.

- Those involved in adult protection interventions should discuss with the service user and carer how they would prefer to engage with the various stages of the process. This may include attending meetings. In these circumstances the DAPO should consider the most appropriate means of including individuals and who should be in attendance to minimise any distress for the individual.
- DAPO's should ensure that timescales for feedback and updates to service users and carers is agreed and actioned. Those responsible for providing updates should consider an alert / reminder system to prompt contact.
- Trusts should review the use of easy read leaflets and alternative forms of information to ensure the service user and carer has access to information in multiple forms for reflection and sharing with those who are supporting them. Throughout the process keyworkers should revisit information with service users and carers to clarify understanding and create opportunity to provide therapeutic support as required.
- There is evidence to suggest that effective collaboration between Trusts, PSNI and regulatory bodies' results in better outcomes and safety for service users and carers. Professionals should seek to find innovative ways to enhance working relationships to improve the outcomes for those who remain feeling unsafe.
- Trusts should proactively advocate on behalf of service users and carers to seek a timely and person centred outcome from the judicial process. This may require liaison with both PSNI and PPS to ensure that those involved with supporting the adult are informed of the judicial outcome as appropriate and that information is communicated in a meaningful way with the adult in need and / or their carer.
- Keyworkers collecting experiences should view 10,000 More Voices adult safeguarding service user and carer feedback as a post investigation opportunity for meaningful therapeutic intervention. This should include supporting the adult to process the outcomes of the investigation and build on promoting future safety. At the point of closure if an adult reports that they still feel unsafe or not a lot safer further work should be undertaken to explore potential safety.

4.3 Recommendations for Service Improvement by PSNI

In general, service users have reflected that they have had a positive experience with police. From the project some felt the criminal justice process was too protracted. There is a need for officers to give clear information on the investigation, and the time it may take to reach an outcome. Consideration should also be given to clarifying service user/carer understanding of the information given to them, especially after a traumatic event. Investigating officers should also ensure there is ongoing engagement to keep service users/ carers updated, manage expectations and share outcomes.

5.0 Local Trust Actions taken to date or that need to be taken forward

5.1 Belfast Trust

- The BHSCT have reviewed the experiences of service users and carers as they have been received. Where there has been learning identified this has been discussed with the relevant practitioners to inform service improvement and shared learning.
- BHSCT have support for professional protection staff where there are opportunities for shared learning and development.
- The actual questionnaire was previously noted by one programme of care as being too complicated for the service-user to understand.

5.2 Northern Trust

- The Adult Safeguarding team provided in reach training to any hospital staff at a number of sessions with all hospital sites in the NHSCT area. This training will be a rolling event.
- All Designated Adult Protection Officers and Investigating officers have been reminded of their responsibilities and are asked to provide regular feedback to service users and carers. This message is shared at all safeguarding forums and safeguarding training. Correspondence was also sent to all Designated

Adult Protection Officers asking them to ensure feedback was provided in a timely manner.

- One experience referred to a criminal case and therefore parts of the timescale would be out of the NHSCT and PSNI control. The PIA / ABE interviews and investigations should be completed in a timely manner. The NHSCT have an adequately trained workforce to respond to the demands of the Adult Protection work.

5.3 South Eastern Trust

- Senior practitioner reviews 10,000 More voices experiences and if any areas of improvement are identified these are discussed with the key worker or investigation team.
- The SET 10,000 Voices facilitator has delivered awareness training on the ethos and use of the tool in training for DAPOs and IOs. It is hoped this will improve completion of the surveys with the realisation that this is a core part of the protection process and not an add on.
- Use of the 10,000 Voices surveys have been highlighted in various DAPO, Social work and Team forums with the emphasis that engagement with service users at the outset of the investigation will ensure management of expectations and agreed outcomes. Following on from that completion of the survey upon conclusion of the investigation will allow a measure of how well the outcomes were met, the experience of the intervention for both the service user and staff and any learning to be gained.
- SET DAPOs will be asked to ensure completion of the 10,000 Voices survey following conclusion of the investigation and to be discussed in supervision as part of reflective practice.
- SET have facilitated training within the Ulster Hospital ED dept and Radiology Department. The emergency department have also established a safeguarding page on i-connect with relevant information uploaded.

5.4 Southern Trust

- 10,000 Voices adult safeguarding project has been promoted within the Trust as a professional intervention prior to the closure of the adult protection process. This has encouraged engagement and supported professional reflective practice in endings. However there is wide recognition of the workload capacity issues within operational teams to provide this type of intervention with competing demands.
- There is a need to revisit the importance of reflecting back to service user /carers what they understand the concerns to be and what the service users/carers expectations are in relation to their preferred response and outcomes.
- Learning points to be shared at relevant adult safeguarding Forums for discussion and reflection.
- A Learning Sheet has been developed to highlight corporate, directorate and team learning from protection investigation recommendations and outcomes.

5.5 Western Trust

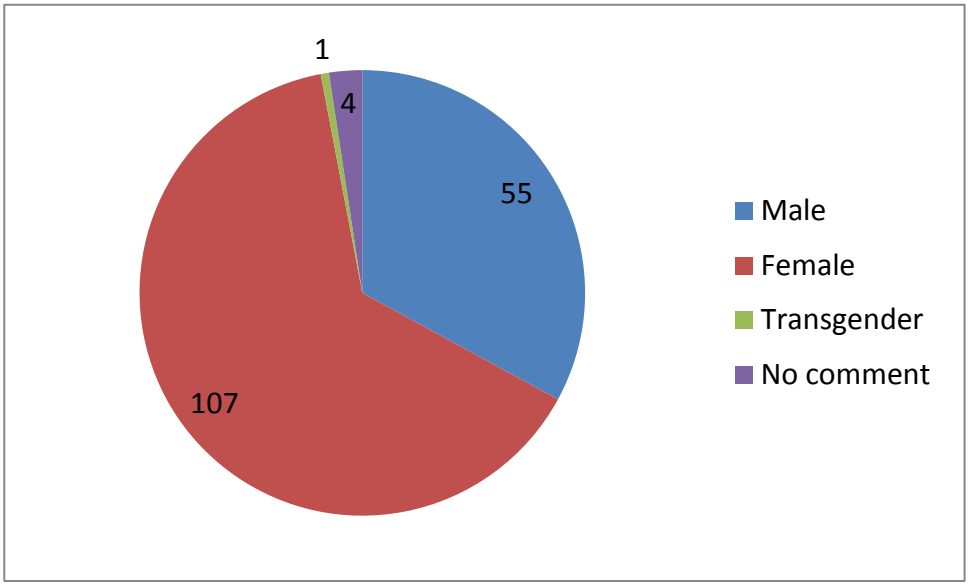
- Senior managers within PCOP have been made aware of the need to reinforce the importance of communication of the completion of the adult safeguarding process.

6.0 Conclusion

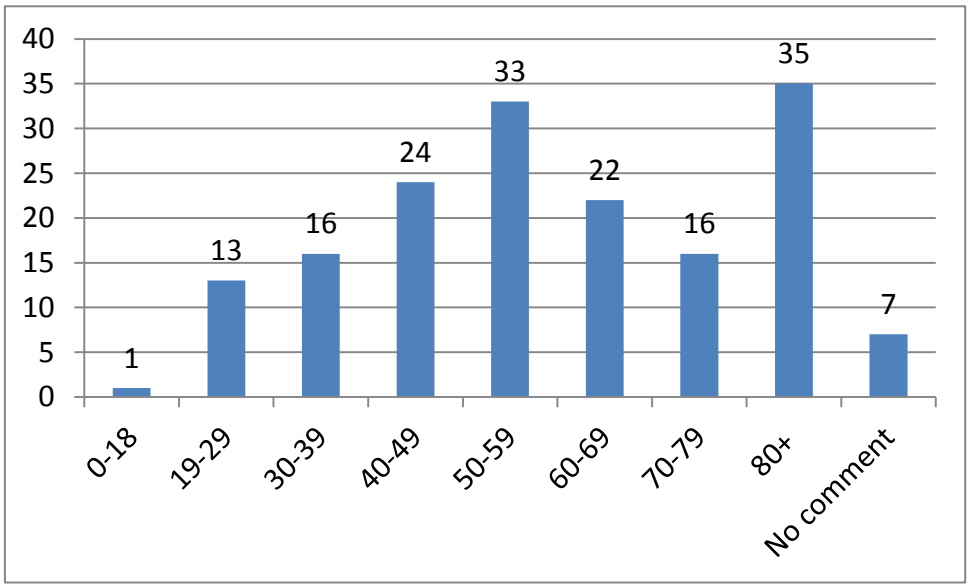
The findings of this project have been presented to the Northern Ireland Adult Safeguarding Partnership. Representation from the partnership (including trusts, PSNI and third party agencies) will be responsible for integrating the key messages from service users into service improvement work at a Regional level. Each trust is also reflecting on local messages as demonstrated in Section 5.0. The 10,000 More Voices project will be kept open and will be embedded into practice in the adult safeguarding processes as an ongoing method to ensure the patient client experience influences future innovations and strategy.

Appendix 1: Demographic information

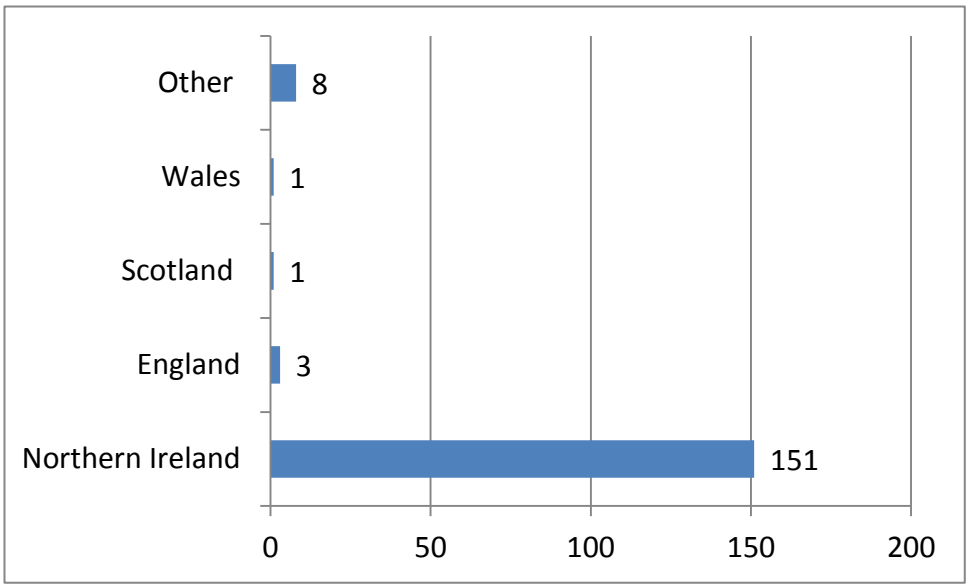
Returns by gender



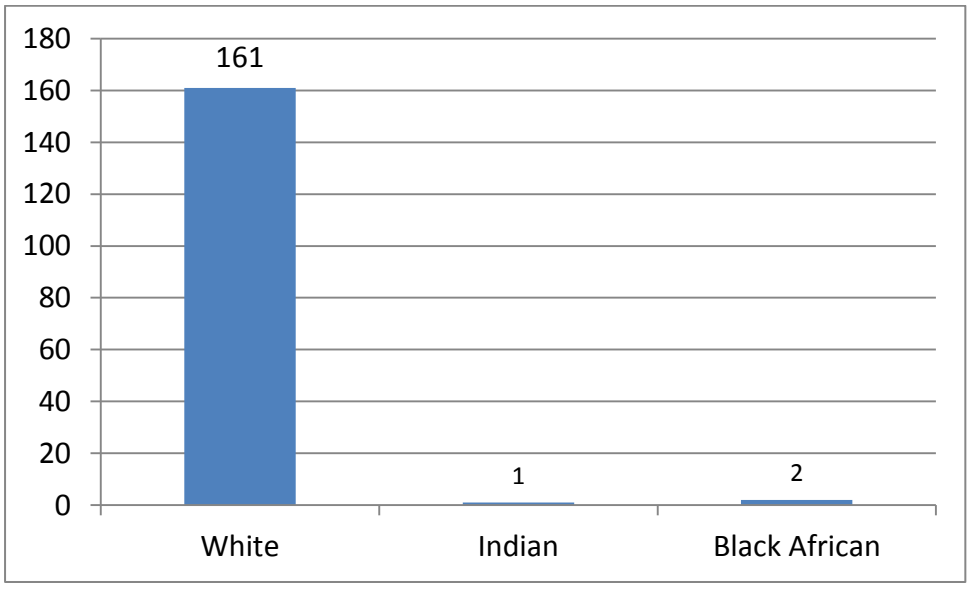
Returns by age



Returns by country of birth



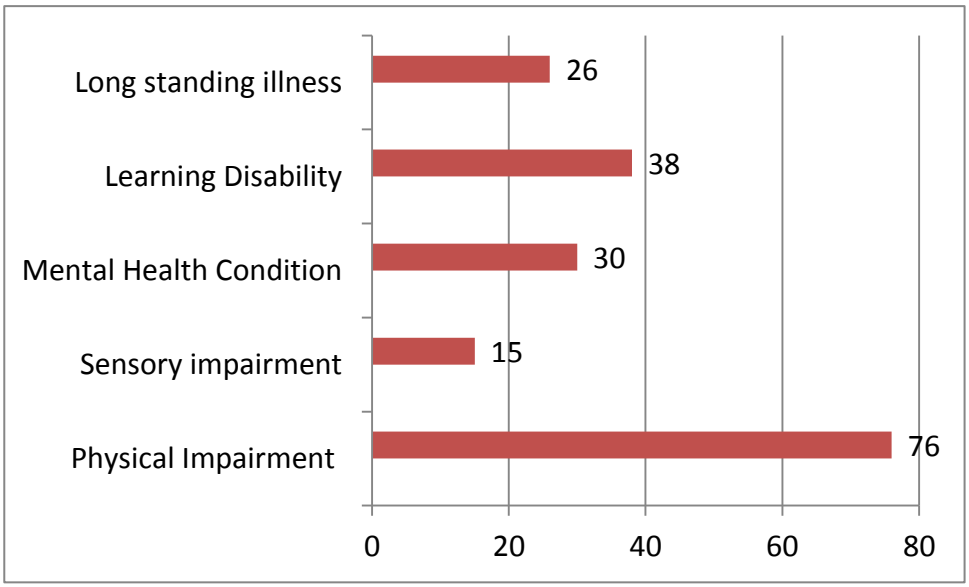
Returns by ethnicity



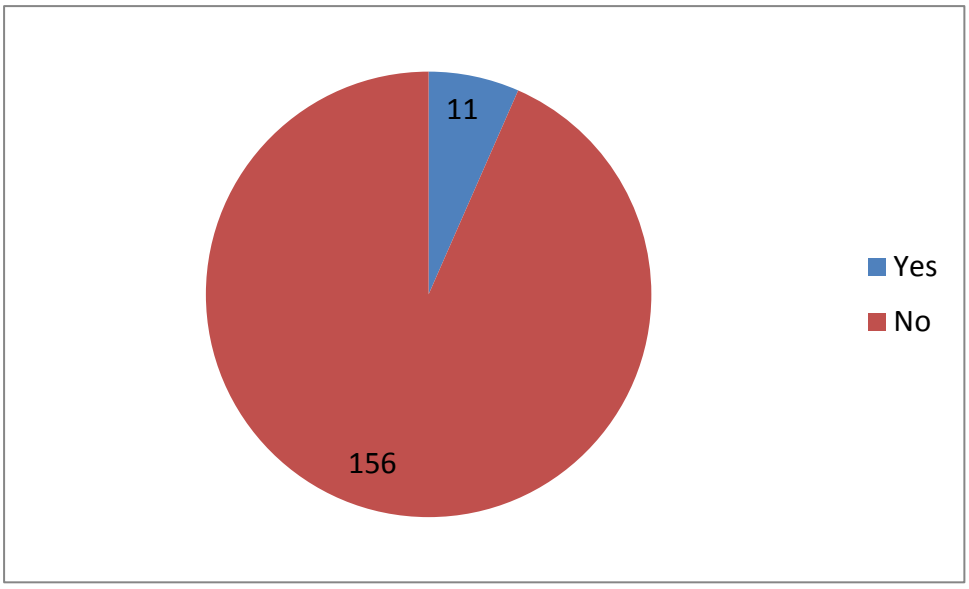
Do you consider yourself as having a disability?

Yes	131
No	27
Prefer not to say	9

If yes, please indicate which type of impairment(s) applies to you.



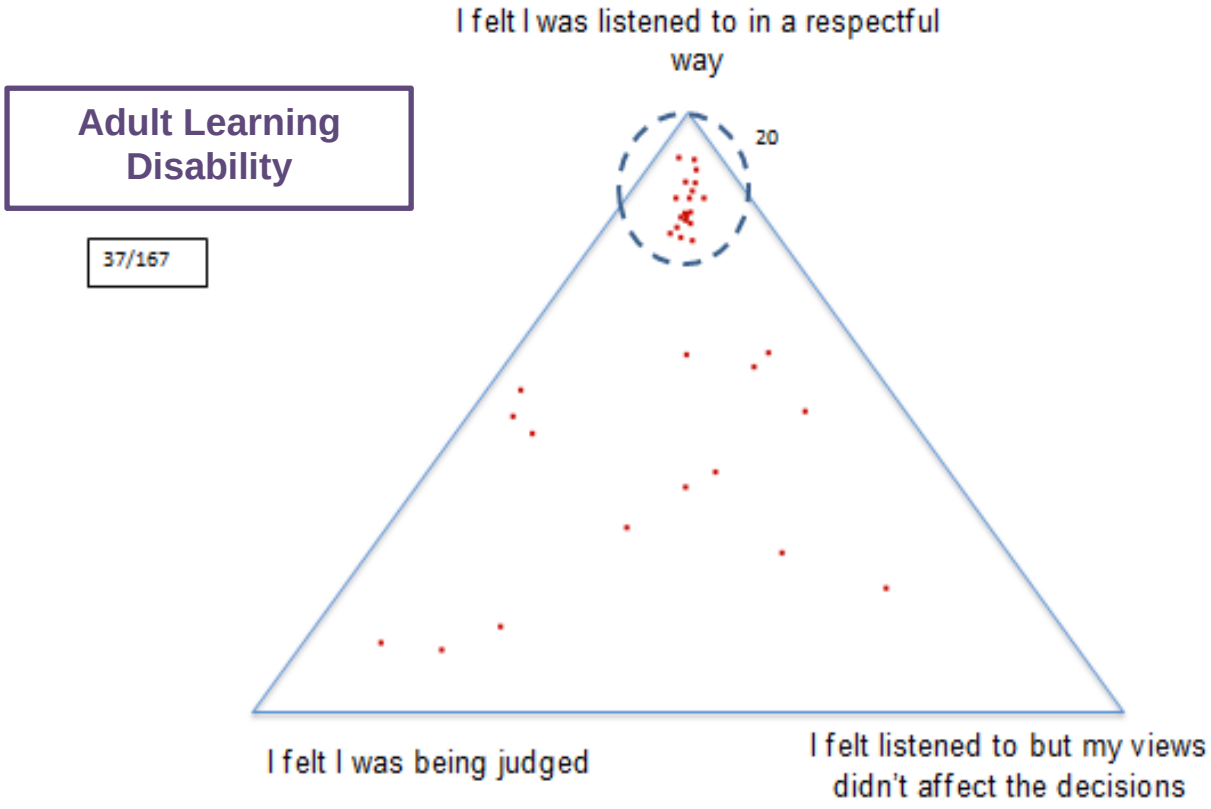
Please indicate if you (or the person) are living with a rare disease or a probable diagnosis of a rare disease?



In your experience, which of the following professionals and support services were you involved with?			
Helpline/advice line	6	**GP**	38
999 emergency call staff	15	**Physiotherapist**	6
Ambulance Crew/Paramedics	15	**Occupational therapist**	6
Reception/ Administration Staff	13	**Interpreting services**	2
Nurses	37	**Registered Intermediary**	1
PSNI	61	**Doctor**	23
Victim support	10	**Voluntary Organisation**	14
Social Worker	146		
Investigation Officer	87	**Designated Adult Protection Officer**	61
ABE Social Worker	26	**ABE PSNI Officer**	20
Other	27	**Don't know/ not identified**	5

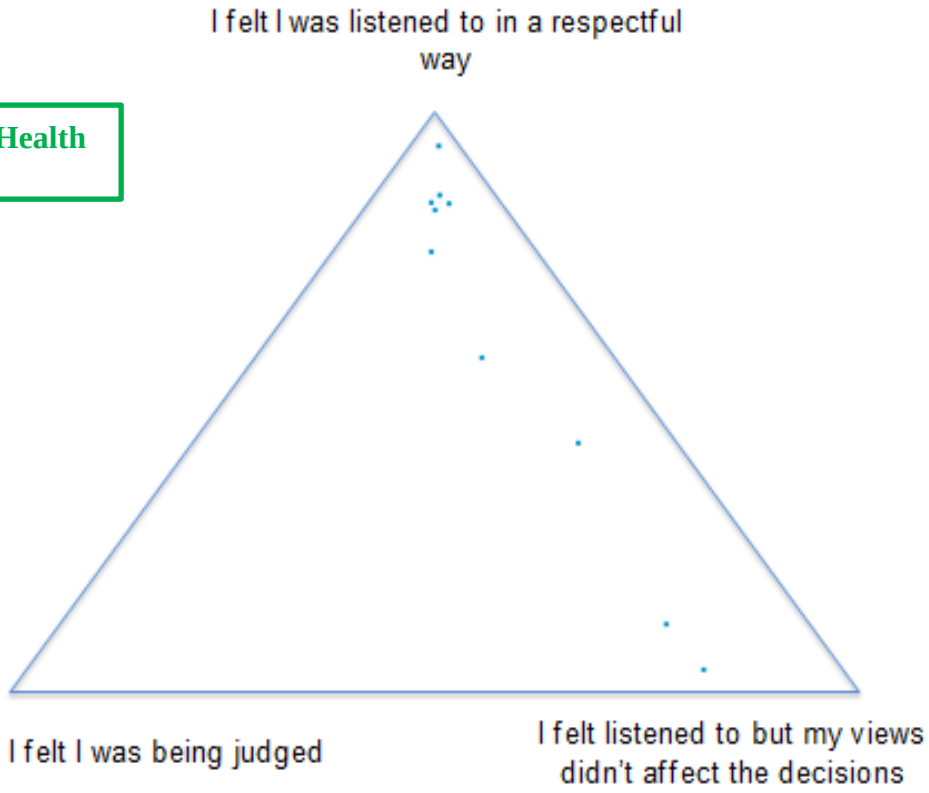
Appendix 2 Signifiers by programme of care

Question 1: To what extent did you feel listened to during meetings and conversations?



Adult Mental Health

10/167

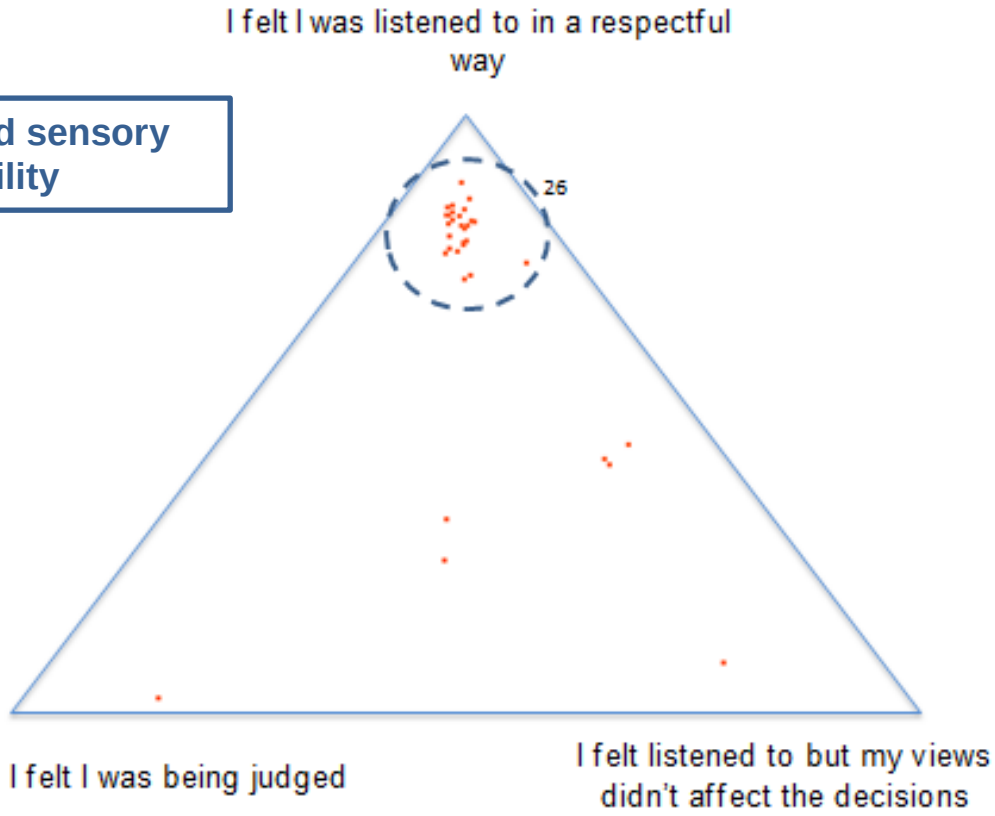


Primary Care & Older People

50/167

Physical and sensory disability

33/167



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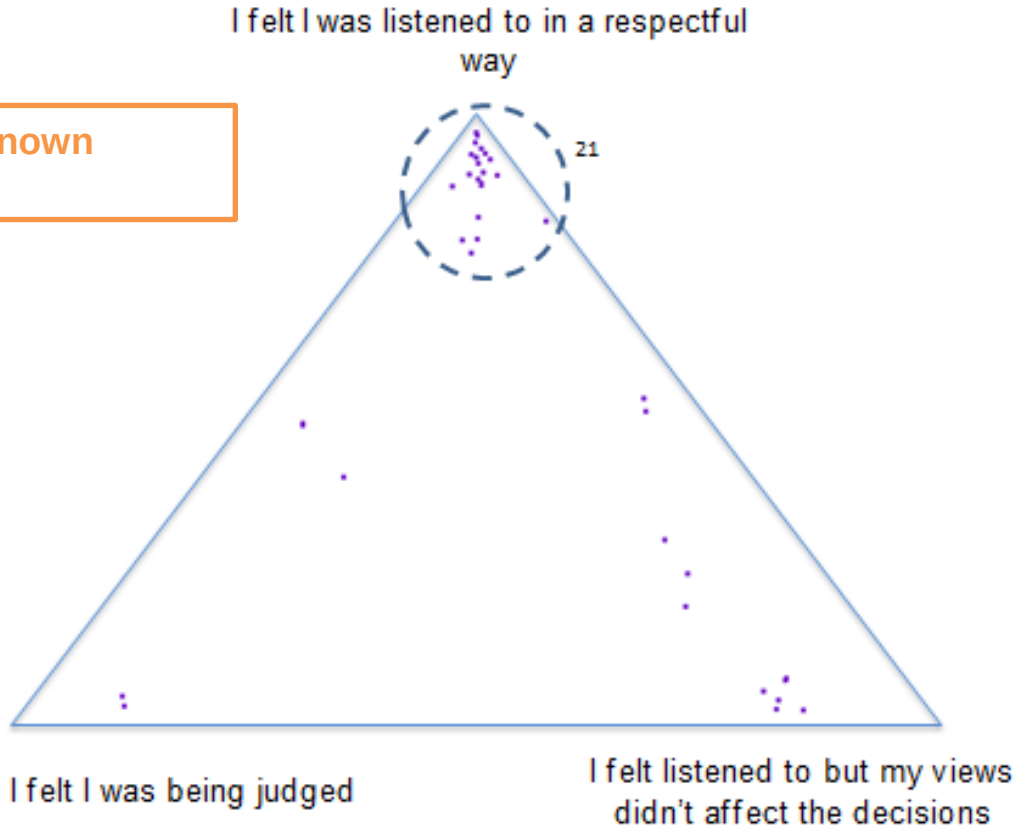
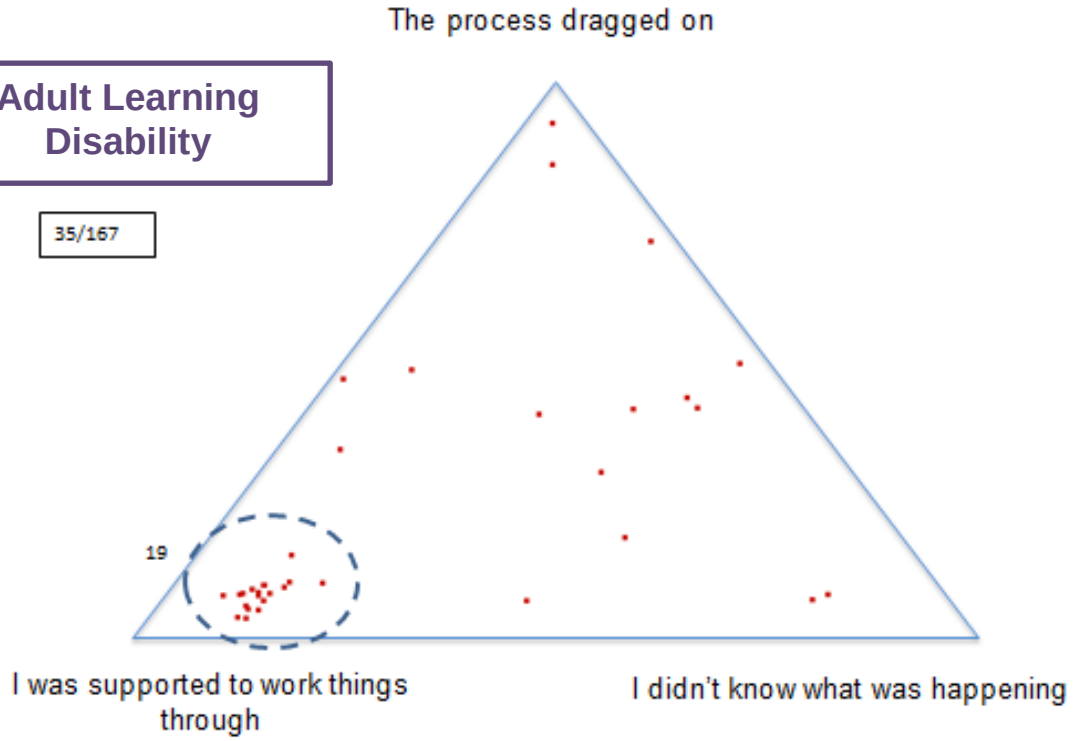


Question 2: To what extent did you feel satisfied with how the SAFEGUARDING INVESTIGATION was carried out?

Adult Learning Disability

35/167



Adult Mental Health

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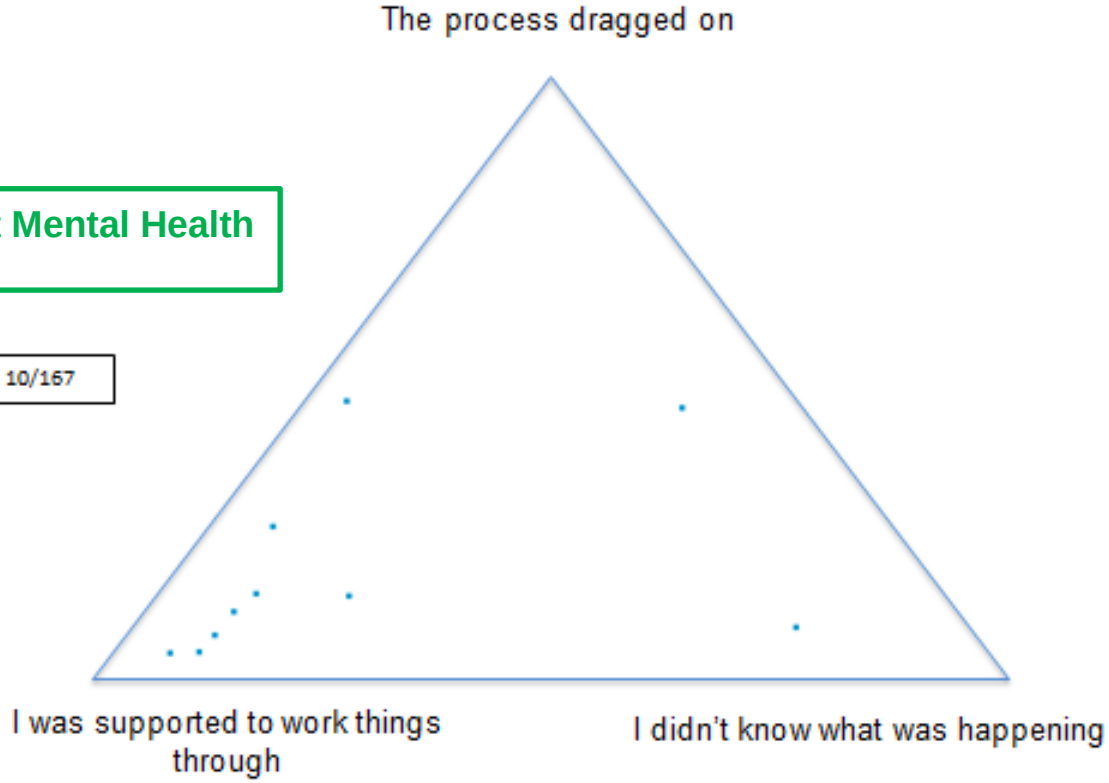

Primary Care & Older People

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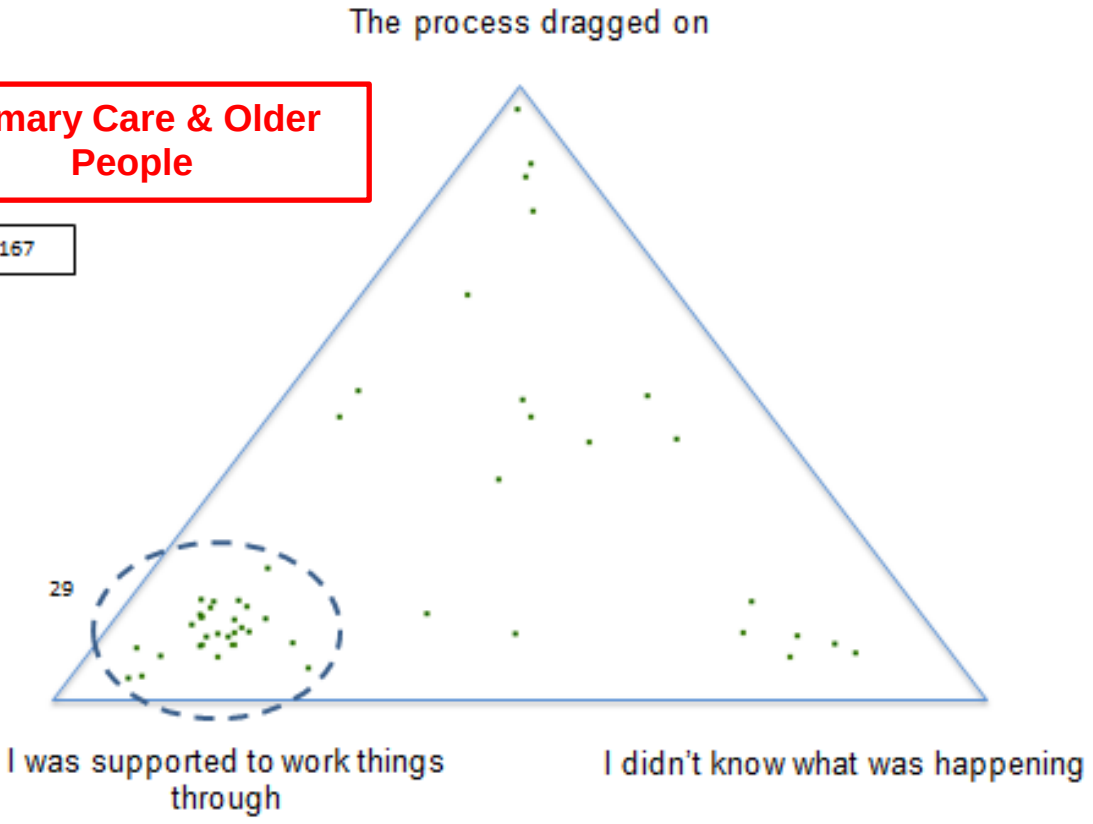

Physical and sensory disability

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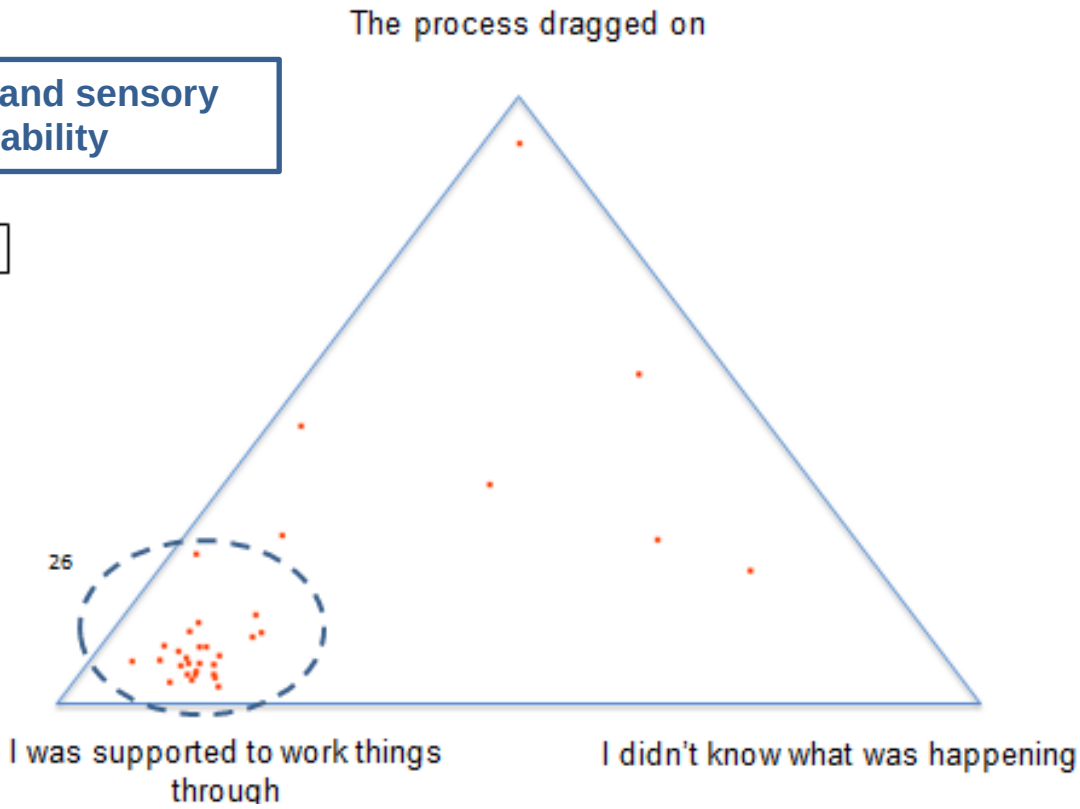
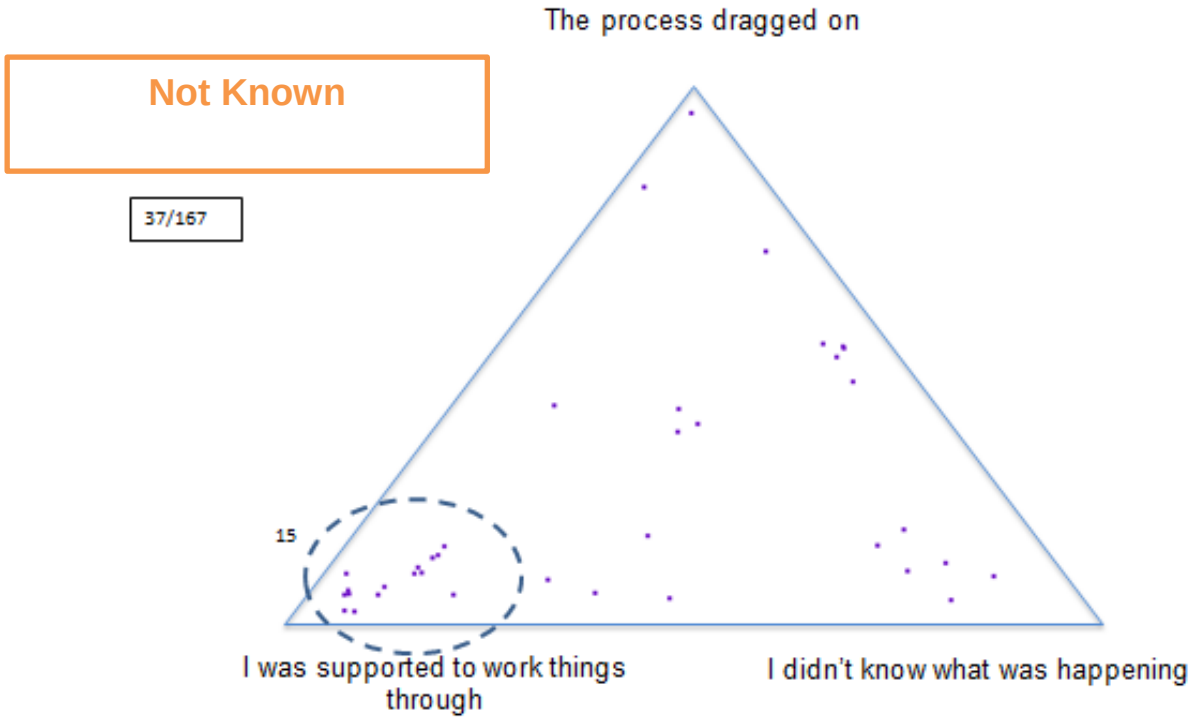
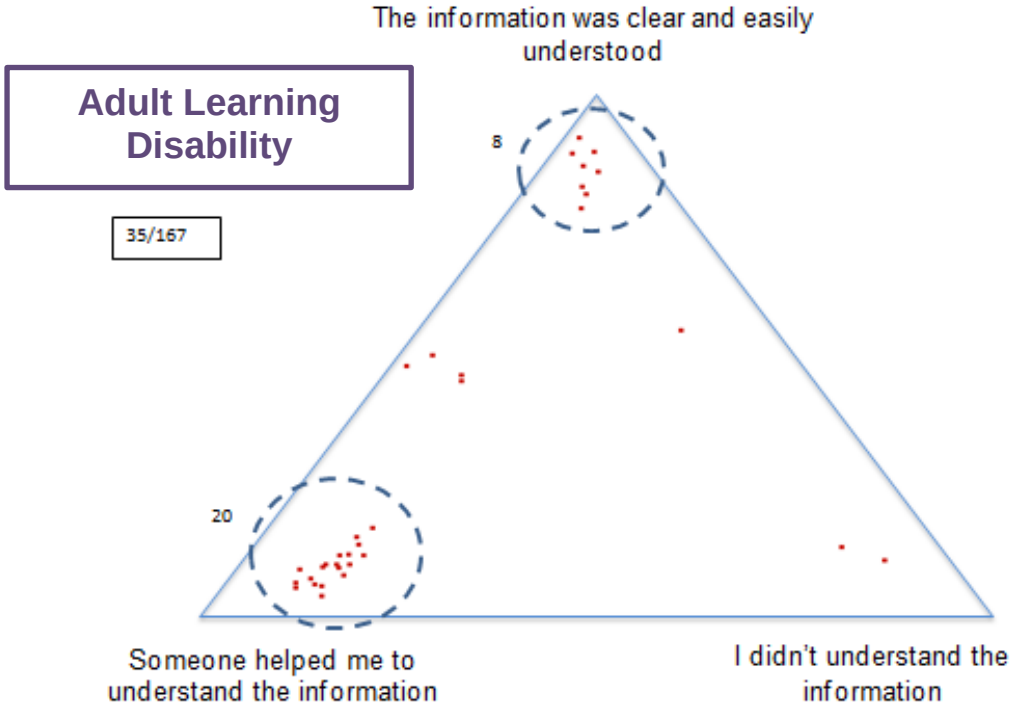
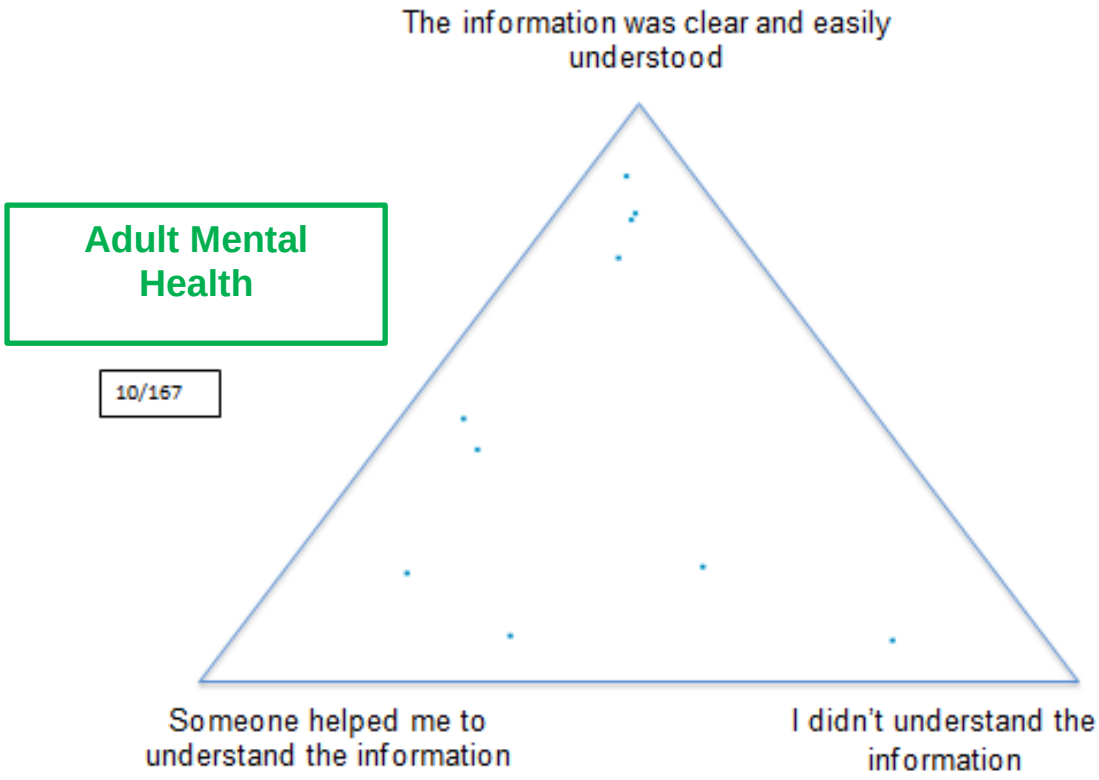
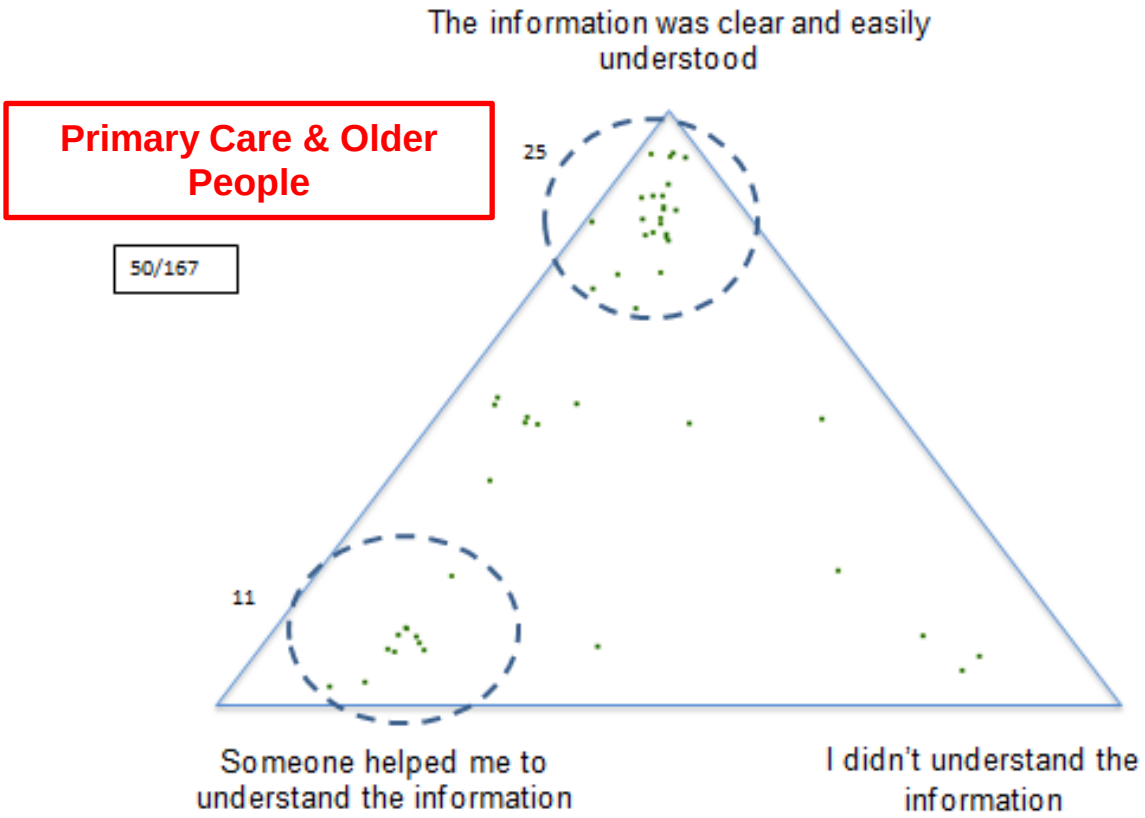




Question 3: To what extent were you able to understand the information given to you DURING the safeguarding investigation?




The information was clear and easily understood
Adult Mental Health
10/167
Someone helped me to understand the information
I didn't understand the information


The information was clear and easily understood
Primary Care & Older People
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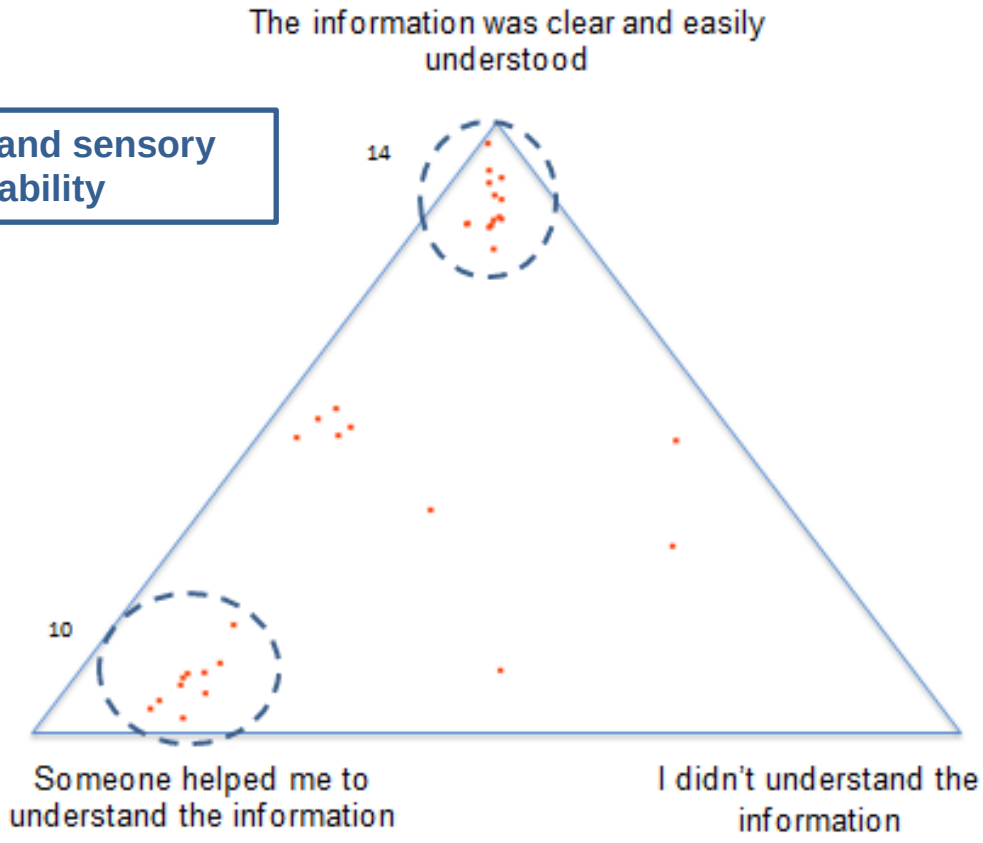
25
11
Someone helped me to understand the information
I didn't understand the information

Physical and sensory disability

33/167



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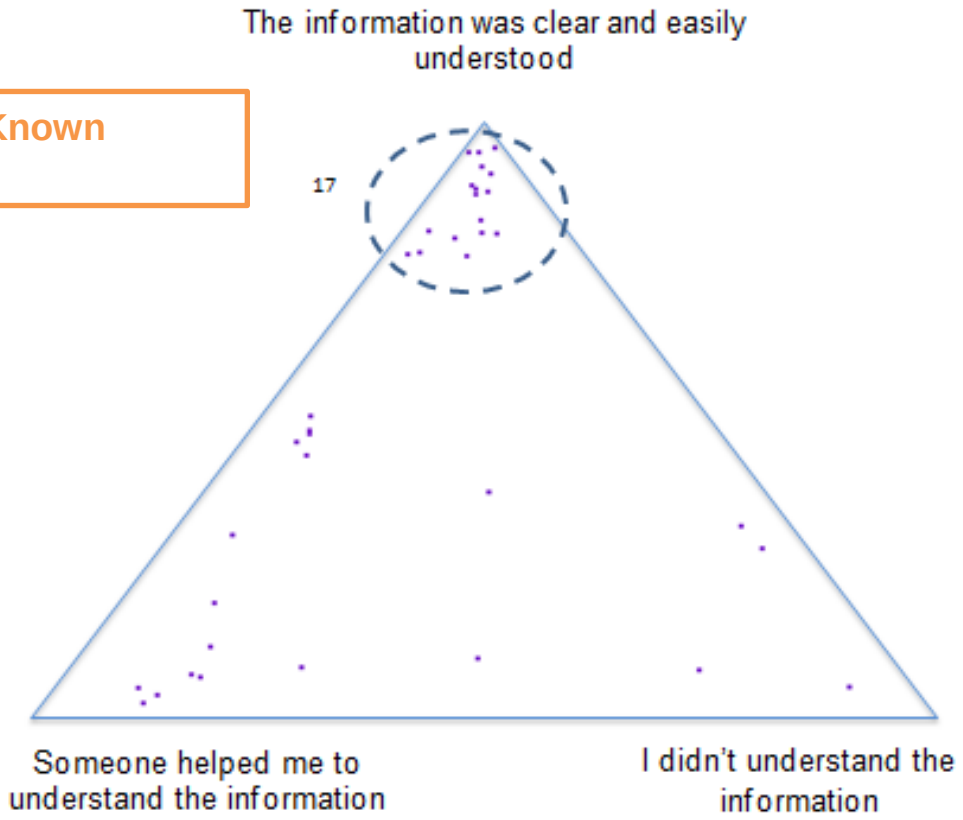
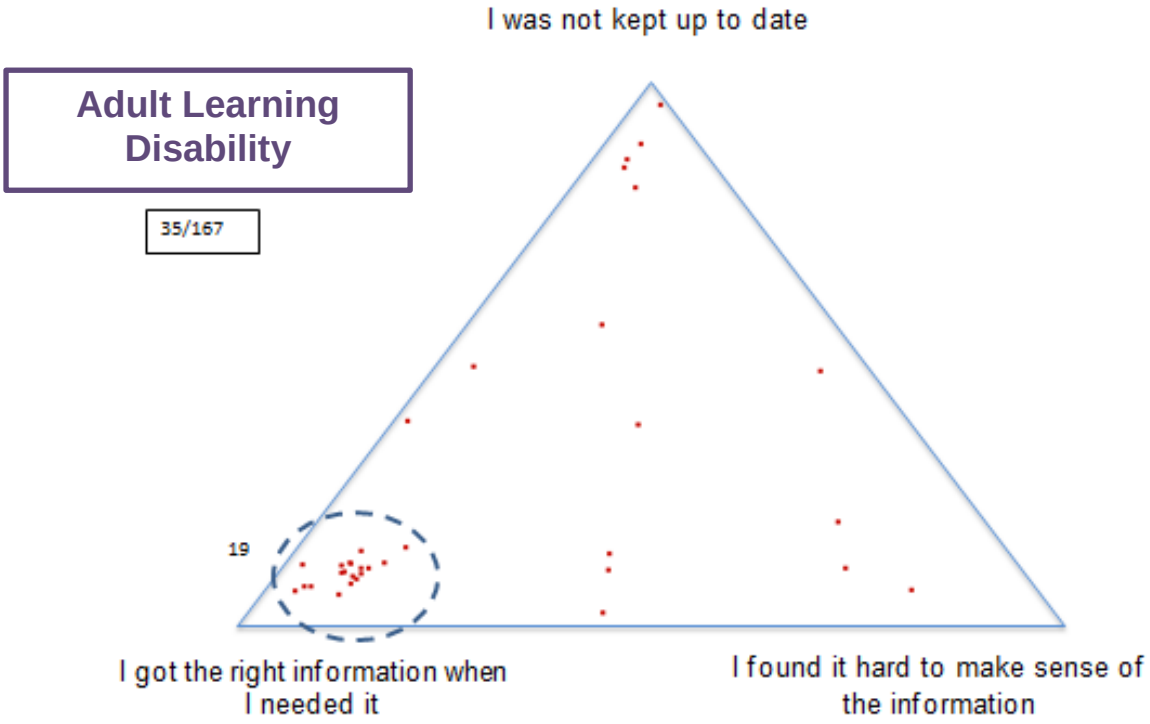
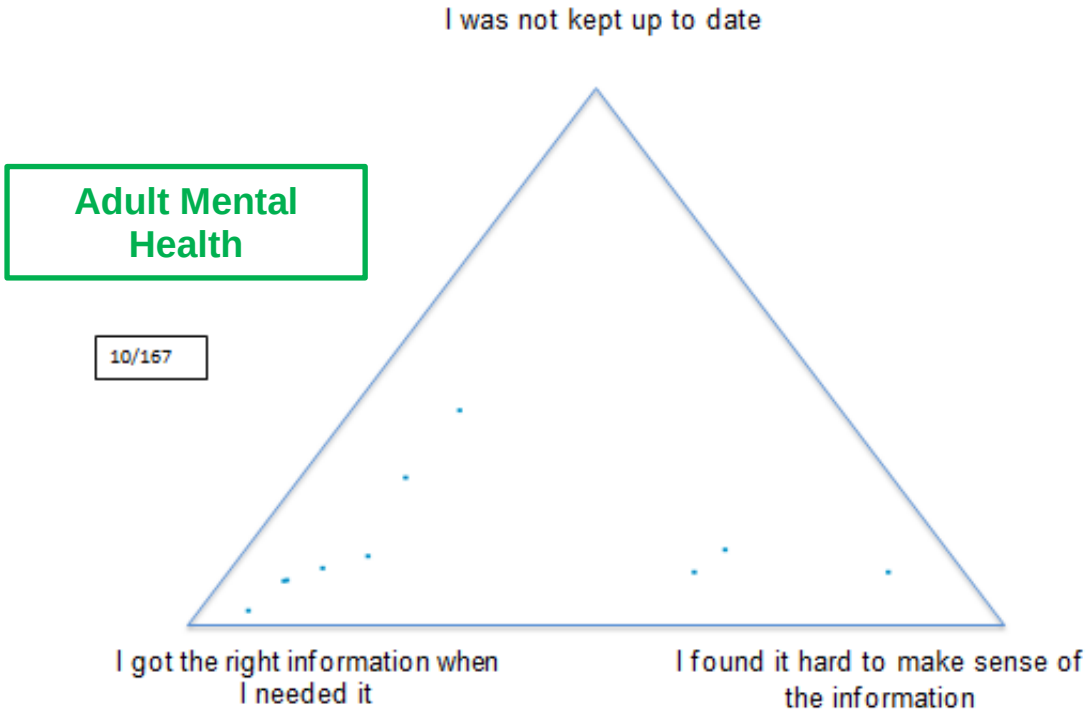


Question 4: To what extent were you given the information you needed at the RIGHT TIME during the safeguarding investigation?

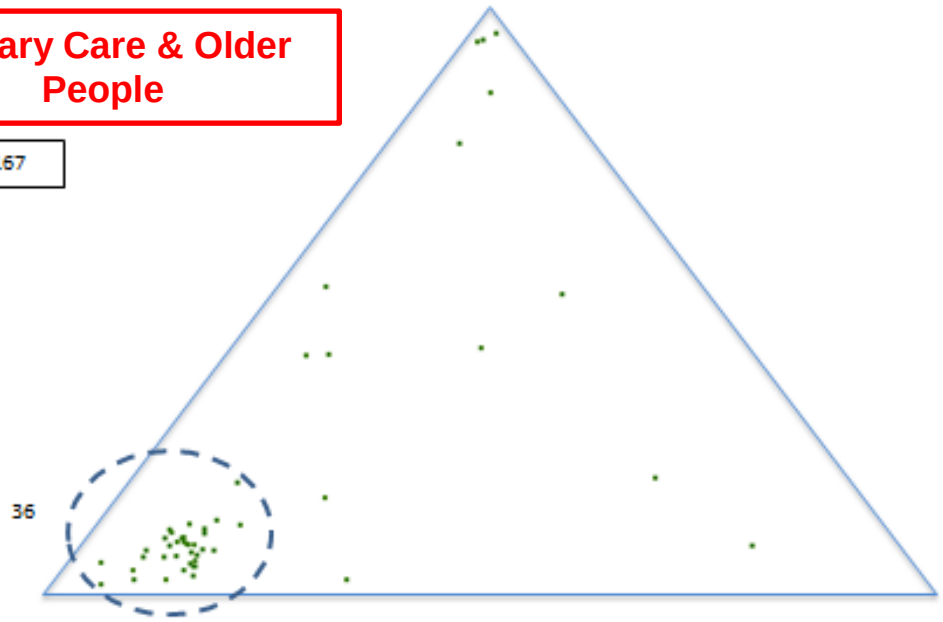




I was not kept up to date

Primary Care & Older People

50/167



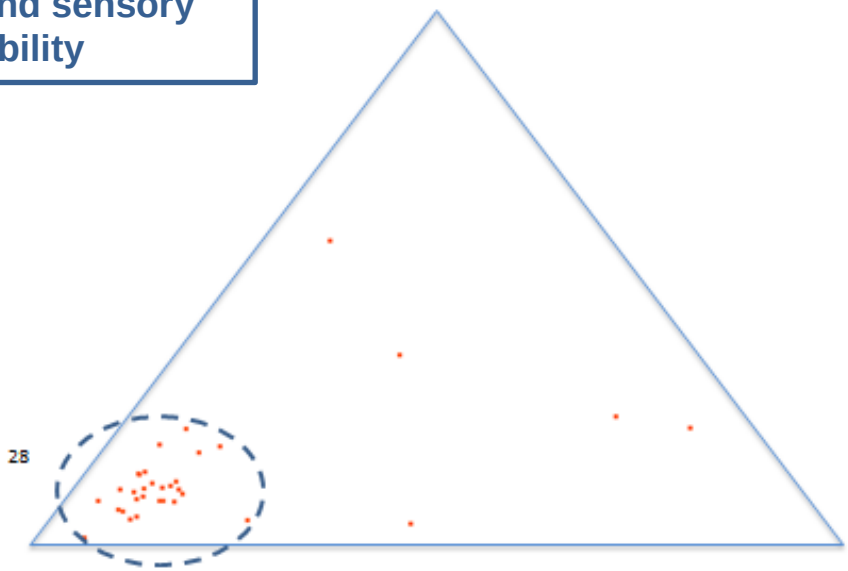
I got the right information when I needed it

I found it hard to make sense of the information

I was not kept up to date

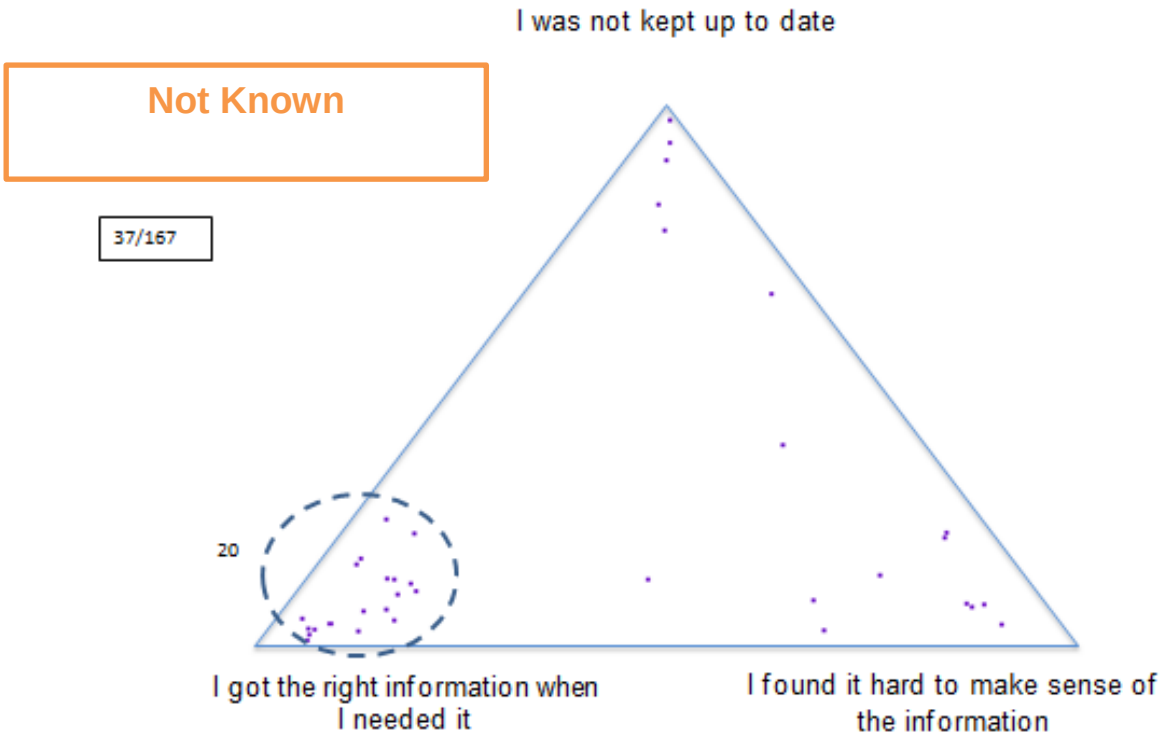
Physical and sensory disability

33/167

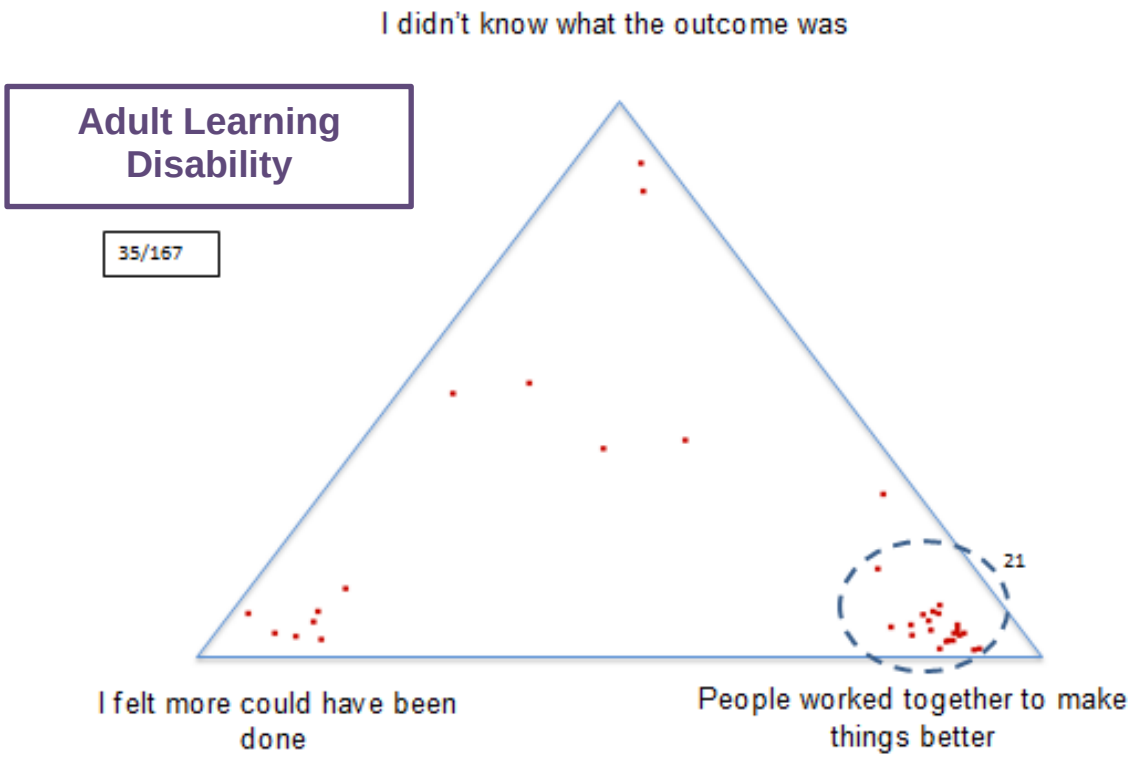


I got the right information when I needed it

I found it hard to make sense of the information



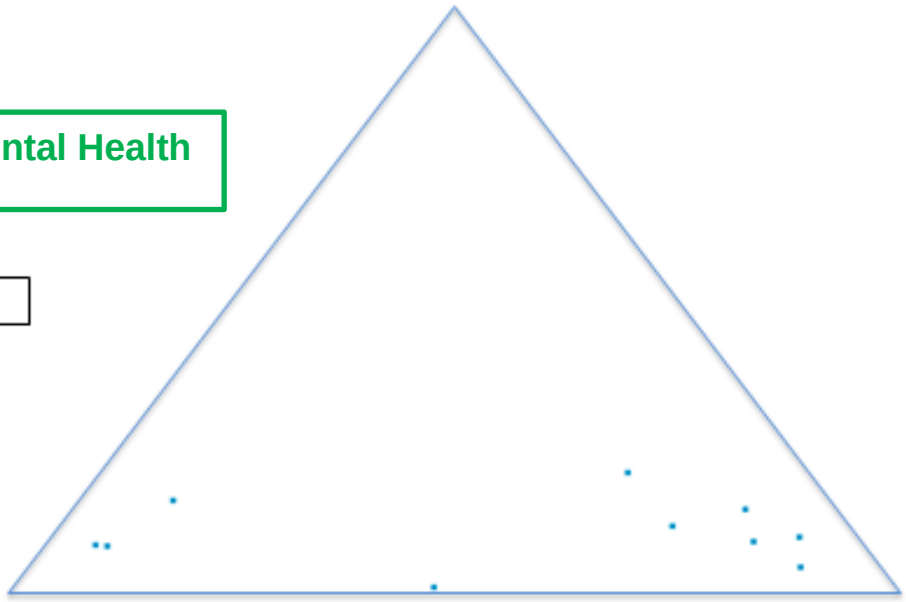
Question 5: To what extent were you satisfied with the outcome of the investigation?



I didn't know what the outcome was

Adult Mental Health

10/167



I felt more could have been done

People worked together to make things better

I didn't know what the outcome was

Primary Care & Older People

49/167

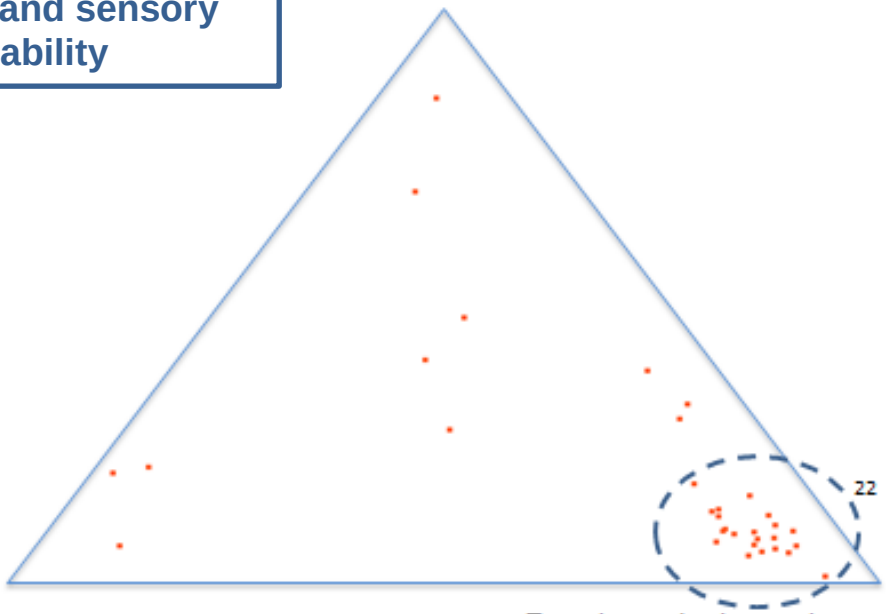
I felt more could have been done

People worked together to make things better

I didn't know what the outcome was

Physical and sensory disability

33/167



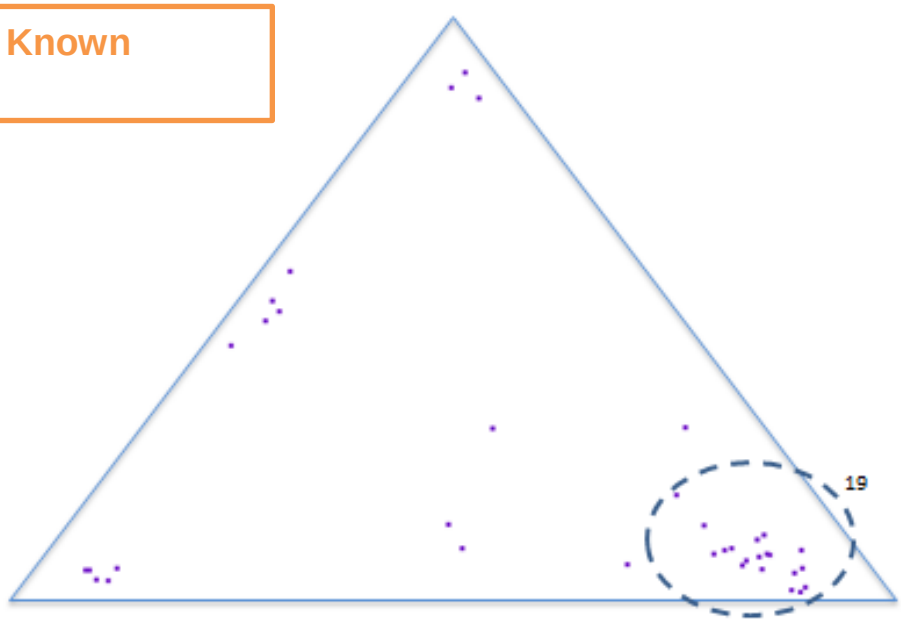
I felt more could have been done

People worked together to make things better

I didn't know what the outcome was

Not Known

37/167



I felt more could have been done

People worked together to make things better