MAKING SAFEGUARDING PERSONAL

TEMPERATURE CHECK 2016

(Commissioned by the
Association of Directors of
Adult Social Services)

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Dr. Adi Cooper, Mike Briggs, Jane Lawson, Bill Hodson, Moira Wilson

Data analysis and research advice provided by:
Dr Pippa Belderson & Prof. Marian Brandon, University of East Anglia

Administrative support:
Rivka Cocker

Foreword from Margaret Willcox, Vice President of ADASS

CONTENTS Page

1. INTRODUCTION
1.1 Background 3
1.2 Scope 3
1.3 Method 4

2. SUMMARY OF FINDINGS 5

3. FINDINGS
3.1 Overview 9
3.2 Organisational commitment 9
3.3 Measuring outcomes
3.3.1 Reporting and evidencing 'making a difference' 14
3.3.2 Recording systems 15
3.3.3 Hearing the voice of the person using safeguarding 16
3.4 Impact
3.4.1 Impact on people who use services 17
3.4.2 Impact on practice 18
3.4.3 Development of staff and promotion of MSP 19
3.4.4 Strengths of MSP implementation 19
3.4.5 Blockages to implementation 21
3.4.6 Staff reaction to the MSP culture change 21
3.5 Coaching
3.5.1 Respondents' views on how they can take MSP forward in their own organisations 23
3.5.2 The single thing that would really advance MSP in respondents' organisations 24
3.5.3 What respondents would like to see in the 2016/17 safeguarding development programme 25
3.6 Evaluation of progress
3.6.1 Level of organisational achievement 26
3.6.2 Respondents' reflections 28

4. RECOMMENDATIONS 28

5. GLOSSARY 30

6. REFERENCES 30

Appendix 1 Views from service users and carers 31
Appendix 2 Suggestions for inclusion in the Adult Safeguarding Development Programme 2016/17 40
Appendix 3 Learning examples 41

Appendix 4 List of participating local authorities 46

FOREWORD

I am very pleased to introduce this important piece of development work which we commissioned earlier this year. Safeguarding adults at risk of abuse or neglect is one of the most important things that Social Services and their partners do and remains one of our top priorities at ADASS. We have championed the person-centred and outcomes focussed approach that is Making Safeguarding Personal (MSP) for a number of years and wanted to check on its progress as well as to help and encourage people to embed it within their authorities and with their boards and partners.

The work itself was very wide-ranging, achieving coverage of 76% of English local authorities through in depth interviews with their safeguarding leads. When compared to previous MSP evaluations, the results revealed much progress with a positive picture of dedication and innovation. The vast majority of those interviewed had built MSP into their mainstream services and were achieving better outcomes for people needing care and support who had experienced abuse or neglect.

However some areas are still struggling to make headway with MSP and some have stalled and the approach itself has only gained limited traction within partner agencies such as the police and NHS. So there is still much to do. The comprehensive recommendations offer a practical way forward and many examples of good practice are given where people are willing to share them with others. ADASS will be actively working to support Directors and I would encourage you to read and use this report within your own locality and region.

Margaret Willcox
ADASS Vice President

1. INTRODUCTION

1.1 Background

The Making Safeguarding Personal (MSP) programme has been running since 2010. The Care Act 2014 guidance required adult safeguarding practice to be person led and outcome focused, aiming towards resolution or recovery. This embodies the MSP approach. During 2014/15 the programme was mainstreamed with all local authorities supported to develop plans to implement the MSP approach to adult safeguarding, through regional workshops and direct contact with the MSP project support team.

Safeguarding referrals appeared to almost double in the first six months after the Care Act 2014 came into force in April 2015 and it was unclear what impact MSP had on these changes or vice-versa. This could have been because safeguarding had become statutory, because a wider group of people than previously were now included or because there were concerns about provider quality and CQC inspections were highlighting a need for improvement in management of safeguarding referrals in this area of regulated services. Leadership had been identified as requiring development in key sectors, including partners and providers as well as support in collecting and using information and data.

The 2014/15 MSP programme was evaluated by Research in Practice for Adults (RiPfA), commissioned by the Local Government Association (LGA), who published their report at the end of 2015 (Pike & Walsh, 2015). It indicated that many places were still in the early stages of their MSP journey. Some councils had been absorbed with implementing the broader approaches to the Care Act 2014 and this work had led to them putting MSP on hold.

1.2 Scope

ADASS fully supports the MSP approach and wants to see it fully implemented in all councils. Given the questions raised by the RiPfA 2015 evaluation and other concerns about quantity and quality of safeguarding alerts and referrals, it commissioned this 'Temperature Check'.

The temperature check has three aims:

1. To measure progress towards full implementation of MSP
2. To gather information and views from safeguarding leads in order to shape the 2016/17 safeguarding development programme
3. To offer reflective coaching and expert advice to MSP leads in local authorities

The scope covers: where local authorities have got to in their work on MSP; impact on people experiencing safeguarding, staff and practice; recording systems, evaluation of outcomes and performance monitoring; strengths and good practice; barriers to implementation and what is needed to overcome them; and level of partner organisations' commitment to MSP. The interviews also provided an opportunity for reflection and sign posting to known resources.

1.3 Method

The main method was to conduct a series of guided interviews with safeguarding leads from a sample comprising of just over three quarters (76%) of English local authorities, to establish their perceptions of progress with MSP in their own authority. The sample was randomly picked and balanced to give a fair representation of the different types of councils. The East Midlands commissioned additional interviews as they wanted a complete picture of all councils in their region for some work they were currently engaged in. The Director of Adult Social Services in each local authority was initially contacted, briefed on the temperature check and asked to nominate a respondent for their organisation. Respondents were told that their comments and views would be kept in confidence by the researchers and no single council would be identified in the report. To promote mutual learning they were also asked if they would permit identification of their Councils where good practice or innovative work was identified, which would prove helpful to others. Subsequently the councils named in this report are willing to share their experiences with others. Most interviews were with a single respondent and some were together with two or three others. Additionally there was some follow-up work on engagement with people using services reported in Appendix 1.

All councils who were contacted responded, apart from two. All respondents had some responsibility for adult safeguarding in their area with 52% being heads of safeguarding, 20% being other middle managers and another 20% being senior managers. Respondents also included four SAB managers and one SAB chair.

The interviews were conducted by a team of five people all with broad and deep experience of adult safeguarding and currently practising independent chairs of SABs. The interviewers all followed a prepared schedule consisting of a mixture of open and closed questions and an opportunity for reflective coaching. All interviews were held over the phone and averaged one hour duration.

At the end of each interview respondents were asked to make an assessment on a six point scale of how far they perceived their organisation had made progress in achieving MSP. The interviewer was also given the opportunity of making their own judgement given what the respondent had told them and their knowledge of where other organisations stood. We chose to use the interviewers' ratings as, with the advantage of an overview of many other councils, they were better placed to make a consistent judgement (Figure 3 and Table 10). Only 14 self evaluations were moderated - all except one were evaluated to a lower category.

The interviews and fieldwork took place during May and June 2016. The University of East Anglia provided expert advice on compiling the interview schedule, data capture and assisted with data cleaning and collation of information.

The previous RiPfA evaluation took place over the period January to May 2015 and consisted mainly of on-line questionnaire responses with a small number of interviews resulting in a response rate of 63% of self-selected councils. The current work had a virtually 100% response rate from a randomly pre-selected number of councils giving 76% coverage and so is statistically more reliable. The current work was not a repeat of the previous, but two of the closed questions were included for benchmarking purposes to discern any trends.

Two of the RiPfA evaluation's open questions were repeated to gain a more in-depth view of the impact on people who use services and changes to practice.

2. SUMMARY OF FINDINGS

The results point to the impression that the majority of local authorities have now completed the first step of introducing MSP, i.e. they have trained their workers and modified their systems. Most local authorities are now moving into the next phase of embedding user-focused work into their practice and culture and are at various points along that journey. However most have still to engage partner organisations beyond a mere acceptance of MSP as 'a good thing'.

We found that there has been a substantial shift in the adoption and implementation of MSP by Adult Social Care (ASC) over the past year. Although only 6% of local authorities were evaluated as having fully implemented MSP, all had embarked on the road to implementation, with only 17% still at the development stage. The remaining 77% were currently actively rolling out MSP.

The MSP approach started mainly in safeguarding teams and services but is now rapidly spreading out into generic teams. MSP is proving to be a natural partner of personalisation of services and in some areas MSP has made a home within the 'golden thread' of a user-focussed approach. Social workers appear to have embraced MSP and see it as a refreshing change to care management methods and a return to social work core values. They have welcomed the opportunities to be more creative in response to the wishes of service users. These quotes are typical of their responses:

> *Years of care management have veered people away from person centred services - lots of forms and processes. MSP enables people to be more creative and inventive.*

> *It's given an opportunity to totally revamp the whole approach to safeguarding. Forms etc were very confusing and not people friendly.*

People needing services have been brought onto centre stage with the change in culture from process-led to user-focused work. Evidence showed efforts to create a big turnaround from 'doing to' people to 'doing with' them. Most local authorities had rewritten their procedures to promote a user-focused approach and many had prioritised good outcomes over and above the time it took to reach them - there was evidence of a retreat from fixed time targets to complete interventions. People needing safeguarding were reported to feel more in control and listened to. There were reports of a big decline in meetings of professionals which had been replaced with individual meetings with the individuals concerned, often in their own homes. Services were moving away from purely substantiating abuse as an output to safer and restorative resolutions for the people who had been abused. Some were surprised to find that when people were actively engaged, the outcomes they wanted were very often very modest, for example, an apology; re-assurance that it would not happen again; recognition of the risks and how to deal with them.

> *For the first time service users are in the driver's seat, they can say how fast they want to travel and when they want to put the brakes on.*

> *Sometimes my role is stating the obvious – I keep asking 'what does Doris want?'*

People at risk aren't concerned about processes, all they want is for abuse to stop and not happen again.

97% of councils were now asking people what outcomes they wanted at the very start of the intervention, although almost 30% said that it was only happening partly at the moment. 85% said they had changed their recording systems to ask for information on what people wanted and how far their outcomes had been met - this has been a driver towards a user-focused culture. However a patchy picture of IT systems emerged: some councils have more success with the same system than others and some have either bought in or grown their own modifications. It is an area ripe for further investigation and development.

Progress has been made in response to the question "how do you know if you are making any difference?" with 30% saying they had now made the shift, and over half saying they were partly there, in measuring how they were making a difference to people's lives. Some recording systems (especially paper-based) were not being used to gather systematic performance data and many are relying on case file audits. There is a distinct move to outcome based performance dashboards which combine a mix of qualitative and quantitative data and are presented regularly to Safeguarding Adults Boards (SABs), management and staff. While these are locally-driven there is a call for at least a baseline dashboard which can be published nationally.

Having the outcome measure results on a corporate score card made it a 'live' issue that would be monitored and "something they wanted to do well in".

While it seems natural that ASC is the natural home for MSP and has been overwhelmingly the cauldron for its development, there is a danger that it will not transfer into other partner organisations. As recommended by the national MSP programme, ASC leaders and (SABs) have led in getting the message out to partners, but involvement in MSP is slow. Compared to the previous year's evaluation there has been an overall increase in partner's involvement in MSP but some partners' involvement has actually decreased (primary care, ambulance service and police). It became clear that a straight cut and paste from the local authority experience to partner agencies would not work and more development is needed to translate MSP into what it would look like in each of the partner organisations.

Having a multi-agency approach has not reached the front-line staff in services outside the council.

Acute hospitals are tied into a more traditional approach and are focused on bed-blocking

The Care Act 2014 and enthusiasm of social workers were said to be the main drivers of change but to really get things going also required commitment and support of senior management and changes to infrastructure such as: training, supervision, systems and partnership working. We found many examples of good practice in each of these areas, some of which are listed in appendix 3.

There is now an emphasis on asking in supervision "how good are you at having difficult conversations?"

We also found areas where MSP had stalled or hardly made an impact due to a variety of causes. Unsurprisingly lack of resources (staff, money, time, etc) was often given as a blockage but workers and managers had found ways around the resource issue with varying degrees of success. Councils that engaged better with their neighbours and were outward facing and collaborative appeared to be further on with MSP than those who were fairly isolated regardless of resources. An emerging trend in last year's evaluation was now increasingly backed up by evidence from practice - that an MSP approach appears to take up no more time than a traditional approach to safeguarding but from experience to date seems to lead to better outcomes for service users and can save time and resources in the long run as people are able to manage their own safety a lot better.

> *The number of formal meetings has significantly reduced as a result of MSP so coordinators released to champion from area bases.*
>
> *Staff now realise that raising safeguarding is not necessarily negative, they appreciate that people just want to be safe, nothing dramatic.*

Similarly excess pressure from additional referrals and alerts was seen as a blockage to progress, especially the added pressure due to the massive increase in Deprivation of Liberty Safeguards (DoLS) since the 2014 Supreme Court judgment. Moving to a single point of access has helped to filter out safeguarding alerts and concerns, as has a more asset-based approach. Most were still using some kind of risk assessment/threshold tool to ensure that the urgent and complex cases were seen quickly.

Some respondents said that they had used the MSP brand to lever in practice change. Some are using the term as shorthand for a user-focused, outcome-based approach. However a warning was sounded by a couple of respondents that some staff had misunderstood the concept and closed cases where abused people said they did not want any intervention, failing to take into account the wider implications of coercion, for others at similar risk and the public duty to protect people.

> *The 'brand' of MSP has given an identity to good personalised approaches and a positive direction of travel for workforce development, training and engagement with other agencies.*

Based on these findings it is possible to construct a road map of the route to full implementation of MSP. It consists of ten steps which normally will follow in that sequence, but is not given as an iron rule as some areas will have unique local characteristics. It is offered as a method to aid leaders in judging where their organisation currently stands and then to check that the next steps are within their plans.

directors of adass
adult social services

A suggested road map to MSP implementation

1. Not yet started.
2. MSP agreed as a strategic priority and planning is in progress.
3. Considering, piloting and testing ideas, innovations and recommended models.
4. MSP implementation plan agreed and implementation started.
5. Current systems and procedures revised and modified to incorporate MSP principles. Workers being trained in an MSP approach.
6. Period of embedding change of practice into the social care culture in the Local Authority.
7. MSP extended into multi-agency call centres and prioritisation arrangements.
8. MSP extended to partners who undertake safeguarding enquiries (Section 42 of the Care Act) on behalf of the local authority e.g. Mental Health Trusts, Care Providers.
9. Shift to user-focussed approach in core partner organisations.
10. Shift to user-focussed approach in all partner organisations.

3. FINDINGS

3.1 OVERVIEW

The first question we asked respondents was "what does MSP mean to you?" All gave a relatively full answer largely in line with the standard definition. There were many similarities in their replies, almost half used the term 'outcome' in their response and at least 1 in 5 used the term 'social work' with many also saying that MSP was a welcome return to social work values. The following quotes are typical responses:

> *A shift in culture from a process to the person being at the centre.*
>
> *Making sure safeguarding is proportionate, follows good social work practice and focuses on the individual not the system.*
>
> *Valuing the individual as a human being, recognising their right to lead a risky lifestyle.*

It appears that the concept of MSP is now widely understood among the ASC workforce having been built into mainstream training and particularly given a boost in councils' work to ensure they were Care Act compliant.

3.2 ORGANISATIONAL COMMITMENT

MSP now appears to be strategically mainstreamed; it is in the majority of councils' strategies with 7% saying it was their overriding objective and only 3% reporting that it was not in their strategy (Table 1). This finding is supported by over 80% of councils saying that MSP was well engaged at board level (Table 2). However this figure falls to 60% within their overall organisation. In follow-up questioning it was clear that MSP figured very strongly in SABs' strategies and that councils were working closely with them. Most of the organisations in the 'other' category did in fact have MSP built into their strategies but in some cases it was not specifically named because it was seen as a mainstream person focused approach - some of these spoke of MSP as the 'golden thread' that runs through everything that they do. Most of the remaining organisations in the 'other' category were currently revising their strategies and business plans or were in the middle of organisational change.

An extremely positive picture emerges when examining engagement of MSP within Adult Social Care departments. Across senior, middle and operational levels there is an almost identical 93% level of overall positive engagement. On closer examination there is a gradient of engagement from the top down: 50% senior mangers, 39% middle managers and only 34% of operational staff are reported to be very well engaged (Table 2).

Table 1: How would you describe where MSP fits into your organisational strategy?

	Number of responses	% of responses
The overriding strategic objective	8	7%
One of our main strategic objectives	62	54%
A particular task among a collection of others	11	10%
It isn't in the strategy	3	3%
We don't yet have a strategy	0	0%
Other	31	27%
Total	**115**	**100%**

Table 2: How well is MSP engaged with at various levels?

Level	Very well	Fairly well	Not very well	Not at all	Don't know	Total
Strategic/partnership/board	45 39%	48 42%	19 17%	2 2%	1 1%	**115** **100%**
Corporate within your organisation	22 19%	47 41%	37 32%	2 2%	7 6%	**115** **100%**
Senior management	58 50%	49 43%	7 6%	0 0%	1 1%	**115** **100%**
Middle management	45 39%	61 53%	9 8%	0 0%	0 0%	**115** **100%**
Operational workers	39 34%	68 59%	7 6%	1 1%	0 0%	**115** **100%**

When we asked about other agencies' involvement in MSP the almost total involvement of ASC departments was repeated, however the figure dropped to 35% across the corporate body of the council (Table 3 and Figure 1). Comments showed that many safeguarding leads were making in-roads into other departments but others were still finding it a difficult or slow process to get wider corporate traction.

Figure 1 plots organisations who were reported to be 'very involved' in MSP. It shows peaks for ASC, SABs, advocacy services and CCGs, which is encouraging but relatively low levels for the other organisations points to a more sporadic roll-out. The overall involvement in using an MSP approach for the three statutory SAB partners pointed to a slow journey to roll MSP out beyond the acceptance of the principles by the police and NHS. Their overall involvement was: ASC 98%, CCGs 65% and the police 48%. At the 'very' involved level the figures drop to ASC 55%, CCGs 33% and police to 11%.

When comparing levels of involvement to the previous 2015 evaluation (using an improvement score based on the difference between overall involved and overall not involved) a general trend of progress is apparent but the police, acute trusts and care providers show a slight downturn while primary care showed a far bigger drop (Table 2). From respondents' comments it appears that the Police and the NHS have not been able to embrace MSP outside small specialist units. The concept of having a conversation with the person about outcomes was said to be either alien to accepted practice or outside the time

limit they have to spend with that person. This was particularly marked with Ambulance Trusts who tend to refer everything on. Comments on primary care were few and mixed but focused on reluctance of GPs to get involved; however there was mention by a very small number of respondents where a GP had actively committed themselves to the SAB with a subsequent rise in involvement of primary care.

CCGs seem to have understood the concept of MSP but many were struggling to translate the principles into commissioning. This is reflected in the responses to NHS provider usage of MSP where only 7% of areas reported their NHS provider organisations to be "very" involved, overall 37% were involved in some way and 13% of areas reported no involvement from them at all. A breakdown of the responses shows that Mental Health Trusts are the most involved and Ambulance Trusts the least involved. Comments showed that in many areas hospitals were not finding the time and resources to become more user-focused, faced with unrelenting pressures on beds, fast patient turnover and many holding a view that an MSP approach would be more time-consuming.

The trend among the other partners showed a growing involvement of housing providers at 40%. In the 'other' categories Fire and Rescue services was the most frequently mentioned at 32% followed by Probation at 14% and prisons at 6%, although some reported problems in trying to get prisons involved.

Table 3: How involved have the agencies listed below been in using an MSP approach in your Local Authority's area?

Agency	Very involved	Fairly involved	Not very involved	Not at all involved	Don't know	Too soon to say	Total
Council Adult Social Care	55% 63	43% 50	1% 1	0% 0	0% 0	1% 1	**115**
Other council departments, e.g. trading standards	10% 11	25% 28	39% 44	15% 17	9% 10	4% 4	**114**
Police	11% 13	37% 43	35% 40	8% 9	5% 6	3% 4	**115**
Ambulance Trust	4% 5	10% 11	41% 47	31% 35	10% 11	4% 5	**114**
Acute hospital	7% 8	45% 52	34% 39	9% 10	2% 2	3% 4	**115**
Primary Care	5% 6	26% 29	46% 52	13% 14	5% 6	4% 5	**112**
Mental Health Trust	15% 17	54% 61	25% 29	5% 6	1% 1	0% 0	**114**
Other specialist NHS provider	5% 4	16% 14	11% 10	7% 6	56% 49	5% 4	**87**
Housing Providers	9% 10	31% 36	33% 38	16% 18	8% 9	3% 4	**115**
Advocacy	40% 44	29% 32	11% 12	10% 11	10% 11	1% 1	**111**
Care Providers	5% 6	42% 47	34% 38	10% 11	4% 5	4% 5	**112**
The SAB	46% 51	42% 47	9% 10	0% 0	2% 2	1% 1	**111**
CCG	33% 38	32% 37	28% 32	4% 5	2% 2	0% 0	**114**
Other	16% 5	52% 16	13% 4	6% 2	0% 0	13% 4	**31**

Fig. 1: Partners who were reported to be 'very involved' in MSP

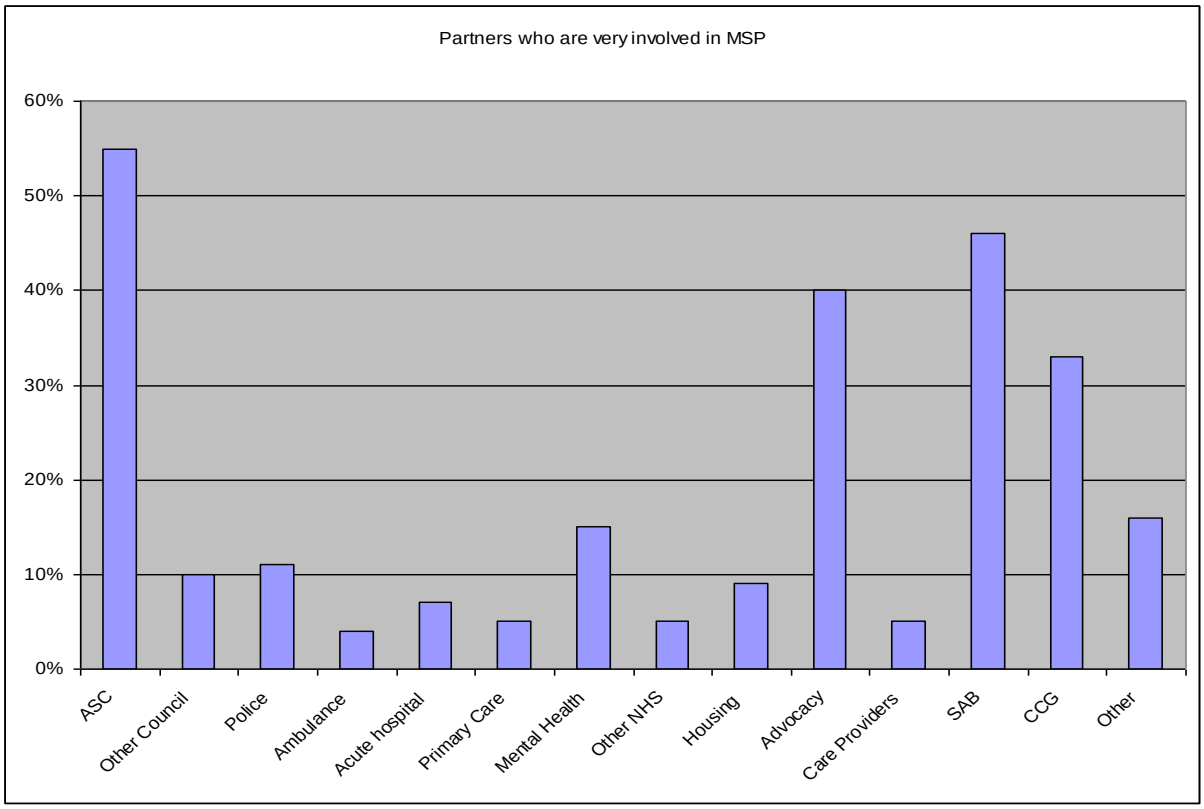
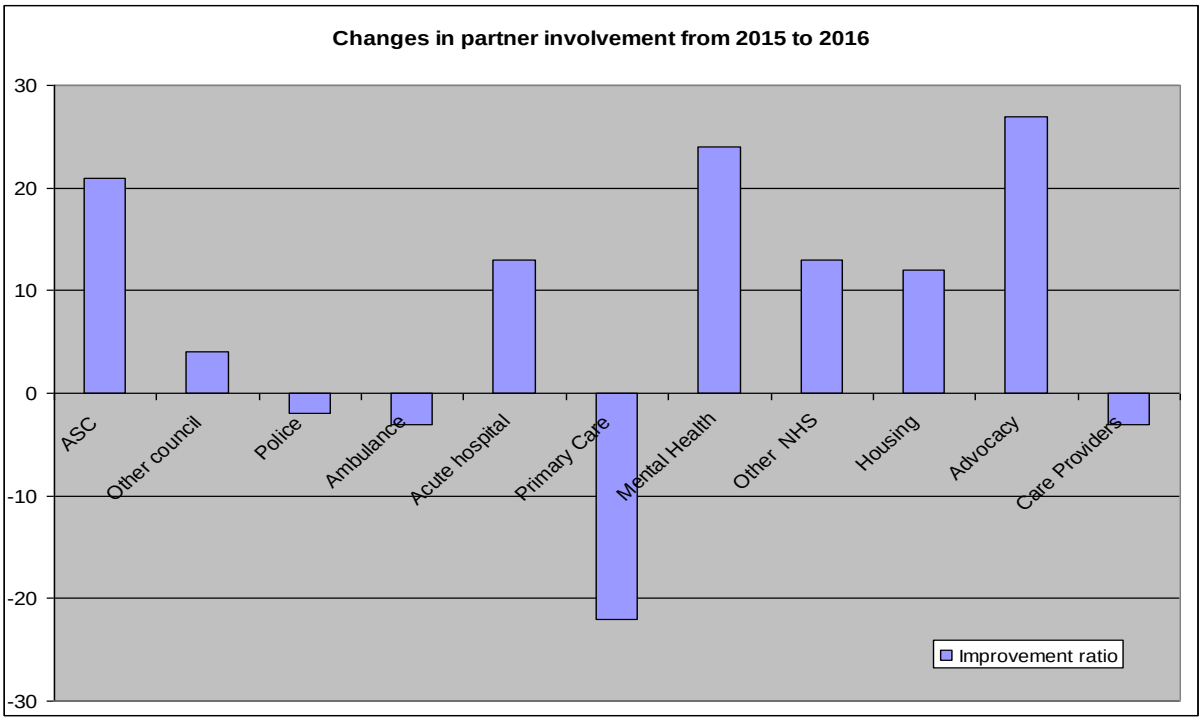


Fig. 2: How partner involvement has changed since the evaluation in 2015



Note the categories for SAB, CCG and Other were not in the 2015 evaluation.

3.3 MEASURING OUTCOMES

3.3.1 Reporting and evidencing 'making a difference'

The data indicates a big improvement in mainstreaming MSP in Adult Social Care: 7 out of 10 councils now ask people what outcomes they want at the beginning of the safeguarding process and the rest are working on it (Table 4). Of those who answered that they were currently partly doing so, just over half said that the outcome questions were not always consistently asked. About a third of councils said they had only just started and the rest were still developing an outcome based recording system.

It has always been difficult to measure how much of a difference such a change in practice has made to the people using services themselves but the work showed that councils and SABs were now grappling with this issue and are making good progress. Table 5 shows that almost a third have now made the shift to active measurement and over half are on the road to achieve it.

A picture emerges of councils still at a fairly early stage in finding the best ways to evidence the answer to the question 'have you made a difference?' Few have made the shift to a reliable and fully comprehensive system. Most were using their electronic reporting systems to gather outcome data and many of these were triangulating with case audits, quality assurance measures and sometimes follow-up questionnaires. Most were reporting on outcomes to management and SABs and some had developed dashboards combining a mix of quantitative and qualitative measures.

> *We have a whole range of methods. We have a SAB dashboard reflecting outcomes much more now. We report on findings in a MSP newsletter. We have 3 workshops for ASC planned in June combining SAR (Safeguarding Adults Review) messages, managing risk and MSP which will have a focus on getting the difference made across to staff. We have now 3 key performance measures that have been introduced over the past two years that asks whether the person has been spoken to in the first 24 hours; how people are being involved (e.g. through attendance at meetings, visits to their home, through an advocate); and outcomes being discussed at the beginning, during and at the end of safeguarding support. Our IT system Liquid Logic allows us to change the system and add in mandatory fields. It is still a bit clunky but practitioners can record as simply as possible information on outcomes at all stages.* (Slough)

> *MSP is one of the outcome measures on the organisation's 'Performance Wheel' which is reported regularly to management, all staff and the Board of governors.* (NE Lincolnshire)

Of those who said they had only partly made the shift to measuring how they are making a difference to people's lives, almost a third were still making improvements to reporting and a quarter were grappling with making changes to their IT systems, a similar number were making refinements to drill down into greater detail of user outcomes. Others reported the following factors that were still preventing them from making the final shift to how they measured the difference:

- Systems not yet fully accepted and operational.
- Outcome measures not yet fully embedded into practice.

- Unreliable data needs further auditing.

Table 4: Are people who experience safeguarding processes asked about what outcomes they want?

	Number of responses	% of responses
Yes	79	69%
Partly	32	28%
No	4	3%
Total	**115**	**100%**

Table 5: Has your organisation and/or SAB made the shift to measuring how you are making a difference to people's lives?

	Number of responses	% of responses
Yes	35	30%
Partly	62	54%
No	18	15%
Total	**115**	**100%**

3.3.2 Recording systems

The transition to recording MSP responses and outcomes is well on the way with 85% of respondents saying that they have made changes to their recording systems (Table 6). Overall we found that 70% of all respondents had completed the implementation of these system changes and a further 15% were "almost there". Only 12 councils were "just starting" and 2 had not yet begun Table 7).

> *Our data base can determine that people are involved at start, throughout and what they think of outcomes. It shows that people are generally satisfied at the end and often change what they want part way through. Where people have representatives involved, when options presented, they are really satisfied with the work done. Sometimes people say they don't feel better but the problem is solved.* (Southwark)

Many respondents said that building in specific questions and screens had helped to embed MSP at the practice level and this was improving outcomes. These changes were contributing to the measurement of overall safeguarding effectiveness and were helping drive the attempts to develop outcome frameworks for councils and SABs. However it was apparent that there are a number of IT systems in use across England, some are off-the-shelf, a few have been modified to make them MSP compliant and a very small number are made-to-measure systems. Satisfaction with the IT systems was variable and no single system appeared to be ideal.

Our IT system includes 3 key questions at the beginning about: what people want to happen; how people want that to happen; and outcomes. These thread through the system to closure. It links to a web based alert form where those three questions are repeated. We

have done multiagency training on the alert form including what is the point of those 3 questions and also top 10 handy hints to help fill in the form. We can draw off for example good and poor alerts from say a provider and help people learn from that. In the closure form there is more information / understanding on the service user perspective. **(**Oxfordshire)

Table 6: Have you changed any of your reporting and recording systems to implement MSP?

	Number of responses	% of responses
Yes	98	85%
No	17	15%
Total	**115**	**100%**

Table 7: If not yet complete, how far are you in your planning to update them?

	Number of responses	% of responses
Almost there	18*	51%
About halfway there	3	9%
Just starting	12	34%
Not yet started	2	6%
Total	**35**	**100%**

*****18 of these responded 'yes' to previous question – so were in the process with more changes to make.

3.3.3 Hearing the voice of the person needing safeguarding

Most local authorities struggle with engagement with people at a strategic level and many SABs are still struggling to get meaningful involvement of those people on their Boards. However many Boards used Healthwatch to represent the voice of people needing services and support. Quite a few were still in the early stages of developing wider user/carer/public engagement outside of strictly case centred follow-ups and it did figure in business and development plans. Appendix 1 explores these areas in more detail.

14 (12%) LAs had service user forums that were specifically for safeguarding and a further 11 (10%) were actively running engagement sub-groups. A sizeable proportion of Boards engaged with existing user and carer groups to find their views on safeguarding. The groups that SABs engaged with most frequently were Learning Disability Boards. While good engagement with people who had experienced abuse or neglect is still a minority activity, where it had taken off it really had an impact as demonstrated in this quote from the London Borough of Lambeth.

> *People don't want to identify as users ' like running a fan club for dentistry!' Learning from this was that people didn't know they had been through a safeguarding process. A family member spoke to social work practitioner forums about his experience - social workers say this is the single thing that has changed their practice.*

Some respondents sounded a note of caution on the use of post-intervention questionnaires. Some service users said that it can be traumatic to go over the whole thing again *"people don't keep notes as they are going through the experience and so can't recall important and significant details".* It does not offer anything of value to them and one person likened the questioning to 'mining'.

3.4 IMPACT

3.4.1 Impact on people who use services

Most respondents believed that MSP was having a positive impact on safeguarding. There was a tangible shift in focus away from processes and on to the person with many examples and reported feedback from staff and service users. These comments sum up what many had said:

> *"People are more involved in the process right from the start and they have developed an expectation that people will be asked from the beginning about what they want."*
>
> *"We got rid of the term 'strategy meeting' and stopped having meetings before we engaged with the customer - we now go out to the customer to plan an investigation with them."*
>
> *"Workers now look at the level of risk that the person will allow."*
>
> *"More and more service users are more enthused because we are listening to them and getting great feedback regardless of whether outcomes achieved*."

A considerable number of respondents either did not know if MSP was having an impact or personally felt that it was not. Some felt it was too soon to say in their journey to adopt MSP and many of those who were not or had only just started measuring outcomes did not feel confident enough to make a firm judgement. One respondent stated that the risk averse culture in their council was preventing the implementation of MSP principles.

Respondents spoke almost exclusively of the impact that their (local authority) service was having. Extrapolating from our findings on partners' lack of engagement with MSP, it can be assumed that there has not been such an impact in other care/health settings.

Most respondents said that they intuitively knew that MSP was having an impact. When probed on how they had formed that perception many said that it was based on audits of safeguarding cases, which now appear to be taking place widely and on a planned basis. Examples of other indicators were an increased number of home visits (Ealing) and less work for the long term team (Rutland). However, due to the early stages of most measurement systems very few (5%) could assert their view on impact with total confidence (table 9). Where councils were measuring impact they found high rates of satisfaction e.g. 81% felt safer in Redbridge, 60% felt safer in Lambeth. The third of respondents who said they were "reasonably confident" that they were having a positive impact almost matches the proportion of respondents who said they had made the shift to measuring how they had made a difference to people's lives (Table 8).

Table 8: How confident are you that you can measure/are measuring that impact?

	Responses	% of responses
Totally confident	6	5%
Reasonably confident	38	33%
Partially confident	44	38%
Not very confident	23	20%
We're not measuring it at all	4	3%
Total	**115**	**100%**

3.4.2 Impact on practice

There was a marked change of practice in ASC among the large majority of councils where MSP had been put into place, it is summarised very well in this quote from one of the respondents *"we have given permission to practitioners to work in the way that works best for the person and to use their professional judgement."*

The main changes were:

- A move from process-led to user focused practice
- Involvement of people all the way through the intervention
- An increase in workers going out to visit people in their own homes
- Active involvement of people in meetings about them
- Less meetings of professionals
- Processes and systems reviewed and changed to ensure service users were listened to, involved and informed
- Timescale targets loosened to allow the intervention to progress at a pace that suits the person
- More reflective supervision
- The use of family meetings was on the increase

Among other practice changes were; the introduction of risk panels to support workers in taking less risk averse approaches; joint clinic with the police to look at 'stuck' cases (Camden); amending the section 75 agreement Mental Health Trust to specify an MSP approach.

The practice changes gave some surprises. In one local authority where staff thought they were already working to an outcomes based approach *"when we looked more closely we've had to change more than we thought we would."* Another found that when they moved away from doing things that the person didn't want *"we were given some staggering messages e.g. people didn't want more services, and 50% just wanted an apology and assurance it wouldn't happen to someone else".* In another area, where the social work investigation

always ran secondary to a criminal investigation, through MSP they realised that *"you could talk to people about what they want to achieve without contaminating the police evidence".*

However a sizeable proportion of local authorities are either still in the early stages or struggling to embed the practice changes that are needed to implement MSP. Again, there is little comment on other partner organisations changing their practice.

3.4.3 Development of staff and promotion of MSP

MSP had been built into nearly all councils' staff training programmes and the passing of the Care Act 2014 had given it an added boost. Most had undertaken extra rounds of training when the Care Act 2014 came into force. MSP skills and values had also become an integral part of staff development. The concept of reflective practice has taken a firm hold in many councils both in one-to-one supervision and in other formats such as staff forums, peer groups, risk management and complex case groups. We found some collaboration and resource sharing between organisations and councils as well as some partnerships with local universities. Only a very small number spoke about using the MSP toolkit even though most were aware of it - given comments to other questions in the interview we got the impression that either people had moved on since the early days of MSP or they did not find it relevant at present. Some were looking at MSP tool kit elements in their 'next steps'.

Some representative quotes from respondents:

> *"Some staff 'get it' and really just need permission to get on with MSP. Others want more of a tool-kit and it would be helpful to prioritise up-to-date tools for councils to use".*
>
> *"Everyone has protected facilitated development time".*
>
> *We also ran 2-way briefing events to ask service provider staff "what do you want from us?" (*York)

SABs were running annual or in some cases quarterly conferences and workshops for all partners and most had a training plan which incorporated MSP. Some also published newsletters which featured MSP, but we found little evidence of adoption of MSP practice outside Adult Social Care.

3.4.4 Strengths of MSP implementation

Nearly all respondents reported areas where they felt MSP implementation was strong and gave an overall picture of it having moved to a central place in safeguarding.

> *"For us MSP is not in a box - but it is embedded in our language and all practice, MSP is our benchmark for if something is good or not - whether that is in training, ICT system, casework"*

The most frequently mentioned strengths were enthusiastic staff and strong management support for MSP (a fifth of responses) followed by:

- Good engagement with partner organisations.
- Support and drive from the SAB.
- A supportive infrastructure of staff training, development and supervision.
- MSP was now an integral part of everyday working.

Factors often cited that had helped to implement MSP were:

- Being an early adopter
- MSP champions among the workforce
- The emphasis on MSP in the Care Act 2014
- Specific training on user-focused ways of working
- Revision of reporting systems to build in service user outcomes
- Inviting in a peer review and acting on its recommendations.

It was clear that management drive was also a major factor in embedding MSP into adult social care as summed up by the comment,

> *"MSP has been owned and backed by senior management since the start - they see it as the right thing to do - it's seen as a golden thread and not as an add-on."*

MSP had also strengthened other areas of work such as: more co-production with service users; increased preventive work; a stronger role for adults in some MASHs; more involvement with councillors; more cooperation between councils. These comments give a picture of where the strengths lay:

> *"Safeguarding was very process driven - but because we had fairly robust processes they were filling in forms and not listening to people. This has changed, no question."*

> *"A flow chart now provides guidance for social workers, it has MSP expectations at each stage and hyperlinks to practice guidance for more detail."*

> *"It gives older people with assertive relatives and who find it difficult to speak up for themselves a voice."*

> *"There has been strong support from councillors who have protected the services from some of the Local Authority cuts."*

> *"Good buy-in from SAB partners to promote MSP."*

> *"One thing MSP has really brought to the table is learning to have those difficult conversations with service users."*

> *"MSP brought together things they did already and gave these a name."*

3.4.5 Blockages to implementation

There were a reported minority of councils where the blockages are so great that MSP has hardly had an impact, but the vast majority are making progress. A range of factors are blocking full implementation or considerably slowing down the rate at which it is being introduced.

The most frequently mentioned blockage was cutbacks to staff and resources (almost a quarter of responses) followed by:

- Difficulties in meeting the pressures of high service demand.
- Lack of take-up in implementing MSP from partner organisations.
- Delays in revising and implementing recording systems.
- High staff turnover (practitioner and managerial).
- Staff resistance to change.

Even though spending cuts are having an adverse impact across the board, a large degree of enthusiasm and evidence of creative initiative came across; many respondents added how they were tackling the blocks as part of their reply to this question. For example, a prevailing belief among some local authorities and many of their partner organisations was that an MSP approach would mean more time commitment from their staff but evidence from those who had implemented MSP showed just the opposite. In fact, once established, the extra interaction with the person was said to be counterbalanced by shorter amounts of time spent system-feeding, with the added bonus of more realistic and empowering outcomes for the service user. It is summed up in the following two comments: *"we have not found it to be any more time intensive because of the work we did on the systems first"* and from another respondent *"there is a belief that MSP takes longer - sometimes it does but in fact it is outweighed by far better quality outcomes and real prevention."*

The MSP approach was found by some to lower the 'rate of conversion' of safeguarding concerns to s.42 enquiries – "*having a proper conversation and asking what the person wants at the very first stage seems to enable some diversion away from formal enquiries as resolution can be achieved and alternative solutions managed."*

Additionally there is evidence that an MSP approach reduces the amount of 'revolving door' cases, due to more cases achieving resolution for the service user which leaves them better able to prevent further abuse (shown in a decrease in 'repeat referrals').

3.4.6 Staff reaction to the MSP culture change

There was a marked amount of progress in how positively staff reacted to the culture change required to deliver MSP with half of respondents now saying staff had responded very positively. Last year almost a quarter reported that it was too soon to tell but only one respondent said this in 2016, making an increase in the overall positive response from 74% to 97% (Table 9).

Social work staff were reported to be more enthusiastic because they felt they were helping people to take charge of their own lives rather than going through a process. Many saw it as a much-welcome return to social work. Champions were emerging from operational staff and they were taking the MSP message out to practitioners in partner organisations.

Respondents spoke of shifting from substantiating claims of abuse to putting the person in a position of control and that people were more realistic now about the outcomes that they sought.

Although the overall response was overwhelmingly positive there were some 'yes buts'. There were anxieties about capacity to make the changes; rolling it out to the rest of the workforce where implementation had initially focused on safeguarding teams; and how to sustain the changes improvements already made.

A selection of comments gives a picture of some of the reactions to the culture change:

> *"Now they are very positive, 6 months ago - fairly, a year ago - not very."*
>
> *"It's putting the human touch back into safeguarding."*
>
> *"Freeing up timescales and processes has been warmly welcomed."*
>
> *"Safeguarding team are fully on board but only about 50% of other professional staff really engaged with MSP."*
>
> *"As social workers this is what we are all aiming to do but we do get stressed about risk and capacity."*
>
> *"They love it!"*
>
> *"We have restored the valuing of social work and put the person at the heart of the whole system."*
>
> *"No one has ever said why are we doing this? Because as social workers this is what we are all aiming to do."*

Where there was or had been resistance to change the following factors were seen as the biggest contributors:

- Attachment to old ways of working.
- Fear that using an MSP approach would take longer.
- Discomfort in asking people for feedback on the service they had received.
- Aversion to risk-taking.
- Lack of understanding of MSP.

A selection of comments gives a picture of where the struggles were taking place:

> *"The staff culture of 'I know best ' still exists."*
>
> *"MSP was seen as an add-on so has suffered because it was not mandatory in the process."*
>
> *"We focused too long on the safeguarding team but it would have been better to have rolled MSP out to other teams sooner."*

"Other organisations don't put up blocks but they are not self-starters."

"We had experienced a difficult SUI (serious untoward incident) which had scarred everyone."

"Staff fear of legal challenge when we support the individual's allegations of neglect."

"The biggest problem is that staff thought they were doing MSP but have now recognised that they were not."

"What would help is a tool to enable us to get them to recognise and undertake MSP in other organisations."

Table 9: Broadly, how have social work staff reacted to the culture change needed to implement the MSP approach in your area?

	Responses 2016	% of responses 2016	% of respondents 2014-2015
Very positively	57	50%	36%
Fairly positively	54	47%	38%
Not very positively	2	2%	2%
Not at all positively	0	0%	0%
Don't know	1	1%	1%
Too soon to tell	1	1%	23%
Total	**115**	**100%**	**100%**

3.5 COACHING

3.5.1 Respondents' views on how they can take MSP forward in their own organisations

Most respondents had a clear view of what they wanted and needed to do next. Some actions were part of an existing business plan and some were a response to blockages or further developments built on successes in the roll-out of MSP. The most-mentioned activities fell into the following categories:

- Further initiatives to embed the culture change of MSP into frontline staffs' everyday practice.
- Actions to encourage partners to become more involved in MSP through the SABs.
- Audits to make sure staff were fully utilising new user-focused recording systems.
- Explore ways of developing an evidence base to demonstrate if/how MSP was having a positive impact.
- Initiatives to engage service users in service planning and listen to the views of those who had been through a safeguarding intervention.

It was apparent that some councils were outward-facing since they were actively working together with their neighbours, subsequently mutually benefitting from the shared learning. On the other hand there were a number of councils who could not find the time or motivation to work with others and were subsequently fairly isolated, struggling to get traction for MSP or even local partnership working in general. However the range of answers to this question was impressively wide. Here are some of the things that respondents wanted to do and had already embarked on to take MSP to the next stage.

- Talk to advocacy organisations to understand what they are seeing (Tower Hamlets).
- Take forward the 'My Life' approach (Isle of Wight).
- Promote the 'Citizen First' approach (Nottingham).
- Some councils were commissioning local organisations to independently gather service user views.
- Explore possibility of joining up with the 'Signs of Safety' initiative in the local children's service (W Sussex and Oxfordshire).
- Set up a task and finish group to measure the difference we are making (Gloucestershire).
- Carry out a 'ground zero' audit (Cumbria).
- Work with independent providers to enhance understanding of the 'new' types of abuse from the Care Act (Bracknell Forest).
- Extend the MSP approach into Housing and Public Health (Sandwell).
- Review and improve police and ambulance safeguarding reporting forms (Newcastle).
- Produce a DVD to help MSP move into the mainstream (Enfield).
- A multi-agency launch of MSP (Coventry).
- Training in and promotion of family group conferencing in a number of councils.
- An MSP sub group of the SAB to drive change in partners' safeguarding practice (E Riding).
- Some councils were going to establish forums across a number of areas for variously: social workers; registered managers; independent providers; experts-by-experience.
- Promote examples of good practice where workers have successfully used the MSP toolkit (York).
- Build on synergies between Personalisation and MSP (Lincolnshire).
- Locally adopted and adapted the Bournemouth competency framework to be MSP based (Nottinghamshire).

3.5.2 The single thing that would really advance MSP in respondents' organisations

Unsurprisingly the highest occurring single thing that would help is more resources but answers covered a range of areas for which respondents wanted to use the resources. To make improvements: update procedures; do proper co-production; collect feedback from service users; do more staff training; improve communication between SAB and practitioners. To plug gaps: appoint a SAB business manager/development officer/fully staff the safeguarding team; deliver the full range of safeguarding training; to cope with the extra DoLS work; and "a good mentor to stop me from drowning."

Other frequently occurring responses came into the following categories:

- Getting other partners on board with MSP.
- Empowering practitioners.

- Effective user-focused recording systems.
- Clear ways of measuring how effective safeguarding interventions had been and benchmarking against other local authorities.
- Raising awareness of MSP among other allied organisations, the public and service users.
- Proven toolkits and practical workshops.
- MSP to remain a high national priority and to maintain a high profile.

There was a range of other responses ranging from "short and snappy literature to explain MSP" to "CQC to have an allegations management system that filters out safeguarding issues". We have translated many of these responses into the next section on suggestions for the national safeguarding plan.

3.5.3 What respondents would like to see in the 2016/17 safeguarding development programme.

There was a real thirst to share and learn from other areas at a sub-regional, regional and national level on:

Practitioner issues:

- Family approaches.
- Recovery and resolution models.
- Worked examples of case studies that show how MSP can be effective.
- How to balance service user expectations against public duty of care.
- Preventative work.
- Risk management.
- Self neglect.
- Human trafficking/ modern slavery.
- Expectation of standards of practice for social workers and principal social workers.

Managerial issues:

- How managers can lead and sustain culture change.
- Making the final step of MSP becoming part and parcel of everyday working.
- Following up on peer review recommendations and gaining critical appraisal on their responses.
- Sharing practice and methods on how best to filter safeguarding alerts, building on the old threshold guidance.
- How to identify and encourage MSP champions.
- Structured conversations and celebrations to embed MSP at practice level.

Strategic issues:

- More guidance for commissioners to help them build MSP expectations into service specs and contracts.
- Work on translation of MSP into other settings "what would it look like in..." e.g. acute hospitals; police work; primary care; ambulance service, etc.
- Agreed 'milestones' against which organisations can measure where they are on the journey to fully embed MSP.

- More guidance/tools/good examples of how to meaningfully engage service users/carers/public in MSP e.g. experts -by-experience, community forums, video presentations.
- How to make sure strategies and plans are properly developed with service users/carers/public.
- Guidance and good practice examples of how to improve engagement with independent care providers and improve quality.
- Guidance and exploration of how to integrate MSP into SARs.
- How to improve engagement of other partner organisations and prevent ASC from becoming the exclusive holder of the MSP torch.
- How to make use of the local SAB as a resource.

Many respondents made helpful requests for things they would like to see coming from the national development programme such as:

- Revision of the MSP toolkit in light of experience and practice development and to include recent innovations.
- Nationally available PowerPoint documents that can be used with staff, partners, public.
- User-friendly communications.
- An adult safeguarding app.
- An up-to-date MSP e-learning package (accredited?)
- A benchmarking tool for local areas.
- Standardisation of metrics to measure service user outcomes (a national task and finish group was suggested).
- A nationally agreed performance reporting template.
- A list of accredited/tried and tested trainers (could be on Knowledge Hub).
- More in-depth evaluation of the MSP programme (this paper is one response to that request).

We have drawn on the rich responses in this section to develop the 2016/17 national adult safeguarding development programme recommended in appendix 2.

3.6 Evaluation of progress

3.6.1 Level of organisational achievement

Table 10 and Figure 3 show the results of where the respondents' organisations currently are in their journey to fully implement MSP. While 6% are at the 'fully implemented' stage, three quarters have finished planning and are currently in the process of implementation. Almost a fifth are still planning but everyone said that they had started. This generalised picture of progress appears realistic when cross-referenced to the responses to other questions in the temperature check which showed a progressive trend, with some organisations almost within reach of full implementation and others well on the way with clear plans and good support.

There was no overall rating of progress in the last temperature check so it is not possible to do a quantitative comparison but the ratings do show a considerable amount of progress against the qualitative findings of the previous year's study. This measure will provide a baseline for future evaluations of councils' progress.

Figure 3: Interviewer evaluation of organisation's achievement of MSP implementation

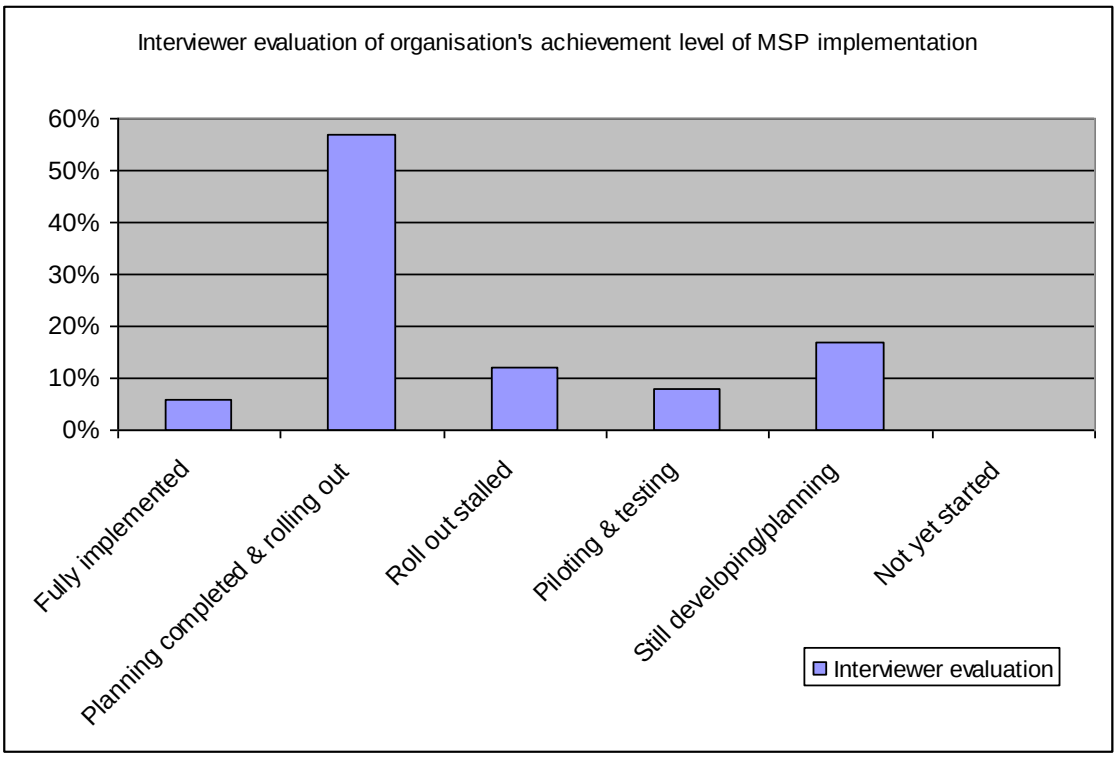


Table 10: How would you rate your organisation's achievement of MSP at the moment?

Level of achievement in implementing MSP	No. of responses*
A) Fully implemented	6% (7)
B) Planning completed and rolling out	57% (66)
C) Roll out currently stalled	12% (14)
D) Piloting and testing stage	8% (9)
E) Still developing and planning	17% (19)
F) Have not yet really started	0% (0)
Total	**100% (115)**

* 14 of the respondents' evaluations were moderated by interviewer to produce consistency across rating levels.

3.6.2 Respondents' reflections

Although respondent feedback was not built into the interview script, it was picked up in many interviews - respondents overwhelmingly said that they had found the interview helpful. They expanded by saying: *it provided time to reflect* (many respondents); *gave me an opportunity to recognise what we are doing well; it's not very often we have a chance to think about where we are and what we need to do*. Some respondents took advantage of the coaching element: *welcome prompts for next steps*; *thankful for suggestions of other places/tools/resources/projects to look at*; *it provided positive challenge; it reinforced my own knowledge of what I've let slide; food for thought.*

4. RECOMMENDATIONS

Based on the findings from the respondents' ratings, views, examples and conversations, we were able to draw out the following recommendations. For ease of use we have divided them into actions that can be taken at local, regional and national level, although many will have implications across all the levels.

National level

1. The current MSP toolkit should be reviewed to include: any new tools being used to achieve resolution and recovery; evidenced improvements in practice and feedback from practitioners and managers on using tools; and a critique of the current set of tools.

2. The relative effectiveness of IT systems currently in use to support MSP should be reviewed to look at the merits of different systems and also consider how they are being used and modified to improve practice.

3. National materials should be developed and circulated to raise awareness of MSP among other organisations, service users, special interest groups and the wider public. Examples might include downloadable leaflets, easy-read documents, press release templates, PowerPoint presentations, etc.

4. Develop tools/guidance on what MSP looks like in partner organisations, how MSP principles can be translated into different settings and how the MSP approach to safeguarding can be implemented, particularly for acute hospital trusts; primary care services, ambulance services and the police.

5. Work should be carried out with NHS England and CCGs on guidance for commissioners on how to build in MSP into their commissioning practice.

6. Building on the regional and local developments in evaluating outcome-based performance, an ideal type of outcomes measurement and reporting framework should be agreed, that can be offered as a template and a means for local authorities to measure MSP progress and compare themselves to each other (see 8).

Regional level

7. Opportunities for practitioners should be created so that they can share their experiences of MSP at local and regional levels. In particular, there should be a focus on reflective supervision; family-based work; positive risk-taking; balancing user wishes against duty to others.

8. Developments in reporting on outcome measures should be shared and pooled at a regional level in the drive to answer the question 'have we supported people to be any safer?'

9. Commissioners and CQC should work together to ensure that MSP is fully built into regulatory work so that it supports provider staff to make their own judgements, take managed risks, filter out safeguarding issues before referral into the Local Authority safeguarding services and ensure people's rights are respected.

10. Where Safeguarding Adult Review repositories are being developed at a regional (or national) level, these should be enhanced to include reflective opportunities from MSP practice and users' views.

Local level

11. Local organisations should improve ways of managing the increase in safeguarding alerts and referrals by considering integration of front doors either through MASH or a jointly staffed Single Point of Access.

12. Local organisations (Safeguarding Adults Boards) should develop a means of gaining a picture of what happens to safeguarding alerts that do not progress to a s.42 enquiry.

13. Directors of Adult Social Services should take stock of where their service stands on the road to full implementation of MSP (using the road map if they find that helpful) and then reflect on their current plans using the evidence in this temperature check.

14. Adult Social Care departments should consider how they can get greater corporate council buy-in to MSP and ensure local authority councillors are aware of MSP and are supportive of the changes required to implement it, particularly the need to promote personal empowerment and positive risk management.

15. Local training commissioners should ensure that staff training providers review their materials to modify and update them according to evidence of effective practice and blockages in shifting the culture to embed MSP values.

16. All organisations and SABs need to do more to meaningfully engage service users in planning and shaping safeguarding services. This report gives examples of where and how this is being achieved and we would encourage organisations to share their approaches. See appendix 1 for more specific recommendations.

17. Statutory organisations should enhance prevention of abuse by building a pathway from alerts and referrals into voluntary and community assets for lower levels of safeguarding intervention.

18. Local adult social care and health commissioners need to work more closely with independent care providers to link and embed MSP into good service quality.

Cross cutting

19. Where there are blocks to implementing MSP then leaders and opinion formers should use the evidence from this temperature check to demonstrate how MSP does not take longer and produces more effective results, leading to better use of resources.

20. The remaining Councils (36) that were not part of this temperature check should have a temperature check conversation during 2016/17 and, together with feedback collected in this report, this would inform regional programmes for sharing, developing and improving safeguarding practice and multi-agency working, and supporting further embedding of the MSP approach.

5. GLOSSARY

ADASS	Association of Directors of Adult Social Services
ASC	adult social care
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DoLS	Deprivation of Liberty Safeguards
LA	local authority
LGA	Local Government Association
MSP	making safeguarding personal
RiPfA	Research in Practice for Adults
SAB	Safeguarding Adults Board
SAR	safeguarding adults review
SUI	serious untoward incident

6 REFERENCES

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Appendix 1 Views from service users and carers

Context

There are a number of ways of engaging people in safeguarding activity, and getting feedback on what is important to them and how it is working. A major theme in Making Safeguarding Personal has always been to ensure that the person's voice is heard. This has driven improvement in practice to engage people during the safeguarding process, to ensure that they are at the centre and that their outcomes are identified and met wherever possible. Gaining feedback from people about the safeguarding process has also been pursued, to understand how effective it has been and whether there are areas for improvement, although this is complex (HSCIC, 2014; Norrie et al 2015). A further dimension of services user engagement is to inform and co-produce safeguarding strategy, policy, plans and products, which is the focus of this Appendix.

Safeguarding Adults Boards (SABs) responsibilities in this respect are set out in the Care and Support Statutory Guidance (March 2016). They should:

- In establishing mechanisms for developing policies and strategies for protecting adults, "take account of the views of adults who have needs for care and support, their families, advocates and carer representatives (para 14.139)
- When preparing the strategic plan, "consult the local Healthwatch and involve the local community [which] has a role to play in the recognition and prevention of abuse and neglect but active and on-going work with the community is needed to tap into this source of support" (para 14.153)
- "understand the many and different concerns of the various groups that make up its local community" (para 14.154)
- In their annual reports consider, "feedback from the local Healthwatch, adults who use care and support services and carers, community groups, advocates, service providers and other partners" (para 14.157)

Safeguarding Adults Boards have been encouraged to establish mechanisms for user engagement especially to work on prevention in communities through awareness raising (SCIE, 2015). User engagement in co-production of publicity, whether producing leaflets or DVDs, or training of staff and volunteers is a specific area where engagement can be especially effective. Research evidence is patchy but shows that involving people in design, development and delivery of information can make it more accessible and useful (Pike, 2016). There is a range of broader questions however with which Boards might engage with those in their communities in connection with Care Act 2014 responsibilities. This might include: what support people want to help keep themselves safe from abuse; what help they want if they have been abused; what help they want after the abuse; what outcomes service users want; what people think about the steps that social services follow to support and help them if they have been abused.

Temperature check feedback

As part of the Making Safeguarding Personal temperature check 2016, the theme of how 'end users' of safeguarding were involved in safeguarding was explored in the conversations. Question 5b asked 'What mechanisms exist, in addition to individual feedback through safeguarding work, for the service user voice to be heard in respect of

safeguarding adults?' There were prompts to elicit information about local feedback mechanisms, such as whether the SAB had sub groups, and questions on activity currently being undertaken, in the context of the statutory guidance requirements outlined above. The feedback from the conversations shows that there is a wide variation in the levels of engagement of service users in the work of Safeguarding Adults' Boards.

Many people talked about representatives of voluntary and community groups or lay people being members of their SABs. However around a quarter (24%) of local authorities had little or no mechanisms for wider user and carer engagement, and had struggled with this, or had mechanisms previously but were not able to sustain them. They mostly recognised that it was important and were thinking about how best to proceed. Comments included:

"We had them in the past but haven't been able to maintain them."

"We need to look at how we get views from people and their voice."

"Not aware of a service user rep on SAB; not aware of any engagement with service user groups; attempting to get Healthwatch engaged in this area."

"A carer and a service user attend the Board. However this is a carer with a voice rather than a representative of "the carer voice".

"Advocacy and care organisation reps sit on the SAB but no service user groups or forum."

This did not mean that there was no activity, for example, one said "*we have not discussed MSP with service user groups but have involved people in producing information on safeguarding and MSP."*

A fifth of local authorities (19%) had plans for setting up mechanisms and were committed to trying to establish mechanisms for service user and carer engagement. For example:

"We have involved people in preparing information materials. Have been out and about in local areas to talk about safeguarding. Still considering issue of involvement on SAB."

"We are developing a safeguarding focus within the disability partnership."

"We are planning to do some work on this next year: we know it's a priority."

In a third of local authorities (35%), rather than having a specific sub-group of the SAB focusing on service user engagement, there were links made with existing service user and carer groups, partnerships and networks for particular tasks or communications. For example Learning Disability Partnerships or Carers' Group, or advocacy organisations or Healthwatch were approached on safeguarding issues. Some respondents talked about testing out ideas – going to existing groups that may have an interest and working out with them what to do, to achieve service user engagement and establish feedback systems rather than trying to set up or restart a subgroup.

"SAB has a poor track record on engagement – we had service users on sub-groups but without support or clarity of role. SAB have just completed a new engagement strategy - which will be mainly about going out to existing groups. Also setting up a 'virtual' user group

who can comment on issues. The SAB has also started to have service user 'stories' at each meeting."

"Healthwatch to feed in from their normal collection channels... we are developing a forum: Being developed by a dedicated facilitator with a specific focus on safeguarding adults. It started as a LD group but vision is for it to embrace a range of service."

"Advocacy service run 'voice groups' which have been really positive partners in safeguarding work."

"Patient experience group via LD partnership board. Links with carers group."

"We invited service users to recent Board away day and asked their views. This was very successful. We discussed experience of safeguarding issues and how in general people feel about coming into contact with professionals. They gave advice about groups of service users we could talk to in future. They contributed ideas about what priorities should be for the Board. We should be able to build on this as a small authority."

"Health watch give quarterly feedback to Board on what they have heard from the community on health and social care issues. This is used to help shape the strategic plan of SAB. The Board Chair and ASC and Health meet with Healthwatch ahead of Board meeting to discuss."

Service user engagement was more mature in almost a quarter of local authorities (22%), where they had developed a range of ways in which people could be involved, and could provide evidence of significant positive impact and co-produced resources. Service user engagement with SABs, through established and sustained sub-groups, with a range of appropriate means of communicating, provided evidence of examples of service users influencing the strategic priorities of the SAB or co-producing strategies and products for the local communities.

Healthwatch is taking a leadership role in some of these local authorities, making the links to service user or carer forums, sometimes chairing groups or service user forums, and acting as a channel for service user feedback in a variety of ways to the SABs.

"The service user network sub group has discussed MSP and provide good challenge and representation on the SAB." **Cambridgeshire**

"We are working through a community engagement group on consultation - mechanism is via sub group/ chair and SAB members attend the sub-group. We have done a lot of consultation with people on what person centred response looks like in practice with an outcome focus - with 36 Voluntary organisations representing a range of groups on what they want the SAB to deliver for them. We asked about their experience of safeguarding - feedback was that they don't know they're going through the process, don't understand the terms 'outcome 'or 'safeguarding', but do know they want to feel safer and abuse to stop." **Triborough**

"We have 2 service user forums - one is AEA local user group which has struggled to get traction, the other chaired by Healthwatch - for people who had been through process. They were passionate about some things - people in Care Homes outside Lambeth, hospital

discharge. As people don't want to identify as users 'it's like running a fan club for dentistry!' the learning from this was that people didn't know they been through a safeguarding process. We have produced with Healthwatch some info for people, which is now generating some more interest." **Lambeth**

*"In **Liverpool** there are a number of forums in place e.g. Older Person's and Physical and Sensory Impairment Making it Happen Group, Carers Making it Happen group, which would give people the opportunity to contribute their views on safeguarding, however, these meetings tend to focus on specific service/operational issues. The SAB coordinator attends service user and carer forums on an ad hoc basis generally when invited to the forums to discuss safeguarding and answer any questions or to update the group on any changes in procedures e.g. The Care Act 2014 and changes to safeguarding policy and procedures. We have recently set up a SAB Prevention and Community Engagement sub-group. One of the actions for the sub-group is to produce a communication plan which will include what forums are available for sharing information and capture feedback from service users around safeguarding."*

Good practice examples

We contacted some recommended local groups separately to ask them their views on experiences of safeguarding in their localities and to request more details about the mechanisms that exist to feed these back, e.g. to the Local Authority or Safeguarding Adults Board.

Buckinghamshire has shared their experience in developing a range of ways of engaging with people and of 'hearing the voice of those who may be in need of safeguarding support'. They have:

1. Established a Service User and Carer Forum – Safeguarding Adults for Everyone (SafE)
2. SAfE was constituted as sub-committee of the BSAB providing a voice, influence at a strategic level. They have their own agenda items and reports to the Board.
3. Engaged advocacy services and plans in place to have an advocate based at the MASH
4. Talk Back – Self Advocacy/Peer Advocacy – project to support people with learning disabilities to develop Person Centred Safeguarding plans unsing the PCP approaches and Circles of Support
5. Service User Feedback form given to all service users/representatives following an enquiry
6. Compliments and Complaints process

The SAfE Forum
This forum started 18 months ago when there were a number of complaints about people's experience of the safeguarding process. Those individuals who had made the complaints were engaged on an individual level as part of the complaints process. So their involvement started when they held the Council to account. There was a degree of hostility from the individual complainants at first, but now the forum has developed into a really effective

"sounding board". The compliments and complaints process is a good route through which to find the service user and carer voice. This forum has designed an awareness campaign and worked with the council on a feedback form for audit purposes.

The Council also provides administrative support and the Board Manager is a link between the SAB and the subgroup. Talk Back, Healthwatch and the Learning Disability Partnership Board are represented at SAfE meetings. The group meets bi-monthly. There is a focus on engaging with wider constituency.

The **Bradford Safeguarding Voice** group provided information about what they do. This group has been running since 2011. It is a community reference group made up of service users, carers and members of the general public who are interested in safeguarding, have experienced safeguarding or know people who have experienced it. The group supports the work of the SAB by listening to people's views and experiences and feeding these back to the Board so that services can be improved. Therefore, through the Voice group people have the opportunities to give their views and speak up on safeguarding. Voice has:

- Delivered safeguarding workshops in the form of "Safeguarding Bingo" to organisations and their service users during safeguarding week and on an ad hoc basis for 2 years, and will be in Safeguarding Week 2016.
- In September and October 2016 Voice members will run 2 sessions on 'Learn how to deliver Safeguarding Bingo Workshops' to train others to deliver this in their own organisations aiming to educate and empower as many services users and members of the public about safeguarding as possible
- Worked with the SaferProject (a community protection and empowerment programme in Bradford, supporting older adults aged 55+) providing people with the knowledge to protect themselves against Doorstep Crime and Scams. Due to the links developed people do get the opportunities to learn more about safeguarding and have a say.
- Supported the safeguarding team at safeguarding information stalls at as many public events as possible and at GP surgeries, where '*we talk to people about safeguarding, conduct surveys as a way to find out how much people know about safeguarding, give those we talk to an opportunity to have a say. Comments made are taken back to the SAB's Communication, Engagement & Training Sub-group to inform their work and ultimately the work of the Board.'*
- Feedback on SAB Annual Reports; SAB Business Plans. They are working on an EasyRead quick guide to the safeguarding procedures for staff and volunteers, an EasyRead (and in other formats) publication for adults who may go through the safeguarding adults process, which will explain how the safeguarding concern be dealt with and who will be involved; and a Toolkit for organisations on 'How to keep people safe in organisations' (including those who abuse).
- Been part of the interview panel for the recruitment of the independent chair of SAB. The Chair of Safeguarding Adults Board attends Safeguarding Voice at least twice a year.

Also, each SAB agenda has a service user slot built in so that the representatives can take issues/ have speakers, show DVDs etc. to highlight what safeguarding means to people on the street. Representatives from Voice, Strategic Disability Partnership and Advocacy services attends each SAB meeting. Other members of the Safeguarding Adult Board's Communication, Engagement & Training Sub-group also try to attend Voice meetings on an

ad hoc basis. This builds strong links between Voice members and the Sub-group. In the past, issues have been taken back to Board from Sub-group members who attended Voice meetings. Key factors for their success include: good links with engagement partnerships, safeguarding staff who work with the group, a chair from an independent organisation, links with the Hate Crime Action group; great opportunities to coproduce information; ideas for work from Voice are endorsed and supported by the Board; strong links with advocacy groups. They said:

"*The work we have produced so far has made a big difference. For example the information we now give is more accessible and user friendly to many people. The work we undertake is in response to the experiences of real people in Bradford which have been brought to the attention of the Voice Group. Some work has also been in response to incidents, which allows us to reflect on how we can reduce the likelihood of such incidents occurring again."*

National insight

During the temperature check conversations, when asked about service user involvement, respondents mentioned local advocacy organisations. We approached the two national advocacy organisations who had been most frequently mentioned, Powher and Voiceability, recognising that there were also many local groups that were active in this area. As advocacy organisations, it could be assumed that they shared the value base and explicitly or implicitly promoted a making safeguarding personal approach to safeguarding. These partners offer potential sources of feedback and insight into local adult safeguarding practices. However, it was reported that generally the local feedback mechanisms are about individual casework issues and are conducted through the contract monitoring meetings of the advocacy providers and this information doesn't come through to the SAB.

Where advocacy organisations have representation on the SABs, and are actively involved with service users and carers, they can support effective feedback mechanisms and improve the quality of engagement. However their role on SABs seems to be generally about feeding back on the numbers of people they see rather than the quality of local safeguarding practice across the partnership. In the MSP temperature check three quarters (76%) of local authorities said that advocacy partners on SABs were very or fairly involved in delivering making safeguarding personal (see main report). We wondered whether this was a missed opportunity for improving the triangulation of service user feedback on practice to the SABs about service users' experiences of safeguarding. It would be helpful to learn from those places where advocacy groups have been most effective.

Examples of co-production materials resources:

During the MSP temperature check, we collected the following, which could be useful as models in this area of work:

- Gloucestershire has shared a link to a DVD which has a focus on the significance of personalised responses. https://www.youtube.com/watch?v=hAh37bBqE9Q
- Hampshire made a film with service users (supported by the Safeguarding Adults Board) called the "A Team" which aims to raise awareness of safeguarding

issues[1] http://www.making-connections.co.uk/uploads/modules/a0bbb6e95a3cd5ad0433ca112fe35b49e780419e.pdf

- A film 'Cycles', made with professional actors, using a script based on real stories emerging from a writers course at a Mental Health arts café, for use as a safeguarding tool.[2] https://vimeo.com/73272252
- 'Magic Me', an intergenerational arts organisation based in East London carried out preventive work at the request of a social housing organisation where there were issues about older people being frightened of younger people on a housing estate. Theatre and drama were used for an intergenerational group to get to know one another, before working on an intergenerational photography campaign to break down barriers and stereotypes. There is some evidence that this began to break down barriers[3]: http://magicme.co.uk/shared-views-2/ and http://magicme.co.uk/wp-content/uploads/2015/02/Magic-Me-Annual-Report-2013_14-low-res.pdf
- Leicester City group made of 'experts by experience' are currently developing a DVD for use in training and for social media/public/key messages for raising awareness. It talks about user experience of safeguarding, what to look out for etc.
- **Bradford**[4] Safeguarding Voice has co-produced publicity materials about safeguarding**:** Leaflets including easyread / audio, posters, contact cards, and event banners.
- Easy read - What is Abuse? was produced in partnership with self-advocates and agreed at the learning disability partnership and the SAB in **Liverpool**.

Producing tangible products is a useful and creative way of engaging people in safeguarding work and ensuring that information is accessible.[5]

Recommendations and next steps

In the MSP temperature check conversations, respondents talked about prioritising this area of development and requested support to take this further; some wanted toolkits and guides for user engagement and participation in safeguarding. London ADASS is piloting a resource: Making Safeguarding Personal for Safeguarding Adults Boards, which contains a section on 'Engaging with and involving people: what can the Board focus on' (Tool No 3) which provides prompts in this area (Cooper & Lawson, 2016)

Proposed recommendation for the 16/17 MSP programme:

[1] Supported by Jane Hughes, Director of *Making Connections, Isle of Wight Limited,* and Will Geffin who has created numerous live dramas, documentaries, live presentations, films and videos on social issues with an award winning Drama Company of people with disabilities (Sunny Arts).
[2] Produced by Kate Lovell, when working for Toynbee Hall
[3] Produced by Kate Lovell, when working for Toynbee Hall
[4] Information provided by Bradford Safeguarding Voice
[5] Establishing trust and the group through a shared task (film/photography) is beneficial: using art forms can support confidence to speak out and talk about safeguarding and makes it less abstract, encouraging prevention for participants and audiences, see for example http://www.toynbeehall.org.uk/case-study

All organisations and SABs need to do more to meaningfully engage service users in planning and shaping services. This report gives examples of where and how this is being achieved and we would encourage organisations to share their approaches.

Specific recommendations are:

1. To develop a guide/toolkit for user engagement with Safeguarding Adults Boards using the MSP approach
2. To develop a section of the Making Safeguarding Personal for Safeguarding Adults Boards for Advocacy organisations to promote good practice in working with local advocacy organisations

References

Cooper A. and Lawson J. (2016) Making Safeguarding Personal for Safeguarding Adults Boards draft for piloting, London ADASS

Department of Health (2016) *Statutory guidance to support local authorities implement the Care Act 2014 Updated March 2016*, London, HMSO

HSCIC (2014) *Developing an Adult Safeguarding Outcomes Measure for Inclusion in the Adult Social Care Outcomes Framework: Findings from the pilot Study*, Leeds: Health and Social Care Information Centre

Norrie C., Cartwright C., Rayat P., Grey M., and Manthorpe J. (2015) "Developing an adult safeguarding outcome measure in England", *The Journal of Adult Protection*, Vol. 17 (5), pp.275 – 286

Pike L. (2016) *Involving people in safeguarding adults, Leaders' Briefing, research in practice for adults* Dartington, RiPfA

Social Care Institute of Excellence SCIE (2015) *Care Act 2014 Engagement and Communication*. Available at: http://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/engagement-and-communication/

Appendix 2 Suggestions for inclusion in the Adult Safeguarding Development Programme 2016/17

These suggestions have contributed to the recommendations on pp29-31 and proposals for an action plan, which will take them forward.

- A review and update of the current set of MSP tools with supportive evidence of what works.
- National Task and finish group to develop a standardised approach to recording and reporting service user outcomes including a performance report template or dashboard.
- Agree areas of co-production with the Independent SAB Chairs network.
- Commission or start a task and finish group to conduct an in-depth study of the relative effectiveness of IT systems currently in use. It would not only look at the merits of different systems but also consider how they are being used and modified to improve practice.
- Produce guidelines/tools to translate MSP from a social work context into partner organisations' contexts e.g. what are the implications for nurses on a ward; police beat officers, etc.
- Offer a separate report to each region which would provide a summary of regional development priorities.
- Work with CQC to ensure they fully understand and embrace MSP so that they support provider staff to make their own judgements, take managed risks and safeguarding issues are filtered out before referral into the LA Safeguarding Team.
- Encourage development of downloadable materials to raise awareness of MSP among other organisations, service users, special interest groups and the wider public.
- Produce a guide to the current publications (toolkits, resources, guides, research, practice, etc.) on MSP.
- Use the results of sector led improvement and peer reviews as a way of evidencing MSP implementation, and sharing areas of excellence.
- Follow up examples of good practice in user engagement identified in this temperature check and considering what would be appropriate to take this area of work forward.
- Carry forward the recommendations of the 14/15 MSP evaluation that remain outstanding
- Regional practice development workshops that focus on the operational level aimed at practitioners and supervisors in the subject areas of:
    - empowering people at risk of harm
    - 'new' types of abuse
    - how to work with marginalised people
    - family based intervention
    - reflective supervision
- Regional organisational development workshops covering:
    - promoting positive risk management.
    - dealing with abusive or neglectful staff
    - institutional abuse
    - gathering feedback from service users
    - case audit tools
    - core components of MSP training

Appendix 3 Learning examples

A3.1 Staff support and development
A3.2 Involving service users
A3.3 Working with partners
A3.4 Working with care homes
A3.5 Developing MSP practice
A3.6 Measuring outcomes

The named local authorities are all happy to be contacted about and share these examples.
(* also appears in main body of the report)

A3.1 Staff support and development

We have developed peer support group sessions for safeguarding coordinators (40 coordinators and 160 safeguarding enquiry officers) over the past 2 years. They have found it very helpful and supportive. **North Yorkshire.**

Staff user survey on adult safeguarding and MSP. **Hackney**

'The Big Conversation' – helping people to have difficult conversations (working with the University of Lancaster)

*Locally adopted and adapted the Bournemouth competency framework to be MSP based. **Nottinghamshire**

A3.2 Involving service users

Experts by experience service quality assuring local provision **North Lincolnshire.**

We ran 2-way briefing events to ask service provider staff "what do you want from us?"* **York

DVDs developed by and for service user group on their experience of safeguarding and the safeguarding process. **Gloucestershire (for Learning Disabilities service area) and Leicester City (under development)**

Developed "safeguarding packs" including easy-read versions which explain the safeguarding process, how strategy meetings work, agendas and the role of advocates. They consult people throughout the process of support and 94% of the people who express the outcomes they wish to achieve describe those as partially or wholly met. **Northumberland**

Advanced work going on in terms of engaging citizens/service users in informing the shape of safeguarding support - *"safeguarding doesn't always look like safeguarding at first so MSP needs to be right there at that initial assessment"*. **Buckinghamshire**

"We changed what we do at start of process. Rather than having strategy meeting we changed the conversation we have with people/ the questions we ask. There were really good outcomes for us from the pilot. Really struck by the results. We saw how people can have unrealistic expectations and by engaging we can see that and support their understanding." **West Sussex**

"There is a very positive initiative in QA at present where service users in receipt of commissioned home based care services are asked for value statements about the service received for example whether they have been treated with dignity. This is set out in a spider gram alongside the provider's view on how the service has been delivered and this informs improvement. There is scope to read this idea across into MSP." **Surrey**

A3.3 Working with partners

SAB partners producing and delivering their own MSP action plans. **Enfield**

The SAB has established a MSP sub group to drive change in partners' safeguarding practice. **East Riding of Yorkshire**

The acute trust 'does MSP' in **Southwark** and 'gets MSP' in **Nottingham City**

Dedicated social work and housing team working with vulnerable tenants embrace an MSP approach. **Southwark**

Regular case surgery with the police that is helping align MSP approach and culture. **Camden**

'Choice Support' signposting providers who embrace an MSP approach. **Southwark**

Early Intervention offices working with Care Providers, coaching and mentoring Managers, promoting person centred care, improving quality and preventing safeguarding. **Nottingham City**

Bristol Police seem to have a real grasp on MSP.

*A joint clinic with the police to look at 'stuck' cases. **Camden**

*Work with independent providers to enhance understanding of the 'new' types of abuse from the Care Act. **Bracknell Forest**

A3.4 Working with care homes

Care Homes project doing life story work to generate a personalised approach. **Wandsworth**

Safeguarding training including MSP being rolled out in Lincolnshire Care Homes by LINCARE. **Lincolnshire**

"Early Intervention officers (clinician and social care practitioner) work with safeguarding/quality issues with care home providers to pre-empt formal provider investigations (CCG part funded) - so work to improve care quality - support providers to improve. 5-6 months of work to date. Do coaching and mentoring with Managers in care homes - on leadership. Observe shifts to see evidence of care delivery and practice in visits. Talk about good practice and person centred care. Monthly QA meetings to share soft and hard information - and identify potential sites for working. Also supported a home closure -personalised approach." **Nottingham City Council**

Bristol has a tested MSP approach for institutional safeguarding issues "*.... we go to the care homes and talk to people FIRST before looking at other evidence about what is going on. We go to talk to people to see what it is like in a general way before looking at for example CQC reports, complaints, safeguarding issues that have arisen that start to show a pattern. We get both sides of the story....what is going well and not so well. In one care home where there were two floors ...one for residents who have dementia and one for those requiring nursing care, the residents on one floor said how much they liked it but that they were really worried about those on the other floor. This MSP in institutional situations is not yet fully threaded through...it would be good at the end to sit with service users and talk through the changes and how that now feels."*

Blackpool Council's Professional Leads Team has delivered 46 bespoke full day training events focusing on Dignity, Respect, Safeguarding, MCA & DoLS to provider services in Adult Social Care. The overall aim of the training is to support and drive-up the quality of service delivery in Blackpool. Following the training feedback from a wide range of providers and partners evidences a significant increase in the confidence of staff and managers to challenge poor professional practice; together with improvements in their own practice resulting in better quality services and more fulfilling outcomes for individuals. In the words of one of the participants:
"I will now be more aware of people's rights and be more active in finding out what it is they really want, to ask questions about any concerns and make sure they are recorded, acted upon. That I use the channels available to seek out answers and actions to help resolve problems and issues."

A3.5 Developing MSP practice

'Light touch minutes' focus on the person and their outcomes, keeps the person at the centre and reduces administrative burdens. **Richmond**

Use “Josephine” and “Jack” who are life size, anatomically correct cloth people to help people with learning disabilities talk about issues including physical or sexual abuse, healthy relationships and sexual health. **Northumberland**

Bristol and **Oxford** councils are thinking across to the child protection model “Signs of safety”.

"We have encouraged people to hold meetings outside the civic centre - there has been a huge change in this practice. We have developed an aide memoir for social workers to use when they start the conversation with the service users, to support discussion, which can help with some of the more difficult conversations. We have now eliminated any instance where safeguarding activity is undertaken unbeknown to the person concerned." **Hillingdon**

A3.6 Measuring outcomes

We are planning to set up a task and finish group to measure the difference we are making. **Gloucestershire**

Tested use of a locally developed case file audit tool. **Hackney**

**MSP is one of the outcome measures on the organisation's 'Performance Wheel' which is reported regularly to management, all staff and the Board of governors.* (NE Lincs)

"We do live case file audits where they sit with staff and go through cases combining reflective learning and quality assurance. Every team does these each month, staff were terrified at first but it now works really well. It is reflective learning in action. Board business manager comes in to the audits too." **Oxfordshire**

The local authority will be working with Coventry University (whom they’ve worked with before) to evaluate a 6 month project to embed MSP. The project will include co-delivery of training with managers to operational staff, collation of data and target setting, improved user information and the monitoring of the use of advocates. Work will also be taking place with the Adult Safeguarding Board to look at partners roles in MSP. **Coventry**

Focus (an independent Social Work Practice commissioned to provide social work and safeguarding services) developed and implemented a sub-system of System1 to process Safeguarding Adult Concerns & Enquiries including outcomes and MSP information. It goes into the electronic Integrated Health & Social Care record and sits alongside the individual's NHS record. It has replaced all local forms, paper and historical recording. It adds simple mandatory checks and prompts for the conversations and outcomes to be recorded by the practitioner. This was adopted well by the team and enabled them to move to a new way of monitoring individual outcomes that are more personal and unique to them. It enables a more accurate and timely exploration of experiences and gives more information for those who did not achieve their expressed outcomes. **North East Lincolnshire**

Have configured AIS to give feedback on range of outcomes (6) including: wanting abuse to stop and to feel safer; help to be confident; police to prosecute; help to access support that might be available; There is also scope for free text. Latest figs show 84% of people said outcomes we met and 80% felt safer. **Hampshire**

A robust QA framework which goes way beyond enquiries. The SAB receives performance indicators from all partners. Outliers get examined in detail. Multiagency safeguarding audit is undertaken quarterly - 5 cases chosen randomly, using themes. Recent themes include transition to adulthood, domestic violence, self-neglect. Audit includes looking at outcomes from the person's perspective. Learning is reported to Board and involved in setting up training. **Rochdale**

"In our IT system Liquid Logic there are 3 key questions at the beginning about: what people want to happen; how people want that to happen; and outcomes. These questions were asked at every stage through to closure. The system only went live in November (We had SWIFT before and this allowed staff to bypass the safeguarding module but they have to complete the safeguarding module in Liquid Logic and it links to a web based alert form. These 3 questions are also asked on the safeguarding alert which enables greater multiagency commitment to address those questions. The web based alert form has had training attached to it across organisations including what is the point of those 3 questions. Also top 10 handy hints are on the OASAB website to help fill in the form. We can draw off for example good and poor alerts from say a provider and help people learn from that. In the closure form there is more information/understanding on the service user perspective." **Oxfordshire**

* *"We have a whole range of methods to measure outcomes. We have a SAB dashboard reflecting outcomes much more now. We report on findings in a MSP newsletter. We have 3 workshops for ASC planned in June combining SAR messages, managing risk and MSP. This will have a focus on getting the difference made across to staff. We have now 3 key performance measures that have been introduced over the past two years that ask: whether the person has been spoken to in the first 24 hours; how people are being involved (eg. through attendance at meetings, visits to their home, through an advocate) and outcomes being discussed at the beginning, during and at the end of safeguarding support. Our IT system Liquid logic allows us to change the system and add in mandatory fields. It is still a bit clunky but practitioners can record as simply as possible information on outcomes at all stages."* **Slough**

"Our data base can determine that people are involved at start, throughout and what they think of outcomes. It shows that people are generally satisfied at the end and often change what they want part way through. Where people have representatives involved, when options presented, they are really satisfied with the work done. Sometimes people say don't feel better but the problem is solved."* **Southwark

Appendix 4 List of participating local authorities

Derby City Council	East Midlands
Derbyshire	East Midlands
Leicester City	East Midlands
Leicestershire County Council	East Midlands
Lincolnshire	East Midlands
Milton Keynes	East Midlands
Northamptonshire	East Midlands
Nottingham City Council	East Midlands
Nottinghamshire	East Midlands
Rutland	East Midlands
Cambridgeshire	East of England
Central Bedfordshire	East of England
Essex	East of England
Hertfordshire	East of England
Luton	East of England
Norfolk	East of England
Peterborough	East of England
Southend-on-Sea	East of England
City of London	London
Ealing	London
Enfield	London
Hackney	London
Hammersmith	London
Kensington & Chelsea	London
LB Bexley	London
London Borough of Barking and Dagenham	London
London Borough of Brent	London
London Borough of Bromley	London
London Borough of Camden	London
London Borough of Haringey	London
London Borough of Havering	London
London Borough of Hillingdon	London
London Borough of Hounslow	London
London Borough of Lambeth	London
London Borough of Lewisham	London
London Borough of Redbridge	London
London Borough of Southwark	London
London Borough of Tower Hamlets	London
London Borough of Waltham Forest	London
London Borough of Wandsworth	London
Merton Council	London
Richmond	London
Royal Borough of Greenwich	London
Westminster	London
Darlington	North East
Durham	North East
Hartlepool	North East

Middlesbrough	North East
Newcastle upon Tyne	North East
Northumberland	North East
Redcar and Cleveland	North East
South Tyneside	North East
Sunderland	North East
Blackburn	North West
Blackpool	North West
Bury	North West
Cheshire West and Cheshire	North West
Cumbria	North West
Halton	North West
Knowsley	North West
Lancashire	North West
Liverpool	North West
Manchester	North West
Rochdale	North West
Salford	North West
Sefton	North West
Stockport	North West
Tameside	North West
Trafford	North West
Wigan	North West
Bracknell Forest	South East
Brighton & Hove	South East
Buckinghamshire	South East
Hampshire	South East
Isle of Wight	South East
Kent	South East
Oxfordshire	South East
Portsmouth	South East
RBW&M	South East
Reading	South East
Slough	South East
Southampton	South East
Surrey	South East
West Sussex	South East
Wokingham (The Board covers Wokingham, West Berks and Reading)	South East
Bath and North East Somerset	South West
Bristol City	South West
Dorset	South West
Gloucestershire	South West
Plymouth	South West
Poole	South West
South Gloucestershire	South West
Swindon	South West
Wiltshire	South West
Birmingham	West Midlands

Coventry	West Midlands
Dudley	West Midlands
Herefordshire	West Midlands
Sandwell	West Midlands
Stoke-on-Trent	West Midlands
Telford and Wrekin	West Midlands
Warwickshire	West Midlands
Worcestershire	West Midlands
Bradford	Yorkshire and the Humber
City of York	Yorkshire and the Humber
Doncaster	Yorkshire and the Humber
East Riding of Yorkshire	Yorkshire and the Humber
Hull	Yorkshire and the Humber
Kirklees	Yorkshire and the Humber
Leeds	Yorkshire and the Humber
North East Lincs	Yorkshire and the Humber
North Lincolnshire	Yorkshire and the Humber
North Yorkshire	Yorkshire and the Humber
Rotherham	Yorkshire and the Humber
Wakefield	Yorkshire and the Humber