

Making Safeguarding Personal Outcomes Framework

Final Report

May 2018

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1 Acknowledgements

The Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) appointed the Institute of Public Care (IPC) at Oxford Brookes University and Research in Practice for Adults (RiPfA) to develop a Making Safeguarding Personal (MSP) outcomes framework that will provide a means of promoting and measuring practice that supports an outcomes focus for safeguarding adults work.

IPC and RiPfA worked with the sector to develop this outcomes framework. Many thanks to colleagues from the following councils, regions and organisations who contributed to its development:

ADASS adult safeguarding network
Birmingham City Council
Camden Council
Central Bedfordshire Council
Cornwall Council
Croydon Council
East Midlands region
Leicestershire County Council
Local Government Association
NHS Digital
Nottinghamshire County Council
Oldham Council
Oxfordshire County Council
Slough Borough Council
Yorkshire and Humber region

We include anonymous quotes throughout; these are taken from notes made during the interviews so may not be exact quotes but give a sense of people's views.

Thanks also to the many other colleagues who shared examples of outcome frameworks for us to review, and to the MSP Informatics Task and Finish group for their guidance.

Jackie Daru, Institute of Public Care
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Fiona Richardson, Institute of Public Care
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2 Introduction

The Making Safeguarding Personal (MSP) programme has been running since 2010. It emphasises that safeguarding adults should be person centred and outcomes focused, and advocates a move away from the ‘process’ that characterised practice under *No Secrets*¹, to being centred on conversations with people about what they think needs to happen. The Care Act (2014) guidance incorporated MSP as the recommended approach to safeguarding, alongside the six principles to work to in safeguarding:

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

Making Safeguarding Personal also means embracing core statutory principles within a Human Rights framework, the wellbeing principle detailed in the Care Act 2014, and the core principles of the Mental Capacity Act 2005 (LGA and ADASS, 2017).

During the MSP Temperature Checks (national and regional) and the survey of Directors of Adult Social Services in 2016 and 2017 considerable information was gathered that indicated areas of good practice and areas of challenge. Recommendations from the national MSP Temperature Check of English councils (Cooper et al, 2016) included:

‘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.’

Developments in reporting on outcome measures should be shared and pooled..... in the drive to answer the question ‘have we supported people to be any safer?’.

Local organisations should develop a means of gaining a picture of what happens to safeguarding concerns that do not progress to a section 42 enquiry.

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’.

The Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) appointed the Institute of Public Care at Oxford Brookes University and Research in Practice for Adults to develop an outcomes framework that will provide a means of promoting and measuring practice that supports an outcomes focus and person led approach to safeguarding. We also present some guidance around developing audit-style questions for Safeguarding Adults Board (SAB) partners, which look more broadly at the systems they are using to embed MSP. This is based on a number of existing sources

¹ No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (2000)

including: A framework to support improving effectiveness of Safeguarding Adults' Boards (Doorly et al, 2017); and the audit tool used by London SABs and adapted elsewhere across the country [Safeguarding Adults at Risk Audit Tool 2015 – 2016](#).

The project objectives were:

- To propose an MSP outcomes framework that will provide a means of promoting and measuring practice that supports an outcomes focus for safeguarding adults work.
- To develop an MSP outcomes framework that will help practitioners, teams, councils, SABs and their partners know how far they are making a difference to the safety and wellbeing of people who are at risk of, or who have suffered, abuse or neglect in their area.
- To provide an approach that will enable councils and SABs to better identify how practice is impacting on outcomes, indicate areas for improvement, benchmarking and enable learning from others.
- To identify the ways in which recording and data capture via IT systems and processes can support the MSP outcomes framework, and make recommendations regarding improvement for those that have not.
- Engage with stakeholders and build on local and regional initiatives in this area.

This report sets out the findings from desktop research and telephone interviews that were carried out with stakeholders, and outlines a proposed outcomes framework for Making Safeguarding Personal. While we hope that this framework will go some way toward prompting good practice in MSP, a key message we have received from stakeholders is the importance of audit work, described by one interviewee as 'invaluable'. This has the potential to provide context and meaning to numerical data and we encourage councils to share and develop practice in doing this.

2.1 Method

In order to answer the brief above, a request was sent out to councils via the ADASS newsletter to share the MSP outcomes frameworks that they use. We received frameworks from 14 councils as well as three regions. We also took into consideration some parallel work (in its early stages) being carried out by Jane Lawson, looking at examples of case file audit tools and had conversations with NHS Digital about their consultation around the update of the Safeguarding Adults Collection (SAC) data.

We arranged telephone interviews which discussed the approaches of ten councils and two regions. In the course of conversations with practitioners other previous work was highlighted, and we have included findings from previous, relevant sector led and research projects below.

Following the telephone interviews, we developed a project update which outlined key issues in developing an outcomes framework, and proposed a draft framework. This was amended following feedback from the MSP Informatics Task and Finish group, and sent out to a small number of councils and group members. A second round of telephone interviews was held to discuss the revised model, and amendments made before presenting the model below.

3 The outcomes framework

Below we outline the proposed outcomes framework along with our rationale for the questions that we have included. Further detail about the sources that we used to create the framework can be found in section 4.

3.1 Principles for an outcomes framework

Through our conversations with colleagues from councils across England we have developed the following principles to work towards in the outcomes framework. We suggest the framework should strive to:

- Be integrated – draw on existing reporting frameworks including the Safeguarding Adults Collection (SAC) and local / regional work.
- Be proportionate – be mindful of not increasing the burden on councils / business intelligence and performance teams.
- Reflect core statutory principles for safeguarding in the data collected, including principles of the Mental Capacity Act 2005 and Making Safeguarding Personal as outlined in the Care Act (2014) guidance.
- Be meaningful – record and measure what matters.

3.2 How the framework will be used

The data collected may, in time, inform the setting of benchmarks. However, this would be subject to consultation with the sector. Please see section 7.2 below for a discussion of benchmarking.

We are proposing two parts to the framework:

1. An MSP outcomes framework which councils could opt to use, which draws on existing MSP frameworks as well as national outcomes frameworks. These relate to individual case level practice and recording in Making Safeguarding Personal.
2. Guidance around developing audit-style questions for Safeguarding Adults Board partners which look more broadly at the systems they are using to embed Making Safeguarding Personal (see section 5).

3.3 Timescales for implementation

We suggest the implementation timescales shown in the table below:

April 2018	Draft framework is reviewed by Task and Finish group
May 2018	Final version of the framework is agreed and disseminated to councils and boards via ADASS
May 2018 – February 2019	The framework is tested - councils voluntarily sign up to trialling the collection of data suggested by the framework
March 2019	Evaluation of process and outcome of the use of the MSP outcomes framework.

3.4 Outcomes framework

The MSP outcomes framework is outlined below. Further detail about the rationale for including questions is found in section 4. A full version of the framework including alternative questions for different respondents can be found in the accompanying framework document.

	Question	Answer options	Source/ further information	Domain
Outcomes focused questions				
1.	Was the individual or individual's representative asked what their desired outcomes were?	Yes they were asked and outcomes were expressed Yes they were asked but no outcomes were expressed No Don't know Not recorded	SAC (voluntary MSP data) (wording amended) This data is also collected by the SAC (voluntary collection). See Section 4.1 for the detail and rationale for this question.	Outcomes – involvement
2.	Did the person or their representative feel that the desired outcomes were achieved?	Fully Achieved Partially Achieved Not Achieved	SAC (voluntary MSP data) (wording amended) See Section 4.1 for the detail and rationale for this question.	Outcomes – achievement
Question about risk				
3.	To what extent was the individual or individual's representative involved in understanding and responding to levels of risk?	Fully involved Partially involved Not involved	Developed for this project to measure the level of involvement of the person in understanding and responding to risk. This question can be answered by the individual, their representative or a member of the safeguarding team. See Section 4.2 for the detail and rationale for this question.	Risk / involvement
Questions about the experience of the safeguarding enquiry				
4.	<i>Requires response from the adult or their representative</i> Did you understand why people did what they did to try to keep you safe?	Fully understood Partially understood Did not understand	This question is included to check whether people understood why the action taken was taken. See Section 4.3 for the detail and rationale for this question.	

	Question	Answer options	Source/ further information	Domain
5.	<i>Requires response from the adult or their representative</i> Did you feel listened to during conversations and meetings with people about helping you feel safe?	I was always listened to I was listened to quite a bit I was not listened to very much I was not listened to at all Not answered	HSCIC Safeguarding Outcomes Measure Pilot Study and East Midlands Region The concept of safe and feeling safer was explored in detail in the cognitive testing of the HSCIC project. See Section 4.4 for the detail and rationale for this question.	Listened to
6.	<i>Requires response from the adult or their representative</i> How happy are you with the end result of what people did to try and keep you safe?	I am very happy with the end result I am quite happy with the end result I am not very happy with the end result I am not at all happy with the end result Not answered	HSCIC Safeguarding Outcomes Measure Pilot Study and East Midlands region In the cognitive testing the HSCIC authors substituted the word 'happy' for 'satisfied' because not all participants understood the meaning of the word satisfied. See Section 4.5 for the detail and rationale for this question.	End result – overall (not just whether outcome met or not)
7.	<i>Requires response from the adult or their representative</i> Do you feel that you are safer now because of the help from people dealing with your concern?	I feel that I am a lot safer now I feel that I am quite a bit safer now I feel that I am not much safer now I feel that I am not at all safer now Not answered	HSCIC Safeguarding Outcomes Measure Pilot Study As with questions 5 and 6, we propose including the question as worded in the Health and Social Care Information Centre (HSCIC 2014) work as it has been through cognitive testing with a range of people. See Section 4.6 for the detail and rationale for this question.	Feeling safer

3.5 Gathering feedback from people who use services

The framework above includes questions from the Health and Social Care Information Centre (HSCIC 2014) pilot project, which looked at how to gain feedback about safeguarding from people who had experienced an enquiry, or their advocates. Questions 4, 5, 6 and 7 were written to be asked using an interview method by an independent person (i.e. not the person leading the enquiry) after the case was closed, but within 8 weeks of the case closing. The 8 week time frame was chosen to 'aid recall of the events' and also to minimise distress to participants by going back a long time after and asking them about things that they may wish to leave in the past. However, the pilot showed that the cost of conducting such follow up interviews was prohibitive to councils. While several councils that we spoke to had considered, or are undertaking independent gathering of feedback from people, many warned that few adults were providing feedback in this way.

One interviewee noted a challenge with any attempt to get feedback, as people's perceptions of how the concern or enquiry might have helped will change over time. They gave the example of a survivor of domestic abuse who had commented:

"If you asked what I thought of what you'd done after you'd finished, as a victim of domestic violence, I'd have told you where to go. It's only now reflecting on it five years after I can see if it was a useful part of the process. How I feel about it is very temporal." (Interview 3)

This captures the difficulty of measures such as safety and happiness that will change over time; so while there is value in capturing them, they should also be read with caveats about their meaning and accuracy.

The alternative is for the person leading the information gathering or enquiry to ask the questions at case closure. There are limitations to this method, because the practitioner is in essence asking the person for direct feedback about the quality of their practice, which may influence the responses that the person gives – as one interviewee put it, there's a 'built-in bias'. An interviewee from a council whose region has signed up to reporting on a set of questions closely modelled on the Health and Social Care Information Centre (HSCIC 2014) work explained that their council often attributed the high returns of those questions, which are asked at the end of the enquiry, to the fact that the social worker leading the enquiry asks them. They highlighted the 'balance' between timing, independence and resource (Interview 9). However, some interviewees said that people may also be more likely to "feel more comfortable telling a person they've built a relationship with" (Interview 10). Our suggestion is that these questions can be integrated to the broader conversation about safeguarding – as an interviewee commented, "my head says it works best when it's part of the whole process" (Interview 9).

"In one council, the solution has been to talk to people as they're going through the process. The alternative is that, with the person's agreement, another agency goes to speak to the person throughout to gather feedback. However, it's been very difficult to find people who want to do that." (Interview 10)

3.5.1 Post-involvement questionnaires

A related topic of discussion was post-involvement questionnaires. Some examples of these were given to us, but again in discussions concerns were raised about the appropriateness of timing of them, and the general lack of responses. This echoes findings from the MSP Temperature Check (Cooper et al, 2016):

"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'." (ibid, p17)

In general, using post-involvement questionnaires seems to be taking up valuable (and scarce) resource without bringing clear benefits, either to councils or people themselves. We would recommend that if feedback in addition to the above is required, to arrange a targeted, purposeful and time limited gathering of evidence by an independent group. For

example, one council asked a user group to conduct a survey and interviews and presented feedback to the Safeguarding Adults Board. Droy and Lawson (2017a) outline examples of gathering feedback about safeguarding.

4 Developing the framework: supporting evidence

This section outlines the rationale behind the development of the framework.

4.1 Questions 1 and 2: outcomes – involvement and achievement

These questions are adapted from the voluntary data on MSP which is collected as part of NHS Digital's annual Safeguarding Adults Collection. All of the frameworks we reviewed, and councils that we spoke to included questions along these lines. This reflects the fact that in 2016/17 61% of local authorities (n=93) submitted voluntary data about whether individuals (or their representatives) had been asked to express outcomes, and whether those outcomes were met. This proportion represents a steep upward trend from 2015/16 where 55 councils submitted data (Adult Social Care Statistics Team, NHS Digital 2017b). This trend can reasonably be expected to continue upwards in the reporting of the data for 2017/18. These outcomes measures were also suggested in a paper developed on behalf of the national independent chairs' network (Doorly et al, undated).

Because the data is being collected by councils anyway, and measures the very essence of what Making Safeguarding Personal is about, it is included in the outcomes framework.

Question 2 was originally phrased as 'were the desired outcomes achieved'? This was a close reference to the SAC question, 'Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases were the desired outcomes achieved?'. One respondent suggested that it was important that we record the person or their advocate's view, rather than the professional's view, of achievement of outcomes. The SAC guidance makes it clear that this is the intention behind the question.

There have been discussions in the SAC working group about rewording the MSP questions slightly, but no decision had been taken at the time this report was written. We would recommend that the MSP outcomes framework aligns with any future change in wording of these questions in the SAC.

4.2 Question 3: risk

At the core of practice in safeguarding adults is a tension between two important principles; duty of care and individual autonomy (the right to take risks). Reducing risk of harm is a key objective in safeguarding, with the caveat of ensuring that the adult is in control, wherever possible and with regard to their Article 2 and 3 rights and public interest, of determination of the level of risk they are willing to accept. A question about risk was therefore seen as important to include here.

The SAC proforma (NHS Digital, 2017a) includes two questions about risk; one about risk assessment, and another about the risk outcome.

Around risk assessment: was a risk identified and was any action taken/ planned to be taken? Options include:

- Risk identified and action taken
- Risk identified and no action taken
- Risk - Assessment inconclusive and action taken
- Risk - Assessment inconclusive and no action taken
- No risk identified and action taken
- No risk identified and no action taken
- Enquiry ceased at individual's request and no action taken

Around risk outcomes: where a risk was identified, what was the outcome / expected outcome when the case was concluded? Options include:

- Risk remained
- Risk reduced
- Risk removed

The most up-to-date SAC guidance (NHS Digital, 2018) maintains these categories.

Some interview respondents suggested that these options on their own might be too simplistic, and don't adequately reflect the nature of MSP. A key issue that an MSP outcomes framework should address is that of involvement of the person, or their representative, in understanding and responding to levels of risk. It was agreed to add a question about people's involvement in understanding risk. The question needs to account for the fact that people may choose to live with a level of risk. This makes the measures of whether risk has been reduced or not (where reduction of risk would be the obvious marker of 'good') too blunt; as there could be examples of excellent work where a person weighs up the options and decides to maintain the level of risk they are at, or live with a comparable level of risk.

For one council with targets around the proportion of cases where the risk was removed or reduced, a record that risk remained would prompt them to "look for why the risk remains, if it's the person's decision – making the link about what they want" (Interview 8). Another advised cautioned "we need to be mindful we don't start a league table" about reducing risk (Interview 9), as it is not the sole aim of safeguarding.

Some interviewees also discussed the fluid nature of risk; as one risk is minimised (e.g. the risk of financial exploitation reduced by limiting contact with the perpetrator) another risk appears (the risk of social isolation). In this way it is not possible to capture a holistic measure of 'risk', as there may be various dimensions of risk that are more or less severe at any one time. The problem, as one person put it, is that 'people merge the risk' when different risks should be measured separately.

In response, and with the guidance of the Task and Finish group, we developed the pilot question here, which uses a similar format of responses to the SAC outcomes questions. This did not ask for a measure of whether risk has reduced, but instead asks about 'the person or their representative's level of involvement in defining and deciding levels of acceptable risk.'

The final wording of the question was changed following feedback from the Task and Finish group, to 'To what extent was the individual or individual's representative involved in *understanding* and *responding* to levels of risk' (emphasis added). The group felt that 'defining and deciding' were too strong as verbs, given the proportion of people experiencing safeguarding who lack capacity to make decisions about the enquiry. This change also resulted in us dropping the word 'acceptable' from 'levels of risk'.

4.3 Question 4: understanding

A person's, or their representative's, understanding of the reasons why safeguarding activity is being undertaken is another measure of involvement. The Task and Finish group recommended that a question on understanding should therefore be included. The wording of the question is based on the later questions which were developed by HSCIC (2014), and there are two options presented; one for the person and another for their representative. The disadvantage of including this question in addition to the others is that of burden, both on individuals or their representatives, and on practitioners. However, it could be asked at case closure along with the others.

4.4 Question 5: feeling listened to

One of the core principles of Making Safeguarding Personal is keeping the person at the centre of the enquiry. The question used here is taken from the Health and Social Care Information Centre work on an outcomes framework for safeguarding adults (HSCIC 2014a). The question was subject to cognitive testing, a process that aimed to make sure that 'respondents understood the questions in the way that they were meant to be understood and... they were willing and able to answer them' and 'topics covered in the questionnaire were salient and relevant to different groups' (ibid, p14). The authors state:

'This question aims to capture if the participant felt they were involved in the safeguarding investigation as much as they wanted to be and whether they thought their view was heard and taken into consideration. The question worked well in cognitive testing and people thought the term "listened to" meant the process of others listening to what they had to say and taking it on board. For those that struggled to fully comprehend what was meant reference to the social worker by name and descriptions of the meetings that took place helped elicit a response.' (ibid, p23)

Numerous frameworks that councils sent in had a question on this theme. One region is also using this question as a regional benchmarking measure. We recommend using this wording due to the cognitive testing and piloting it has been through.

The wording can also be slightly amended in practice for use with the adult, their relative, friend or carer, or an Independent Mental Capacity Advocate (IMCA). Comprehensive guidance is available to use (HSCIC, 2014b).

4.5 Question 6: happiness with the end result

This question aims to capture people's level of satisfaction with the safeguarding enquiry as a whole. It adds an additional dimension to asking about whether outcomes were achieved, as numerous interviewees made the point that people may have not been able to achieve their expressed outcomes for numerous reasons, but may have still been happy

with the way that they were involved, or the explanation of why things happened as they did.

“As the manager of the [safeguarding] team, I am more concerned with if people aren’t satisfied, why not” (Interview 1)

As with question 5, it is taken from the Health and Social Care Information Centre work on an outcomes framework for safeguarding adults (HSCIC, 2014), and is also used by one region that responded to our call for frameworks.

The HSCIC authors substituted the word ‘satisfied’ for ‘happy’ in the cognitive testing stage because not all participants understood the meaning of the word satisfied. The authors state:

“This question aims to understand how satisfied people were with the outcome of the safeguarding [enquiry]. Cognitive testing showed some adults at risk were able to understand the question and focussed on what had been done and what had been discussed at the end of the [enquiry]. Some people needed help focussing on what to think about and support workers aided the adult at risk by mentioning specific meetings or asking respondents to think about the meeting where we discussed e.g. what happened when X was arrested for stealing your money. The word “outcome” proved problematic, not everyone understood what it meant and it does not exist in British Sign Language, therefore it has been substituted with “end result”.” (ibid, p24).

The wording can also be slightly amended in practice for use with the adult, their relative, friend or carer, or an Independent Mental Capacity Advocate (IMCA). Comprehensive guidance is available to use (HSCIC, 2014b).

Feedback on including this question from a second round of consultation was generally positive. The question was seen as important, though one person raised the question of gathering the data; ‘it’s a tricky one as we need an impartial way of getting these responses’. This is discussed above.

Two people questioned the wording of the question, querying “‘What people did’? Not very MSP.’ (R4) ‘could we say something about how everyone worked together as ideally we won’t be doing to people we should be working with’ (R5). The word ‘happy’ was also questioned. Our view is that as these questions have undergone extensive cognitive testing, they should be used as they are.

4.6 Question 7: feeling safer

A key objective of safeguarding adults is to increase adults’ safety. One interview respondent described the question of whether a person felt safer after a safeguarding enquiry as ‘the golden question’. Numerous frameworks that were sent in to us by councils ask a question about whether the enquiry had resulted in the adult feeling safer. However this also needs to be recognised as a subjective question. Interviewees made the point that questions about safety need to be clear that they’re asking about feeling safer as a result of the safeguarding activity, not about safety in general.

We considered using the wording of the question from the Adult Social Care Survey 2016-17 (NHS Digital): ‘which of the following best describes how safe you feel / do care and

support services help you in feeling safe?’ However, this was discounted as there was concern that the question is ambiguous about what elements of safety are being discussed – it is not clear enough that we want to find out whether the safeguarding activity led to people feeling safer in relation to the safeguarding issue being discussed.

As with questions 5 and 6, we propose including the question as worded in the Health and Social Care Information Centre (HSCIC 2014) work as it has been through cognitive testing with a range of people. Again, numerous versions of this question are available for different stakeholders, depending on who is able to answer the question (the adult, their family/ relative/ carer, or their IMCA), and whether it should be asked in present or past tense. The authors state:

“This question aims to understand if what the local authority did during the safeguarding [enquiry] and any actions taken have helped the adult at risk to feel safer, or whether those that supported the adult at risk feel that the adult at risk was made safer. When asked about safety, some people thought about general safety and some thought about specific things, e.g. safety over money or how safe the adult at risk felt in their own home, this depended on what the initial risk was and how many times a risk had been identified.

In cognitive testing one of the answer choices was “I feel completely safe now or I feel that the person in this case is completely safe now”, however feedback was that you can never be completely safe and so this was changed to “I feel I am a lot safer now or I feel that the person in this case is a lot safer now”. For relatives/friends/carers/IMCAs two versions of question 7 have been developed, one which is present tense (question 7b) and to be used when the adult at risk is alive and one which is past tense (question 7c) for where the adult at risk has since died. “Interviewers should be aware before the interview which version they should use (along with the relevant show card).” (HSCIC, 2014: 25)
Comprehensive guidance is available to use (HSCIC, 2014b).

5 Developing audit style questions for Safeguarding Adults Boards

An essential as part of the assurance role of Safeguarding Adult’s Boards is to measure the difference MSP makes for people. This must include qualitative and quantitative information, both regarding section 42 enquiries and in those situations which do not reach a formal enquiry. There must be encouragement of a whole partnership commitment to asking people about outcomes at the initial point of discussing a concern.

A number of councils sent in examples of quarterly reporting to their board on safeguarding data. A strong feature was the need to contextualise data with a narrative account which often drew on findings from audits and reviews. This helped to explain and give meaning to the trends presented. Some councils had devised measures under the six principles of safeguarding under the Care Act. Some of these are presented below, with a focus on prevention and partnership, as well as questions that we felt were better suited to be collected via audit and reviews. We recommend that boards also review the ‘9 essential steps to Making Safeguarding Personal’ outlined in Lawson (2017a). We also recommend that boards review the work carried out by other boards and regions to develop auditing tools, for example the [Safeguarding Adults at Risk Audit Toolkit](#) developed by the London

Chairs of Safeguarding Adults Boards network and [Making Safeguarding Personal for safeguarding adult's boards](#) (LGA and ADASS, 2017).

5.1 Understanding the reasons why outcomes were not expressed

Many of the frameworks reviewed, and auditing tools, look into why someone might not have been able to express outcomes. One outcomes data flowchart presents several possible options:

- Person Known To Lack Capacity
- Person Thought To Lack Capacity
- Would Lead To Increased Risk
- CHC Customer
- Out of County
- Person Too Ill
- Person Deceased
- Person Upset/Inappropriate To Ask
- Lack Of Staff Resource
- Staff Did Not Get Information Needed
- Insurmountable Communication Difficulties
- Lack of Interpreter
- Person Refused Contact
- Refused Access to Person

Others check whether information and support was provided to the person to express their outcomes. We suggest that such measures are integrated in local or regional auditing tools.

5.2 Understanding the reasons why outcomes were not being achieved

This was raised by numerous interviewees as important. This is an important issue for national data collection because it provides context to the numbers; outcomes may not have been achieved for any number of reasons (for example a criminal prosecution may not have been successful) other than a failure on the part of the enquiry lead. One interviewee suggested it would make a useful research project, though it should not be included in a national framework.

We recommend that, as many already are, individual councils carry out audit work to uncover the reasons behind lack of outcome achievement, which will provide crucial context to the figures.

5.3 Outcomes domain

The majority of councils that we spoke to were not using typologies of outcomes domains to record the outcomes that people were expressing. Some councils had tried to develop them in the past, or had used them, or still used them in conjunction with free text responses. However, there was much discussion about the danger of practice being led by recording tools, rather than the other way around. One responder described it as 'a

massive can of worms – far too difficult’ and described how ‘if there is a box, people will tick it’ – for example even if the original concern wasn’t about relationships, people may tick ‘relationships’ as a domain as most things relate to relationships. Other interviewees were similarly cautious:

“the downside is the tail starts wagging the dog... people need to start from free outcomes – and then categorise them – and there are risks in doing that” (Interview 9)

“You get that safeguarding spread – you go out to talk about one issue, and others come up too” (Interview 1)

“I’m certainly not in favour of a tickbox of outcomes – there’s got to be the culture of talking to the person and listening to them” (Interview 5)

Another described MSP as “about the person and not our processes’ and was concerned it would be another means of ‘putting people in a tick box” (Interview 3).

Most councils therefore recorded the outcomes that people were requesting using free text, and some had the option of either drop down menus or free text for recording outcomes. However, some councils did use drop down menus or mentioned neighbouring councils who were doing so:

“It was working quite well – you can get thematic information... but it depends on whether people are choosing the right category” (Interview 2)

One of the limitations of a national outcomes framework is the need to develop quantitative measures (i.e. numbers or categories) rather than using qualitative (free text) data. This is because there is not the capacity to analyse or code free text responses on such a large scale.

The people we spoke to did recognise the value in knowing what types of outcomes people were requesting. One respondent noted it is important to know because it can challenge our assumptions. For example, people may wish to prioritise relationships with the perpetrator over their safety.

Data collected on this issue could help councils in planning services and responses. For example, if ‘justice’ outcomes are seen to be important to a significant proportion of people, looking to ensure that practice that promotes different ways of accessing justice is encouraged, or if ‘financial wellbeing’ is a key priority, ensuring that information and advice around finances is more readily available to people with care and support needs. It could also help partners to see the extent to which safety is balanced with wellbeing, and the extent to which we enable risk to support the range of things that make up wellbeing.

Initial feedback from colleagues show that this is not something that councils do at the moment, and concerns were raised about the likelihood of practitioners coding outcomes in a consistent way. Additionally, many outcomes could be coded along any dimensions, making it difficult to ensure consistency in coding.

A second round of feedback raised further questions about inclusion of this question. As described above, these were split into two types; principle, and practicality.

Principle

“I prefer the free text option so as to truly represent what the person sees and wants... To have a drop-down list option could negate how the person’s views are expressed but can be useful if ‘we’ need data. What would be the purpose and use of having [this] data?” (R4)

“It feels like moving away a bit from the person’s outcomes... and what we’re trying to achieve” (Interview 13)

Practicality

“I am not clear on the outcomes domains, who would fill them in, where and how they would be used... we need to be mindful that the data capture is not too cumbersome for front line practitioners” R1

“it adds too heavy a burden on the practitioner to analyse and then make judgements and the effort to do so is disproportionate to the information that will be collected” R3.

“Code sets run the risk of either having a code set that is too small, making each code too broad and therefore meaningless, or too large, leaving coders with a drop down menu of sixty-odd items which is unwieldy” (Task and Finish group respondent).

As a result of this feedback we suggest that this question is included as a suggested local audit tool and its use evaluated. Below we provide guidance around using it.

Question	Answer options
In which domain(s) did each outcome sit? You can choose more than one domain for each outcome.	Free text

Guidance

We advocate that councils use a qualitative approach to recording outcomes i.e. writing in free text the outcome that the person or their advocate expressed. We would suggest these could then be mapped against the list proposed below, to find out which are the most common outcomes requested by adults. The list of domains was developed by comparing existing outcomes frameworks (see the Appendix at section 9 below). Each outcome expressed can be coded along one or more domains. Outcomes should be coded by the practitioner using their professional judgement.

Domain	Explanation
Being in control	The person wishes to retain or gain control over some aspect of the situation that has led to a safeguarding enquiry.
Safety	The person wants to be or feel safer and the outcome expressed details how this will happen.
Dignity	The person feels that the situation that has led to a safeguarding enquiry has undermined their dignity, and wants to take action to regain it.
Occupation / daily living / contribution	The person’s outcome relates to activities in their daily life, or their contribution to society.

Social life / relationships	The person wishes to create, develop, maintain, or change aspects of their social life or relationships in response to the safeguarding situation.
Physical and/or mental health	The person's outcome relates to improving or changing an aspect of their physical or mental health.
Financial wellbeing	The person's outcome relates to changing their economic or financial situation, or preventing further economic or financial abuse.
Resilience	The person wants to protect themselves in the future or have help to recover.
Feeling good	The person's outcome relates to taking steps to make them feel better or improve their wellbeing in response to a safeguarding situation.
Justice	The person's outcome relates to obtaining some form of justice for the abuse experienced. This may be civil, criminal, restorative, or any other type of justice.
Accountability	The person wants professionals to be held accountable for their decisions and actions, and for there to be proper scrutiny of the situation.
Addressing care and support needs	The person's outcome relates to meeting their needs around care and support to prevent further abuse or neglect from occurring.
Other	Any outcome that does not fit into one of the above categories.

5.4 Measuring prevention

Recent MSP resources (Lawson, 2017a) describe the importance of case file audit in measuring and understanding outcomes, and the need to measure pre section 42 to understand impact on prevention. They also describe combining staff development with performance information, so that live case file audit key messages from the performance data are fed back to practitioners.

One council asks a series of questions on prevention which are reported to the Board. These are:

- The number of quality and monitoring checks (of adult social care providers) that have been undertaken in the quarter
- SAB training attendance by agency
- The number of reviews undertaken by the vulnerable adults' mortality subgroup in the quarter (plus a summary of the lessons learnt)
- The number of Safe and Well checks undertaken (including checks by the fire and rescue service about fire safety, falls, warmth, clutter / hoarding, alcohol and drug misuse and financial abuse such as scams)

Another uses the following measures of prevention:

1. The adult, or their advocate, has clear information about abuse and how and where to report in the future.
2. Judgements made on the balance of probabilities, and recommendations are made to prevent, minimise or reduce repeat abuse or victimisation.
3. Plan includes longer term actions to minimise risk of further harm. This plan is shared effectively with all agencies.
4. Organisational learning prior to closure which is intended to minimise reoccurrence more widely across the partnership if appropriate.
5. Evidence of working with family networks to make decisions and manage complex situations.

5.5 Partnership effectiveness

[A framework to support improving effectiveness of safeguarding adult's boards](#) (Doorly et al, undated) was written on behalf of the independent board chairs network, and invited Chairs to send in suggestions of measures of partnership effectiveness. Suggestions included:

- Multiagency audit information on frontline practice around MCA, risk assessment and management, person-centredness, and evidence of protection planning and review
- Conversion rates from concerns to enquiries
- Quality of provider services
- Number and proportion of people referred for services who define (or whose advocate defines) the outcomes they want
- Percentage of people whose outcomes were met
- Measures relating to effective operation of the board (e.g. attendance, service user involvement, level of agency engagement in safeguarding)
- Community and public awareness e.g. how many concerns received from the adult or the general public
- Staff views on agency response to safeguarding.

Some councils we spoke to asked people to record outcomes on the concern form. One council then reported, on a monthly basis, the percentage of people asked for outcomes at both concern and enquiry stage. This was described as 'a prompt to get people to talk to people about the fact they're reporting... if it then goes to an enquiry, we can check, update or change the outcome if need be.' The data shows a near continual increase in the proportion of people asked at the concern stage, up to over 90% (Interview 1). This could be a measure of partnership, i.e. ensuring that regardless of the agency bringing a concern to the attention of the local authority, MSP principles are being followed by asking about outcomes.

One council explained they would soon be implementing a 'caused enquiry approach', which would use all the same MSP focused fields as in an enquiry led by the local authority. Councils using this method could assess the strength of support for MSP over the partnership by the quality of practice demonstrated in 'caused enquiries'.

A report by Action on Elder Abuse (2017) suggests that greater transparency is needed about the number of safeguarding enquiries that related to a crime, and what proportion involved the police. This is an important issue – some evidence (Clarke et al, 2016) suggests that older people especially may not always be supported to access their right to justice after being victims of crime. Some councils have built this question into their auditing tools (see below).

Other councils have developed audit tools with headings that correspond to the six principles of safeguarding adults outlined in the Care Act 2014. Some examples of the Partnership sections of these are outlined below:

Council R: Partnership

1. Has the funding Authority been notified if not xx council funded or self-funded individual?
2. If appropriate, has the provider, CQC or the Quality Team been notified?
3. If the allegation constitutes a possible criminal offence, has the matter been reported to Police and have they been consulted with regard to any strategy?
4. Were relevant agencies consulted and appropriate information shared (and if no strategy meeting, were these recorded as strategy discussions)?
5. Was a strategy meeting convened at the appropriate time?
6. Were relevant agencies represented, including service users view?
7. Was the discussion and outcome / action plan clearly recorded?
8. Is there evidence of a coordinated multiagency response?

Council D: Partnership

1. All appropriate partner agencies consulted and appropriate information shared with appropriate and timely feedback given to all relevant parties.
2. Appropriate onward referrals have been made based on agreements reached by the safeguarding professionals supporting the adult (including MARAC, Quality Improvement teams, SAR referrals etc.)
3. Professionals' meetings / discussions are convened at the appropriate time with appropriate levels of information sharing. Discussion and outcomes / action plans are clearly recorded.
4. There is evidence of a coordinated multiagency response and effective challenge where appropriate.
5. The adult at risk or their representative was an equal partner in the process. Where professionals have a legal duty to report or act on behalf of the adult at risk this is clearly identified.

6 Implementation – case recording systems and processes

From our interviews we found that MSP information is already recorded within adults' services case recording and reporting systems, and this is reflected in existing research. For example, in London, 94% of councils have adapted systems in order to implement MSP (Lawson, 2017b). Those we spoke to told us that there is typically a single form in place to capture safeguarding information, and that form may be split into sections to cover

the different aspects of the safeguarding task, presented in a logical order to match process.

The most used adult services case recording systems are: AIS/SWIFT, CareFirst, Frameworki / Mosaic, and LAS. An estimated 88% of councils use one of these systems². How easily these systems could adopt the MSP framework is summarised in the table below:

How easily can the most used case recording systems adopt the MSP framework?

System	Supplier	Estimated % of councils where system is in use	Ability to adopt the MSP framework
AIS/SWIFT	OLM	16%	A way to implement the framework through local adaptation of the existing system design has been provided by the supplier
CareFirst	OLM	19%	Flexible system – amendments can be carried out by the council without recourse to the system supplier
LAS (Liquidlogic Adults' Social Care System)	Liquidlogic	26%	Flexible system – amendments can be carried out by the council without recourse to the system supplier
Frameworki / Mosaic	Servelec HSC	27%	Both Frameworki and its successor, Mosaic, are flexible systems – amendments can be carried out by the council without recourse to the system supplier

In terms of making the technical changes necessary to adopt the proposed outcomes framework, for the most frequently-used systems (CareFirst, Frameworki / Mosaic, and LAS) this was not considered to be problematic.

In terms of amending the design of their system, AIS/Swift does not have the same level of flexibility as other popular systems, but the system supplier (OLM) has provided guidance as to how the framework could be implemented within the system. However, the format of this proposed implementation as provided by the supplier is split over several screens, which could have an impact on usability.

Questions in the framework require answers at different times in the process. For example, questions 1, 3 and 4 could be answered at an earlier stage than the remaining questions, which focus on outcomes that would be recorded later in the process. When implementing the outcomes framework, the system design should take account of this.

² Adult Social Care Core Application Providers 2015-16 (not published).

In order to implement changes to systems, in terms of governance, councils said that the requirements would need to be signed off at various levels. For example, this may include sign off by the Safeguarding Adults Board and Director of Adults Services / Senior Management Team. This aspect of implementation was not viewed as likely to be problematic by those interviewed.

Once amendments to the case recording system had been agreed, the work required would then need to be prioritised against other planned system design changes. Whilst the waiting time for changes may vary widely across councils, those interviewed anticipated relatively short waiting times e.g. less than three months.

In terms of local reporting, councils use a variety of reporting systems, such as Business Objects for example. These flexible systems would be adaptable and able to report on the data held within the outcomes framework. Frequency of reporting at local and regional level would need to be agreed; for national reporting see below.

7 How does this framework fit into the broader context and concerns?

Any implementation of a national framework for MSP outcomes should be done with acknowledgement of the following contextual challenges and concerns.

7.1 Links to the Safeguarding Adults Collection

As one interviewee noted, 'MSP is such a small part of the national return so we need to collect more data ourselves' (Interview 7). At the same time as we were undertaking this project, NHS Digital was undertaking a review of numerous national data collections including the SAC. We discussed the development of this framework with colleagues from NHS Digital to ensure alignment as far as is possible. There is not yet consensus about whether the MSP questions in the SAC will be made mandatory as there are arguments for and against this.

A key question will be how to link this framework to the national data collection. For example, could there be an option to link data by case so that we can cross reference the MSP outcome measures with the demographic and other data collected in the SAC?

7.2 Benchmarking

Several interviewees discussed the implication of using benchmarks to identify targets around safeguarding and MSP data. A key concern was that as quantitative data cannot capture nuance, and there may be very good reasons why targets are not being met. One interviewee explained that their council audited cases where people or their representatives were not asked for their outcomes. The audit found that while in a third of those cases the practitioner had not asked, in the other two thirds there were good reasons. For example, the person had died; or there had been an error in recording; or, because of the timescales that teams were pressured to work to, the team had decided to pass it to the next stage of safeguarding without ascertaining outcomes, rather than 'make a bad decision in a short period of time'.

Some respondents expressed frustration with benchmarking being used as another reason to criticise practice without addressing underlying issues of funding, demand and capacity. Another interviewee noted that if their Key Performance Indicators (e.g. on involvement) were dipping below the set level they would look into it – so the benchmark acts as a flag to look into issues rather than a reason to criticise practice.

One council explained it did not include a benchmark for whether outcomes were met or not as they recognised that sometimes achieving outcomes is out of their control (for example with HR issues or prosecutions).

Interviewees in general highlighted the importance of ‘rather than reams of data, have a narrative report’ and ‘getting curious about data’ (Interview 7).

7.3 Shared understanding of terms

Numerous people we spoke to discussed the challenge of creating meaningful data sets from data where people don’t always share an understanding of key terms. An example given by interviewees was the recent finding by the Adult Social Care Statistics Team NHS Digital (2017a) of the massive range in the percentage of safeguarding concerns converted to enquiries between councils (nine councils showed 100% conversion rate; 22 showed between a 0 and 19.99% conversion rate; and one recorded no concerns, but a number of enquiries). The variation in conversion rates (among other statistics) was reported by Action on Elder Abuse (2017) as demonstrating a ‘postcode lottery’ in how councils respond to safeguarding.

As one interviewee said ‘the Care Act guidance is open to interpretation’ (Interview 4). One region has subsequently done some work around this to create a shared definition of what constitutes a section 42 enquiry, but it highlights the challenge of enabling meaningful national data collection when there is scope for local interpretation.

7.4 Narrative person-centred approaches

Some councils that we spoke to were in discussions about using more narrative approaches to practice, such as the ‘Three Conversations’ approach. This approach provides one solution to perception that social care recording systems have become a ‘bureaucracy beast to feed’, while potentially still neglecting to measure the important things. However, using a purely narrative (free text only) approach raises challenges for pooling and analysing data. The organisation behind the approach clarified that while they do advocate getting rid of forms and reducing bureaucracy they absolutely support the need to be accountable and record both ‘conversational records’ and ‘data’, and feel that a ‘middle ground’ where the important things are recorded should be sought.

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9 Appendix: Outcome Domains

The purpose of recording the outcomes domains that people are requesting is for planning services and developing practice. It could also help partners to see the extent to which safety is balanced with wellbeing, and the extent to which we enable risk to support the range of things that make up wellbeing.

Table 1, below, shows 4 established typologies of outcomes generally in social care (ASCOT, TLAP, Outcomes Star, and Supporting People), the typology for safeguarding outcomes suggested by one council (Hampshire), the categories used in the MSP evaluation 2014/15, and the 9 domains of wellbeing outlined in the Care Act 2014. The theme column has been developed for this project to illustrate commonalities across these typologies, and we suggest including the ones **highlighted in bold**.

An additional established typology by Glendinning (2006) is not included in the table below. The model categorises outcomes into three types; change, maintenance and process. Our view is that this model is not as useful for planning purposes.

Themes	ASCOT	TLAP personal budget review template	Outcomes star	Supporting people	Hampshire	MSP Evaluation 2014/15	Care Act 2014 wellbeing
Being in control	Control	Choices and changes	*	*	I want to be involved in what happens next	To gain or maintain control over the situation / To be involved in making decisions	Control by the individual over day-to-day life (including over care & support provided and the way it is provided)
Safety	Safety	Living safely and taking risks	Staying safe	Stay safe	I want the abuse to stop and to feel safe	To be and feel safer	Protection from abuse and neglect
Food & drink	Food & drink	*	*	*	*	*	*
Self care	Personal cleanliness	*	*	*	*	*	*

Care of home	Cleanliness of home	*	*	*	*	*	Suitability of living accommodation
Dignity	Dignity	*	Bring treated with dignity	*	*	*	Personal dignity
Occupation/ daily living/ contribution	Occupation	Everyday tasks	Looking after yourself	Make a positive contribution	*	*	Participation in work, education, training or recreation The individual's contribution to society
Social life / relationships	Social contact	Community life / Family and relationships	Keeping in touch	*	I want help to feel more confident	To maintain key relationships	Domestic, family and personal / Social and economic wellbeing
Financial wellbeing	*	Managing money	Managing money	Economic wellbeing	*	*	
Health	*	Health and wellbeing	Staying as well as you can	Be healthy	*	*	Physical and mental health and emotional wellbeing
Feeling good	*	*	Feeling positive	Enjoy and achieve	*	*	
Resilience	*	*	*	*	I want help to protect myself in the future	To be able to protect myself in the future / To have help to recover	*
Accountability	*	*	*	*	I want people involved in my case to do what	*	*

					they say they will do		
Justice	*	*	*	*	I want the police to prosecute	To have access to justice or an apology, or to know that disciplinary or other action has been taken / To know that this won't happen to anyone else	*
Address care and support needs	*	*	*	*	I want help to access any support that may be available to me.	To know where to get help	*
Other					Other		