Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

MHC Coimisiún Meabhair-Shláinte | Mental Health Commission

ADULT SAFEGUARDING

Background document to support the development of national standards for adult safeguarding

May 2018

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high quality and safe care for people using health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA aims to safeguard people and improve the safety and quality of health and social care services across its full range of functions.

HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

- **Setting Standards for Health and Social Services –** Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation –** Registering and inspecting designated centres.
- **Monitoring Children's Services –** Monitoring and inspecting children's social services.
- **Monitoring Healthcare Safety and Quality –** Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment –** Providing advice that enables the best outcome for people who use health services and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.
- **Health Information –** Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

About the Mental Health Commission

The Mental Health Commission (MHC) was established under the Mental Health Act 2001 to promote, encourage, and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services in Ireland.

The MHC's remit includes the broad spectrum of mental health services including general adult mental health services, as well as mental health services for children and adolescents, older people, people with intellectual disabilities and forensic mental health services.

The MHC's role is to regulate and inspect mental health services, support continuous quality improvement and to protect the interests of those who are involuntarily admitted and detained under the Mental Health Act 2001. Legislation focuses the MHC's core activities into regulation and independent reviews.

Regulation:

- Registration and enforcement — registering approved centres and enforcing associated statutory powers e.g. attaching registration conditions.
- Inspection — inspecting approved centres and community mental health services and reporting on regulatory compliance and the quality of care.
- Quality improvement — developing and reviewing rules under the Mental Health Act 2001. Developing standards, codes of practice and good practice guidelines. Monitoring the quality of service provision in approved centres and community services through inspection and reporting. Using enforcement powers to maintain high-quality mental health services.

Independent reviews:

- Mental Health Tribunal Reviews — administering the independent review system of involuntary admissions. Safeguarding the rights of those detained under the Mental Health Act 2001.
- Legal Aid Scheme — administering of the mental health legal aid scheme.

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Executive summary

Adult safeguarding is fundamental to providing high-quality health and social care services. The Health Information and Quality Authority (HIQA) and the Mental Health Commission (MHC) recognise the importance of increasing the quality and safety of services for all adults in Ireland, especially adults who may be at risk of harm.[*] HIQA[†] and the MHC[‡] are therefore developing joint national standards for adult safeguarding in health and social care services, including mental healthcare services.

At any point in our lives, we may be at risk of harm and in need of safeguarding or protection for a period of time. Abuse, exploitation and neglect have devastating impacts on people's lives and it is vitally important that timely and effective measures are taken to safeguard people who are at risk of harm. It is also critical that as a society we need to prevent abuse, exploitation and neglect by adopting a 'zero tolerance approach' to these issues.

Everyone has the right to be safe and free from fear or harm. Safeguarding means putting measures in place to promote people's human rights, health and wellbeing, and empowering people to protect themselves. There is a need to increase awareness and education about safeguarding among health and social care staff, people using services and members of the public. At present, many international countries or regions believe safeguarding is 'everyone's business' (England, Northern Ireland) or 'everyone's responsibility' (Wales).

Adult safeguarding in Ireland is currently undergoing significant change including:

- the drafting of specific adult safeguarding legislation,[§]
- the development of a new national adult safeguarding policy by the Department of Health to assist in framing legislation for the health and social care sector,

[*] Harm is the impact that abuse, exploitation or neglect may have on a person. Harm arises from any action, whether by a deliberate act or an omission, which may cause impairment of physical, intellectual, emotional, or mental health and wellbeing.

[†] In accordance with section 8(1)(b) of the Health Act 2007, HIQA has statutory responsibility to develop standards for health and social care services. Under section 8(1)(c) of the Health Act 2007, one of HIQA's functions is to monitor compliance with standards.

[‡] Under the Mental Health Act 2001, one of the functions of the MHC is to develop standards, codes of practice and guidelines for the broad spectrum of mental health services including general adult mental health services, as well as mental health services for children and adolescents, older people, people with intellectual disabilities and forensic mental health services.

[§] The Adult Safeguarding Bill 2017 was drafted in March 2017.

- and a review of the current national policy[**] for Health Service Executive (HSE) and HSE-funded services.

HIQA and the MHC are developing national standards for adult safeguarding to promote best practice in providing person-centred, safe and effective care and support in health, including mental health, and social care services across Ireland. While not all healthcare, mental healthcare, and social care services are within HIQA's or the MHC's regulatory remit, the expectation is that all services will work to achieve compliance with the standards and promote and protect the rights of adults who are at risk of harm.

This background document was developed as part of HIQA's and the MHC's standards development process. While much of the evidence relates to adult safeguarding generally (in a wide range of service, community and societal settings), all information was reviewed to inform the development of national standards for adult safeguarding as they may be applied to healthcare, including mental health, and social care settings.

This document provides the results of an extensive programme of research conducted by HIQA and the MHC and which consists of:

- A **review of adult safeguarding in Ireland** — this includes an overview of legislative and policy progress, a description of the current model and arrangements for adult safeguarding, and a review of outcome data. This review was informed by academic papers, authoritative national websites, annual reports and statistical reports from key organisations, alongside collaboration with national adult safeguarding experts. This review describes the context in which national standards for adult safeguarding are being developed.
- An **international review of adult safeguarding** in six countries and regions — this includes a review of information from academic papers, authoritative international websites, annual reports and statistical reports from key organisations, and teleconferences with international adult safeguarding experts. As no specific adult safeguarding standards were identified internationally, this section of the document describes the scope of adult safeguarding in these jurisdictions, alongside relevant legislation, policy, health and social care standards, and the current model or safeguarding arrangements in place there. It also provides an overview of adult safeguarding outcome data, for example number of referrals. This section

[**] The Health Service Executive's (HSE) 2014 policy 'Safeguarding Vulnerable Adults at Risk of Abuse – National Policy and Procedures'.

provides international context and valuable lessons for developing national standards for adult safeguarding in Ireland.

- A **systematic literature review** — this is a review of 10 years (2007–2017) of relevant academic material relating to adult safeguarding drawn from evidence-based search databases. Information from this material and analysed the information under an eight-theme standards development framework.

Information and findings from each of these three elements will be used to inform the development of national standards for adult safeguarding.

Key findings and next steps

The review of adult safeguarding in Ireland highlighted the absence of adult safeguarding legislation. Specific legislation would place an obligation on state bodies to ascertain if adults are at risk of harm, and to intervene when necessary to protect adults at risk. This review also highlighted that while national policy is in place regarding safeguarding adults with a disability and older adults, this is limited in its remit. It does not extend to other adults who may be at risk of harm. In addition, the adult safeguarding structures in Ireland are at early stages of implementation and this is still an emerging area of practice.

The international review highlights the disparity in terms of how adult safeguarding is approached in different jurisdictions. While some jurisdictions have specific adult safeguarding legislation in place, others rely on policy, guidelines, and principles. There has been a clear shift in recent years internationally to a focus on human rights, empowerment and choice in the adult safeguarding field. However, issues around resourcing, training and streamlining models of adult safeguarding are evident across all jurisdictions reviewed in this report. Of note, no international jurisdiction has developed or implemented specific adult safeguarding standards for health, mental health and social care services; though elements of safeguarding appear more generally in national standards in many countries. Despite the absence of specific adult safeguarding standards, reviews of policies, frameworks, principles, and broader health and social care standards provided clear direction to informing national standards for adult safeguarding.

Finally, the systematic literature review found that adult safeguarding should be viewed from a human-rights perspective. The importance of empowering adults to protect themselves from harm and including people in making decisions about their care was also highlighted. The research points to the need for effective communication within and between services when managing safeguarding concerns and the need for services, organisations and agencies to work together and share

information as needed. The research indicates that staff need to be skilled and trained and also need to be supported by management to create an open, transparent and safe culture within services. The need for strong leadership within services and clear governance arrangements was also evident in the literature reviewed.

The evidence reviewed and collated in this document forms one part of the development process for national standards for adult safeguarding. This document outlines the evidence base that will inform the draft standards. Extensive stakeholder engagement will also be undertaken to inform an initial draft of the national standards; including convening an advisory group made up of a diverse range of interested and informed parties, including representatives from patient and service-user advocacy groups, the Health Service Executive (HSE), the Department of Health, regulatory bodies and professional representative organisations. A series of focus groups will be held with people who use services and staff working in these services to discuss their experience and obtain their opinions as to what the draft national standards should address.

In addition to this, HIQA and the MHC will undertake a six-week public consultation process in 2018 for members of the public and interested parties to submit their views on the draft standards.

Following approval by the Boards of HIQA and the MHC, the standards will be submitted to the Minister for Health for approval. Once approved by the Minister for Health they will become nationally mandated standards placing a responsibility on service providers to begin implementing the standards.

Introduction

1.1 Overview

Everyone has the right to be safe and to live a life that is free from harm. Safeguarding means putting measure in place to promote people's human rights and their health and wellbeing, and empowering people to protect themselves. Safeguarding is fundamental to high-quality health and social care.*

Anyone may need to be safeguarded at any point in their lives. Risk is not defined by age, social class, disability, race or gender. Any adult can go through a period of being at risk, and during this time, they may need appropriate support and care to manage or mitigate risk and live a safe and fulfilling life.

Research commissioned by the National Safeguarding Committee(1) in 2016 found that half of Irish adults (in a sample of 1,004 people) claim that they have experienced the abuse of vulnerable adults either through being abused themselves or somebody close to them abused. The research highlights widespread public concern that many adults in Ireland are experiencing physical, emotional, psychological and financial abuse.

The Health Information and Quality Authority (HIQA) and the Mental Health Commission (MHC) recognise the importance of increasing the quality and safety of services for all adults in Ireland, especially adults who may be at risk of harm.†† In response to this, the two organisations‡‡§§ are developing joint national standards for safeguarding adults in health and social care services, including mental healthcare services.

At the time of writing this document, adult safeguarding in Ireland does not have a specific legislative framework. A draft safeguarding bill was published in March 2017. In addition, the Department of Health in Ireland is developing policy to assist in framing legislation for the health and social care sector. Finally, the Health Service

†† Harm is the impact that abuse, exploitation or neglect may have on a person. Harm arises from any action, whether by a deliberate act or an omission, which may cause impairment of physical, intellectual, emotional, or mental health and wellbeing.

‡‡ In line with section 8(1)(b) of the Health Act 2007, HIQA has statutory responsibility to develop standards for health and social care services. Under section 8(1)(c) of the Health Act 2007, one of HIQA's functions is to monitor compliance with standards.

§§ Under the Mental Health Act 2001, one of the functions of the MHC is to develop standards, codes of practice and guidelines for the broad spectrum of mental health services including general adult mental health services, as well as mental health services for children and adolescents, older people, people with intellectual disabilities and forensic mental health services.

Executive (HSE) is in the process of revising its current adult safeguarding policy*** which applies to all HSE and HSE-funded services.

National standards for adult safeguarding will aim to assist services in providing safe, high-quality care and support to adults who may be at risk of harm. National standards provide a framework for best practice in health and social care services. Standards for safeguarding adults will aim to ensure that adults at risk of harm are appropriately safeguarded through person-centred care (as defined in these standards), and safe and effective care and support in any health or social care service. Once approved by the Minister for Health, standards become nationally mandated, placing a responsibility on services to implement them. While not all health, mental health, and social care services are within HIQA's or the MHC's regulatory remit, all services will be expected to work towards complying with the standards and promote and protect the rights of adults at risk of harm. Therefore, this document focuses primarily on safeguarding adults within health and social care settings. It also reviews practice and arrangements in a wider range of settings that may be applicable to adult health and social care services.

This background document has three aims:

1. To summarise current adult safeguarding arrangements in Ireland.
2. To summarise arrangements and best practice in adult safeguarding in six jurisdictions using a range of data sources and draw recommendations to inform the content of the national standards for adult safeguarding.
3. To systematically search, review and summarise academic evidence in the field of adult safeguarding from 2007–2017 and make recommendations in line with the eight themes of the national standards development framework.

These aims will be addressed in sections 2–4 of this document.

1.2 Standards development framework

HIQA uses an established framework to develop nationally mandated standards.[2] This framework was developed following a review of national and international evidence, engagement with national and international experts and applying HIQA's knowledge and experience of the health and social care context. Figure 1 illustrates the eight themes under which the draft standards are presented. The four themes on the upper half of the circle relate to the dimensions of **safety and quality** in a service, while the four on the lower portion of the circle relate to the key areas of a service's **capacity and capability**.

*** The Health Service Executive's (HSE) 2014 policy 'Safeguarding Vulnerable Adults at Risk of Abuse – National Policy and Procedures'.

Figure 1. Standards Development Framework

The four themes of quality and safety are:

- **Person-centred Care and Support** — how services place people using their services at the centre of what they do. This includes how services communicate with people using these services to ensure they are well informed, involved and supported.
- **Effective Care and Support** — how services deliver best outcomes and a good quality of life for people, using the best available evidence and information.
- **Safe Care and Support** — how services protect people and promote their welfare.
- **Better Health and Wellbeing** — how services work in partnership with people using their services to promote and enable their health and wellbeing in a holistic manner.

Delivering improvements within these quality and safety themes depends on service providers having capacity and capability in the following four key areas:

- **Leadership, Governance and Management** — the arrangements put in place by services for clear accountability, decision-making, risk management and performance assurance, underpinned by effective communication among staff.

- **Responsive Workforce** — how services plan, recruit, manage and organise their workforce to ensure enough staff are available at the right time with the right skills and expertise to meet the needs of people using services.

- **Use of Resources** – how services plan, manage and prioritise their resources to meet the service's infection prevention and control needs.

- **Use of Information** — how services use information as a resource for planning, delivering, monitoring, managing and improving services.

1.3 How the draft national standards will be developed

The draft national standards will be informed by the evidence presented in this document. All documents and publications were reviewed and assessed for inclusion in the evidence base to inform the development of the draft standards.

HIQA and the MHC have convened an advisory group comprised of a diverse range of interested and informed parties, including representatives from support and advocacy groups, regulatory bodies, professional representative organisations, the HSE and the Department of Health. The function of the group is to advise HIQA and the MHC, support consultation and information exchange, and advise on any further steps.

HIQA and the MHC will also organise focus groups with people who use services and with staff working in these services to discuss their experiences and obtain their opinions as to what draft national standards for adult safeguarding should address.

In addition to this, HIQA and the MHC will undertake a six-week public consultation process in 2018 for members of the public and all interested parties to submit their views on the draft standards.

Following approval by the Boards of HIQA and the MHC, the standards will be submitted to the Minister for Health for approval.

1.4 Structure of this report

This document sets out the findings of the review undertaken to inform the development of the draft national standards for adult safeguarding. It includes:

- Section 2: A review of adult safeguarding arrangements in Ireland

- Section 3: An international review of adult safeguarding in six jurisdictions
- Section 4: A systematic literature review undertaken by the HIQA and MHC Project Team and a summary of evidence from this review.

2 Adult safeguarding in Ireland

To date, Ireland has not implemented specific legislation for safeguarding adults, but at the time of writing this background document, a draft bill entitled the Adult Safeguarding Bill 2017[3] was in the early stages of being examined and amended by the Irish Senate.[4] In Ireland, the main responsibility for responding to allegations of abuse rests with the Health Service Executive (HSE) or, in criminal cases, An Garda Síochána (Ireland's National Police Service). Non-HSE services are governed by their own policies.

Without legislation, the HSE's Safeguarding Vulnerable Adults at Risk of Abuse – National Policy and Procedures[5] (hereafter referred to as the HSE's safeguarding policy), published by the HSE in December 2014, is the central policy for adult safeguarding. However, this policy has its limitations, as its focus is on HSE and HSE-funded services only. Those in need of safeguarding in Ireland are described as 'vulnerable persons' and the policy focuses on older people and people with a disability.[5] At the time of writing, this policy is under review by the HSE.

This section on adult safeguarding in Ireland comprises the following areas:

- Scope of adult safeguarding
- relevant legislation
- National adult safeguarding policy
- National Safeguarding Committee
- The role of HIQA and the MHC
- Inquiries relating to adult safeguarding
- The role of the HSE: policy model and outcomes.

2.1 Scope of adult safeguarding

Without specific legislation in Ireland, adult safeguarding has focused on the remit of the HSE's 2014 safeguarding policy document[5] developed by the HSE's Social Care Division. This is an overarching policy to safeguard and protect older people or people with a disability that, as a result of physical or intellectual impairment, may be at risk of abuse. This policy document defines a 'vulnerable' person as:

> An adult who may be restricted in capacity to guard himself or herself against harm or exploitation or to report such harm or exploitation. Restriction of capacity may arise as a result of physical or intellectual

impairment. Vulnerability to abuse is influenced by both context and individual circumstances.[5]

However, the definition and conceptualisation of adult safeguarding in Ireland is likely to change with the introduction of the proposed Adult Safeguarding Bill 2017.[3]

2.2 Relevant legislation

Despite Ireland not having specific adult safeguarding legislation at present, a number of other laws make reference to the protection of rights and reporting of abuse. This section outlines current and proposed legislation relating to adult safeguarding in Ireland including:

- the draft Adult Safeguarding Bill 2017
- the Health Act 2007
- the Mental Health Act 2001
- the Assisted Decision-Making (Capacity) Act 2015
- the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012
- Heads of Bill on deprivation of liberty safeguards which will form part of the Assisted Decision-Making (Capacity) Act 2015.

The legislation that established both HIQA and the MHC are outlined at a high level in this section; the roles of both organisations in relation to adult safeguarding are set out in section 2.5.

2.2.1 Draft Adult Safeguarding Bill 2017

The Adult Safeguarding Bill 2017[3] was drafted in March 2017. This bill is being examined and amended by the Irish Senate[4] at the time of writing. The proposed bill would bring about a number of changes to adult safeguarding in Ireland, including:

- mandatory reporting where an adult has suffered abuse or harm or is at risk of suffering abuse or harm
- the establishment of a national adult safeguarding authority that would:
    - be required to respond effectively if significant concerns are reported
    - have the power to investigate, including powers of entry

- have powers to direct the HSE and others to provide additional support if required
- be able to appoint an independent advocate.

The Adult Safeguarding Bill 2017 defines an adult at risk as:

> A person, who has attained the age of 18 years who is unable to take care of himself or herself, or is unable to protect him or herself from abuse or harm.(3)

Abuse is defined as:

> Act, failure to act or neglect, which results in a breach of a person's constitutional or legal rights, physical and mental health, dignity or general wellbeing, and may include ill-treatment, intimidation, humiliation, overmedication, withholding necessary medication, censoring communications, invasion or denial of privacy, or denial of access to visitors.(3)

Harm in relation to an adult at risk is defined as:

> (a) assault, ill-treatment or neglect of the adult at risk in a manner that seriously affects or is likely to seriously affect the adult at risk's health or welfare, (b) sexual abuse of the adult at risk, (c) financial abuse of the adult at risk, whether caused by a single act, omission or circumstance or a series or combination of acts, omissions or circumstances, or otherwise.(3)

2.2.2 Health Act 2007

The Health Act 2007(6) makes provision for the reform of the regulation of health and social care services in Ireland, providing for the establishment of HIQA. It also established a registration and inspection system for residential services for children in need of care and protection. In addition to this, under the Health Act 2007, HIQA has statutory responsibility for setting standards for health and social services.

The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulation 2013(7) states a requirement for registered providers to notify HIQA of any adverse events including allegations or suspected abuse of residents. The regulations for older people as set out in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013(8) also require registered providers to implement policies and procedures for the prevention, protection and response to abuse, and require that any incidents be reported to HIQA.

2.2.3 Mental Health Act, 2001

The Mental Health Act, 2001[9] establishes the MHC and its functions as the regulator of mental health services in Ireland. The Act addresses two main requirements in the provision of mental healthcare in a modern society:

- the establishment of a legislative framework within which persons with a 'mental disorder' (as defined in the Mental Health Act, 2001) may be admitted, detained and treated involuntarily in approved centres
- the promotion and maintenance of quality standards of care and treatment that are regularly inspected and properly regulated.

2.2.3.1 Involuntary admissions under the Mental Health Act 2001

Most people receiving treatment in an approved centre do so by choice. However, people with mental disorders are sometimes admitted and treated as involuntary patients. The 2001 Act[9] provides two methods for detaining a patient who has a mental disorder:

- admission by a consultant psychiatrist on the recommendation of a registered medical practitioner, or
- 're-grading' a voluntary patient to an involuntary patient following review by two consultant psychiatrists.

Under the 2001 Act, a person who is involuntary admitted to an approved centre has their case independently reviewed by a mental health tribunal within 21 days of their admission or renewal order. Every tribunal is made of a chairperson, consultant psychiatrist and lay-person. A patient has the right to attend their own tribunal and adults receive free legal representation for their hearing during their period of involuntary detention.

2.2.4 Assisted Decision-Making (Capacity) Act 2015

The Assisted Decision-Making (Capacity) Act 2015[10] provides a statutory framework for individuals to make legally-binding agreements to be assisted and supported in making decisions about their welfare and their property and affairs. This assistance and support is particularly required where the person lacks, or may lack, the capacity to make the decision unaided. The Assisted Decision-Making (Capacity) Act 2015 reformed Ireland's previous capacity legislation which had been in place since the 19th century. It establishes a modern statutory framework to support decision-making for adults who have difficulty in making decisions without assistance.

This act enshrines the presumption of capacity and sets out a functional test for the assessment of a person's capacity. This functional approach to the definition of capacity allows for changes in a person's capacity over time. The Act also provides for the Decision Support Service to be set up within the MHC to support decision-making by and for adults with capacity difficulties and to regulate individuals who are providing support to people with capacity difficulties. At the time of writing, the Act has not been fully commenced. A Director of the Decision Support Service has been appointed but the service is not yet fully operational.

2.2.5 Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012

The Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012[11] makes it an offence to withhold information on certain offences (including sexual assault, false imprisonment, abduction, manslaughter and rape) against children and vulnerable persons from An Garda Síochána. The Act ensures there is an obligation on individuals who have knowledge of any serious offence including sexual offences against children and vulnerable adults to inform An Garda Síochána.

2.2.6 Heads of Bill on Deprivation of Liberty Safeguards

In line with the Assisted Decision-Making (Capacity) Act 2015,[10] a person's capacity to decide to live in a relevant facility (in circumstances which amount to a deprivation of liberty) is to be assessed using a functional capacity assessment.[†††] The development of legislative provisions relating to deprivation of liberty is a highly complex undertaking. In addition to satisfying the requirements of the UN Convention on the Rights of Persons with Disabilities,[12] the provisions must also align with Ireland's obligations under the European Convention on Human Rights.

Ireland must also ensure that the new provisions appropriately align with the existing Assisted Decision-Making (Capacity) Act 2015[10] and the Mental Health Act, 2001.[9] In order to satisfy the requirements of the Convention and to align with the approach adopted in the Assisted Decision-Making (Capacity) Act 2015,[10] a more formal process than that which currently prevails, with the involvement of the court in certain circumstances, is required.[13]

2.3 National adult safeguarding policy

In December 2017, the Department of Health announced that a new national adult safeguarding policy was to be developed for the health sector.[14] This acknowledges the need to build further on the existing range of policies, procedures, codes of

[†††] The Act sets out a functional test for the assessment of a person's capacity. This functional approach to the definition of capacity allows for changes in a person's capacity over time.

practice and legislation aimed at protecting and safeguarding vulnerable adults in the health sector in Ireland.

At the time of writing this document, the Department of Health is developing policy to assist in framing legislation for the health and social care sector. According to the Department, it will be a broad and complex piece of work involving an extensive scoping exercise to determine the precise nature of the policy and the legislative framework that may be required to support it. It includes reviewing current practice and legislation, researching best practice internationally and wide-ranging consultation.[14]

2.4 National Safeguarding Committee

The National Safeguarding Committee is a multi-agency and inter-sectoral body with an independent chairperson. It was established by the HSE in December 2014 with an overarching remit of supporting the development of a societal and organisational culture that promotes the rights of people who may be vulnerable and safeguards them from abuse. It recognises the need for a number of agencies and individuals to work collaboratively to achieve this common goal.[15] The National Safeguarding Committee brings together expertise in public services, legal and financial services, health and social care professions, regulatory authorities and non-governmental organisations (NGOs) representing older people, people with disabilities and carers.

The National Safeguarding Committee published its Strategic Plan 2017–2021 in November 2016,[15] outlining four main objectives over the five-year time frame of the plan:

- raising public awareness and understanding
- supporting and promoting the protection of people's rights
- informing and influencing government policy
- building the Committee's capacity and capability.[15]

While the HSE safeguarding policy[5] encompasses both the prevention, detection and management of elder abuse and abuse of people in disability services, the National Safeguarding Committee recognises that any vulnerable adult can be subjected to abuse. Vulnerability is not dictated by a person's age or disability alone; circumstances and the external environment can contribute to vulnerability. Vulnerability can be a transient or a permanent state depending on many influences, including dependencies, family circumstances, and societal attitudes and behaviours.[15]

One of the main objectives of the National Safeguarding Committee is "to inform and influence government policy and legislation to safeguard the rights of people who may be vulnerable". One of the Committee's actions in working towards achieving this objective is to "influence the development of nationally mandated standards for the protection of vulnerable adults by HIQA and the Mental Health Commission".[15]

2.5 The role of HIQA and the MHC

The Health Act 2007[6] updated the regulation of certain health and social care services in Ireland, providing for the establishment of HIQA. Amongst its functions, HIQA has a remit under the Health Act 2007 to set standards for Ireland's health and social care services and to monitor services against these standards. The Act also establishes a registration and inspection system for residential services for dependant people and inspecting services for children in need of care and protection.

Although HIQA only has a legal mandate to set and monitor standards for certain services as outlined above, section 7 of the Health Act 2007 outlines HIQA's role in promoting safety and quality in the provision of health and personal social services for the benefit of the health and welfare of the public. HIQA's aim in developing standards is to enable a move beyond questions of strict legal compliance to ensuring delivery of effective health and social care services which respect and put the needs of people using services at the centre of what they do. Safeguarding is reflected in a number of national standards developed by HIQA, including:

- *National Standards for Safer Better Healthcare*[2]
- *National Standards for Residential Care Settings for Older People in Ireland*[16]
- *National Standards for Residential Services for Adults with Disabilities*[17]
- *National Standards for Safer Better Maternity Services*.[18]

Under the Mental Health Act, 2001,[9] the statutory mandate of the MHC is to 'promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres'.

The MHC promotes safeguarding and protection from abuse in inpatient mental health settings through the inspection and enforcement of the Mental Health Act 2001 (Approved Centre) Regulations 2006.[19] As referred to earlier, service-user autonomy, capacity and involvement in decisions about care and treatment is a key theme in the MHC's Quality Framework for Mental Health Services in Ireland.[20]

2.5.1 Overview of HIQA's monitoring programme

The Regulation Directorate within HIQA is responsible for regulating the quality and safety of specified health and social care services across Ireland. The Directorate is structured into four separate pillars of regulation:

- designated centres for older people
- designated centres for people with disabilities
- healthcare
- children's services.

The Regulation Directorate meet their strategic objectives through regulatory activity by ensuring that care is improved, that people are safeguarded, that people are informed, and that they influence the way in which policy and service decisions are made. The Regulation Directorate carries out three different types of inspections:

1. registration inspections to inform a decision in relation to an application to register
2. monitoring inspections to monitor ongoing compliance with regulations and standards. A specific number of outcome areas are considered during these inspections
3. thematic inspections which focus on specific areas of care, for example, dementia thematic inspections.(21)

As well as carrying out inspections, HIQA receives, analyses and risk assesses information from a range of sources, including notifications from providers relating to specific events set out in the regulations. Residents, people using services, relatives, staff, advocates or third parties who have direct contact with residents also submit information to HIQA. All information is used to inform assessment of compliance and risk within services, and further informs HIQA's monitoring and inspection programmes.(21)

2.5.2 Overview of 2016 HIQA regulation of social care and healthcare services

A HIQA report reviewing the work of its Regulation Directorate‡‡‡ in 2016(22) stated that safeguarding is a key component in providing health and social care services and as such is reflected in regulations and nationally mandated standards. The

‡‡‡ In 2016, 608 inspections were undertaken in Older People's services, 750 in Disability services and 66 inspections against healthcare standards.

report outlined that HIQA had continued to encounter services where safeguarding was not sufficiently comprehensive at the time of inspection. For example, it was reported that in residential centres for older people in 2016, HIQA inspectors found that some providers did not have sufficient measures in place to comply with Garda vetting requirements in residential centres for older people.[22] In addition, in a range of disability services, HIQA found that leadership and practice in recognising, preventing and protecting people from harm was deficient.[22] Of note it was reported to the Oireachtas Committee on Children and Youth Affairs, in May 2017, that HIQA has seen an improvement in compliance with Garda vetting requirements across all of HIQA's regulatory fields. Garda vetting was cited as one of the single easiest ways to protect people who may be vulnerable.[23]

Challenges in providers' ability to safeguard adults at risk were manifested in some instances by the absence of person-centred care, while institutional practices were assessed as a form of system abuse and neglect.[22] HIQA reported that staff did not always recognise poor safeguarding practice and some staff had been resistant to improving their professional practice.[22] Regarding disability services, HIQA inspectors found that there continued to be a worrying level of non-compliance with regulations aimed at achieving better outcomes on safeguarding (Figure 2).[22]

In 2016, HIQA inspectors also found that significant improvements were required to safeguard residents from the risk of injury or harm through peer-to-peer altercations in disability settings.[22] Such incidents were often related to behaviour rather than abuse issues. However, inspectors found that some providers were failing to safeguard residents and failing to implement effective positive behavioural support arrangements that minimised such behaviours and reduced risk to residents.[22]

Figure 2. HIQA non-compliance with safeguarding and safety analysis for 2016

Source: HIQA. (2017). *Overview of 2016 HIQA regulation of social care and healthcare services.*[22]

2.5.3 Overview of nutrition and hydration care in public acute hospitals

Between July 2015 and April 2016, HIQA conducted a monitoring programme to look at nutrition and hydration care of patients in Irish public acute hospitals, which included self-assessment questionnaires and unannounced inspections. Nutrition and hydration of patients in acute hospitals forms an important part of overall care and promoting and protecting patients' health and wellbeing. Nutrition and hydration is fundamental to their treatment and recovery plan of care. Malnutrition and dehydration can compromise the quality of life of patients, affect their recovery and cause unnecessary illness and death. In patients at risk, it can go undetected unless systems are in place to identify and manage it.[24]

The report[24] from this monitoring programme outlines four key areas for improvements:

1. All hospitals should have a nutrition steering committee in place.

2. All patients admitted to hospital should be screened for the risk of malnutrition.

3. Hospitals must audit compliance with all aspects of patients' nutritional care and share the findings with all relevant staff groups involved in food service and patient care.

4. Hospitals should strive to improve patients' experience of hospital food and drink by engaging with patients about food variety and choice.[24]

Additional opportunities for improvement identified included:

- Hospitals should have a system in place to ensure all patients who need it get assistance with meals in a timely way.
- All patients, without exception, must have access to fresh drinking water throughout the day.[24]

2.5.4 Overview of the Mental Health Commission's monitoring programme

All in-patient facilities providing care and treatment to people suffering from mental illness or mental disorder must be registered as 'approved centres' by the MHC. Every approved centre registered by the MHC must under law be inspected at least once a year by the Inspector of Mental Health Services. During each inspection, the approved centre is assessed against all relevant regulations, rules, codes of practice and Part 4 of the Mental Health Act 2001[9] (Consent to Treatment). A judgment support framework has been developed as a guidance document to assist approved centres to comply with relevant regulations. The framework incorporates national and international best practice for each regulation under four 'quality pillars' as follows:

- processes
- training
- monitoring
- evidence of implementation.

In addition, the inspector may visit and inspect any premises where a mental health service is provided, including community residences, day hospitals, and prisons. Links between safeguarding issues and the MHC regulations are outlined in Table 1.

Table 1. MHC regulations relevant to adult safeguarding

Identifying, inspecting and monitoring adults at risk of harm	
Types of harm	**MHC regulations to promote safeguarding**
Physical harm: includes hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions.	▪ Regulation 23: Medication [covert/crushing medication, inappropriate prescription], code on physical restraint, rules on mechanical restraint & seclusion ▪ Regulation 32: Risk Management [assault], Part 4 Consent to Treatment. Serious Reportable Events reporting requirements.
Sexual harm: includes rape and sexual assault, or sexual acts to which the vulnerable person has not consented, or could not consent, or into which he or she was compelled to consent.	▪ Regulation 32: Risk Management. Serious Reportable Events reporting requirements. ▪
Psychological harm: includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.	▪ Rules on seclusion.
Financial or material harm: includes theft, fraud, exploitation, pressure in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.	▪ Regulation 8: Personal Property [maintain checklist, secure storage, signing for money], Code on discharge [returning property].
Neglect and acts of omission: includes ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life such as medication, adequate nutrition and heating. May include self-neglect.	▪ Regulation 5(2): Food and Nutrition [meeting special dietary needs] ▪ Regulation 16: Therapeutic Services [appropriate provision of services] ▪ Regulation 19: General Health [provision of general health care services] ▪ Regulation 22: Premises [access to outdoors, appropriate environment, ligature risks]. ▪ Regulation 32: Risk Management [self-neglect].
Discriminatory harm: includes ageism, racism, sexism, that based on a person's disability, and other forms of harassment, slurs or similar treatment.	▪ Regulation 21: Privacy [dignity]
Institutional harm: may occur within residential care and acute settings, may involve poor standards of care, rigid routines and inadequate responses to complex needs.	▪ Regulation 15: Individual Care Plans [meeting complex needs] ▪ Regulation 22: Premises [locked units, locked bedrooms, no access to outdoors] ▪ Regulation 26: Staffing [inadequate number, inadequate training].

2.5.5 Standards relating to adult safeguarding

HIQA develops standards to ensure that people using health and social care services are provided with person-centred, safe and effective care and support. HIQA aims to promote progressive improvements in this care by:

- creating a basis for improving the quality and safety of health and social care services and highlighting areas for improvement, and
- providing people using health and social care services and their families with a guide to what they should expect from the service.

Safeguarding is a feature of a number of national standards developed by HIQA including:

- *National Standards for Residential Care Settings for Older People in Ireland*[16] (a standard relevant to adult safeguarding reads: 'Each resident is safeguarded from abuse and neglect and their safety and welfare is promoted.')
- *National Standards for Residential Services for Children and Adults with Disabilities*[17] (a standard relevant to adult safeguarding states: 'Each person is protected from abuse and neglect and their safety and welfare is promoted.')
- *National Standards for Safer Better Maternity Services*[18] (one standard reads: 'Maternity service providers ensure all reasonable measures are taken to protect women and their babies from all types of abuse.')

2.5.6 Mental Health Commission regulations and Quality Framework

The MHC promotes safeguarding and protection from abuse in inpatient mental health settings through the inspection and enforcement of the Mental Health Act 2001 (Approved Centre) Regulations 2006.[19] Service-user autonomy, capacity, and involvement in decisions about his or her care and treatment are central themes in the MHC's Quality Framework for Mental Health Services in Ireland.[20]

Under Section 33(3)(e) of the Mental Health Act 2001, the MHC is required to make Codes of Practice for the guidance of people working in mental health services. Under Section 59 and 69 the MHC is required to make rules for specific treatments and interventions. Safeguarding is a feature of a number of codes and rules, in particular in the regulation of restrictive practices:

- *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (2009)*[25]

- *Code of Practice on the Use of Physical Restraint in Approved Centres (2009).*[26]

However, despite existing national standards outlining some safeguarding requirements and programmes of inspection by both HIQA and the MHC, a number of high-profile reports have focused attention on shortfalls in health and social services and in wider society in relation to safeguarding adults at risk of harm.

2.6 Inquiries relating to adult safeguarding

Despite existing National Standards outlining some safeguarding requirements, and programmes of inspection by both HIQA and the MHC, a number of high-profile reports have focused attention on shortfalls in safeguarding adults at risk of harm in health and social care services and in the wider civil society. This section sets out the background, key findings and subsequent recommendations made in two such situations regarding the protection of adults at risk in Ireland (the 'Grace' case and Áras Attracta) and one report from the MHC.

2.6.1 The Grace case

In February 2017, the HSE published the Devine Report[27] and the Resilience Ireland Report[28] as part of an inquiry into issues of concern about the case of Grace (a pseudonym), a young woman with an intellectual disability who had been placed in foster care as a child. Grace had resided with foster parents in the southeast of Ireland for 20 years. The foster parents were the subject of allegations of abuse toward Grace and other children who were in foster care or otherwise placed with them. The concerns were first examined in an inquiry commissioned by the HSE arising from protected disclosures made by whistle blowers in late 2009 and early 2010.

The Devine Report[27] examined the case of Grace who had been in full-time foster care from 1989 to 2009 when she was removed by the HSE and provided with an appropriate full-time residential placement with a voluntary provider. The report found that there was:

- inadequate monitoring, supervision and oversight of Grace's care
- an absence of necessary liaison between those responsible for Grace's placement in the foster home
- inadequate response to the need to remove Grace from the foster home on a number of occasions after significant concerns had been raised

- an absence of the necessary protocols and arrangements to support the placement of vulnerable children and adults with a disability with foster families

- serious deficiencies by the HSE regarding record management, recording of case conference decisions, and appropriate case management and follow up of decisions made.[27]

The Resilience Ireland Report[28] undertook a full tracing and look-back exercise on behalf of the HSE which examined the cases of 46 other people using services who had been placed with the same foster family primarily in the period 1983–1995. Upon publication of these reports, a spokesperson for the HSE stated:

> 'It is important to reassure those concerned, and the wider public, that the HSE did not wait for the reports to be published in order to commence a structured process, and working closely with Tusla, to address the deficiencies identified in child care and disability services, and to act on the reports' recommendations. These recommendations capture the extent and nature of the failings in the service, the learnings of which continue to be implemented locally and nationally.'[29]

The Devine Report[27] outlined a wide range of detailed recommendations, to which the HSE responded in detail.[30] One of the most significant recommendations of the Devine Report was the provision and implementation of a safeguarding policy for vulnerable adults.[29]

2.6.2 Áras Attracta

Áras Attracta is a large campus-based residential setting for people with intellectual disabilities in County Mayo, operated by the HSE. In 2014, Aras Attracta was the subject of an RTÉ Prime Time programme. In the course of this programme, an undercover journalist filmed physical and verbal abusive behaviour by some staff in the service towards people using services. Following the programme, the HSE commissioned the McCoy Review Group to undertake an independent review of the quality of care being provided in Áras Attracta.[31] Simultaneously, An Garda Síochána began to investigate the alleged behaviour.

The key objectives of the independent review undertaken by the McCoy Review Group were:

- to identify any issues of immediate concern in relation to the care and safety of the residents, and to bring these to the attention of the HSE

- to identify any factors that might have caused or contributed to the events shown in the Prime Time programme

- to recommend actions to reduce or eliminate the risk of events such as those shown in the Prime Time programme from happening again.[32]

Over the course of the review, the group found that institutional conditioning and control of residents in Áras Attracta was widespread and resulted in limitations in their rights, choices and freedom. Services were set up to meet staff needs rather than those of residents. There was a lack of stimulation, with many residents confined to their unit for long periods of time. Overcrowding, lack of personal space, and lack of access to the external community were further issues.[32] The review stated that while there was some good practice:

> 'These are all factors that paint a bleak picture of life for residents in Áras Attracta and are the complete opposite of a person-centred and person-focused service.'[32]

The report made a series of recommendations to address the issues identified. The overarching recommendations were:

- a move to a rights-based social model of service delivery
- the voices of residents need to be facilitated, listened to, and promoted
- a strengthening and enhancement of leadership and management.[32]

The HSE recognised that the model at Áras Attracta did not respect residents as individuals and they were unable to reach their potential. The residents had a poor quality of life, and their voices had not been heard.[31] The HSE responded to recommendations, committing €3 million to accelerate the transition of residents to community living; improved compliance with the HSE's safeguarding policy;[5] and the development of a 'roadmap' that sets out the vision for the future service model at Áras Attracta and a timeline for its implementation.

In 2015, the HSE developed a three-year improvement plan for Áras Attracta which was monitored by HIQA. While a range of actions were started and significant additional resources allocated across three centres, HIQA found limited progress and improvement overall on the campus.[33] The findings from these reports highlighted that the HSE failed to show the effectiveness of the additional, allocated resources and the sustainability of the measures introduced. The provider failed to implement its own action plan and failed to ensure that any actions taken were effective in reducing risk to residents.[33]

HIQA carried out 14 inspections of Áras Attracta services between July 2015 and May 2017, and found that the HSE was consistently failing to appropriately address the institutional model of care, centralised care practices, safeguarding issues and

lack of opportunities for residents' personal development and growth on the campus.(33)

By May 2017, most residents continued to experience an institutional model of care, with centralised practices and limited or no opportunities for personal development and growth. HIQA found that the provider of Áras Attracta had failed to:

- improve the lives of all residents living on the campus
- implement action plans within the required timelines
- implement and adhere to the HSE's own national safeguarding policy
- respond to a significant number of occurrences and reports of alleged abuse between residents
- progress the plan to transition residents to more appropriate, community-based accommodation
- consult with residents before making decisions impacting on residents' personal finances
- appropriately investigate and respond to concerns
- ensure governance arrangements and improvements were sustained.(33)

In March 2018, HIQA published three inspection reports following unannounced inspections at Áras Attracta, carried out in January 2018 to inform HIQA's final decision regarding registration, following a notice of proposal to cancel Áras Attracta's registration in September 2017. HIQA found that improvements had been made in a number of areas since the previous inspections in May 2017. The HSE had implemented, or was in the process of implementing, the majority of actions required following previous inspections, within the agreed time frames. Revised management and oversight arrangements had been put in place and appropriate action was being taken in relation to safeguarding concerns.(34)

Inspectors found that, as of January 2018:

- Residents were afforded more choice in how they spent their day and in how they decorated their bedrooms
- Residents could take part in activities of interest to them
- Residents and their families could participate in making decisions that affect them through regular resident and family forums

- Some residents had recently moved out of the campus into more appropriate housing in the community, while other residents told inspectors that they were looking forward to their move into the community.[34]

As a result of these inspections, the Chief Inspector of Social Services in HIQA withdrew the notices of proposal to cancel registration and invited the HSE to apply to register these centres. However, HIQA remained concerned about continued non-compliance in areas such as the workforce, risk management, governance, suitability of accommodation on the campus and aspects of social care provision.[34]

HIQA will continue to monitor the campus closely to ensure that the provider continues to improve residents' care, safety and quality of life.[34]

2.6.3 Report of the Inspector of Mental Health Services on 24-hour Supervised Residences (2018)

In 2017, the Inspector of Mental Health Services undertook a wide-ranging programme of inspections of forty-three 24-hour supervised residences (also known as 'community residences') in Ireland. Community residences facilitate the closure of large psychiatric hospitals and accommodate people who had been discharged from both long-stay and acute mental health care services. Community residences are unregulated services which accommodate a vulnerable cohort of service users, many of whom have spent decades in psychiatric hospitals. Over 1,300 service users are accommodated in 118 known residences.

The Inspector reported that community residences were often poorly maintained, too big, institutionalised, restrictive and at times not respectful of service users' privacy, dignity and autonomy. Despite these residences being a person's home, the Inspector found that 14% of residences were locked and did not allow residents to come and go as they liked, and 44% did not provide access to a kitchen to make a cup of tea or a snack. More than half of the residences inspected exceeded the number of beds recommended in 'A Vision for Change'[35] and 41% included shared room accommodation. Over half (56%) of residences were in poor physical condition, with 19% requiring urgent maintenance and refurbishment.

The Inspector concluded that the residences were not supporting service users towards independent community-based living. The Inspector found that the lack of regulation in this area was a safeguarding concern, leading to the risk of abuse and substandard living conditions and treatment.

2.7 The role of the HSE: policy model and outcomes

Within the HSE, the core systems and structures for adult safeguarding include:

- the HSE's Safeguarding Vulnerable People at Risk of Abuse policy
- the National Safeguarding Office
- the HSE's Safeguarding and Protection teams.

2.7.1 Safeguarding Vulnerable Adults at Risk of Abuse – HSE National Policy and Procedures

At time of writing this document, adult safeguarding in Ireland relies on services developing and implementing their own policies and procedures, rather than statutory legislation. The most widely cited policy in this area is the HSE's safeguarding policy.[5] This policy was developed by the HSE's Social Care Division (responsible for providing services for older people and people with a disability) and published by the HSE in December 2014. It provides an overarching policy for HSE and HSE-funded services to subscribe to and implement in their service. The policy applies to older people or people with a disability that, as a result of physical or intellectual impairment, may be at risk of abuse. The person may be in receipt of a care service in their own home, in the community or in a residential care home, nursing home or other setting. Equally, the person may not be in receipt of a care service.[5]

The HSE's safeguarding policy defines abuse as:

> Any act, or failure to act , which results in a breach of a vulnerable person's human rights, civil liberties, physical and mental integrity, dignity or general well-being, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms.[5]

This definition excludes self-neglect. However, the HSE acknowledges that people may come into contact with individuals living in conditions of extreme self-neglect. Although this abuse definition focuses on acts of abuse by individuals, abuse can also arise from inappropriate or inadequacy of care or programmes of care.[5]

The HSE's safeguarding policy focuses solely on protection for adults receiving HSE services, or services funded by the HSE. Additionally, this policy has no statutory force to ensure the safety and rights of vulnerable persons. At the time of writing, the HSE was in the process of revising its safeguarding policy with a revised policy set to be published in late 2018.

The HSE Social Care Division is responsible for the implementation of the HSE's safeguarding policy at national level. The head of social care in each community

healthcare organisation[§§§] has overall responsibility for implementation of the policy and procedures in their area.[(36)]

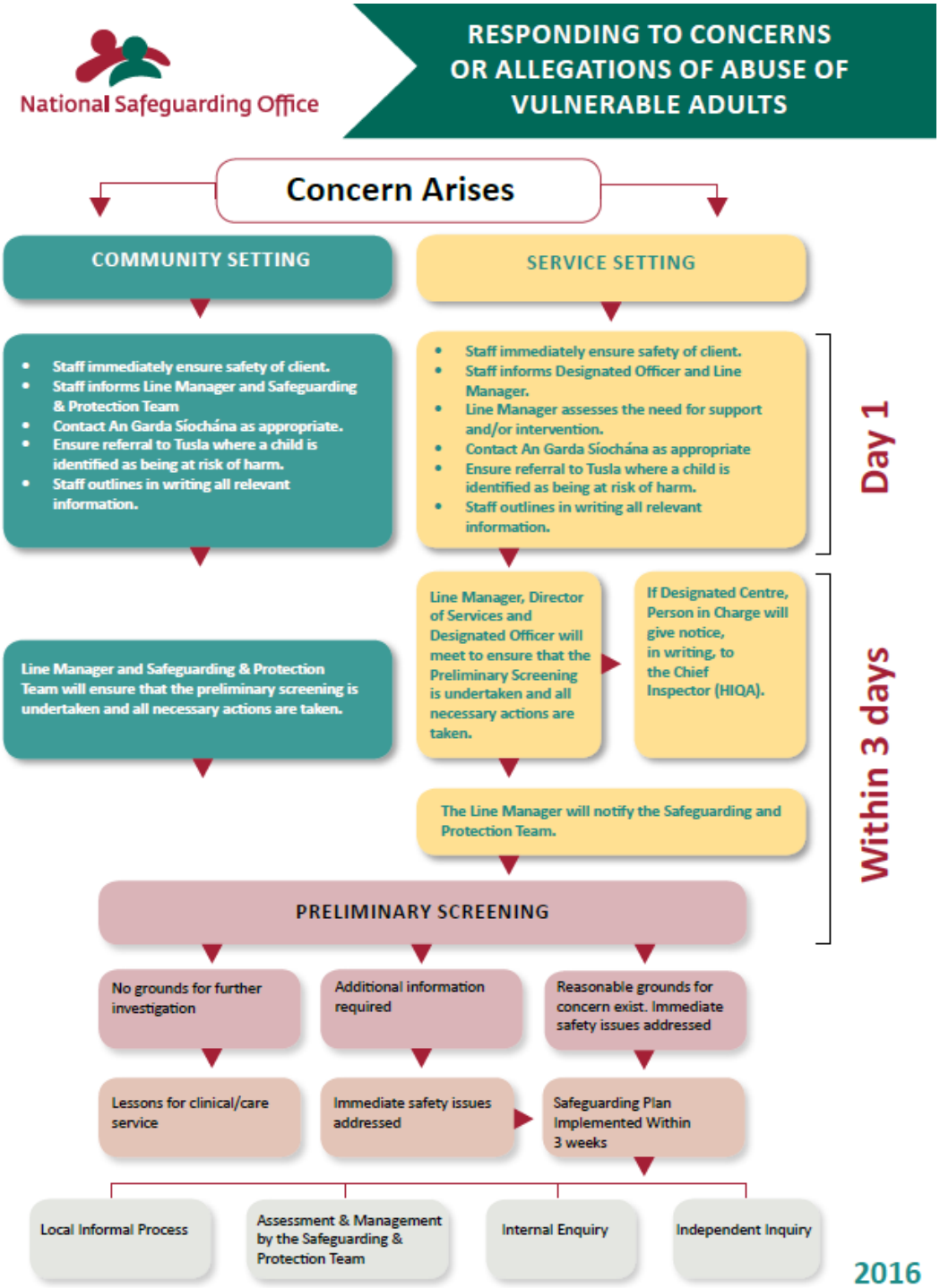
There are a range of services that operate in a social care setting that receive statutory or other funding (public fundraising, philanthropy, trusts and foundations) and which have a range of service policies and procedures in place, including complaints, concerns and safeguarding policies and procedures. Statutorily funded services are subject to service-level agreements which include periodic self-reporting of complaints and safeguarding issues to statutory funders. These services include but are not limited to: homeless services; drug rehabilitation services; and domestic violence refuges. The HSE collates quarterly and annual complaints that are self-reported by funded services.

2.7.2 HSE National Safeguarding Office

The National Safeguarding Office was established in line with the HSE's Social Care Division adult safeguarding policy.[(5)] The core function of the office is to oversee the implementation, monitoring, review and continuous evaluation of its safeguarding policy, in addition to coordinating development and delivery of safeguarding training. The National Safeguarding Office employs a Confidential Recipient to respond to safeguarding concerns, independent of the HSE, who anyone can make a complaint to or raise concerns with about the care and treatment of any vulnerable person receiving residential care in a HSE or HSE-funded facility. The National Safeguarding Office referral pathway guidance is illustrated in Figure 3.

[§§§] There are, at the time of writing this document, nine community healthcare organisations in Ireland responsible for delivering primary and community-based services responsive to the needs of local communities.

Figure 3. National Safeguarding Office referral pathways



Source: National Safeguarding Office. (2018). *Safeguarding Vulnerable Persons Flowchart*.[37]

2.7.3 HSE Safeguarding and Protection (Vulnerable Persons) teams and Designated Officers

The HSE's Safeguarding and Protection (Vulnerable Persons) teams (HSE safeguarding teams) support statutory, voluntary and private services to respond to safeguarding concerns. The head of social care in each community healthcare organisation has overall responsibility for implementing the policy and procedures in their area. In each area, the HSE safeguarding team provides an advice service and receives reports on concerns or complaints of alleged abuse of a vulnerable person. As of 2017, there were 60 HSE safeguarding team staff members responding to reports and providing training across the nine community healthcare organisations. In 2016, the team received 7,884 safeguarding concerns.[38]

Designated officers are appointed to services (HSE and HSE-funded) providing supports to people who 'may be vulnerable'. The designated officer is usually a relevant professional or someone working in a supervisory or management role with specific training in safeguarding (particularly legal and policy aspects). The designated officer is responsible for receiving concerns or allegations of abuse, ensuring the appropriate manager is informed and necessary actions are identified and implemented. They must also ensure reporting obligations are met through the return of an initial screening form to the relevant HSE safeguarding team.

In 2017, the HSE stated that there were 900 designated officers appointed across services.[38] There is no consistent implementation of designated officers in community-based social care services. In these services, the relevant practitioner, volunteer or concerned member of the public reports a concern to the HSE safeguarding team. The 2016 Safeguarding Data Report[38] stated that while the designated officer role is operational nationwide in services, the system would benefit from a designated officer structure for community referrals not affiliated with services.

2.7.4 Safeguarding outcomes

In 2017, the HSE produced an overview report[38] of the nature of safeguarding reports that the National Safeguarding Office had received in 2016 (see Table 2 and Table 3). The report outlines the first year of data collection on safeguarding concerns reported to the Safeguarding and Protection Teams in each of the nine community health organisations across the HSE.

Table 2. Summary of alleged abuse categories recorded by the National Safeguarding Office for 2016, by age from the National Safeguarding Office Ireland

	All	%	18-64 yrs	%	Over 65 yrs	%
Alleged Physical Abuse	3064	35%	2328	47%	711	20%
Alleged Sexual Abuse	665	8%	516	10%	144	4%
Alleged Psychological Abuse	2074	24%	1160	23%	895	25%
Alleged Financial Abuse	1010	12%	305	6%	688	19%
Alleged Neglect	1022	12%	390	8%	618	17%
Alleged Discriminatory Abuse	77	1%	30	1%	46	1%
Alleged Institutional Abuse	145	2%	99	2%	45	1%
Alleged Self Neglect	582	7%	131	3%	440	12%
Total	8639	100%	4959	100%	3587	100%

Table 3. Summary of referral source by setting and age for all concerns received by the safeguarding and protection teams in 2016

Referral Source	Community			Service			Overall Total
	18-64	65+	Total	18-64	65+	Total	
Voluntary Agency	170	55	225	2017	204	2221	2446
PHN/RGN	184	998	1182	399	119	518	1700
PCCC Staff	118	173	291	345	87	432	723
Hospital Staff	56	238	294	31	62	93	387
Family	27	160	187	18	7	25	212
Carer/Home Help	23	70	93	40	26	66	159
Self	18	58	76	52	9	61	137
GP	24	81	105	1		1	106
Gardaí	28	71	99	1		1	100

Table 2 provides a summary for all abuse categories inclusive of self-neglect cases, which represent 7% of the overall cases, most of which relate to people in the over-65 age category.[38] Table 3 provides information in relation to the referral source. This indicates that voluntary agencies are the main source of referrals into the HSE safeguarding teams, followed by public health nurses, and primary community and continuing care staff. Safeguarding concerns from voluntary agencies were primarily within the disability sector (89%), with concerns of relevance to older people representing 11% of voluntary agency safeguarding concerns.[38]

2.8 Summary of Irish evidence

This section has outlined legislative and policy progress relating to adult safeguarding in Ireland. At the time of writing this document, no specific legislation for adult safeguarding has been enacted in Ireland, but a draft bill has been proposed. The Department of Health is currently developing a national policy for adult safeguarding. Additionally, the HSE is revising its current adult safeguarding policy. This section has described the current operational model and arrangements for adult safeguarding in Ireland — specifically the HSE's safeguarding and protection (vulnerable persons) teams in each community healthcare organisation which support statutory, voluntary and private services to respond to safeguarding concerns. This was followed by a review of the data regarding adult safeguarding in Ireland. Finally, an example of HIQA's and the MHC's roles in the regulation of services and how this relates to adult safeguarding was outlined, and two relevant reviews and one MHC report relating to adult safeguarding in Ireland were summarised. This review of adult safeguarding in Ireland was informed by academic papers, authoritative national websites, annual reports and statistical reports from key organisations, alongside collaboration with national adult safeguarding experts. This review describes the context in which national standards for adult safeguarding are being developed.

3 International literature review

3.1 Adult safeguarding: a review of international jurisdictions

This review provides an overview of adult safeguarding in six jurisdictions:

- Scotland
- England
- Wales
- Northern Ireland
- Australia
- Canada.

The review focused on these jurisdictions for three reasons. They:

1. have similar health and social care models,
2. are at an advanced stage of considering adult safeguarding as a whole-population issue,
3. and speak English as a first language.[****]

For each of the international jurisdictions, the review looks at six key areas:

1. Scope of adult safeguarding.
2. Relevant legislation.
3. Standards, guidance and policies.
4. Model of safeguarding.
5. Safeguarding outcomes.
6. Summary and lessons learned.

3.1.1 Methodology

Initially, a desktop review was carried out. This involved reading annual reports of adult safeguarding bodies, web-based searches of relevant literature and websites, and speaking with contacts identified by the Project Team as having experience in the area of safeguarding. A list of key experts in safeguarding was compiled and a

[****] Other jurisdictions were considered, including those in Scandinavia and the USA. The six jurisdictions studied in-depth offer the most up-to-date and relevant (to Ireland) models of adult safeguarding available. This is borne out not only by the research findings but also by extensive discussion with leading academics in this field.

review of relevant publications was carried out on ResearchGate[††††] or based on their university profile.

As part of the international review, experts[‡‡‡‡] in Northern Ireland, England, Wales, and Scotland were contacted by email. These were primarily leading academics in the adult safeguarding field, as well as those in leadership positions in inspectorate organisations. They provided information that the team was unable to access in academic journals or through online searches, and they assisted with providing data which had not been included in a published report.

These experts participated in teleconference calls with the HIQA and MHC team between November 2017 and February 2018. Findings and 'lessons learned' in adult safeguarding from their respective jurisdictions were discussed. Further relevant research was highlighted in the field of adult safeguarding in their respective jurisdictions.

3.1.2 Safeguarding at a glance

To aid interpretation of this document, Table 4 compares the legal status and scope of adult safeguarding in the six jurisdictions covered in this review.

[††††] ResearchGate is a social networking site for scientists and researchers to share papers, ask and answer questions and find research collaborators.
[‡‡‡‡] See Appendix 1 for names and affiliations of adult safeguarding experts.

Table 4. Safeguarding at a glance — the international picture

Country	Legal status of safeguarding definition	Scope of adult safeguarding
Scotland	Adult Support and Protection (Scotland) Act 2007 (ASPSA)	The Adult Support and Protection (Scotland) Act defines 'adults at risk' as individuals aged 16 years or over who: ▪ are unable to safeguard themselves, their property, rights or other interests; ▪ are at risk of harm; and ▪ because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than others who are not so affected. All of the above three criteria must be met to be considered an adult at risk under the Adult Support and Protection (Scotland) Act.
England	Care Act 2014	Under Section 42 of the Care Act 2014, an 'adult at risk' is defined as a person who has needs for care and support, and is experiencing, or is at risk of, abuse or neglect, and as a result of those needs, is unable to protect himself or herself.
Wales	Social Services and Well-Being (Wales) Act 2014	Under this legislation, an 'adult at risk' is an adult who: ▪ is experiencing or is at risk of abuse or neglect ▪ has needs for care and support (whether or not the council is meeting any of those needs) ▪ as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
Northern Ireland	National Policy Document Adult Safeguarding: Prevention and Protection in Partnership (2015)	An 'adult at risk of harm' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal characteristics and (or) life circumstances. Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain. Life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions. An 'adult in need of protection' is: ▪ a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal characteristics and (or) life circumstances;

Country	Legal status of safeguarding definition	Scope of adult safeguarding
		and ▪ who is unable to protect their own wellbeing, property, assets, rights or other interests; and ▪ where the action or inaction of another person or persons is causing, or is likely to cause, him or her to be harmed.
Canada	No legal basis at federal level	No specific definition of adult at risk. 'Vulnerable adult' used in guardianship and adult protection statuses in some Canadian provinces.
Australia	No legal or policy basis at Commonwealth level	No specific definition of adult at risk. 'Vulnerable adult' used in some state policies.

3.2 Adult safeguarding in Scotland

While England, Scotland and Wales have adult safeguarding legislation in place, each country has adopted a different approach to adult safeguarding. Scotland introduced adult safeguarding legislation in 2007 and, of all jurisdictions in this review, Scotland has the most long-standing law in place to protect adults at risk. Unlike other jurisdictions, Scotland does not use the terms 'vulnerable' or 'abuse' when describing adults at risk of harm.

3.2.1 Scope of adult safeguarding in Scotland

As outlined in Table 4, the Scottish legislation, the Adult Support and Protection (Scotland) Act 2007,[39] describes 'adults at risk' as individuals aged 16 years or over who:

- are unable to safeguard themselves, their property, rights or other interests and
- are at risk of harm
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than others who are not so affected.

All of the above three criteria must be met for an adult to be considered at risk under Scottish legislation. This three-part definition was used to broadly incorporate the whole set of circumstances that come together to result in an adult being more susceptible to harm than others.[40] The Adult Support and Protection (Scotland) Act 2007 definition uses the term 'at risk' to avoid assumptions about inherent vulnerability and the stigmatising and labelling of particular groups: the presence of a particular condition does not automatically mean an adult is an 'adult at risk'.[40] Someone could have a disability, or mental health problem, but be able to safeguard their own wellbeing.

For the purposes of the Scottish act, 'harm' includes all harmful conduct and, in particular, includes:§§§§

- conduct which causes physical harm
- conduct which causes psychological harm (for example by causing fear, alarm or distress)

§§§§ Of note, the Adult Support and Protection (Scotland) Act 2007 does not list institutional abuse as a separate type of harm.

- unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion)
- conduct which causes self-harm.

3.2.2 Relevant legislation

Scotland was the first country in this review to pass specific adult safeguarding legislation.[39] Its Adult Support and Protection (Scotland) Act 2007 was passed by the Scottish Parliament in February 2007, received royal assent[*****] in March 2007, and has been in operation since October 2008. It aimed to fill a perceived gap between general welfare law and mental health and mental capacity law.

The overarching principle underlying the Scottish act is that any intervention in an individual's affairs should benefit the individual, and should be the least restrictive option of those that are available and which will meet the purpose of the intervention. This is supported by a set of guiding principles[39] which, together with the overarching principle, must be recognised:

- the wishes and feelings of the adult at risk (past and present)
- the views of other significant individuals, such as the adult's nearest relative; their primary carer, guardian, or attorney; or any other person with an interest in the adult's wellbeing or property
- the importance of the adult taking an active part in the performance of the function under the Scottish act
- providing the adult with the relevant information and support to enable them to participate as fully as possible
- the importance of ensuring that the adult is not treated less favourably than another adult in a comparable situation
- the adult's abilities, background and characteristics (including their age, sex, sexual orientation, religious persuasion, racial origin, ethnic group and cultural and linguistic heritage).[39]

Across jurisdictions, the levels of mistreatment that may trigger a response under adult safeguarding differ. Scotland and Northern Ireland have a threshold based on 'harm', whereas England and Wales narrow their response to 'abuse' or 'neglect'.[41] When developing the Scottish legislation, advocacy organisations, people using services and carer and disability groups were heavily involved, and their input highlighted the need to use language that does not stigmatise or disempower adults at risk of harm. The mention of being in receipt of services was also removed from

[*****] When a bill becomes an Act of Parliament. Once a bill has completed all the parliamentary stages in both Houses, it is ready to receive royal assent. This is when the Queen formally agrees to make the bill into an Act of Parliament (law).

the definition as it was viewed as discriminatory and presumed that those who use support services are inherently vulnerable.(42)

The Adult Support and Protection (Scotland) Act 2007 introduced new measures to identify and protect individuals who fall into the category of 'adults at risk'. These measures are outlined in Table 5.

Table 5. New measures introduced under the Adult Support and Protection (Scotland) Act 2007

1.	A duty on councils to make the necessary inquiries and investigations about an individual's wellbeing, property or financial affairs where the council knows or believes that the person is an adult at risk. The Scottish act authorises council officers to conduct interviews, carry out visits or require health, financial or other records to be produced in respect of an adult at risk. The Scottish act also allows a health professional such as a doctor or nurse to conduct a medical examination with the consent of the individual potentially at risk. The power to visit homes and make inquiries allows early intervention with a focus on prevention of harm.
2.	A duty on councils to consider providing appropriate services, including independent advocacy, to support adults where an intervention under the Scottish act is considered to be necessary.
3.	A requirement for specified public bodies to cooperate with local councils and each other about adult protection investigations.
4.	The introduction of a range of protection orders including assessment orders, removal orders and banning orders (outlined below). In most situations, and in line with the guiding principles of the Scottish act, other less restrictive measures will be sufficient to protect the person concerned. However, in circumstances where firmer action is required, the Adult Support and Protection (Scotland) Act 2007 puts in place sufficient powers to ensure those who need support or protection can have it.††††† **Protection orders:** ▪ **Assessment orders** authorise a council officer to take the adult from a place visited by the officer in the course of their investigations to conduct a private interview and for a health professional to conduct a medical examination in private. An assessment order does not have the power to detain the adult at risk, and the adult may choose to leave at any time. ▪ **Removal orders** allow a council officer to remove an adult at risk to a specified place where there is a likelihood of serious harm if they are not moved. Removal orders are

††††† A protection order must not be made if the affected adult at risk has refused to consent to the granting of the order, unless the affected adult at risk has been unduly pressurised to refuse consent and there are no steps which could reasonably be taken with the adult's consent which would protect the adult from harm. An example of undue pressurise is where it appears that harm is being, or is likely to be, inflicted by a person in whom the adult at risk has confidence and trust, and that the adult at risk would consent if the adult did not have confidence and trust in that person. However, this does not authorise a council officer or a health professional or other council nominee to ignore a refusal by a person to consent to participation in an interview, or a medical examination.

	effective up to a maximum of seven days and they do not authorise the adult's detention, meaning that the adult may leave at any time. ▪ **Banning orders** ban the subject of the order from being in a specified place, for up to six months. It can only be granted where an adult at risk is being, or is likely to be, seriously harmed by another person and the sheriff[‡‡‡‡‡] is satisfied that banning the subject of the order from the place will better safeguard the adult at risk's wellbeing or property than by moving the adult. The sheriff can also grant a temporary banning order pending the determination of a full banning order.
5.	An obligation on councils to establish multi-agency Adult Protection Committees (APC), responsible for overseeing local adult protection polices in their area and producing a biennial report on the Committee's functions.

Other legislation relevant to adult safeguarding in Scotland includes:

- Adults with Incapacity (Scotland) Act 2000(43)
- Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016(44)
- Mental Health (Care and Treatment) (Scotland) Act 2003(45)
- Mental Health Act 2007.(46)

3.2.3 Standards, guidance, and policies

In Scotland, there are three organisations with responsibility for regulating and setting standards for health and social care services: the Care Inspectorate, Health Improvement Scotland, and the Mental Welfare Commission.

3.2.3.1 The Care Inspectorate

The Care Inspectorate is the regulator for care and social services in Scotland. The Public Services Reform (Scotland) Act 2010(47) sets out the types of services that are to be registered. The Care Inspectorate regulates a wide range of services, including adoption and fostering, childcare, nursing agencies and offender accommodation. It also regulates services provided in the home, including nursing agencies, support services (personal care) and housing support services. All services are monitored against the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.(48) In addition, each of the categories of care has a separate set of standards.

[‡‡‡‡‡] Sheriffs deal with the majority of civil and criminal court cases in Scotland. The main role of sheriffs is to sit as a trial judge.

3.2.3.2 Healthcare Improvement Scotland

In terms of healthcare, the National Health Service (NHS) is not overseen by a single regulatory body in the same way that care services are (that is to say by the Care Inspectorate). Instead, the roles of regulation, inspection, complaints and enforcement are divided between different bodies. Healthcare professionals are regulated by professional regulatory bodies such as the General Medical Council (doctors) that deal with complaints about conduct.

Healthcare Improvement Scotland (HIS) is the national healthcare improvement organisation for Scotland. It is a public body which is part of the Scottish National Health Service, created in April 2011. HIS has a key role in setting standards for care and treatment and then inspecting health boards' performance against them. However, health boards still have a large degree of autonomy and HIS has few legal powers to enforce sanctions against those health boards who do not meet the standards.

One exception to this is that HIS is now responsible for the regulation of independent healthcare; HIS registers and inspects services against the national care standards. It can also take enforcement action against an independent healthcare provider and has the power to cancel a service provider's registration. HIS does not have the same powers for NHS services; instead, it describes itself as an improvement body for the NHS as opposed to a regulator. However, at the time of the Project Team's review, HIS had recently been given the power to close NHS hospital wards to new admissions where there is a serious risk to the life, health or wellbeing of persons. HIS also incorporates the Healthcare Environment Inspectorate (HEI), which is responsible for inspecting hospital compliance with healthcare-associated infection prevention and control standards. HEI undertakes one announced and one unannounced inspection of each Scottish hospital every three years.

3.2.3.3 Mental Welfare Commission

The Mental Welfare Commission (MWC) performs a scrutiny function for mental health services. The Mental Health (Care and Treatment) (Scotland) Act 2003[45] gave the MWC a duty to monitor the operation of the 2003 Act and to promote best practice. It also has a role in monitoring the operation of the Adults with Incapacity (Scotland) Act 2000.[43] It carries out its duties by monitoring the implementation of the legislation, visiting those receiving care and treatment, publishing good practice guidance and investigating potential service failures. Like HIS, the MWC does not have statutory enforcement powers.

3.2.3.4 Health and social care standards

New health and social care standards came into effect in Scotland in April 2018. For the first time, these standards will apply to the NHS, alongside services registered with the Care Inspectorate and HIS. They do not replace previous standards and outcomes relating to healthcare that have already been produced under section 10H of the National Health Service (Scotland) Act 1978.[(49)] However, they replace the National Care Standards, published in 2002 under section 5 of the Regulation of Care (Scotland) Act 2001.[(50)]

The Care Inspectorate and HIS will take into account the standards when carrying out inspections and quality assurance functions, and when making decisions regarding provider or service registration. The aim is that non-registered services will also use the new health and social care standards as a guideline for how to achieve high-quality care.

The standards do not replace or remove the need to comply with legislation which sets out requirements for the provision of services. The standards should be used to complement the relevant legislation and best practice that support health and care services to ensure high-quality care and continuous improvement.

The new standards are underpinned by five principles:

- dignity and respect
- compassion
- inclusion
- responsive care
- support and wellbeing.

While not explicitly written in terms of safeguarding, the language of the standards incorporates elements of safeguarding throughout. Some relevant examples are selected and presented in Table 6.

Table 6. Standards relevant to safeguarding in the Scottish health and social care standards

Standard 1.2	My human rights are protected and promoted and I experience no discrimination.
Standard 2.4	I am supported to use independent advocacy if I want or need this.
Standard 2.5	If I need help managing my money and personal affairs, I am able to have as much control as possible and my interests are safeguarded.
Standard 2.7	My rights are protected by ensuring that any surveillance or monitoring device that I or the organisation use is necessary and proportionate, and I am involved in deciding how it is used.

Standard 2.12	If I am unable to make my own decisions at any time, the views of those who know my wishes, such as my carer, independent advocate, formal or informal representative, are sought and taken into account.
Standard 3.20	I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities.
Standard 3.21	I am protected from harm because people are alert and respond to signs of significant deterioration in my health and wellbeing, that I may be unhappy or may be at risk of harm.
Standard 3.24	If I might harm myself or others, I know that people have a duty to protect me and others, which may involve contacting relevant agencies.

3.2.4 Model of safeguarding

The model of adult safeguarding in Scotland has been described as an 'interagency model with a dedicated responder'.[42] The Adult Support and Protection (Scotland) Act 2007 requires interagency cooperation between public bodies and local councils. Additionally, it places an obligation on each local council to set up adult protection committees (APCs). Core membership of the APC must include council officers, and representatives from the police, health service and the Care Inspectorate.[51]

The APCs have four functions:

- review relevant processes and practices
- provide advice and proposals to public bodies as required
- improve knowledge and skills of staff involved in adult safeguarding
- any other functions as determined by government ministers.

In an academic review[51] of the biennial reports of APCs, it was highlighted that the accountability and exercise of power of these committees was unclear. Reports also highlighted differing levels of staff engagement in different areas in relation to attending safeguarding training (for example, there was poor turnout among general practitioners [GPs] and residential staff in some areas).

Local authorities are responsible for assessing risk, investigating, inquiring and, where necessary, intervening to protect adults who meet all three criteria of the Scottish act's definition of an adult at risk of harm. Importantly, this applies whether the person is in receipt of services or not. A council officer (a local authority employee such as a social worker, allied health professional or a trained social care officer) is appointed in each local authority to undertake assessment and risk management functions. The power to request access to records (medical or financial) lies with the council officer.

3.2.4.1 Perth and Kinross Council: a case study

A case study review[52] was undertaken by researchers and subsequently published in the *Journal of Adult Protection* on the implementation of the Adult Support and Protection (Scotland) Act 2007 in one local authority in Scotland based on reports for the Scottish Government every two years, alongside internal annual data and quality reports. The authors analysed six years of data (2010–2016) and noted a steady increase in the rates of referrals up to 2014–15, followed by a decline in 2015–16. This is potentially due to increased awareness of the legislation. Improvement in screening of referrals has resulted in reduced number of inquiries, with a higher proportion leading to investigations, as illustrated in Table 7 below.[52]

Table 7. Adult safeguarding referrals in Scotland

2011–12	2015–16
1,162 referrals	1,310 referrals
439 inquiries	201 inquiries
32 investigations	73 investigations

Of note, the number of protection orders remains very small (one to two per year). Women were more likely to be referred, and half of referrals were for people over 65 years of age. Physical and financial harm were most commonly reported with relatives or paid carers most frequently cited as harmers. Given the lack of publicly available national data sets in Scotland, the comparability of data from this local authority to national averages remains limited.[52]

3.2.5 Safeguarding outcomes

In terms of outcome data, each adult protection committees submits biennial reports to the Scottish Government. However, it is reported the reliability of these data returns cannot be guaranteed and that work is ongoing to try to standardise this data collection.

It has been reported that the Scottish approach has improved safeguarding practice, practitioner confidence, and improved quality of life and safety for people using services.[41]

An investigation[53] of the views of people using services, carers, family members and social work staff was undertaken in relation to experience and impact of adult protection services in Scotland. Adults at risk reported that they had become more trusting of the adult protection system and of the agencies involved. Similar positive experiences with adult protection services have been reported elsewhere.[54]

Research[55] undertaken with 29 practitioners (all were social workers except for one occupational therapist) highlighted the benefits of the Adult Support and Protection (Scotland) Act 2007 including:

- formalisation of practitioners' roles and greater clarity of role
- better framework for practice
- increased support and shared responsibility within agency and from other agencies
- improved system of decision-making
- provision of powers under the act (such as the right to request access to records, particularly in relation to banks, where financial harm was being investigated).[55]

However, while practitioners found thresholds around 'harm' easier to work with than thresholds around 'abuse', they found it more challenging to weigh up if a person was unable to safeguard their wellbeing.[55]

Research[56] investigating the application of the Adult Support and Protection (Scotland) Act 2007 from the perspective of independent advocates outlines benefits of the act, including:

- having a statutory duty of care
- promotion of positive multi-agency information sharing and communications
- positive outcomes in situations of financial abuse and where adults wanted help.[56]

Negative outcomes and concerns included:

- absence of resources to respond appropriately and lack of creative thinking about the use of available resources
- front-line staff not having sufficient authority to respond
- individuals falling between gaps due to the three-point test or non-engagement with adult support and protection processes
- variation in implementation by local authorities
- concerns regarding the consistency of decision-making in relation to referrals.[56]

Advocates suggested future changes in the Scottish system including:

- better interagency working and low level of supports provided to people requiring support at an early stage, less need to resort to adult protection processes
- better supports for people who do not meet the three-point criteria in the Adult Support and Protection (Scotland) Act 2007
- attitudes to older people, people with disabilities and people with mental health issues needed to change in wider society
- more resources for independent advocacy to meet demand.[56]

While tensions between autonomy and protection were raised both by people using services and by social work staff, on balance, the view was that the Adult Support and Protection (Scotland) Act 2007 achieves a balance between support and protection.[53] Research[53] points to the principle of proportionality associated with the act. For example, lawful interventions such as protection orders have to respect the person's private and family life, particularly where the benefit to an individual could not otherwise by achieved and represents the least restrictive alternative in the circumstances. This research[53] concluded that initial concerns regarding the potential of the Adult Support and Protection (Scotland) Act 2007 to create paternalistic approaches in adult protection have not materialised.

While consent is normally required for all interventions, provision is included to set aside consent in circumstances when undue pressure§§§§§ is being applied. This could breach a person's right to a private life but by not including a power to detain the person without consent, the person is not deprived of their liberty and can leave at any time.[57]

3.2.6 Summary and lessons learned from Scotland

To conclude, Scotland was the first jurisdiction in this review to pass specific adult safeguarding legislation in 2007 with the Adult Support and Protection (Scotland) Act 2007.[39] While the weight of evidence suggests successful implementation of the legislation, improvements are needed in Scotland in terms of streamlining data collection, producing national data reports and improving aspects of safeguarding training and training engagement among practitioners. Research in Scotland has also identified the need for improved interagency working[56] in adult safeguarding, which

§§§§§ An adult at risk may be considered to have been unduly pressurised to refuse to consent if it appears that:
- harm which the order or action is intended to prevent is being, or is likely to be, inflicted by a person in whom the adult at risk has confidence and trust; and
- that the adult at risk would consent if the adult did not have confidence and trust in that person.

is relevant to Theme 5 of the standards development framework employed by HIQA and the MHC: Leadership, Governance and Management.

New health and social care standards came into effect in Scotland in April 2018 and are applicable to the NHS, alongside services registered with the Care Inspectorate and Healthcare Improvement Scotland (HIS). The new standards are underpinned by the principles of dignity and respect, compassion, inclusion, responsive care, and support and wellbeing. The standards are written from a person-centred perspective which is relevant to Theme 1 of the standards development framework employed by HIQA and the MHC: Person-centred Care and Support.

In developing the Scottish legislation, advocacy, people using services, carer and groups representing people with disabilities were heavily involved and their input highlighted the need to use language that does not stigmatise or disempower adults at risk of harm. The mention of being in receipt of services was also removed from the definition and it was viewed as discriminatory and presumed that those who use support services are inherently vulnerable.[42]

Adult safeguarding in Scotland focuses on the balance between support and protection. Research has stated a need for a more preventative approach, focusing on early intervention by increasing support for people requiring assistance at an early stage, so that there is less need to resort to adult protection processes.[56]

3.3 Adult safeguarding in England

While safeguarding in England has been a major concern in health and social care settings since the 'No Secrets'[58] policy of 2000, it was only in 2014 that the Care Act[59] set out in legislation the definition of an 'adult at risk'. No Secrets, published by the Department of Health in England, provided guidance on developing and implementing multi-agency policies and procedures to protect adults deemed at risk from harm and or abuse. It has now been replaced by statutory guidance issued under the Care Act.[59] The Care Act[59] signalled a move away from the previous terminology of 'vulnerable adults' and included the types of harm and abuse that these adults may experience as a result of their care and support needs.

3.3.1 Scope of adult safeguarding

In England, the Care Act 2014[59] places statutory responsibility on the local authorities to be the lead agency in responding to safeguarding issues and also requires interagency cooperation from statutory agencies in addressing safeguarding effectively. Under Section 42 of the Care Act 2014,[59] an 'adult at risk' is defined as a person who has needs for care and support, and is experiencing, or is at risk of, abuse or neglect and, as a result of those needs, is unable to protect himself or herself.

Certain groups of people are identified as being particularly vulnerable to abuse. These may include people with care and support needs, such as older people or people with disabilities, who may be more likely to be abused or neglected as they may be seen as an easy target or be less likely to identify abuse themselves or to report it. The NHS Safeguarding Adults Annual Report for 2015–2016[60] highlighted that of the 102,970 reports made, just over half of these (53%) related to individuals who were aged over 65, while 42% of enquiries related to people with physical support requirements.

The development of 'Making Safeguarding Personal' — a national initiative for local authorities to improve the safeguarding practice experience of people who use services — as an approach to putting the person at the centre of the safeguarding process has had some success in allowing practitioners and adults involved in safeguarding to move from a procedural process to a more person-led experience.

3.3.2 Relevant legislation

3.3.2.1 The Care Act 2014

In England, adult safeguarding has explicit legislation as set out in the Care Act 2014,[59] subsequently enacted in 2015. The 2014 act establishes fundamental principles and a new structure for decision-making for adult social care services. Importantly, it sets out that local authorities are the lead agency in the protection of 'adults at risk' and places duties on the local authority to act regardless of whether the adult lacks mental capacity. This is the first such act in England that sets out what adult safeguarding is and the types of abuse, and which places the onus on a specific body for assessing and responding to the needs of adults at risk. Specific adult safeguarding obligations are set out under sections 42–47 of the act.

The Care Act 2014 specifies that 'abuse' includes financial abuse and that financial abuse includes:

- having money or other property stolen
- being defrauded
- being put under pressure in relation to money or other property
- having money or other property misused' [section 42(3)].[59]

While the English act does not define abuse, both abuse and neglect are covered in detail in the Care and Support Statutory Guidance[61] where abuse is defined in a very broad way in relation to: physical, psychological, sexual, financial or material, modern slavery, discriminatory, organisational, neglect and acts of omission, and self-neglect.

Offences under the act apply irrespective of the care recipient's mental capacity and recognise institutional abuse by providing for an offence that may be committed by organisations as well as individuals. This is in direct contrast to the English Mental Capacity Act 2005[62] which covered only those who lack capacity. Guidance for local authorities on the implementation of the Care Act 2014[59] is set out in the 'Care and Support Statutory Guidance'.[63] This guidance was drafted in 2014, published in 2016 and has a number of periodic updates of specific sections.

Previous to the Care Act 2014,[59] a range of guidance and structures were in place whose legal status was unclear. While the new legislation has created a clear legal definition of adult safeguarding, there has been criticism that having 'guidance' which local authorities are required to 'act under', rather than a statutory code of practice which is legally enforceable, is weaker and opens up the possibility of inconsistency of implementation if a local authority can argue its case effectively. Further criticism is that local authorities are required to provide safeguarding services within a pre-determined budget. Therefore, the assessment of eligibility for support is compromised by what the local authority can provide rather than what it should provide.[42]

3.3.2.2 Mental Capacity Act 2005

The Mental Capacity Act 2005[62] applies additionally to adults at risk; however, the act only applies to adults 'who may lack capacity to make decisions for themselves'. It sets out a framework which protects people who may lack capacity and how decisions should be made on their behalf. The act states that:

> A person lacks capacity if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain.[64]

According to the Office of the Public Guardian,[‡] the presumption is that all adults have the mental capacity to make informed choices about their safety and how they live their lives, unless they can be shown to lack capacity at the time the decision needs to be made. Every decision to become involved in a safeguarding issue must take into account the ability of the adult to make informed decisions about the way they live their lives and the risks they want to take.

According to the supporting Mental Capacity Act 2005 Code of Practice:[65]

> The underlying philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the

[‡] The Office of the Public Guardian (OPG) in England and Wales is a government body that, within the framework of the Mental Capacity Act 2005, protects the private assets and supervises the financial affairs of people who lack mental capacity for making decisions. It is an executive agency of the Ministry of Justice.

> decision or act for themselves is made in their best interests. The Act also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves.[65]

The act introduced a statutory advocacy service. This empowers local authorities to appoint an independent mental capacity advocate to represent the interests of the adult who is deemed to lack capacity.

3.3.2.3 Health and Social Care Act 2008

The Health and Social Care Act 2008[66] established the Care Quality Commission (CQC) to regulate health and social care. It makes provision for reviews and investigations under the Mental Health Act.[46] It also provides for the regulation of professionals through an independent regulator. Importantly, the act strengthened the protection of vulnerable people using residential care by ensuring that any independent-sector care home that provides accommodation together with nursing or personal care on behalf of a local authority is subject to the Human Rights Act 1998.[67] The aim of this act was to incorporate the rights set out in the European Convention on Human Rights (ECHR)[68] and to make it unlawful for any public body to act in a way that is incompatible with the Convention. Under the Health and Social Care Act 2008 (Regulate Activities) Regulations 2014,[69] a breach of Regulation 8 (Safeguarding people who use services from abuse) amounts to an offence under Regulation 17.

3.3.2.4 Other legislation

Other relevant criminal legislation in England includes:

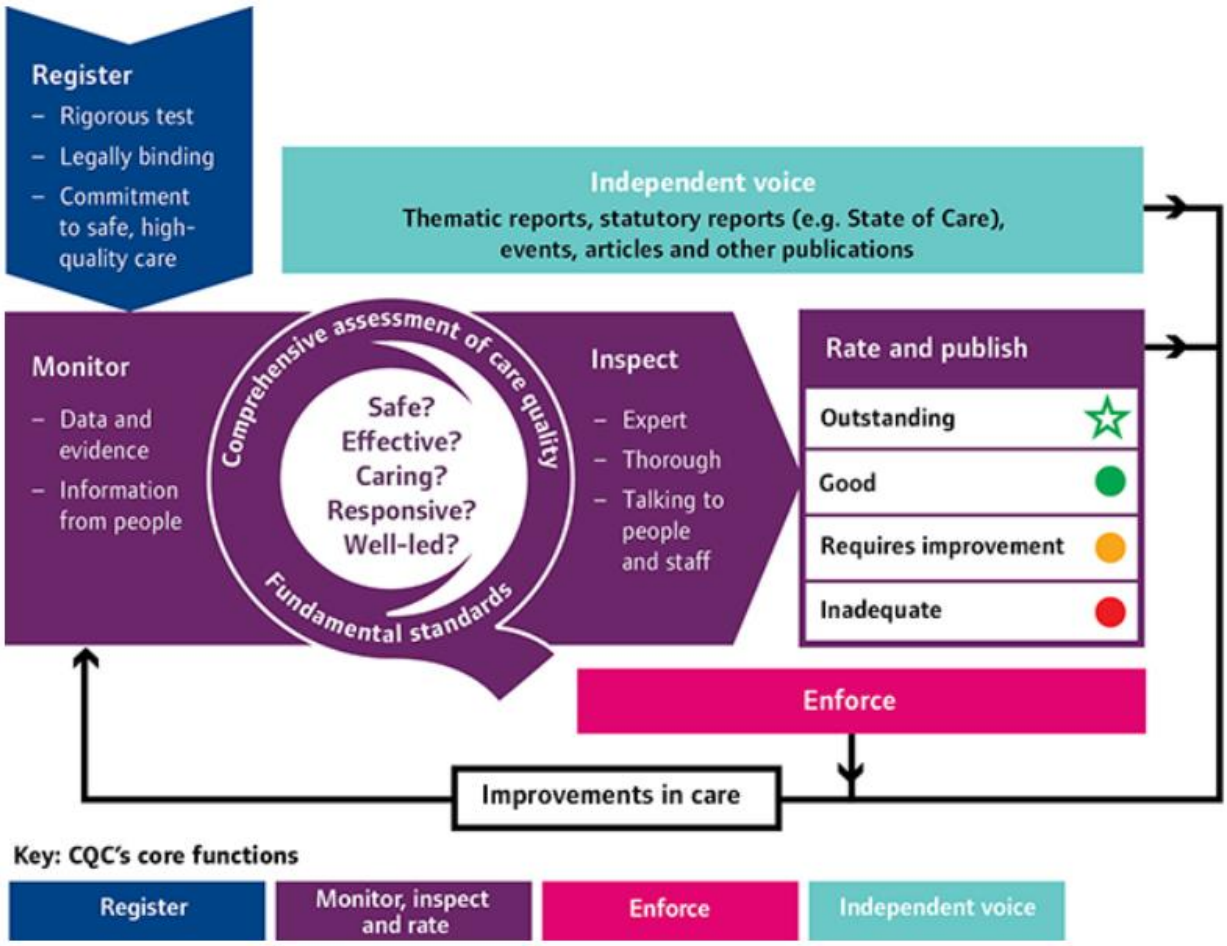
- the Safeguarding Vulnerable Groups Act 2006 (as amended by the Protection of Freedoms Act 2012),[70] which deals with vetting and potentially barring people who wish to work with children or vulnerable adults
- the Domestic Violence Crimes and Victims Act 2004 (as amended),[71] which provides for the offence of causing or allowing the death of or serious physical harm to a child or vulnerable adult
- section 76 of the Serious Crime Act 2015[72] which introduced the crime of controlling or coercive behaviour in an intimate or family relationship.

3.3.3 Standards, guidance, and policies

The CQC is the independent regulator of health and adult social care in England. Its role under the Health and Social Care Act 2008[66] is to make sure health and social

care services provide people with safe and effective care and to encourage care services to improve. The CQC's operating model is set out in Figure 4.[73]

Figure 4. CQC's overall operating model



Source: Care Quality Commission website. (2018). *How the guidance fits with CQC's operating model.*

The CQC inspects against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[69] and the Care Quality Commission Regulations 2009.[74] Regulations 8–20 form the basis of the 'fundamental standards' that services are required to meet. They include person-centred care, dignity and respect and safeguarding people using services from improper treatment. Specifically, Regulation 13 outlines the detailed components and requirements of service providers in safeguarding people using services from abuse and improper treatment. The detail of Regulation 13 is set out in Appendix 2 of this document.

The CQC provides guidance to providers on meeting the regulations but is not prescriptive in how the regulations are met. Using a triangulated approach, it asks a number of key questions (see Table 8) of all services and people using services.[73]

Table 8. CQC guidance on meeting regulations

1.	Is it safe? Are you protected from abuse and avoidable harm?
2.	Is it effective? Does your care, treatment and support achieve good results and help you maintain your quality of life, and is it based on the best available evidence?
3.	Is it caring? Do staff involve you and treat you with compassion, kindness, dignity and respect?
4.	Is it responsive? Are services organised so that they can meet your needs?
5.	Is it well led? Does the leadership of the organisation make sure that it's providing high-quality care that's based around your needs? And does it encourage learning and innovation and promote an open and fair culture?

3.3.3.1 Care and Support Statutory Guidance

The Department of Health in England developed a comprehensive 'Care and Support Statutory Guidance'[61] for local authorities to meet the requirements of the Care Act 2014.[59] Section 1 of the statutory guidance provides local authorities with the information they need about how they should meet the legal obligations placed on them by the act and the regulations. Local authorities are required to act under the guidance, which means that they must follow it, unless they can demonstrate legally sound reasons for not doing so.

The guidance is to be used by local authorities to plan care and support at a local authority level, as well as by practitioners. The guidance is also used by people using care and support, their families, the voluntary sector and providers of care and support to help them understand the new system, and by courts in deciding whether a local authority has acted within the law.

3.3.3.2 National Institute for Care and Health Excellence (NICE)

NICE's role is to improve outcomes for people using the NHS and other public health and social care services by:

- producing evidence-based guidance and advice for health, public health and social care practitioners

- developing quality standards and performance metrics[******] for those providing and commissioning health, public health and social care services
- providing a range of information services for commissioners, practitioners and managers across the spectrum of health and social care.

There are a range of quality standards that have been developed that include standards related to safeguarding specific groups that may be vulnerable in a specific context. These include:

- homecare: delivering personal care and practical support to older people living in their own homes
- domestic violence
- violent and aggressive behaviours in people with mental health problems
- end-of-life care for adults
- safeguarding adults in care homes.[††††††]

3.3.3.3 'Making Safeguarding Personal' initiative

'Making Safeguarding Personal' is a national initiative for local authorities to improve the safeguarding practice experience of people using services. This is driven by the local authorities and is similar to the approach taken to child welfare and protection 'Signs of Safety' initiative which focuses on the protective factors in a child and family's life. 'Making Safeguarding Personal' places people at the centre of the process, to understand their experience of the issue and the outcomes that they want from it — and assessing throughout the process whether these outcomes are being achieved. A toolkit for responses was produced by the Local Government Association and ADASS (Association of Directors of Adult Social Services) and takes a more creative approach to responding to safeguarding situations. The objective of the toolkit is to provide a resource that encourages councils and their partner agencies to develop a portfolio of responses that they can offer to people who have experienced harm and abuse so that they are empowered and their outcomes are improved.(75)

[******] Quality standards help to improve the quality of care that is provided by a service. Performance metrics measure a service's behaviour, activities, and performance in implementing these standards.

[††††††] At the time of writing, standards for adult safeguarding in care homes in England are in development.

3.3.4 Model of safeguarding

3.3.4.1 Local authorities

Under the Care Act 2014,[59] the local authorities have statutory responsibility to protect adults at risk. This is laid out in the 'Care and Support Statutory Guidance'.[61] Each local authority has a safeguarding adult board (SAB) whose purpose is to help and safeguard adults with their care and support needs. The safeguarding adult board leads adult safeguarding arrangements across its locality and oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies. The safeguarding adult board is required to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in the Making Safeguarding Personal resources. These resources were developed by the Local Government Association and the Association of Directors of Adult Social Care.[76]

The local authority 'must make (or cause to be made) whatever enquiries it thinks necessary to enable it to establish whether any action needs to be taken to prevent or stop the abuse or neglect' (section 42(2)) and to decide what action needs to be taken. This is undertaken in consultation with the person and their family, where appropriate. Where the local authority assesses that the person does not have capacity, it is required to appoint an independent advocate. While the local authority may engage other agencies in this process, it is not enough for it to simply refer a case on — rather it is in fact the lead agency.[61]

The concept of wellbeing is central to the guidance and places responsibility on the local authority and their partners to:

> Focus on joining up around an individual, making the person the starting point for planning, rather than what services are provided by what particular agency.[61]

Local authorities' safeguarding adult boards are obliged to conduct adult safeguarding reviews where an adult has died from or experienced serious abuse or neglect, and there is reasonable cause for concern about how those agencies and service providers involved worked together to safeguard the adult (section 44). This approach is designed to look at lessons learned in the process and how to address these in future cases.

There are three different models of adult safeguarding within local authorities. However, while each of these models differ, once the safeguarding issue has been raised by a member of the public or a staff member in services, access to the service comes through the adult social care services within the local authority.

The Care and Support Statutory Guidance[61] advises local authorities to have a qualified and registered social work professional practice lead in place to support the work and to develop social work practice in the adult social services team. These leads may also work alongside the team in direct practice and co-working on cases.

However, this is not always the case in practice. As referred to, there are three different models of adult safeguarding operating across local authorities. These are:

- dispersed-generic model of safeguarding where safeguarding is part of the ongoing work of the social work team
- dispersed specialist model where specialist safeguarding social workers are based in a local social care team, and
- centralised specialist model where a central safeguarding team manages all high-risk referrals.

These models have raised a question as to whether specialist adult safeguarding teams provide an improved level of prioritisation, consistency and knowledge or whether they de-skill and reduce the continuity of care for people using services.[77] A study undertaken on the range of models in use indicated that factors such as budget and local authority culture must be factored into any reviews of the efficacy of one model over another.[77]

Safeguarding vulnerable adults from abuse and neglect remains a major risk throughout the sector, with an increase of 13% in safeguarding referrals recorded by local authorities in England between 2011 and 2013. A report[78] on adult social care in England acknowledges that the increase may reflect increased awareness of abuse; however, it also highlights that it may reflect overstretched resources and pressure within the system. The reduction in funding alongside increased demand for services is also highlighted in the report[78] and is an issue that arises in academic reviews of the implementation of the Care Act.[41,77]

3.3.5 Safeguarding outcomes

3.3.5.1 Safeguarding Adults Annual Report, England 2015–16

According to the Safeguarding Adults Annual Report 2015–16,[79] there were 102,970 individuals with enquiries under Section 42 (adult at risk) of the Care Act 2014. Of these enquiries, six out of 10 (60%) were for females and just over six out of 10 (63%) of individuals at risk were aged 65 or over.

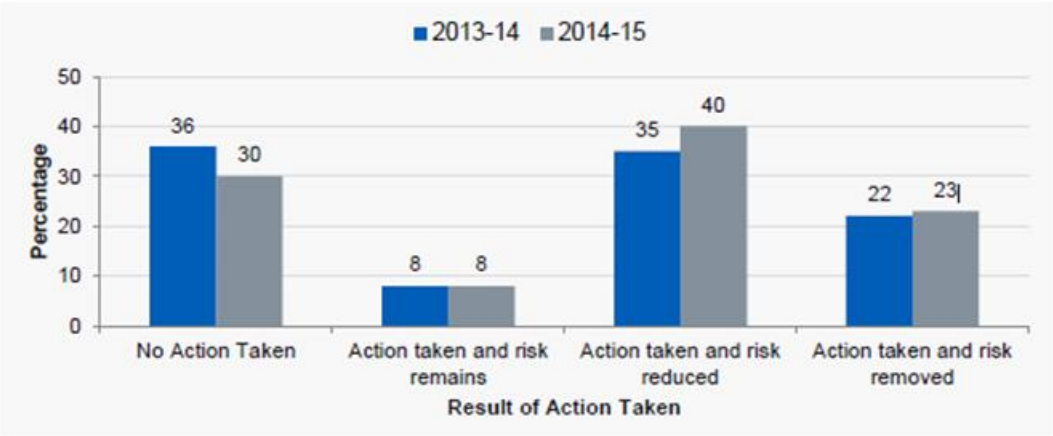
For Section 42 enquiries which concluded during the reporting year, there were 124,940 risks recorded by type of risk. Of these, the most common type was neglect and acts of omission (one in three or 34% of risks), followed by physical abuse (just

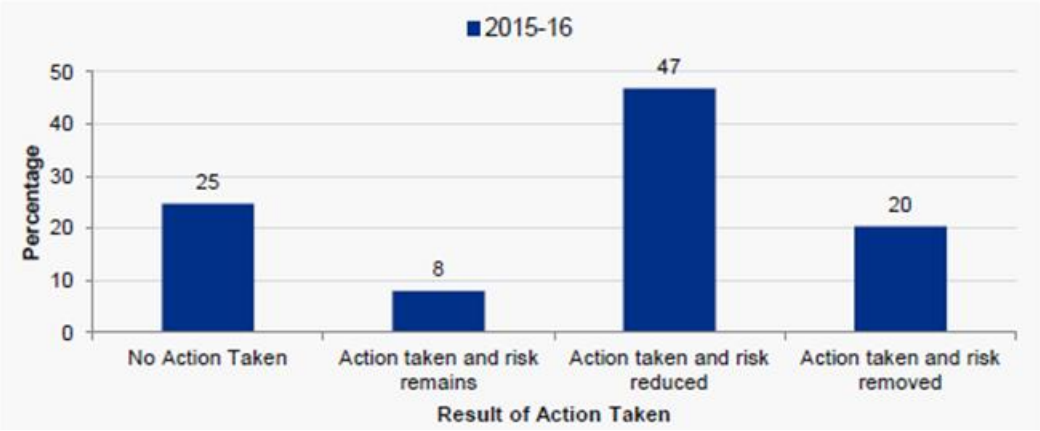
over one in four or 26%). There were 110,095 risks recorded by setting of the risk in concluded Section 42 enquiries. The risk setting was most frequently the home of the adult at risk (43% of enquiries) or in a care home (36%).

Following a safeguarding enquiry, a decision is taken regarding whether actions need to be taken as a result. This section gives data on the outcome of concluded enquiries. Figure 5, taken from the Safeguarding Adults Annual Report[79] show the percentage of concluded safeguarding enquiries by the action taken and outcome of the action.

In 2015–16, no further action was taken other than the safeguarding enquiry for one in four (a quarter of) enquiries. For cases where further action was taken, the risk was reduced for 47% of enquiries. For the remaining cases where further action was taken, the risk was completely removed in 20% of cases. The proportion of enquiries where the risk remained was 8%.[79]

Figure 5. Actions following a safeguarding enquiry in the NHS





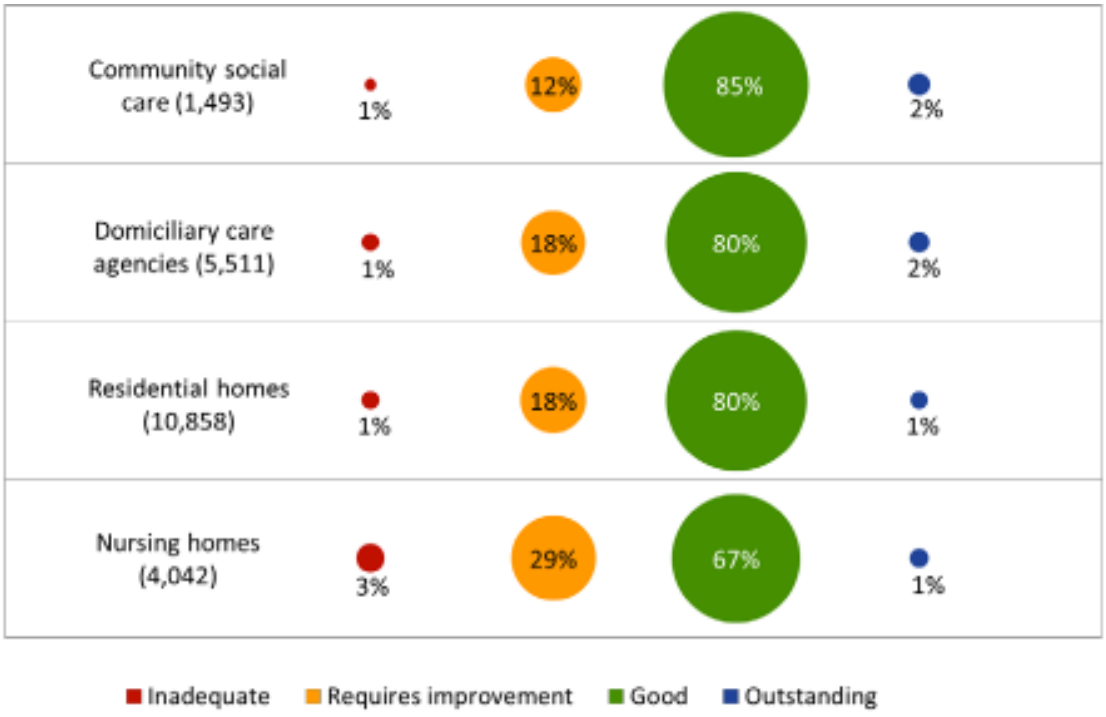
Source: NHS Digital. (2016). *Safeguarding Adults Annual Report, England 2015-16 Experimental Statistics.*

While the data in Figure 5 sets out the results of actions taken following a safeguarding enquiry, no comprehensive data on the nature of the interventions by the adult social care services or the duration of their involvement with a particular case was available at the time of writing this report.

3.3.5.2 State of Care 2014–2017 Report

In 2017, the CQC published a report on its findings from its inspections of adult social care services, entitled 'State of Care Report 2014–2017'.[80] The report highlights positive findings across services but also shows some trends that are concerning, such as those in relation to nursing homes where 32% are below standard (see Figure 6).[80] Alongside the findings from the Safeguarding Adults Annual Report,[81] this illustrates that older people have a higher risk of experiencing safeguarding issues than other group in England.

Figure 6. State of Care Report 2014-2017: overall ratings by service type



Source: Care Quality Commission. (2017). *The state of adult social care services 2014 to 2017.*

However, in collating data on safeguarding reports, it is worth noting that one study has questioned the validity of safeguarding data. That study reported that:

> only half of the designated 'adult safeguarding managers' who were interviewed were able to correctly define the meanings of the recommended terms under which adult safeguarding outcomes are recorded, i.e. 'substantiated', 'not substantiated' and 'not determined'.[82]

3.3.6 Summary and lessons learned from England

To conclude, adult safeguarding has become a more embedded process in England since the introduction of the Care Act 2014.[59] This legislation has ensured that there is a single body, in the form of the local authority, with overall responsibility for responding to adult safeguarding concerns. Furthermore, the legislation has placed a requirement on statutory partners, such as NHS England and the police, to work together to address adult safeguarding issues.

The Care and Support Statutory Guidance[61] sets out how to put legislation relevant to safeguarding into practice, and the principles underpinning all adult safeguarding are made explicit. These principles of empowerment, prevention, proportionality, protection, partnership and accountability have informed the development of practice approaches such as 'Making Safeguarding Personal'. This approach has sought to humanise both legislation and the safeguarding process for people at risk of harm by ensuring they are included in each step of the process and that the outcomes that they want are at the centre of any work being undertaken. This moves the safeguarding process from one that is being done to a person to one that is being done with a person.

The learning from England shows that all relevant services must work together to achieve the outcomes expressed by the person at risk and that the person themselves must be included in each step of the process. This learning can be clearly linked to themes from the standards development framework employed by HIQA and the MHC, including Theme 1: Person-centred Care and Support; Theme 2: Effective Services; Theme 5: Leadership, Governance and Management and Theme 6: Responsive Workforce.

3.4 Adult safeguarding in Wales

Wales introduced adult safeguarding legislation in line with the Care Act 2014[59] in England by introducing the Social Services and Well-being (Wales) Act 2014.[83] However, there are key differences between these acts and between how adult safeguarding has been implemented in practice.

3.4.1 Scope of adult safeguarding in Wales

Wales, like England and Scotland, has established the definition of adult safeguarding in law. The Social Services and Well-Being (Wales) Act 2014[83] states that an 'adult at risk' is an adult who:

- is experiencing or is at risk of abuse or neglect
- has needs for care and support (whether or not the council (local authority) is meeting any of those needs)

- and, as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.[83]

This may include people with physical, learning or sensory disabilities. Factors that increase vulnerability include age, mental health problems, chronic illness, challenging behaviour, lack of mental capacity, social and emotional problems, poverty, homelessness or substance misuse.

The Social Services and Well-Being (Wales) Act 2014[83] states that:

- 'abuse' means physical, sexual, psychological, emotional or financial abuse taking place in any setting, whether in a private dwelling, an institution or any other place

- 'neglect' means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's wellbeing.[84]

In terms of definition and scope, Scotland and Northern Ireland have a threshold for intervention or investigation based on 'harm', whereas England and Wales narrow their threshold to 'abuse' or 'neglect'. Use of the term 'harm' is arguably less stigmatising and emotive than discourses centred on 'abuse'.[85] The term 'harm' has a broader scope which incorporates unintentional actions, self-harm, self-neglect and acts of omission. In England, Northern Ireland and Wales, self-harm is excluded. While this recognises the role that relationships of power and control can play in abusive situations, it potentially excludes those who self-neglect.[41]

According to the Welsh government, one of the most important principles of safeguarding in Wales is that it is 'everyone's responsibility'. Each professional and organisation must do everything they can, to ensure that children and adults at risk are protected from abuse.[86]

3.4.2 Relevant legislation

3.4.2.1 Social Services and Well-being (Wales) Act 2014

The Social Services and Well-being (Wales) Act 2014[83] came into force in April 2016. The act repealed the majority of previous community care legislation and intended to transform the way that social services are delivered in Wales. Welsh adult safeguarding had no legal framework before this act, and practitioners followed the 'In Safe Hands' Guidance issued by the Welsh Assembly in 2000. 'In Safe Hands' in Wales was similar to the 'No Secrets'[58] policy in England.

The Welsh Act differs to the English Care Act 2014[59] in three key ways:

- The Welsh Act includes children, while the English Act does not.

- The Welsh Act places a greater emphasis on adult safeguarding. Both acts contained new legislation to better protect vulnerable adults, and created a new local authority duty to make inquiries and decide if action needs to be taken to protect an at-risk adult. However, the Welsh Act created a new legal tool for protecting adults: the adult protection and support order. Granted by a justice of the peace, these orders permit entry onto private premises to investigate whether a person is an adult at risk. The Welsh Act also provides for a National Safeguarding Board which supports and has oversight of all local safeguarding boards in Wales.
- The Welsh Government is using the legislation change to integrate health (NHS) and social care by giving itself the power in the Act, if necessary, to force partnership agreements between the local NHS and local authority departments.

In terms of funding and payment, the Care Act 2014[59] in England puts a cap on the amount any individual will have to pay for their social care (known as the Dilnot reform). While the Welsh Government has not adopted the Dilnot reform, it has committed itself to reforming payment for services provided by the social care system.[87]

3.4.2.2 The Regulation and Inspection of Social Care (Wales) Act 2016

The Regulation and Inspection of Social Care (Wales) Act 2016[88] became law in Wales in January 2016. It reforms and provides the statutory framework for the regulation and inspection of social care services and the social care workforce in Wales.

There was a phased implementation of the act:

- The first phase (2016–17) contained regulations relating to the new system of workforce regulation required by the act and the production of annual reports by local authorities about the exercise of their social services function. Draft regulations relating to the process underpinning the new system of service regulation and the definition of advocacy services were subject to a public consultation at this stage.
- The second phase (2017–2018) contains regulations relating to the requirements and standards expected of service providers and responsible individuals; regulations in connection with market stability and oversight; and regulations that define 'Advocacy Services' for the purpose of regulating these services.[89]

3.4.2.3 Mental Capacity Act (England and Wales)

The 2005 Mental Capacity Act (England and Wales)[62] provides a legal framework for making decisions on behalf of, and in the 'best interests' of, adults who, because of 'an impairment of, or disturbance in the functioning of, the mind or brain' lack the capacity to make one or more decisions for themselves.[90] It also introduced a statutory advocacy service to provide a voice for these individuals in potentially life-changing decisions. The advocates in this statutory service, called independent mental capacity advocates (IMCAs), are intended to empower and protect individuals who lack capacity by ensuring that their wishes, values and beliefs are taken into consideration by substitute decision-makers in health and social care in certain, specified situations (for example, serious medical treatments).

3.4.2.4 Deprivation of Liberty Safeguards

Welsh ministers are responsible for monitoring the operation of 'Deprivation of Liberty Safeguards' in Wales. The safeguards exist to empower and protect any individual with mental disorder, where there is doubt about their mental capacity, to make informed decisions about their care whenever they are hospital patients, or residents in a care home.[91]

3.4.3 Safeguarding standards, guidance, and policies in Wales

The Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. On the other hand, Care and Social Services Inspectorate Wales (CSSIW) register, regulate and inspect to improve adult care, childcare and social services. The CSSIW works with service providers to make sure they meet the level of quality needed by law. Finally, the Care Council for Wales (CCW) was established under the Care Standards Act 2000[92] as the regulator of the social care profession in Wales. The CCW has a duty to safeguard the public by promoting and securing high standards of conduct and practice among social workers and social care workers. The CCW works with care and support workers to make sure they have the right skills to do their job. At the time of preparing this document, the HIW and CSSIW were undertaking a joint review of community mental health services for people in Wales.[93]

In terms of standards, standard 2.7 of the Welsh Health and Care Standards 2015[94] relates to safeguarding children and adults at risk. Standard 2.7 requires 'health services to promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.' The standards state that the health service will need to consider the following criteria for meeting the standard:

- All Wales Child Protection, and Vulnerable Adult procedures

- Mental Health Act 1983[95] in relation to persons liable to be detained, and the Mental Capacity Act 2005[62] regarding Deprivation of Liberty Safeguards
- assurance that safeguarding services and processes are evident across all levels of the organisation
- effective multi-professional and multi-agency working and cooperation are in place to comply with the Social Services and Well-being (Wales) Act[83]
- staff are trained to recognise and act on issues and concerns, including sharing of information and sharing good practice and learning
- people are informed how to make their concerns known
- priority is given to providing services that enable children and vulnerable adults to express themselves and to be cared for through the medium of the Welsh language because their care and treatment can suffer when they are not treated in their own language
- suitable arrangements are in place for people who put their safety or that of others at risk to prevent abuse and neglect
- risk is managed in ways which empower people to feel in control of their life
- arrangements are in place to respond effectively to changing circumstances and regularly review achievement of personal outcomes.[94]

3.4.4 Model of safeguarding in Wales

At the time of writing this document, there are 22 local authorities, four police forces, six regional adult and children safeguarding boards and seven health boards in Wales. Under the 2014 Act,[83] Wales established a National Independent Safeguarding Board (NISB). It works alongside the six regional adult safeguarding boards and child safeguarding boards to secure improvements in safeguarding policy and practice throughout Wales. The NISB's duties are to:

- provide support and advice to safeguarding boards with a view to ensuring that they are effective
- report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales
- make recommendations to the Welsh ministers as to how those arrangements could be improved.

Under the Social Services and Well-being (Wales) Act 2014,[83] if there is reasonable cause to suspect a person is an adult at risk, the local authority in Wales must make

enquiries to enable a decision to be made and to decide on whether action should be taken. The purpose of Adult Protection and Support Orders‡‡‡‡‡‡ in the safeguarding process in Wales is to allow authorised officers speak privately with adults who may be at risk, assess their decision-making capacity and make a decision on what action or actions should be taken.

3.4.5 Safeguarding outcomes in Wales

According to data from the Welsh government on key adult safeguarding figures from April 2016 until 31 March 2017, there were 15,757 reports received by local authorities where it was suspected that an adult was at risk of abuse or neglect.(96) Of these:

- neglect (32%), emotional or psychological abuse (25%), and physical abuse (25%) were the most common types of abuse reported in completed reports
- over half (53%) of completed reports were for people aged 65 and over
- of the victims who alleged abuse or neglect, 43.2% of the alleged abuse took place in their own home and 37.8% per cent took place in care home settings
- paid employees were most likely to be responsible for alleged abuse or neglect (52.9%) followed by relatives or friends (27.3%)
- of the number of investigations that concluded during the year, one in four (25.9%) were criminal investigations.(96)

3.4.5.1 Healthcare outcomes

In terms of outcomes in healthcare settings, the 2016–17 annual report(97) from the HIW (Health Inspectorate Wales) reported that the overall process for safeguarding vulnerable people needed to be improved. This included the need to ensure that all staff had received training to the required level. Some safeguarding policies also needed to be updated. The HIW also stated that services need to do more to ensure that their policies and procedures provide clarity for staff about how to respond to a potential safeguarding concern.

‡‡‡‡‡‡ Section 127 of the Social Services and Well-being (Wales) Act 2014 enables applications to be made to magistrates' courts for adult protection and support orders. The purpose of such orders is to enable an authorised officer to speak in private to a person suspected of being an adult at risk to establish whether he or she can make decisions freely, to assess whether the person is an adult at risk and to establish whether any action should be taken, and if so, what action. Applications for such orders may be made by an authorised officer who is an individual authorised by the local authority to perform functions under this section.

3.4.5.2 Social care outcomes

Regarding social care settings, the 2016–17 annual report[98] for the Care and Social Services Inspectorate Wales (CSSIW) took a new approach to evaluating the performance of local authorities to ensure more direct engagement with people with care and support needs and their carers. As part of this approach, the focus for 2016–17 was on carers and adult safeguarding. The majority of concerns raised were about possible neglect or abuse. CSSIW worked closely with safeguarding teams in local authorities about these concerns.

The CSSIW found that front-line staff were open and honest about their successes and challenges, and that people were balancing priorities with tight timescales and were highly committed to making a positive difference for adults at risk. However, it also found:

- inconsistent practices in ensuring people are kept fully involved; for most this is an area for improvement
- a need for greater consistency in applying eligibility criteria, timeliness of response, reviews and completion of cases
- and a need for strengthened quality assurance approaches.[98]

3.4.5.3 Outcomes of Deprivation of Liberty Safeguards 2015–16

Monitoring of Deprivation of Liberty Safeguards is carried out jointly by the HIW (Health Inspectorate Wales) and Care and Social Services Inspectorate Wales (CSSIW). The data is collected from the supervisory bodies, comprising 22 local authorities and seven health boards, which carry out the independent assessments of capacity. Key findings and analysis of the 2015–16 data[91] include:

- a continued increase in the total number of applications for Deprivation of Liberty Safeguards received by supervisory bodies across Wales, rising by over 15% from the previous year (from 10,681 to 12,298 applications)
- of the 12,298 applications received, 8,792 were to local authorities, which is an increase of 7.3% since the previous year.[91]

3.4.6 Summary and lessons learned from Wales

To conclude, while Wales introduced legislation in 2014 in line with the English Care Act, there are key differences between the English and Welsh legislation. Standards applying to both child and adult safeguarding are set out in the Wales Health and Care Standards 2015.[94] One of the most important principles of adult safeguarding

in Wales is that it is 'everyone's responsibility' — each professional and organisation must do everything they can to ensure that adults at risk are protected from abuse.

The Care and Social Services Inspectorate Wales (CSSIW) has started evaluating the performance of local authorities in relation to adult safeguarding, to ensure more direct engagement with those who have care and support needs. The inclusion of the voice of the person using services is central to Theme 1 of the standards development framework adopted by HIQA and the MHC — Person-centred Care and Support.

Additionally, criteria for meeting standard 2.7 of the Welsh Health and Care Standards 2015[(94)] regarding safeguarding includes: effective multi-professional and multi-agency working (in line with Theme 5 of the standards development framework adopted by HIQA and the MHC — Leadership, Governance and Management) and that staff are trained to recognise and act on issues and concerns, including sharing of information and sharing good practice and learning (in line with Theme 6 — Responsive Workforce and Theme 8 — Use of Information of the standards development framework adopted by HIQA and the MHC).

3.5 Adult safeguarding in Northern Ireland

Similar to Ireland, Northern Ireland does not currently have specific adult safeguarding legislation in place, but instead relies on a range of criminal and civil law, in conjunction with adult protection policy and guidance.[(41)]

3.5.1 Scope of adult safeguarding in Northern Ireland

The main adult safeguarding policy framework for Northern Ireland was set out by the Department of Health, Social Services and Public Safety in 2006 in 'Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance'.[(99)] This policy defined a vulnerable adult as:

> A person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility; by reason of mental or other disability, age or illness; who is, or may be; unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.[(99)]

The original policy and definition were revised and updated in cooperation with the Department of Health, Social Services and Public Safety and Department of Justice and published in July 2015 as 'Adult Safeguarding: Prevention and Protection in Partnership'.[(100)] The policy provides clear direction for the development of all aspects of adult safeguarding and aims to:

- promote zero-tolerance of harm to all adults from abuse, exploitation or neglect
- influence the way society thinks about harm to adults resulting from abuse, exploitation or neglect by embedding a culture which recognises every adult's right to respect and dignity, honesty, humanity and compassion in every aspect of their life
- prevent and reduce the risk of harm to adults, while supporting people's right to maintain control over their lives and make informed choices free from coercion
- encourage organisations to work collaboratively, across sectors and on an interagency and multidisciplinary basis, to introduce a range of preventative measures to promote an individual's capacity to keep themselves safe and to prevent harm occurring
- establish clear guidance for reporting concerns that an adult is, or may be, at risk of being harmed or in need of protection and how these will be responded to
- promote access to justice for adults at risk who have been harmed as a result of abuse, exploitation or neglect; and
- promote a continuous learning approach to adult safeguarding.[100]

An explicit differentiation between the definition of an adult at risk of harm and an adult in need of protection is provided in the 2015 policy. An 'adult at risk of harm' is defined as:

- a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal characteristics and (or) life circumstances
- personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain
- life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.[100]

An 'adult in need of protection' is defined as:

- a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal characteristics and (or) life circumstances; and

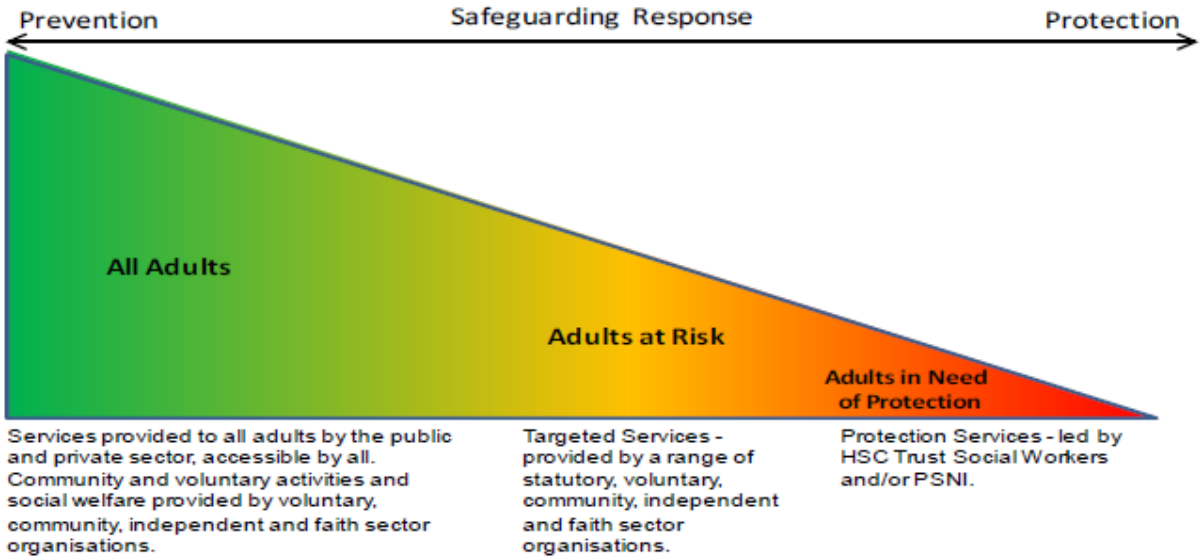
- who is unable to protect their own wellbeing, property, assets, rights or other interests; and
- where the action or inaction of another person or persons is causing, or is likely to cause, him or her to be harmed.[100]

This definition signifies a move away from an explicit focus on an individual being labelled 'vulnerable' just because they are receiving care in a certain setting, using a service, or because of their personal characteristics or circumstances.[42]

It depicts adult safeguarding on a scale (see Figure 7).[100] The decision as to whether the definition of an adult in need of protection is met requires a case-by-case approach underpinned by professional judgment. Considering 'capacity' and 'consent' is central to adult safeguarding, for example, in determining the ability of an adult to make lifestyle choices, such as choosing to remain in a situation where they risk being harmed or where they choose to take risks. There should always be a presumption of capacity to make decisions unless there is evidence to suggest otherwise.

However, the policy states that even where capacity is present, in some cases it may still be necessary to override the withholding of consent (for example, when a crime may have been committed and other people may be at risk due to the ongoing actions of an alleged perpetrator).

Figure 7. The adult safeguarding continuum



Source: Northern Ireland Department of Health, Social Services and Public Safety and Department of Justice. (2015). *Adult Safeguarding: Prevention and Protection in Partnership.*

The Northern Ireland policy is underpinned by five key principles[100] outlined in Table 9.

Table 9. Principles underpinning adult safeguarding policy in Northern Ireland

1	A **rights-based** approach:§§§§§§ (underpinned by human rights and equality legislation).
2	An **empowering** approach: informed decision-making and maximising participation in wider society empowers the individual to keep themselves safe while also respecting exposure to risk.
3	A **person-centred** approach: respecting the right of each individual to make their own informed choices and decisions and promoting and facilitating full participation in any decision-making.
4	A **consent-driven** approach: consideration of consent and capacity are deemed critical, particularly in determining the ability of an adult at risk to choose to remain in a situation where they are at risk of being harmed; determining whether a particular act is consensual and considering whether an individual can and should be asked to make decisions in an adult safeguarding situation.
5	A **collaborative approach**: collaboration is required across statutory, voluntary, community sectors as well as the general public and that safeguarding is delivered in a way where roles, responsibilities and lines of accountability are clear and understood. Adults who are at risk must be central to a partnership approach and this should go hand in hand with a person-centred approach.

The 2015 policy places a renewed emphasis on prevention activity. Full implementation of the policy places responsibility on organisations and groups providing support or services to adults at risk and those in need of protection. It requires both flexible approaches and strong governance arrangements to be in place.

3.5.2 Relevant legislation in Northern Ireland

Relevant acts and orders that influence safeguarding in Northern Ireland include:

- Criminal Law Act (Northern Ireland) 1967[(101)]

§§§§§§ A human rights approach underpins the Northern Irish policy with a strong focus on respecting the rights of adults as individuals, treating all adults with dignity and respecting their right to choose. It involves empowering and enabling all adults, including those at risk of harm, to manage their own health and wellbeing and to keep themselves safe. Northern Ireland's policy acknowledges that this may mean that individuals choose to live with risks or to take risks. Professional judgment is therefore critical in determining the level of risk of harm and whether a referral for an adult protection intervention is required.

- Family Homes and Domestic Violence (Northern Ireland) Order 1998[102]
- Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003[103]
- Health and Personal Social Services Act (Northern Ireland) 2001[104]
- Health and Social Care (Reform) Act (Northern Ireland) 2009[105]
- Mental Health (Northern Ireland) Order 1986[106]
- Safeguarding Vulnerable Groups (Northern Ireland) Order 2007.[107]*******

3.5.3 Standards, guidance, and policies in Northern Ireland

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003[103] to drive improvements for everyone using health and social care services.

RQIA's inspection regime ensures that safeguarding policy is adhered to in the services it inspects. This relates not only to an organisation's governance and staff training arrangements, but is also informed by complaints made, notifiable incidents, accidents and disciplinary procedures. In this way, appropriate attention can be paid to cumulative data and patterns of concern with specific people or services.

In February 2013, RQIA carried out a review[108] of safeguarding in mental health and learning disability (MHLD) hospitals across Northern Ireland. This review was commissioned by the Department of Health, Social Services and Public Safety in Northern Ireland. A sample of 33 inpatient wards was inspected as part of the 2013 review, resulting in 26 recommendations. Recommendations were made regionally and could be applied to all mental health and learning disability inpatient facilities.

In addition, voluntary and community organisations working with adults at risk also follow guidelines and standards. For example, Volunteer Now in Northern Ireland developed 'Keeping Adults Safe: A Shared Responsibility'[109] which contains standards and guidance for adult safeguarding. This publication was developed to help organisations to review or develop their adult safeguarding policy and put in place best practice to protect those in their care. Keeping Adults Safe: A Shared

******* The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 makes provision for checking people seeking to work with children or vulnerable adults, and for barring those considered to be unsuitable for such posts, whether in paid employment or in voluntary work.

Responsibility is a guide and support for organisations from small voluntary and community organisations to larger organisations providing regulated services, in improving their policy and practice.[109]

3.5.4 Model of safeguarding in Northern Ireland

A collaborative partnership approach to adult safeguarding was established through policy in Northern Ireland. The Northern Ireland Adult Safeguarding Partnership (NIASP) and five Local Adult Safeguarding Partnerships (LASPs) were set up under the 'Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements'.[110] These partnerships are tasked with improving adult safeguarding outcomes through a strategic plan, operational policies and procedures and effective practice. If there is a clear and immediate risk of harm or a crime is alleged or suspected, the policy[110] states that the concern should be referred directly to the PSNI (Police Service of Northern Ireland) or Health and Social Care (HSC) Trust[†††††††] Adult Protection Gateway Services.

The lead agency responsible for adult safeguarding referrals is the Adult Protection Gateway Service, located within Health and Social Care trusts in Northern Ireland. This is a specialist service focusing on the need to provide protection to adults who are experiencing abuse either in the community, residential settings, care home settings, or acute care. Specially trained social workers can offer information, advice and support, and determine an appropriate safeguarding response for adults whose lives are affected by abuse. Designated adult protection officers (DAPOs) are in place both within the Adult Protection Gateway Services, and within core service teams.

The Northern Ireland Adult Safeguarding Partnership and the Local Adult Safeguarding Partnership in each trust have been established to give leadership and direction to the work of key agencies. The Northern Ireland Adult Safeguarding Partnership:

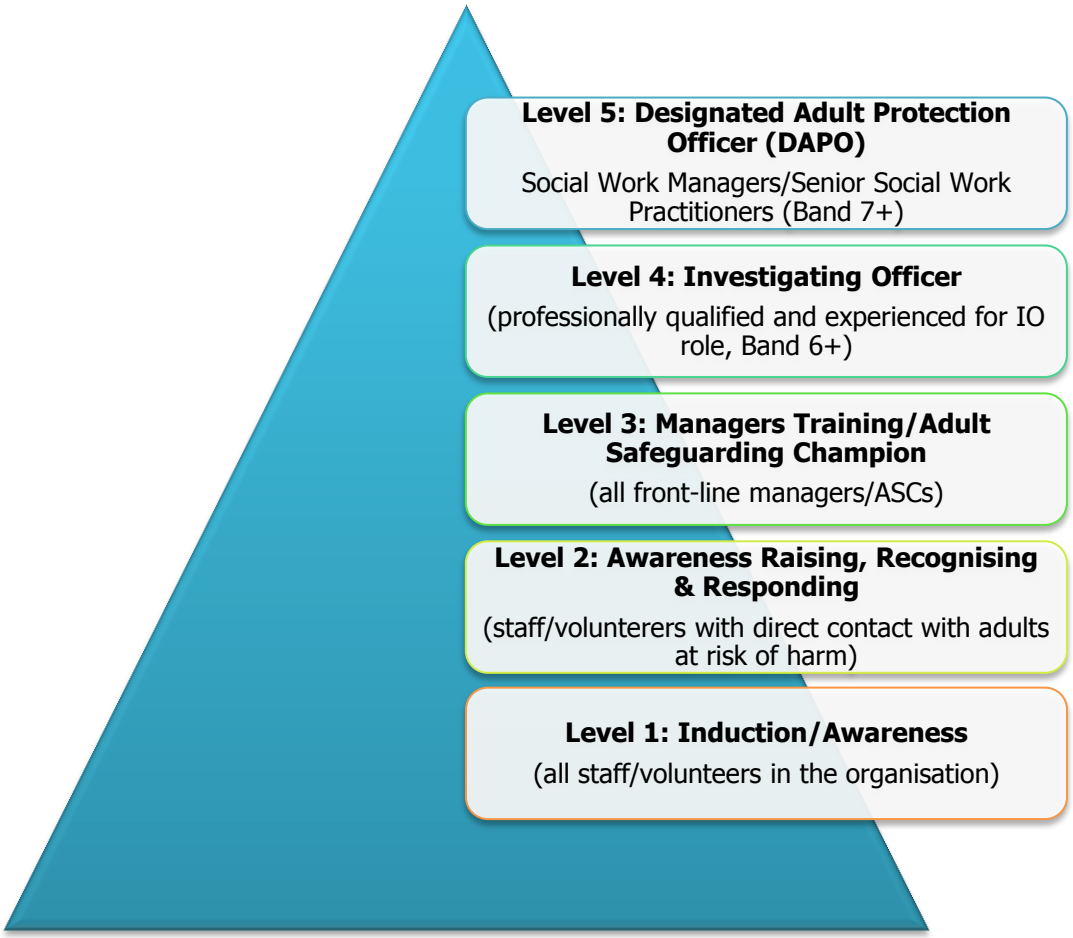
- is instrumental in determining the regional strategy for safeguarding vulnerable adults
- develops and shares guidance and operational policies and procedures
- monitors trends and outcomes

[†††††††] At the time of writing this document, there were six Health and Social Care trusts in Northern Ireland. Five trusts provide integrated health and social care services across Northern Ireland: Belfast HSC Trust, South Eastern HSC Trust, Western HSC Trust, Southern HSC Trust and Northern HSC Trust. HSC trusts manage and administer hospitals, health centres, residential homes, day centres and other health and social care facilities, as well as providing a wide range of health and social care services to the community. The sixth trust is the Northern Ireland Ambulance Service, which operates a single Northern Ireland-wide service.

- monitors and evaluates the effectiveness of new partnership arrangements
- develops and delivers training, in addition to making sure that partner organisations have effective training arrangements in place.

The Partnership's training framework (see Figure 8) sets out what level of training is required for staff and volunteers across the different levels within organisations. The framework does not specify how that training is delivered, as that is a matter for each organisation to decide itself. Both Volunteer Now[111] and the Safeguarding Adults at Risk Information Hub[112] websites direct people to relevant training in each locality.

Figure 8. Northern Ireland Adult Safeguarding Partnership (NIASP) training and development framework



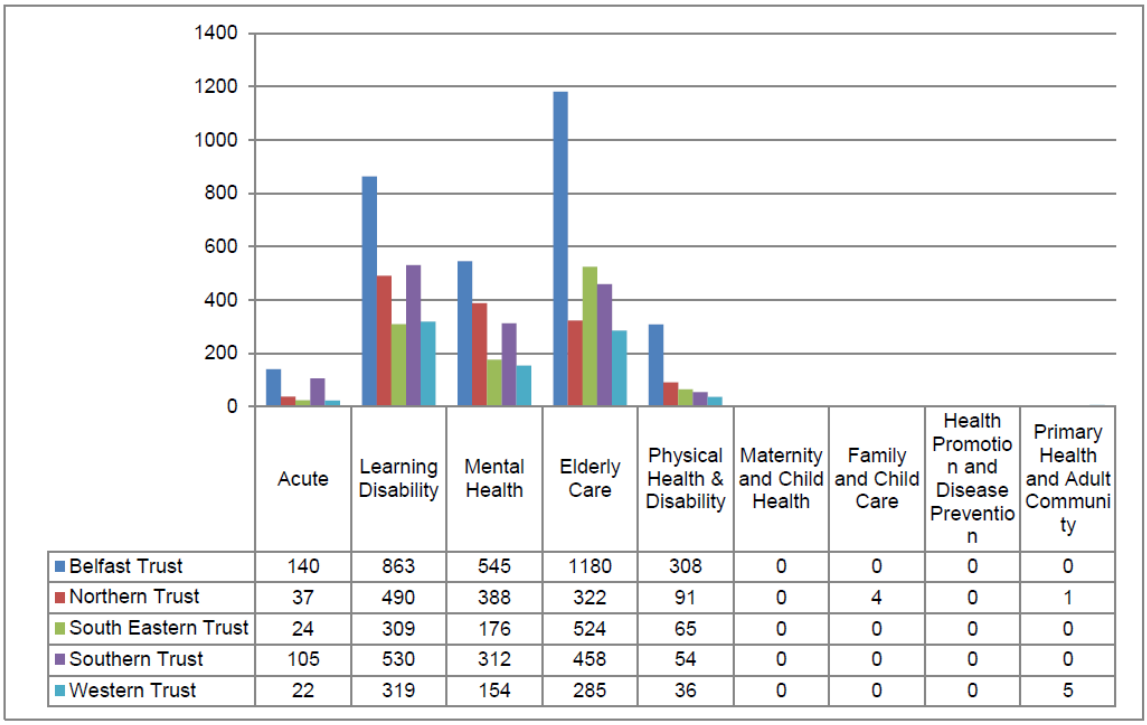
The Northern Ireland 2015 Adult Safeguarding policy[100] sets out the requirement for organisations to have an adult safeguarding champion (ASC). If the organisation or group does not have staff or volunteers who require to be police vetted, then it is not required to have an ASC. However, having an ASC is identified as good practice for every group or organisation. Targeted services include organisations that have staff or volunteers who are subject to any level of vetting under the Safeguarding

Vulnerable Groups (Northern Ireland) Order 2007.[107] All providers of targeted services are required to have an ASC and an adult safeguarding policy which demonstrates zero tolerance of harm to adults.[111]

3.5.5 Safeguarding outcomes

All community trusts in Northern Ireland provide quarterly statistics to the regional Health and Social Care Board on the number, nature and outcome of adult protection activity. The total number of recorded referrals to adult safeguarding services in 2015–16 was 7,747 compared to 9,061 in the 2014–15 period, a decrease of 14%.[113] Figure 9 shows referrals broken down by programme of care. As in previous years, over one in three of all recorded referrals (36%) were made on behalf of older people, with 32% of referrals being made by learning disability services. Twenty per cent of referrals were made by adult mental health services, a reduction of 2% compared to 2014–15. Rates of referrals vary across the Health and Social Care trusts, ranging from 3,036, or 39% of referrals originating in the Belfast Trust, to 821 or 11% originating in the Western Trust.[113]

Figure 9. Recorded referrals received by HSC Trusts in Northern Ireland (April 2015–March 2016) broken down by programme of care



	Acute	Learning Disability	Mental Health	Elderly Care	Physical Health & Disability	Maternity and Child Health	Family and Child Care	Health Promotion and Disease Prevention	Primary Health and Adult Community
Belfast Trust	140	863	545	1180	308	0	0	0	0
Northern Trust	37	490	388	322	91	0	4	0	1
South Eastern Trust	24	309	176	524	65	0	0	0	0
Southern Trust	105	530	312	458	54	0	0	0	0
Western Trust	22	319	154	285	36	0	0	0	5

Source: Northern Ireland Adult Safeguarding Partnership. (2016). *Annual Report 2015-16.*

3.5.5.1 Reasons for referral

It is not uncommon for individuals to experience a range of different types of abuse, for example physical abuse and neglect, or neglect and financial abuse. However,

HSC trusts record only the presenting or primary type of abuse to which an adult in need of protection may have been subjected.

From 2015 to 2016, the most common reason for referral to adult safeguarding services was concern that an individual had been subjected to some form of financial abuse. This accounted for 3,778 or 49% of all referrals, but made up 45% of referrals in relation to older people and 64% of referrals from the learning disability programme of care. This is a significant increase when compared to 2014 to 2015 and there are a number of potential reasons for this:

- growing public awareness of issues of financial abuse, for example, through Trading Standards‡‡‡‡‡‡‡
- more effective leadership in bringing interested parties together, for example, the Northern Ireland Adult Safeguarding Partnership and the Commissioner for Older People for Northern Ireland
- increasing awareness of the prevalence and nature of financial abuse
- specific crime-prevention initiatives such as the installation of Call Blocker devices through the Police and Community Safety Partnerships.

Responding to situations of financial abuse is challenging for HSC trust professionals, with more work being required to equip staff to respond as effectively as possible to this challenging area.(113) Not every referral made to the HSC trust adult safeguarding service requires a protection response. Some referrals will have been made inappropriately; others will be re-directed to other services which can provide a more effective response or result in a better outcome for the person in need of protection. For example, single agency intervention by the PSNI or referral to Trading Standards for support in relation to financial scams.

From 2015 to 2016, HSC trusts recorded that adult protection investigations were started in relation to 4,225 referrals, or 54% of the total number of referrals. A total of 3,172 referrals (41%) were received where the alleged abuse took place in a regulated service or facility.(113)

3.5.5.2 Care and protection plans

Care and protection plans are put in place to ensure that the alleged abuse either reduces or ceases completely. Plans are subject to regular review, not only in the course of an investigation as more detailed information becomes available, but as part of an ongoing support plan after the safeguarding investigation has concluded.

‡‡‡‡‡‡‡ The Northern Ireland Trading Standards Service's role includes promoting and maintaining fair trading, and the protection of consumers in Northern Ireland.

It is also possible that an adult in need of protection will not actually require a care and protection plan as the source of the abuse has been addressed through a referral to adult safeguarding; for example, where a paid employee is placed on precautionary suspension.

In 2015–2016,[113] 4,167 care and protection plans were implemented, approximately 54% of all recorded referrals. There is significant variation across HSC trusts, with 73% of referrals in the Northern HSC Trust and only 45% of referrals in the Southern HSC Trust resulting in a care and protection plan (see Figure 10).[113]

Figure 10. Referral rates and protection plans in Northern Ireland

	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	Region
Total referrals	3036	1333	1098	1459	821	7747
Protection Plans	1580	978	541	650	418	4167
% of Referrals Translating into Care Protection Plan	52%	73%	49%	45%	51%	54%

3.5.5.3 Comparison of Northern Ireland to Wales

The Project Team used adult safeguarding in Wales as a benchmark for Northern Ireland in order to generate meaningful comparisons, as there are sufficient similarities in terms of population size, the mixed rural-urban nature of the population, levels of deprivation and so on. While there are some significant structural and other differences between how adult safeguarding activity in Wales and Northern Ireland is recorded and analysed, a limited comparison of recorded activity between completed cases in Wales and referrals in Northern Ireland provides the following information:

- Northern Ireland screens out a higher proportion of referrals as inappropriate.
- More adult safeguarding cases are concluded each year in Wales than Northern Ireland.
- Adult safeguarding protection activity in relation to people over 65 years appears comparable.
- Adult safeguarding protection activity in relation to people with a learning disability is lower in Northern Ireland than in Wales.
- Northern Ireland is more likely to receive referrals under the category of physical abuse than Wales.

- Adult safeguarding protection activity in relation to care homes is comparable.
- Wales deals with many more adult safeguarding events within service users' own homes in the community compared to within residential services.[113]

This comparison between Northern Ireland and Wales, while limited, supports emerging conclusions from work currently being undertaken within HSC trusts to analyse demand and the capacity available to respond to adult safeguarding concerns. This work has highlighted the number of inappropriate referrals received and lack of activity as areas for future consideration.[113]

3.5.6 Summary and lessons learned from Northern Ireland

Northern Ireland does not currently have dedicated adult safeguarding legislation in place, but clear direction for adult safeguarding is provided in the policy document, *Adult Safeguarding: Prevention and Protection in Partnership*.[100] Adult safeguarding in Northern Ireland focuses on prevention and differentiating between 'adults at risk' and 'adults in need of protection'.

Adult safeguarding arrangements in Northern Ireland give rise to a number of important recommendations for the development of adult safeguarding standards in Ireland, in line with the eight-theme national standards development framework employed by HIQA and the MHC (see Figure 1).

One of the five principles underpinning adult safeguarding policy in Northern Ireland is 'a person-centred approach' in line with Theme 1 of HIQA's national standards development framework of Person-centred Care and Support. A human-rights approach underpins the Northern Irish policy with a strong focus on respecting the rights of adults as individuals and treating all adults with dignity and respect. The clear message from Northern Ireland is that adult safeguarding must respect the rights of individuals to make their own informed choices and facilitate full participation in any decision-making. Blanket approaches to identification of and responses to adult safeguarding concerns should be avoided in the standards.

The policy's focus on identifying the full range of potential harm to any adult in circumstances where they are unable to keep themselves safe strongly accords with Theme 3 of HIQA's national standards development framework — Safe Care and Support — regarding rapid identification of potential harm, followed by minimising or removing the cause of harm. This suggests a need for a preventative aspect to the adult safeguarding standards in the Republic of Ireland, alongside clear statements setting out what is required of health and social care services.

Northern Ireland's policy was designed and mandated, and is currently overseen by, an inter–agency partnership including the Northern Ireland Department of Justice. This approach links clearly to Theme 5 of the standards development framework: Leadership, Governance and Management. The experience in Northern Ireland shows that effective adult safeguarding requires a planned, permanent structure to oversee effective implementation of safeguarding measures.

Finally, Northern Irish policy requires the collection and analysis of data from both Health and Social Care trusts and the PSNI who implement the policy. It sets out the responsibilities of health and social care providers to have arrangements in place for reporting adult safeguarding concerns. The standards in the Republic of Ireland should make clear the need to share information when necessary and to use data on activity and outcomes to measure the impact of the adult safeguarding standards in protecting adults at risk of harm.

3.6 Adult safeguarding in Australia

Adult safeguarding in Australia is fragmented with no overarching legislation at a federal level. Each territory or state operates independently, creating its own legislation or policy to address safeguarding issues for discrete populations that are identified as being at increased risk of abuse. These are older people, people with disabilities and people with mental health issues. As such, this section focuses on the legislation, policy, models and outcomes for these distinct populations.

One accepted definition of abuse in use in Australia is that developed by the World Health Organization (WHO) and adopted by the Australian Network for the Prevention of Elder Abuse (ANPEA), which states:

> Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse can include physical, sexual, financial, psychological, neglect and social abuse.[114]

3.6.1 Scope of adult safeguarding in Australia

Australian states use the concept of 'vulnerability' when developing safeguarding policies for older people and there is no specific definition of an 'adult at risk'.[41]

The 2017 report on elder abuse by the Australian Law Report Commission (ALRC)[115] highlights the fragmentation in legislation and policy, pointing to the lack of power to legislate in this area at a federal level.

The ALRC outline the methods by which elder abuse should be addressed as detailed below:

- improved responses to elder abuse in aged care

- enhanced employment screening of aged care workers
- greater scrutiny regarding the use of restrictive practices in residential aged care
- building trust and confidence in enduring documents§§§§§§§ as important advance planning tools
- protecting older people when 'assets for care' arrangements go wrong
- banks and financial institutions protecting vulnerable customers from abuse
- adult safeguarding regimes protecting and supporting at-risk adults.(115)

While this report is specifically concerned with elder abuse, it recommends the introduction of comprehensive adult safeguarding legislation in each state and territory. The ALRC report states that safeguarding services should be available to 'at-risk adults', who can be defined as:

- in need care and support
- being abused or neglected or are at risk of abuse or neglect
- unable to protect themselves from the abuse.(115)

It contends that a 'functional' approach to vulnerability is preferable to providing safeguarding services to all people over a certain age, stating:

> Most people over 65 are not particularly vulnerable and will not need safeguarding services, while some people under 65 will need these services.(115)
>
> Policies and practices have been developed at state level, resulting in diverse frameworks of understanding between states of what constitutes abuse, who is vulnerable to abuse (apart from those who lack capacity), who should respond, and how the intervention should be communicated, coordinated and followed up on.(116) However, a number of states have set out a specific policy to address abuse issues in relation to discrete populations. For example, in the Australian state of Victoria, guidelines were adopted from the Australian Network for the Prevention of Elder Abuse (APNEA) to both prevent and respond to elder abuse.(117)

§§§§§§§ These are documents that detail an individual's decisions in relation to their medical, health and lifestyle needs that they wish to be put into effect if they lose capacity to make decisions).

3.6.2 Relevant legislation in Australia

Australia has no explicit safeguarding legislation; rather it has a range of federal and state laws that operate independently, creating its own legislation or policy to address safeguarding issues for discrete populations that are identified as being at increased risk of abuse. At a federal level, these include the Aged Care Act 1997[118] and amendments, Australian Human Rights Commission Act 1986[119] and the Law Enforcement Act 2002.[120]

Legislation that addresses specific areas of safeguarding varies from state to state. Victoria has the most comprehensive approach to safeguarding with legislation to protect and support older people, people with capacity issues and individuals who are at risk from family members. This legislation includes the Mental Health Act 2014, Charter of Human Rights and Responsibilities Act 2006, Family Violence Protection Act 2008, Guardianship and Administration Act 1986, Human Rights Act 2004, Personal Safety Intervention Order Act 2010 and the Powers of Attorney Act 2014.

As there is no adult safeguarding legislation at a federal level, legislation is outlined below by population group: older people, people with a disability, and people with a mental health issue.

3.6.2.1 Older people legislation in Australia

At a federal level, the Aged Care Act 1997[118] regulates the provision of services to older people which are funded by the federal government, including residential care and care supports provided in the person's home. The legislation sets quality standards and requires protection of the health and wellbeing of care recipients. The Act outlines how services are accredited. It also sets out the obligations on service providers who are providing federally funded care to older people and establishes the Aged Care Complaints Scheme.

However, a 2015 report[121] identified numerous shortfalls arising from the Act in relation to imposing sanctions on non-compliant service providers, noting in particular that:

> The Charters of Rights and Responsibilities are not enforceable in their own right as there is no process within the legislation for individuals such as care recipients to seek remedies for breaches, save for the Aged Care Complaints Scheme with penalties relating to the implications for service providers' accreditation. In the event that elder abuse is identified, as captured by this Commonwealth framework, reliance on state and territory bodies (for example state and territory criminal justice systems) would nevertheless be required by way of implementation.[121]

In contrast to disability services which are regulated on a state-by-state basis, older people's services are regulated at a federal level through the Australian Aged Care Quality Agency. The Quality Agency was established under the Australian Aged Care Quality Agency Act 2013 and is subject to the Aged Care Act 1997.(118) The Quality Agency's role is to ensure high-quality care for people receiving aged care services subsidised by the Australian government.

As part of its function, the Quality Agency undertakes quality reviews to ensure that federally funded providers meet the standards. The reviews are based the 'Quality of Care Principles 2014' (Accreditation Standards)(122) which outline four standards of quality care for older people's residential services. Each of these four standards is supported by a principle with 44 expected outcomes, while three standards for homecare services are each supported by a principle with 18 expected outcomes. These principles are set out in the Aged Care Act 1997.

At the time of preparing this report, the Department of Health was developing a single quality framework which was due to be rolled out in 2018.

The Australian Aged Care Quality Agency accredits federally funded residential aged care homes and homecare services, and it assesses the service's performance against the accreditation standards. This involves periodic full audits, as well as unannounced visits in order to monitor continuing compliance with standards. The main elements of the accreditation process are:

- self-assessment by the home against the accreditation standards
- submission of an application for re-accreditation (with or without the self-assessment)
- assessment by a team of registered aged-care quality assessors
- a decision about accreditation by a decision-maker (not part of the assessment team)
- issue of an accreditation certificate
- publication of the decision
- unannounced visits to monitor ongoing performance.(122)

When an assessment team identifies that an approved provider of a service may not meet one or more expected outcomes of the Standards, it provides a report to the Quality Agency.

The Quality Agency Principles 2013(123) S 2.63 (2) and S 3.18 (2) require that, if the CEO of the Quality Agency identifies a failure by an approved provider of a service to

meet one or more expected outcomes of the applicable standards, the CEO must decide whether there is evidence that the failure has placed, or may place the safety, health or wellbeing of a care recipient of the service at serious risk. The Quality Agency notifies the Department of Health where there has been a serious risk.

There has been criticism about the scope of these protections, as only a small cohort of the older population in Australia live in federally-funded residential services. Therefore, a significant number of older people who may be vulnerable to abuse and who are in receipt of private or voluntary services are not protected by these processes.[121]

3.6.2.2 Disability legislation in Australia

While there is a range of bodies and policies to support the rights of people with disabilities, there is no federal legislation for safeguarding adults with disabilities. Instead, each state has its own legislation which interacts with the area of safeguarding and protection from abuse. An adult safeguarding review[36] highlighted that Victoria is a particular state that has a more comprehensive approach to safeguarding featuring across its legislation.

Disability support services are provided by non-governmental organisations, the private sector and the Australian Government through the National Disability Insurance Scheme (NDIS). There is a variance across each state's legislation and policies on how safeguarding issues are reported and addressed. Only federally-funded services are required to report abuse and safeguarding concerns, which are then referred to government or advocacy agencies.

The Australian Human Rights Commission has responsibility to promote the United Nations (UN) Convention on the Rights of Persons with Disabilities, which Australia ratified in 2008. People who experience direct or indirect discrimination can complain to the Commission. It is also responsible for enforcing the Disability Discrimination Act 1992, which provides protection for everyone in Australia against discrimination based on disability in a wide range of areas, including employment, education, access, provision of services and accommodation.

Victoria's Disability Act 2006 aims to provide a stronger whole-of-government, whole-of-community response to the rights of people with a disability and a framework for providing high-quality services and supports for people with a disability. In late 2017, the Victorian Government brought in the Disability Amendment Act 2017 to strengthen the powers of the Disability Services Commissioner to investigate reports of abuse or neglect of people receiving disability services which include:

- residential services
- day services
- respite
- advocacy
- aids and equipment services.

Regulation of disability services is the responsibility of individual states in Australia. In the state of Queensland, the Disability Services Act (2006) and subsequent regulations are the legislative framework for regulating disability services. The Act sets out the rights of people with disabilities and also specifies what powers are available to 'authorised officers' in terms of monitoring compliance. Service providers must apply to the state to become 'approved service providers', which makes them eligible to apply for funding from the state.

In its 2014 report, [124] the Australian Law Reform Commission (ALRC) highlighted that — as part of the development of the national quality and safeguards system for the National Disability Insurance Scheme — state governments should review their disability services legislation, with a view to ensuring it is consistent with the National Decision-Making Principles and the Commonwealth decision-making model.

3.6.2.3 Mental health legislation in Australia

According to the Australian Law Reform Commission (ALRC),[124] there is a range of definitions of mental illness across Australia states and territories. In some jurisdictions, it has found a total absence of any statutory definition so that in every Australian state and territory, different definitions of mental illness apply.

Mental health laws have provided for treatment based on a person's need for treatment and the risk of harm posed to themselves and others. New mental health legislation in a number of states, including Victoria has changed the focus of criteria for the involuntary detention and treatment from the risk of harm to a person's capacity to consent to treatment.[124] The new legislation also puts in place protections for the rights of mental health patients through a Statements of Rights that explains the rights of patients who have been involuntarily detained, including the right to external advocacy.[125]

3.6.3 Standards, guidance and policies in Australia

As with legislation, there is no federal adult safeguarding standards, guidance or policies. Illustrative examples of federal, territory or state standards, guidance or policies are outlined by population group: older people, people with a disability and people with a mental health issue.

3.6.3.1 Older people

All states have broad elder abuse policies setting out what constitutes abuse and how to report it. There has been criticism of the fragmented nature of these policies and the inconsistent definition of what constitutes elder abuse.(115) Figure 11 outlines the range of policy frameworks and practice guidelines in operation across the states.(121)

Figure 11. Australian state and territory elder abuse policy frameworks and practice guidelines

State/territory	Organisation/department	Policies and guidelines
Victoria	Department of Health and Human Services	Elder Abuse Prevention and Response Guidelines for Action 2012–14 (2012); and With Respect to Age Practice Guidelines (2009)
South Australia	SA Health	Strategy for the Safeguarding of Older South Australians Action Plan 2014–21 (2015)
New South Wales	Department of Ageing, Disability and Home Care	Interagency Protocol for Responding to the Abuse of Older People (2007)
Tasmanian	Department of Health and Human Services	Responding to Elder Abuse: Tasmanian Government Practice Guidelines for Government and Non-Government Employees (2012)
ACT	ACT Government	ACT Elder Abuse Prevention Program Policy (2012)
Western Australia	Alliance for the Prevention of Elder Abuse	Elder Abuse Protocol: Guidelines for Action (2013)
Queensland	–	Strategy not publicly available, but note Elder Abuse website and Elder Abuse Prevention Unit (UnitingCare)
NT	–	–

Source: Australian Institute of Family Studies. (2015). *Elder Abuse: understanding issues, frameworks and responses.*

An adult safeguarding review(36) highlights that in Tasmania responses to elder abuse are guided by a set of core principles, informed by state, national and international strategies on the abuse of older people. The principles guide all policy responses and include:

- informed choice
- self-determination
- competency
- support and empowerment
- older person's rights and best interests
- diversity
- collaboration

- importance of relationships
- safety.[36]

3.6.3.2 Disability

Australia has agreed to uphold human rights set out in a number of international treaties and declarations, including the UN Convention on the Rights of Persons with Disabilities.[12] The national standards draw on these and in particular the principles within the Convention on Rights of Persons with Disabilities.

An additional principle has been added to strengthen the focus on partnerships, consistent with the National Disability Strategy 2010-2020.[126] This emphasises the importance of people with disability participating in decisions that affect their lives along with family, friends, carers and advocates. The Strategy promotes active participation in decision-making to safeguard and advance the human rights, wellbeing and interests of people with disability.

While there are a set of National Standards for Disability Services, as outlined in Figure 12 ,[127] these are not enforceable and are a best practice guide.

Figure 12. An overview of National Standards for Disability Services in Australia

Rights: The service promotes individual rights to freedom of expression, self-determination and decision-making and actively prevents abuse, harm, neglect and violence.

Participation and Inclusion: The service works with individuals and families, friends and carers to promote opportunities for meaningful participation and active inclusion in society.

Individual Outcomes: Services and supports are assessed, planned, delivered and reviewed to build on individual strengths and enable individuals to reach their goals.

Feedback and Complaints: Regular feedback is sought and used to inform individual and organisation-wide service reviews and improvement.

Service Access: The service manages access, commencement and leaving a service in a transparent, fair, equal and responsive way.

Source: Australian Government Department of Social Services. (2013). *National Standards for Disability Services.*

As with elder abuse and mental health services, there is an incoherent national response to safeguarding with each state setting out its own policy and framework for identifying and responding to abuse. A 2015 report by the Senate Community Affairs References Committee[128] is critical of the policy response to safeguarding people with disabilities and calls for legislation, policy and service provision to recognise the particular issues that may put people with a disability at increased risk of abuse and also to set such policies in a human-rights framework.

3.6.3.3 Mental health

Mental health service delivery in Australia is multifaceted. There are a large number of services in the public, private and community-managed sectors. These services vary in size, location, service delivery and funding models.

There are two sets of national standards that apply to mental health service provision, each developed independently to provide health services with a framework for implementing systems to deliver safe care and continually improve the quality of the services that they provide. These are the National Standards for Quality Health Services (NSQHS) and the National Standards for Mental Health Services (NSMHS).

The National Standards for Mental Health Services, updated in 2010, were designed to be implemented across the full range of mental health services, including those in the public, private and community-managed sectors. While endorsed by health ministers, accreditation against the Standards is not mandatory for mental health services nationally. However, some jurisdictions require this of their publicly-funded services.

While the National Standards for Mental Health Services and the National Standards for Quality Health Services were developed and endorsed nationally for implementation in mental health services, a number of services are also subject to state and territorial regulation, and private or government funding arrangements.

The National Mental Health Commission (NMHC) was set up in 2012 and works with the Australian Commission on Safety and Quality in Health Care (ACSQHC) to improve the uptake of these national mental health standards. The NMHC provides independent reports to government on mental health services, and in 2014 undertook a national review of mental health services and programmes to assess the efficiency and effectiveness of programmes, services and standards in supporting individuals experiencing mental ill health, and their families.[129]

Participants in this national review stated that mental health services are delivered within a context of continuing change, including the legislation which governs mental health services, which impacts on the feasibility of implementing the standards. For example, several jurisdictions have introduced changes to their mental health legislation, and while there have been developments in mutual recognition of these across states and territories, there remains no overarching national mental health legislation in Australia.

3.6.4 Models of safeguarding in Australia

Systems for responding to issues of abuse and safeguarding operate in each state. Government-funded organisations providing services to older people, people with disabilities and people with mental health issues are encouraged to develop policies and procedures on preventing, detecting and responding to abuse. They are also expected to develop interagency protocols between health and community care networks and funded services.

At a national level, there is an Aged Care Complaints Commissioner (ACCC). Its role is to offer advice and support in a specific range of areas. Wherever it encounters concerns that are beyond its remit, these are referred back to the service or to the relevant government department or to an advocacy body.

A National Disability Abuse and Neglect Hotline operates in much the same manner as the ACCC. Individual states also have in place ombudsman, disability commissioners and public advocates; however, in each state, each of these have different mandates, capacities to investigate and differing capacities to impose sanctions.

3.6.4.1 Safeguarding of older people in Australia

The review again used Victoria by way of illustration of an adult safeguarding system. Victoria's 2009 'With Respect to Age' document outlines practice guidelines for the prevention of elder abuse for health services and community agencies in Victoria, focusing on the role of primary care partnerships in responding to elder abuse in the community. Primary care partnerships bring together local health and human-service******** providers to improve access to services and to provide continuity of care for people in their communities.

There are 28 primary care partnerships which involve approximately 600 organisations, including hospitals, community health services, primary health networks, local governments, mental health services, drug treatment services and disability services.

When a safeguarding issue arises, responses are coordinated through the primary care partnerships who undertake the following steps:

- **Initial contact and initial needs identification** (INI) — first contact commonly involves the provision of information on services, needs identification and access to service. Primary health providers should pay attention to suspicion and identification of abuse.

******** Human service providers meet people's needs using the knowledge and skills of a range of interdisciplinary professionals, focusing on the prevention as well addressing problems, and maintaining a commitment to improving people's overall quality of life.

- **Assessment** involves collecting, weighing and interpreting relevant information about the client's situation and needs. The older person must agree to the assessment.
- **Care planning** involves the judgment and determination of need, assisting older person and (or) primary carers to makes decisions appropriate to their needs, wishes and values.

3.6.4.2 Safeguarding of people with a disability in Australia

There are a number of structures in place for monitoring and safeguarding in disability services. The Office of the Public Guardian (OPG) operates in a number of states and is responsible for protecting the rights of vulnerable adults with impaired decision-making capacity.

The Public Guardian can request community visitors to investigate other concerns and refer unresolved complaints to external agencies, such as the Disability Services Commissioner or the police for investigation or resolution.[130]

The Disability Services Commissioner is an independent oversight body established to help resolve complaints regarding the provision of disability services and to promote the right of people with a disability to be free from abuse. These complaints can relate to a wide range of issues including complaints regarding the safety or quality of care in the service, complaints about a lack of involvement in decision-making or complaints related to fees payable for the service.[130]

The role of the Disability Services Commissioner is to undertake:

- complaints resolution
- training, education and information
- community awareness
- oversight of critical incidents, death and matters of abuse and neglect
- Commissioner-initiated investigations
- inspection powers.[130]

Officers are able to inspect disability services and obtain access to staff and records and, most importantly, are able to discuss issues with people with a disability and their families. Under a 2017 amendment to the Disability Act 2006, the Commissioner can conduct an investigation into abuse and neglect of people with a disability in disability services even if they have not received a complaint. The Commissioner can investigate an individual allegation of abuse or neglect, or issues

of abuse or neglect in the provision of disability services that may be widespread across the disability sector. This can include allegations of abuse or neglect from staff member or inadequate safeguards whereby one client may be a risk towards another.(130)

Victoria also has a Public Advocate who is charged with promoting and safeguarding the rights and interests of people with disabilities, and who operates as a guardian of last resort. The post also has an advocacy and investigatory role. The Victorian Civil and Administrative Tribunal can appoint a guardian for a person with disability who is over 18 years of age and may appoint the Public Advocate as that guardian. Investigations are triggered at the request of the Tribunal or in response to a complaint.(131)

3.6.4.3 Mental health

Statements of rights are documents that set out a person's rights and under the Mental Health Act 2014 (Victoria). A statement of rights includes information about people's rights to:

- communicate lawfully
- apply to the Mental Health Tribunal at any time for a revocation of a compulsory treatment order
- choose a nominated person
- make a complaint to the Mental Health Complaints Commissioner
- be legally represented and be supported by a carer, family member or friend at a hearing of the Mental Health Tribunal
- seek the assistance of community visitors.

A similar model for supported decision-making in mental health services is proposed in the state of Western Australia as part of their Mental Health Bill 2013. Guardianship provisions for older people and people with disabilities who are proven to lack capacity exist in most states, complementing mental health legislation. In a number of states, independent guardianship bodies have legal authority to appoint guardians for people with mental illness who are incapable of looking after their own personal affairs. Victoria has a separate Public Advocate's Office established under the guardianship legislation (Guardianship and Administration Board Act 1986) — who, as outlined above, also promotes the safeguarding of people with disabilities.

3.6.5 Safeguarding outcomes in Australia

The Project Team found that reliable and comprehensive information on the nature and scale of safeguarding, adult protection or adult abuse is lacking in the Australian context. Each state has its own reporting mechanisms to funders; however, accessing this information has proved a challenge during this literature review. Reports and articles reviewed highlighted the difficulty in gathering reliable data in each of these areas.[128]

3.6.5.1 Outcomes in older people's services

The Australian Longitudinal Study of Women's Health[132] undertook a survey which included measures relevant to vulnerability, coercion, dependence and dejection. Findings from a cohort of over 5,000 women aged between 85–90 years suggested that 8% had experienced vulnerability to abuse, with name calling and put-downs being the most common forms. According to the Australian Institute of Family Studies,[121] if international indications provide any guidance, it is likely that between 2% and 10% of older Australians experience elder abuse in any given year, with the prevalence of neglect possibly higher.

In 2015, three separate studies of data from elder abuse helplines in three states (Queensland, Victoria, New South Wales)[121] reflect circumstances in which elder abuse is known or suspected and a person concerned has decided to seek advice on the situation. The findings from the Queensland report are indicative of the nature and frequency of elder abuse across the three studies.[121]

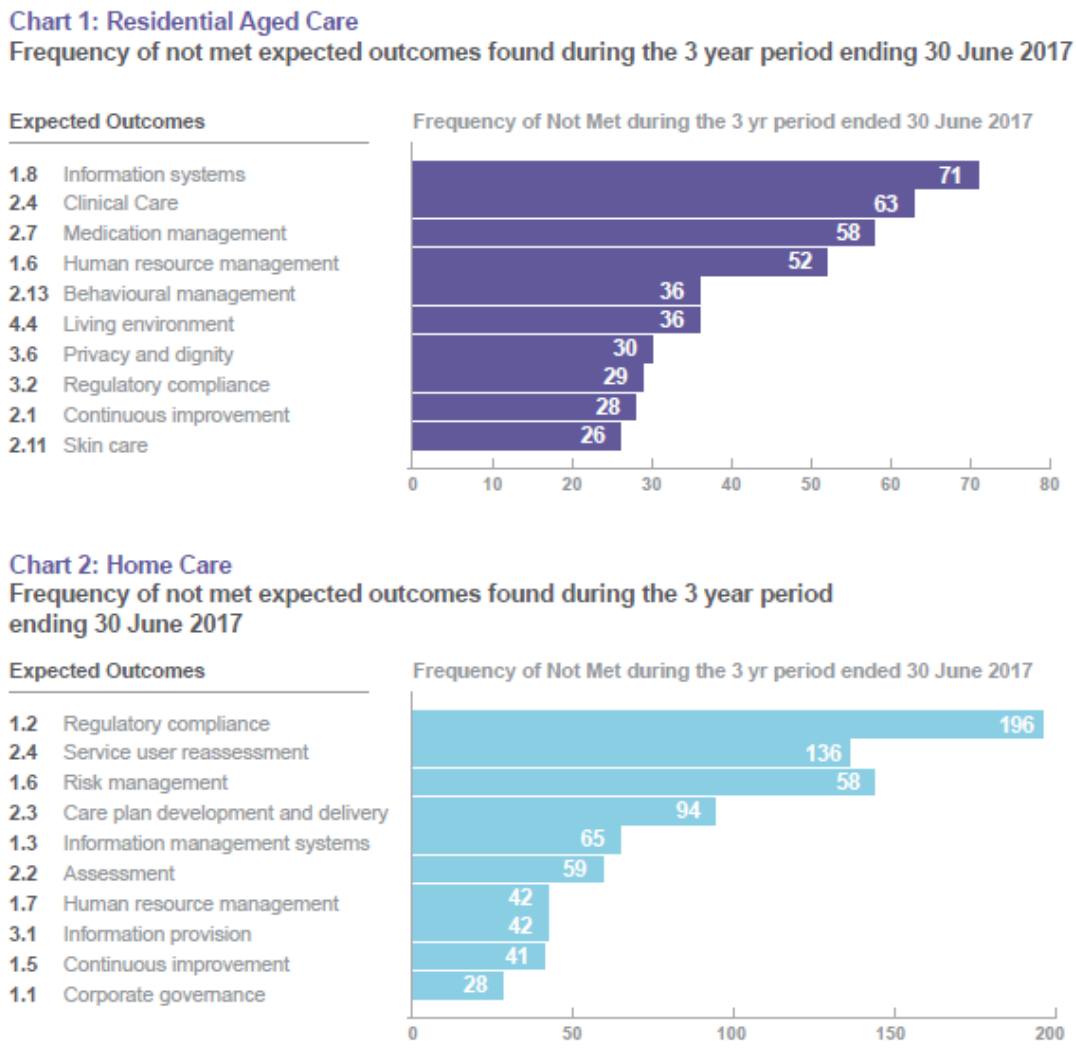
In Queensland, of 1,300 calls received from 2014–15 in regards to allegations of abuse:

- older people's own children were the largest groups of alleged perpetrators reported (31% sons, 29% daughters)
- alleged financial abuse accounted for 40% of reports, compared to 35% for psychological abuse, which had been the most common type up to 2012–13
- the next most common types of alleged abuse were neglect and social isolation, at about 10% each
- physical abuse allegations were reported in just fewer than 5% of calls, and sexual abuse allegations were referred to in about 1% of calls
- where the alleged perpetrator was a partner or spouse, the most likely form of alleged abuse was psychological (41%)

- where the alleged perpetrators were people's own adult children, financial (39%) and psychological (38%) were the most common types of alleged abuse.

In the Australian Aged Care Quality Commission 2017 Annual Report,[133] the commission highlighted three years of non-compliance (see Figure 13) with the stated standards for federally-funded older people's services (residential and home care). The Australian Aged Care Quality Commission also works with the Aged Care Complaints Commissioner in relation to complaints from older people receiving care services, their families and staff. As illustrated in Figure 13,[133] between 1 July 2016 and 30 June 2017 the Commission received 1,254 referrals. Ninety-one per cent of the referrals were for residential aged care services.

Figure 13. Findings based on quality reviews of homecare services in Australia



Source: Australian Aged Care Quality Commission. (2017) *Annual Report.*

3.6.5.2 Safeguarding outcomes in Australian disability services

Referral and outcome data for people with disabilities in Australia is fragmented. However, one overarching report by the Australian Human Rights Commission states that one in four people who have reported sexual assault are people with disabilities, and that nine in 10 women with an intellectual disability have been sexually assaulted.[134] In the report of the 2017 Disability Reportable Incident Scheme for New South Wales, 1,641 reports were notified to the Ombudsman (see Figure 14).[135]

Figure 14. Ombudsman for New South Wales disability incident statistics for 2017

Incident category	Number of notifications	Percentage
Employee to client	800	49%
Client to client	582	35%
Unexplained serious injury	253	15%
Breach of AVO	6	<1%
Total	**1641**	**100%**

Source: Ombudsman New South Wales. (2018).
Note: AVO is an apprehended violence order or a barring order taken by a victim of domestic violence.

The Ombudsman has detailed how these were followed up on. Action had been taken in 83% of cases, including (but not limited to):

- increased supervision — 293 cases
- review of behavioural support needs — 229 cases
- change in behavioural support — 162 cases
- review of health and or medical needs — 152 cases
- change of accommodation — 107 cases
- review of psychological support needs — 91 cases
- change in health support — 77 cases
- change in psychological support — 65 cases.[135]

This report also looked at the outcomes and recommendations from the reviews of deaths of people with disability. These included:

- introduction of minimum requirements relating to first-aid qualifications across all residential care environments
- development and implementation of minimum requirements for identifying and addressing nutrition and swallowing risks
- audit of the use of psychotropic medication for behavioural management purposes (restricted practice) in disability services, and development of a practice improvement initiative

- development of a Joint Guideline relating to support for people with disability in hospital
- development of improved guidance and practices in local health districts, including on the diagnosis of fractures in people with communication difficulties.[135]

3.6.5.3 Outcomes in mental health services in Australia

At the time of writing it was not possible to source comprehensive publicly available data on the number and nature of safeguarding cases in mental health services in Australia. However, data from Victoria provides an insight into the number, nature and outcomes of safeguarding issues that occur in prescribed mental health facilities.

As discussed previously in this review, community visitors in Victoria act as a safeguard to protect and promote the rights, wellbeing and safety of people in prescribed public mental health facilities. In the 2017 Community Visitors Annual Report,[136] the service identified 1,654 issues including assaults and treatment. These are separate from issues resolved at local level. The report notes that almost 70% of these issues were resolved following escalation. The key issues reported were:

- safety: aggression, assaults and self-harm
- treatment and care
- legal rights and information provision
- facility management
- activities and programmes.[136]

3.6.6 Summary and lessons learned from Australia

While there is no overall federal approach to adult safeguarding in Australia, developments at state level in particular can inform the drafting of national standards for adult safeguarding in Ireland. For example, the National Standards for Disability Services in Australia, although not enforceable, outline a number of principles that underpin the delivery of services which include:

- the right to individual expression, self-determination and decision-making
- promotion of meaningful participation and active inclusion in society

- and tailoring supports to build on the individual strengths of people using services.

These principles can inform the development of Theme 1 of the standards in Ireland (Person-centred Care and Support). In Victoria these principles have been implemented through the development of a community visitors programme. Through this programme, volunteers are empowered by law to visit disability accommodation services, supported residential services and mental health facilities.

Community visitors independently observe the environment and staff interaction with residents and patients, make enquiries and inspecting documents, and wherever possible communicating with residents and patients to ensure they are being cared for and supported with dignity and respect. Their role is also to identify any issues of concern. They visit unannounced and write a brief report at the conclusion of the visit detailing who they have spoken with, what documents they have looked at, whether there are any issues of concern, as well as highlighting good practice they have observed.

The use of this innovative approach can also inform the development of Theme 3 Safe Services; and Theme 5 (Leadership, Governance and Management) of the standards development framework employed by HIQA and the MHC.

3.7 Adult safeguarding in Canada

As with Australia, the approach to adult safeguarding in Canada operates at a provincial level rather than a national level. While there are obligations on local government to respond to allegations of abuse and neglect, this is mainly focused on prosecuting perpetrators of elder abuse rather than the prevention of abuse or addressing structural issues that lead to harm or abuse.[36] Community responses to safeguarding is an area that is developing in a number of provinces in Canada and points to an alternative model for operationalising safeguarding.

3.7.1 Scope of adult safeguarding in Canada

The Canadian definition of adult safeguarding has moved from defining a person in need of protection — specifically older people — to a more universal term of vulnerable adult. However, in the province of British Columbia, the British Columbia Association of Community Response Networks (BC CRN) has broadened the definition to an 'adult who has been abused or neglected'.[137] The widening of this definition has ensured that it is not just older people who are vulnerable to abuse and neglect and has allowed local services to be more alert to the signs of abuse.

Local models of adult safeguarding have developed which incorporate prevention of abuse and response to abuse, and examples of these are discussed in more detail later in this section.

3.7.2 Relevant legislation in Canada

Canada operates different approaches to safeguarding legislation in each province and territory. Any criminal offences are dealt with under federal law but are prosecuted by each state in line with the federal Criminal Code. All citizens are protected by the Canadian Charter of Rights and Freedoms. Due to the advances in adult safeguarding legislation in British Columbia this review will use it as an exemplar state. The Public Guardianship and Trustee Act 1996[(138)] and the Adult Guardianship Act 1996[(139)] apply to all adults whether or not they are using services or are in the community.

The Adult Guardianship Act[(139)] sets out that abuse is the deliberate mistreatment of an adult resulting in physical, mental or emotional harm and includes specific references to both neglect and self-neglect. The Act outlines the mandatory requirements of 'designated agencies', that is, any public body, organisation or person designated by the Public Guardian, to respond to a concern that has been raised through a formal report or a concern raised by a representative of the person or any concerned person.

Under the Community Care and Assisted Living Act,[(140)] British Columbia sets out residential care regulations that include the area of safeguarding and states in Section 4 that:

> A licensee must ensure that a person in care is not, while under the care or supervision of the licensee, subjected to (a) financial abuse, emotional abuse, physical abuse, sexual abuse or neglect as those terms are defined in section 1 of Schedule D, or (b) deprivation of food or fluids as a form of punishment.
>
> (2) A licensee must ensure that food or fluids are not used as a form of reward to persons in care.[(140)]

3.7.3 Standards, guidance, and policies

Elder people's care in Canada has a set of overarching model standards for both residential and community services that are set out in the 1999 'Model Standards for Continuing Care and Extended Care Services'.[(141)] These federal standards outline principles that services must uphold in working with older people (see Table 10).

Table 10. Principles from Canadian federal standards for working with older people

Individuality	Each client is unique. Clients' personal preferences, lifestyle choices, and personal environments need to be recognised and respected. Learning the client's unique history, and accepting each client as an individual, facilitates the planning and effective delivery

	of care and services which are sensitive to their diversities.
Caring and wellbeing	Caring and empathy are central to the development of a relationship between client and provider. Demonstrating a genuine concern for the client and their welfare, and providing them with relevant and meaningful support and assistance, enhances the client's ability to achieve an optimum level of health and wellbeing.
Autonomy and decision-making	Client autonomy and self-determination are supported and respected. Clients enhance their ability to direct their own care by defining their unique needs, identifying their preferences and making independent choices about their lives.
Client centred	A client-centred organisation understands and responds to the needs of its clients by measuring client satisfaction, identifying their priorities and applying what is learned to the design and delivery of care and services.
Promotion of health	Clients can enhance their health potential and wellbeing. Creating and sustaining an environment in which clients are supported to make healthy choices enables them to experience quality of life, as they define it, and realise their goals.
Partnership	Organisations should build and maintain cooperative partnerships to respond to community needs and accomplish their overall goals. More effective and meaningful outcomes are achieved when members of the care team interact collaboratively with clients to plan, implement and evaluate care and service delivery.
Quality care and service	Sound organisations strive to achieve the best possible outcomes for their clients while efficiently and effectively managing their resources. Achievement of desired health outcomes is enhanced in an environment in which care providers maintain current professional knowledge and apply best practices drawn from research and outcome evaluation to the delivery of care and services.

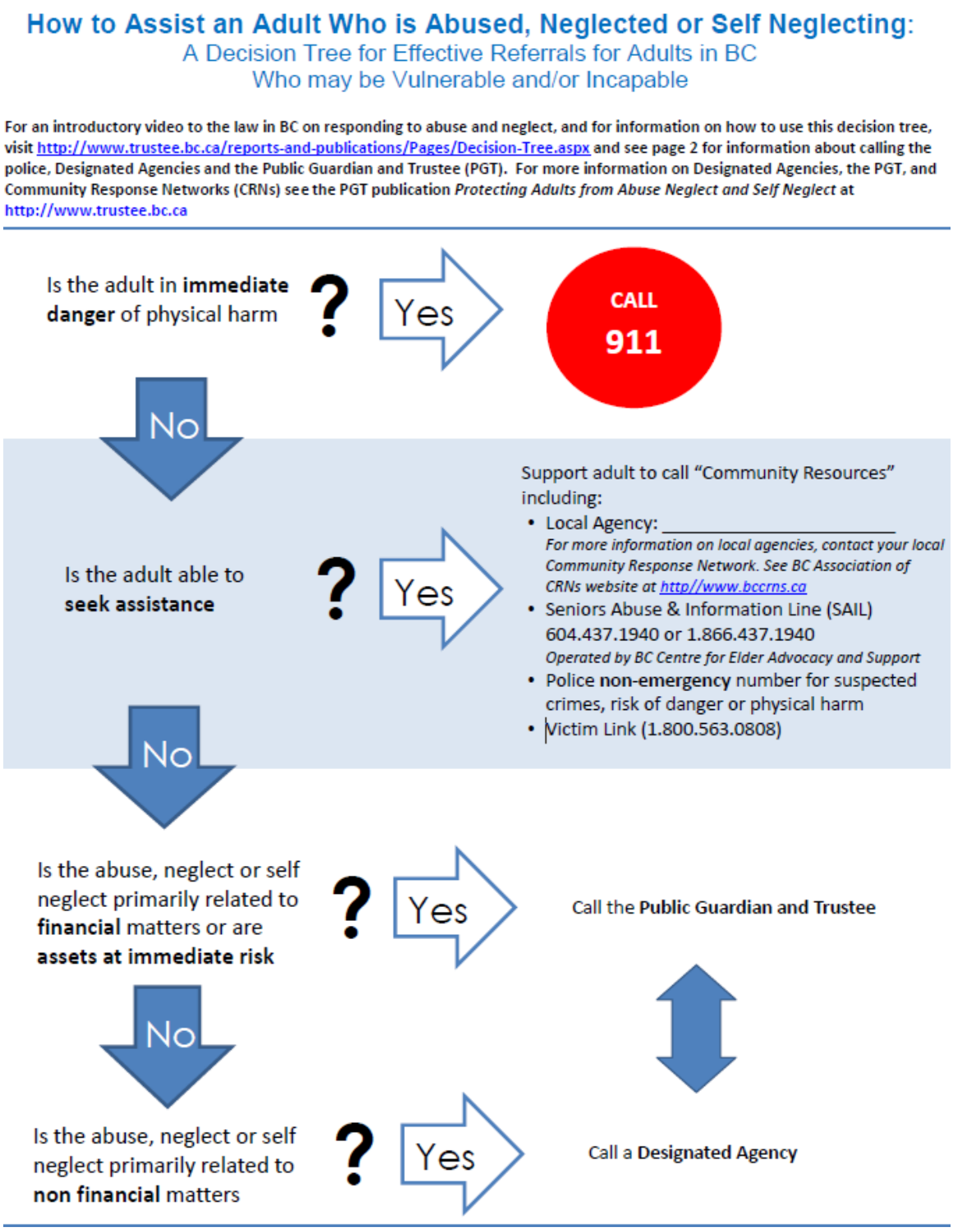
3.7.4 Model of safeguarding in British Columbia

In British Columbia, under the Public Guardian and Trustee Act 1996,[(138)] a designated agency looks after safeguarding issues. The designated agency has a social worker who acts as the designated responder coordinator (DRC) who coordinates the response across the services that the adult is engaged with.

Once a report is made, the employee who receives the report must complete the report form and ensure the correct Designated Responder Coordinator (DRC) has been informed and that the DRC accepts the report. Where the adult is known and receiving services, staff involved with the care of the adult are informed that a report has been made. They must then document the information on the adult's records. Criminal cases are reported to the police. Once the report has been received by the designated responder coordinator, he or she must follow a series of steps to assess the seriousness of the matter and respond appropriately.

Figure 15 shows a flow chart that outlines the steps taken in responding to alleged adult abuse and neglect.[142]

Figure 15. Decision tree for making an adult safeguarding referral in British Columbia



Source: Public Guardian and Trustee of British Columbia. (2018).

3.7.4.1 Follow up on investigations

Following its investigation, the designated agency has powers to follow up on areas of concern by:

- referring the adult to available healthcare, social, legal, accommodation or other services
- reporting the case to the Public Guardian or another agency
- applying to court for an interim order (lasting 90 days) requiring a person to stop living with, visiting, communicating or otherwise interfering with the adult
- applying to the court for an order under Part 7 of the Family Law Act for the support of the adult (that is to say, an order for child and or spousal support)
- preparing a support and assistance plan that specifies any services needed by the adult, including healthcare, accommodation, social, legal or financial services.

The Public Guardian and Trustee Act 1996[138] outlines the requirements on those investigating to include the adult in decision-making whenever possible, but it allows for a court order to be made without the consent of the alleged victim of abuse in order to protect them fully. Finally, dedicated agencies have emergency powers where an adult can be removed in specified situations.

Community Response Networks are also an integral part of responding to community-based abuse concerns and operate at a local level across British Columbia. A range of state, voluntary and private organisations form this network and share good practice, ways to respond to abuse, neglect or self-neglect and to support initiatives that benefit adults experiencing or at risk or experiencing abuse, neglect or self-neglect.

3.7.5 Safeguarding outcomes

According to the Community Response Network Overview Guide 2016,[143] it is a challenge to verify how widespread adult abuse is in Canada. Its report on abuse statistics are outlined below. For elder abuse, factors such as under-reporting, confusion about what constitutes elder abuse and a general lack of awareness impact on determining how widespread an issue it is. However, based on available Canadian data, it is estimated that between 4% and 10% of older adults in Canada experience some type of abuse.[144]

The report[144] which included statistics from Statistics Canada (Canada's central statistical office) found that Canadians with disabilities are more likely to be victims of violent crimes than other Canadians, and individuals with disabilities who experienced violence were more likely to experience multiple episodes of violence than their counterparts without disabilities. Furthermore, it found that adults with

disabilities are more likely to be victims of violence compared to people without disabilities, and that adults with intellectual disabilities and adults with mental health issues were at even higher risk of violence.

From a gender perspective, the report found that sexual assault, the most common form of abuse among women with disabilities, takes place at a rate twice that of women without disabilities. As well as this, Canadian women with disabilities are more likely to experience intimate partner violence than other Canadian women. Similarly, adult men with disabilities experience sexual abuse more often than those without disabilities.[144]

3.7.6 Summary and lessons learned from Canada and British Columbia

In conclusion, Canada cannot be viewed as a single jurisdiction with an overarching view of what constitutes harm or abuse but rather as a collection of jurisdictions each responding to the safeguarding needs of discrete population groups, most particularly older people and people with disabilities. While Ireland can learn from Canadian models and initiatives that have been developed in response to abuse, these are localised initiatives rather than programmes operating at a federal level across the country.

Canada has a number of state acts and localised models that the national standards for adult safeguarding proposed for Ireland can learn from. For example, state legislation in British Columbia accepts that people may refuse support, assistance or protection as long as they do not harm others and are capable of making decisions. It highlights that an adult's way of communicating with others is not grounds for deciding that they are incapable of making decisions and that they should receive the most effective but least restrictive and intrusive form of support, assistance, or protection when they are unable to care for themselves and their assets.

This example, and how it is put into practice, can inform the development in Ireland of Theme 3: Safe Services. The learning for Theme 5 (Leadership, Governance and Management) comes from the example of the community response networks — this points to a model of activating state, voluntary and private organisations to respond in a coordinated and proportionate way to safeguarding concerns in a way that puts the person at the centre of the process.

3.8 Summary of international review

This section presented the findings from an overview of safeguarding in six jurisdictions:

- Scotland

- England
- Wales
- Northern Ireland
- Australia
- British Columbia in Canada.

Based on the results of a desktop review and correspondence with international experts in the field of adults safeguarding, an overview of relevant legislation, standards, guidance, and policies was presented, alongside a description of the model of adult safeguarding and statistics on safeguarding outcomes in each of the six jurisdictions.

Lessons learned from each of these six jurisdictions were summarised at the end of each subsection, and this learning will be drawn on in the development of national standards for adult safeguarding.

4 Systematic literature review

4.1 Overview of the systematic literature review

A systematic literature review was carried out in order to apply learning from academic research on adult safeguarding to the development of the national standards for adult safeguarding for Ireland. The purpose of this literature review was to retrieve and document recently published evidence (from 2007–2017) in relation to adult safeguarding research as it relates to the eight themes set out in HIQA's established framework for developing national standards, which are:

1. Person-centred Care and Support.
2. Effective Care and Support.
3. Safe Care and Support.
4. Health, Wellbeing and Development.
5. Leadership, Governance and Management.
6. Responsive Workforce.
7. Use of Resources.
8. Use of Information.

This review was undertaken between November 2017 and February 2018, and written up and edited between February 2018 and April 2018. Evidence gathered will help to inform the development of national standards for adult safeguarding for Ireland.

4.1.1 Scope of the systematic literature review

This systematic literature review examined material published by the scientific community relating to adult safeguarding in a range of community and acute settings, with a focus on health (including mental health) and social care settings. The Project Team documented the evidence under the eight-theme framework used by HIQA to develop nationally mandated standards.

4.1.2 Systematic literature review objectives

The three objectives of this systematic literature review were to:

1. Use online search databases to conduct a systematic literature review of recent (2007–2017) published academic material supporting the development of standards, guidelines and best practice regarding adult safeguarding.

2. Categorise the search results under the eight themes of HIQA's standards framework to help guide the subsequent development of adult safeguarding standards.

3. Inform HIQA and the MHC in their engagement with key stakeholders.

4.2 Database search strategy methodology

4.2.1 The research question

Systematic literature reviews collate evidence without bias and should be reproducible, thorough and transparent.[145] Formulating the right research question from the beginning is an essential part of producing an effective systematic literature review. The following research question was proposed:

> 'What evidence from academic literature identifies characteristics of good adult safeguarding practices in health, including mental health, and social care settings?'

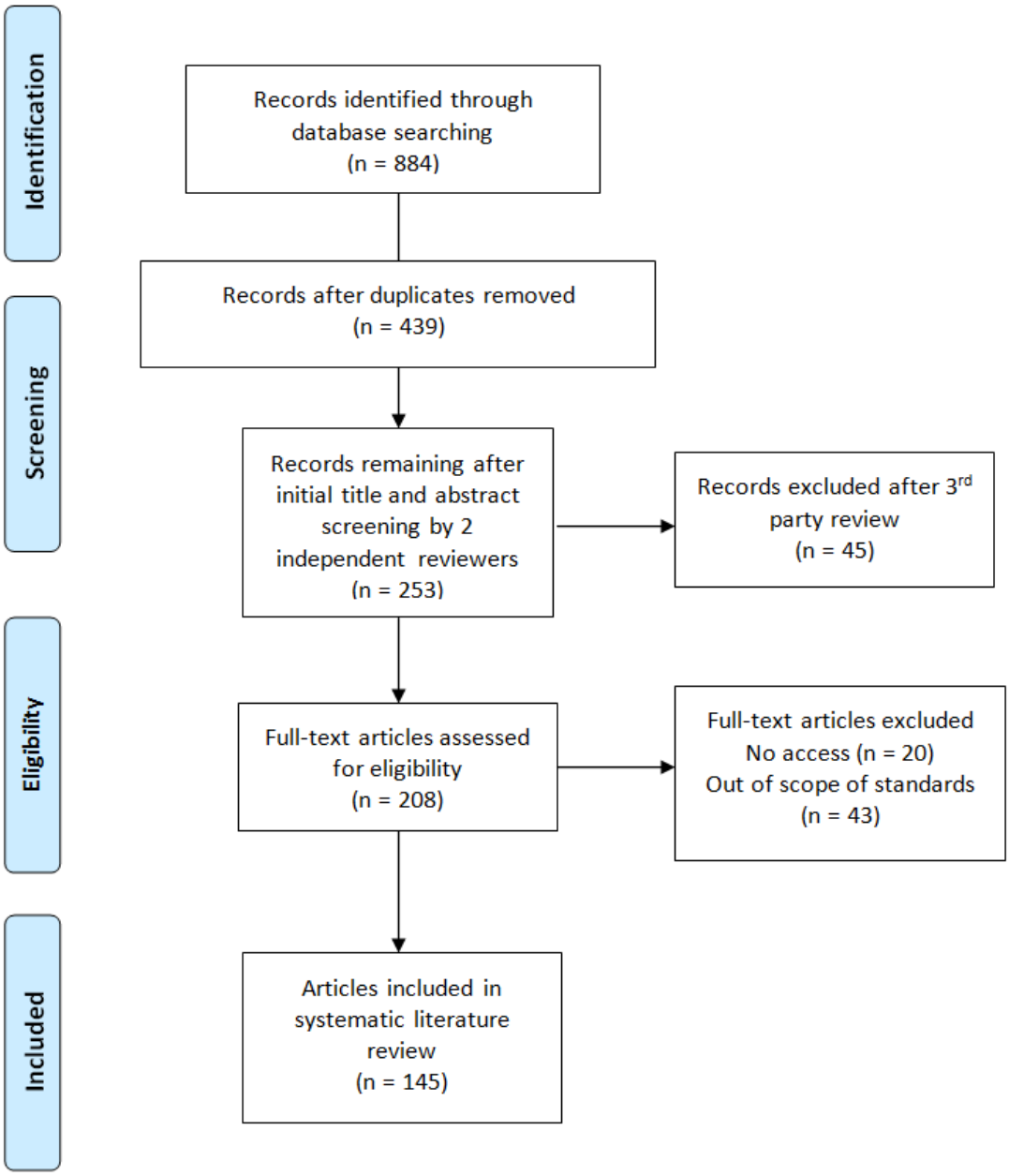
4.2.2 Database searching

The Systematic Reviews and Meta-Analyses standard for reporting systematic reviews (PRISMA) guided this review. The research question was addressed by searching for terms under specific 'concepts' (see Appendix 3—Summary of literature review concepts and search results). The Project Team agreed the terms to be used to search under each concept. The databases searched for relevant articles using these terms were ASSIA, PubMed, PsycInfo, Embase, CINAHL, Social Sciences, Social Services Abstracts and Social Sciences Citation Index. Additional limits placed on returned results included publication dates of between 2007 and 2017, English language publications and, where possible, scholarly journals.

4.3 Summary of search results

Search queries identified a total of 884 articles, where two search concepts were used (see Appendix 3—Summary of literature review concepts and search results). Titles of papers were reviewed and relevant papers were selected for abstract review. Following a blind review, second and third-party review of abstracts (see Figure 16), papers of interest were selected for retrieval and full text reading. A total of 145 publications met all criteria. The 145 articles were divided between two members of the research team for full text review. Findings from this evidence base are summarised and presented under the eight themes of the standard development framework in the next section.

Figure 16. Systematic literature review flow diagram for adult safeguarding standards (based on PRISMA 2009 flow diagram)



4.4 Structure of the systematic literature review

The systematic literature review is presented under HIQA's eight themes used in its standards development process, with sub themes covered within these as identified in the literature:

4.5 Theme 1: Person-Centred Care and Support

Person-centred care and support refers to how health and social care services place people using services at the centre of their delivery of care, support, or treatment. It includes concepts of access, equity and protection of rights. Being person-centred means service providers and staff communicate in a manner which supports the development of a relationship based on trust, and provide the people using services with adequate information to make informed decisions about their care. People should be able to express their views whenever their experience of care, support or treatment is not satisfactory via a well-structured and easy-to-access complaints process or through reviews of the service.

Articles identified as relevant for the theme of person-centred care and support were analysed and categorised into the following sub-themes:

- empowerment and autonomy
- making choices
- setting outcomes
- rights and human rights
- the views of people using services.

4.5.1 Empowerment and autonomy

Person-centred health and social care services are tailored to the needs of every person, rather than delivered in a one-size-fits-all fashion. Research[146] suggests that this means balancing empowerment and protection, self-determination, independent living and safeguarding. Safeguarding must be built on empowerment, or listening to the person's voice, and practitioners should work beyond simply making people feel safe.[147] Research indicates that people using services should be enabled to define their own risks and empowered to recognise, identify and report abuse, neglect and safeguarding issues.[146] Adults at risk are more likely to live 'a safer life' if they have been involved in a safeguarding process which empowers them to take measures to protect themselves.

Research indicated that people using services should be involved in resolving their situations.[148] Research[149] suggests that it is essential the adult at risk recognises the need for change and receives support to make those changes. This is seen as a more empowering approach than assuming that external solutions and mechanisms are always necessary to safeguard an adult; however it is recognised that external supports will often be part of the answer. With support, advice and information, the capability of people to build resilience and awareness (and in doing so make themselves less vulnerable to abuse and neglect) should not be underestimated.[149]

Research on adults with disabilities[150] highlights that autonomy and vulnerability are often seen as opposites; however, this should not be the case:

> Autonomy and vulnerability are often seen in opposition, with vulnerability being seen as a kind of 'autonomy deficit', as it implies a dependency on others. However, relational approaches to autonomy consider that it is our social connections which make autonomy possible, and therefore dependency is implied in this. Thus, being dependent and vulnerable does not equate to a loss of autonomy.[150]

Research[151] stresses the importance of taking the least restrictive option when a safeguarding issue arises, so as not to infringe on human rights and personal autonomy, but also to offer protection whenever necessary. Arguably, autonomy and protection are not mutually exclusive, but it is stated that staff working with people at risk of harm need to grasp how they relate to one another. For example, an adult at risk may require protective frameworks in place before they can achieve autonomy.[151] A 2015 publication[152] looked at how crimes against those with disabilities are constructed:

> The message the police gets is that social care professionals should "protect vulnerable adults from abuse" rather than the police needing to support people to take action against offenders.[152]

This research further highlights the need to simultaneously empower and protect people at risk.

Research[153] on safeguarding people with intellectual disabilities argues that there must be recognition that people who receive adult social care services because they have an intellectual disability are more vulnerable to abuse than other citizens. Unlike people who receive services because of a physical or sensory impairment, or because of the frailties of older age, the entitlement of people with intellectual disabilities to publicly-funded services arises from their reduced capacity to process new information, understand complex situations and, therefore, to make independent decisions. This can and does create particular vulnerabilities. Awareness of vulnerability should therefore be as fundamental as the promotion of rights, independence, choice and social inclusion when planning services for people with learning disabilities. Balancing the competing demands of independence and protection is what good practitioners should do every day.

Research indicates that services should balance empowering adults at risk and managing risk. Public sector organisations are operating in a risk-averse environment in which the need for empowerment is balanced against reducing risks to the safety of people using services.[154] Therefore, practitioners have day-to-day dilemmas of how far to empower a person using services without intervening in risk-taking behaviours in a culture that is typically adverse to risk.[154]

Research suggests that it is vital to ensure that adults at risk are empowered to make decisions for themselves about the risks they may face, and that they have the opportunity to make choices about the care they receive and where and how they receive it.[155] Empowerment and choice are core to safeguarding policy and practice; this means adults at risk should be enabled to recognise and protect themselves from abuse.[155] It also means taking a risk-enabling approach within

services and ensuring that people using services have genuine choices; both of services and within services.[155]

4.5.2 Making choices

Wherever possible, people using services and their carer, or an advocate (particularly where the person lacks decision-making mental capacity), should be included in decision-making as a matter of good practice.[151] Along with empowerment, increasing choice and control for people is central to the person-centred care and can only be achieved by recognising an adult at risk as an individual with strengths, aspirations and preferences. Adults at risk should be at the centre of the process of making choices about how and when they are supported to live their lives.[156]

An 'asset-based approach' should be used to identify a person's strengths and networks, which can help them and their family to make difficult decisions and manage complex situations and potentially delay the need for long-term care.[147] Research states that it is important for people working in services to reflect on their practice and not to limit people's choices. Limiting choices disempowers the adult at risk who can become an onlooker in the decision-making process, rather than being allowed to develop their own ability to take control and make informed choices.[150]

The role of family members, friends, carers and advocates in the decision-making process is important. Mediation and family group conferences are two examples of family-led decision-making approaches which seek to empower families and wider networks to find solutions.[156] Families and friends can help identify risks and formulate strategies for balancing risk and choice, for example, by highlighting resources and support that may not be easily identifiable to outside agencies. The person at risk should be placed at the centre of the decision-making process. When harm occurs, these approaches also seek to enable a person at risk and their family (including their wider network of support) to reach consensus about why harm occurred, what needs to be done to repair this harm, and what needs to be put into place to prevent it from happening again. A small qualitative study[157] found that adults at risk and family members experience tension between autonomy and protection: what choices do they think they have and why might they choose one above another? This exploration of choice, autonomy and capacity confirms that safeguarding oneself from harm is a complex phenomenon.[157]

A study on safeguarding people with mental health difficulties[158] indicated that the safeguarding system in England disempowers people using mental health services and excludes them from decisions about their level of risk. In this study, 84% of respondents felt that they were vulnerable or at risk of abuse some or all of the time. Only 16% of respondents said that they never felt at risk. However, the majority (86%) of survey respondents felt that they were responsible for their own

safety — sometimes in partnership with professionals (see Table 11).[158] Participants strongly felt that an individual's right to choose and make decisions for themselves must be protected as far as possible, even if others think they are at risk from abuse.

Table 11. Perceptions of responsibility for safety among people with mental health difficulties

People were asked to tick all answers that applied to them.		
Answer	**Percentage**	**Number of respondents out of 84**
Me	86%	72
Health professionals	55%	46
My family	43%	36
My Friends	37%	31
Police	35%	29
Social workers	30%	25
Housing workers	27%	23
General public	23%	19

Alongside involvement in decisions at multi-agency meetings, research has drawn attention to the involvement of people using services and user-led organisations in the actual governance of adult safeguarding through their representation on Safeguarding Adult Boards in England.[84] Health professionals acknowledge the sometimes difficult balance between providing relatives with appropriate involvement in decision-making while not conferring on them a monopoly in making decisions about a person who is unable to consent to treatment.[159]

One study[53] looked at adults' participation in case conferences and other discussions relating to their case. From a position of initial anxiety and, in some cases, reluctance to engage, most adults became more vocal and forthcoming with information as they became more familiar with and trusting of service delivery professionals involved in the case.

4.5.3 Setting outcomes

Introducing a person-centred approach to adult safeguarding is about ensuring that the voice of people at risk of harm is heard and their views and interests are kept to the fore, particularly in terms of expressing what outcomes they want from the

safeguarding process.[148] In a study[160] with social care teams, participants flagged the importance of social workers changing their questioning from "What happened?" to: "What do you want to happen?"

Of note, while participants agreed this was a positive move, they were unsure when the outcome moved from being the outcome of the person using the service to a negotiated outcome. In another study,[161] participants suggested a change to safeguarding-recording systems, to focus on direct and accurate citation of the voice of the adult at risk, as opposed to recording systems that focus on the staff members' perspective. The sub-theme of setting outcomes will be presented under three sub-headings:

- setting safeguarding outcomes with people using services
- involvement and monitoring of outcomes throughout a safeguarding process
- evaluation of whether an outcome has been met.

4.5.3.1 Setting safeguarding outcome with people using services

Staff recommend early engagement with people using services to get their views on what they wanted from a safeguarding process in a number of studies.[160,162] In one study[163] with adult social care teams, staff felt that engaging the adult at risk from the very beginning of the safeguarding process about what they needed and wanted was beneficial for everyone involved. The adult at risk should be part of the safeguarding strategy discussion even if they do not want to be part of the safeguarding process (for example, if they do not see themselves in need of a safeguarding intervention).[163]

4.5.3.2 Involvement and monitoring of outcomes throughout a safeguarding process

Research indicates that using an outcome-focused approach and engaging with the adult at risk throughout the safeguarding process is important. Person-centred, outcome-focused approaches that empower the person to draw on their strengths and personal networks are having a positive impact as practitioners start to apply these principles to all complex cases and as there is a gradual shift in culture within services.[147] For example, two studies[150] on adults with disabilities indicated that whenever the person was involved and informed in the safeguarding process and could set their own outcomes, their goals were achieved.

However, the practice of involving adults at risk in setting their desired outcomes from a safeguarding process is still under-researched. A review article[164] found that, in practice, agencies tend to be risk-averse and people using services often do not feel involved in their safeguarding processes. The review stresses that involving

people using services in the safeguarding process can result in people having increased control over their lives.[164]

Research[165] with older people describes an outcomes framework which focuses on the abilities, goals, aspirations, health and wellbeing of people using services. Such an approach is conceptually more empowering, enabling and rehabilitative than care focusing on problems and deficiencies. However, the paper[165] acknowledges that outcomes incorporating the perspectives of people using services are complex for numerous reasons (for example, people using services may not know what they require, or may know what they want but be unable to articulate it, or may want something known to be harmful). People may want to take risks (for example, one participant in the study was losing her sight but insisted going out alone everyday) and may not want to think about the future or the outcomes of their care, but rather just to focus on each day.[165] Therefore, developing methods to support staff in setting outcomes in conjunction with people using services is essential.

4.5.3.3 Evaluation of whether an outcome has been met

In terms of involvement and monitoring of outcomes throughout the safeguarding process, research[150] with adults with disabilities found that while people using services were informed and involved in the safeguarding process, there were parameters around this.

The person was asked what they would ultimately like to happen, but were not typically involved in making it happen:

> There is no question that the service user(s)' views are a part of the social workers' considerations when conducting a safeguarding inquiry, but by marginalising them in the resolution of the incident and the development of any future plan for safeguarding against further harm, this does not provide the individual with the skills to protect themselves, and keeps them vulnerable to future harm. They remain an object of protection, rather than a full, empowered subject.[150]

Research[166] found that staff felt discussing outcomes can help an adult at risk to think about what they want and that this can change throughout the safeguarding process. Whenever the outcomes that the person wanted were considered to be unrealistic, this was discussed and expectations were thought to have been better managed as a result of this discussion.[166] As they became more experienced in discussing outcomes with people, some social workers were reported as saying that their practice had become more person centred.[166]

Research[167] has pointed to the importance of collecting data from adults who have gone through a safeguarding process to assess whether or not the outcomes that

people had said they wanted had been met. Given the general move towards person-centred practice in health and social care over the last decade, this lack of input is not good enough and there is a push to measure safeguarding performance with data from people using services.(167) It is seen as a way of moving from the management of processes to the acquisition of evidence for increasing the resourcing of adult safeguarding.(167) However, the authors noted that it is important that measuring outcomes does not become part of an overly bureaucratic culture, resulting in staff being increasingly monitored and evaluated.(167)

An audit was carried out on case files in a review of safeguarding arrangements in four English local councils.(166) In the majority of cases, outcomes had been met; when they had not been met, it was largely because people using services felt there had been no retribution for the perpetrator (such as a criminal conviction). Research(161) has indicated that little is known regarding how adults at risk feel about the final the outcome of a safeguarding enquiry, because it is difficult to discern the criteria for 'success' or 'failure' for the person at the heart of the safeguarding enquiry.(161) The authors suggest that the question of outcome recording ought to be changed to a question that is more implicitly person-centred, yet tangible: 'does the person feel safer?' as a result of being safeguarded.(161)

4.5.4 Rights and human rights

The UK's Association of Directors of Adult Social Services defines adult safeguarding as 'all work which enables an adult who is or may be eligible for community care services to retain independence, wellbeing and choice and to access their human right to live a life that is free from abuse and neglect'.(168)

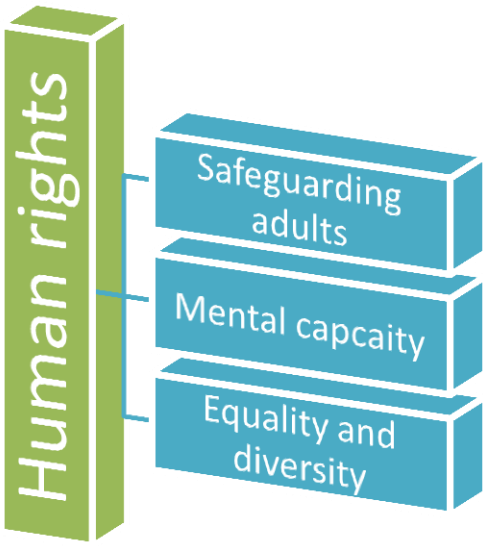
Human rights are the rights that all human beings should have regardless of nationality, place of residence, sex, national or ethnic origin, colour, religion, language or any other status. Human rights include the right to life, education, protection from torture, free expression and a fair trial. The UK's Mental Capacity Act 2005[††††††††](62) and a 'Deprivation of Liberty'[‡‡‡‡‡‡‡‡] support the human rights of

[††††††††] The Mental Capacity Act 2005 is an Act of the Parliament of the United Kingdom applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The five principles of this Act are:
1. A person must be assumed to have capacity unless it is established that he or she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he or she makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests.
5. Before the act is done, or the decision is made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

[‡‡‡‡‡‡‡‡] A Deprivation of Liberty occurs when a person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. The Mental Capacity Act 2005

those who lack capacity to make decisions for themselves. Researchers[168] have proposed that safeguarding of adults, mental capacity, and equality and diversity should sit under the umbrella of human rights, to create a human-rights approach for training professionals (see Figure 17).[168] By presenting all three subjects as integral and complementary elements to upholding all people's human rights, safeguarding work is more likely to be incorporated into everyday care and support activities, rather than being seen as a freestanding and separate entity.[168]

Figure 17. Conceptualisation of a human-rights approach to social care



Safeguarding issues and human rights infringements are intricately linked as outlined in Table 12. This table links safeguarding issues to human rights violations in three cases of abuse in care in the United Kingdom. [168]

allows restraint and restrictions to be used, but only if they are in a person's best interests. The Deprivation of Liberty Safeguards is an amendment to the Mental Capacity Act 2005 in England and Wales only. The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings, the Court of Protection can authorise a deprivation of liberty.

Table 12. Specific links between safeguarding issues and human rights violations

Case	Safeguarding issues	Human rights issues (article in brackets)
Investigation into the Service for People with Learning Disabilities at Sutton and Merton Primary Care Trust	▪ Institutional abuse ▪ Physical abuse (restraint) ▪ Sexual abuse ▪ Discrimination	▪ Degrading treatment (3)
Abuse at long stay homes	▪ Institutional abuse ▪ Physical abuse ▪ Sexual abuse ▪ Discrimination ▪ Psychological abuse ▪ Neglect	▪ Torture and degrading treatment (3) ▪ Liberty (5) ▪ Private and family life (8) ▪ Discrimination (14)
Joint Investigation into the Provision of Services for People with Learning Disabilities at Cornwall Partnership NHS Trust	▪ Institutional abuse ▪ Physical abuse ▪ Discrimination ▪ Psychological abuse	▪ Degrading treatment (3) ▪ Liberty (5) ▪ Private and family life (8) ▪ Discrimination (14)

A study in Ireland on the views of older people of the relationship between safeguarding and protection of rights demonstrated that participants viewed the denial of human rights as a form of elder abuse.[169] Participants felt older people were often targets of abuse because they looked or behaved like an 'old person' or that they were 'outliving their usefulness'. Elder abuse was conceptualised as the loss of voice, agency§§§§§§§§ and self-determination, a diminishing role and status in the family and Irish society, the experience of growing intergenerational tensions and the perceived violation of rights.[169]

Research in the UK[158] suggests that people with mental health difficulties are denied equal access to justice which infringes on their human rights. The authors emphasise the need for a shift in focus away from viewing safeguarding as protecting 'vulnerable' people from abuse, towards the principle of upholding everyone's human right not to be subjected to inhuman or degrading treatment (Article 3 of the Human Rights Act 1998).

In a situation where a person has been abused, it is crucial for the person to be empowered to know their rights, understand what safeguarding procedures and criminal justice processes might involve, and to be signposted to support and

§§§§§§§§ The capacity of individuals to act independently and to make their own free choices.

information.[158] Research notes that it is equally important that whatever remedy is applied to prevent further abuse and bring the perpetrators to justice is agreed with the full involvement and in the best interests of the person who has been abused. Fundamentally, a rights-based approach must bring an end to the misperception that safeguarding is outside the mainstream criminal justice system. Everyone has a right to expect crimes against them to be treated as crimes.[158]

A safeguarding system which empowers individuals should include access to an independent advocate for those that have been abused, to support them in reporting an incident and to ensure that it is handled through the appropriate channels.[158,170] Research states that decisions to intervene against a person's wishes in the most serious cases should be made on a case-by-case basis that weighs up people's human rights, in line with the approach to handling cases in the domestic violence field.[158] One article suggested that where intervention is against the person's wishes, a specialist officer with dedicated training in mental health and human rights could be called on to provide advice.[158]

The Assisted Decision Making (Capacity) Act 2015 (Part 2) defines different types and thresholds for intervention for people who may need support to make decisions due to capacity difficulties. In Ireland, the 2015 Act sets guiding principles of intervention which include a presumption of capacity, intervention as a last resort and minimisation on the person's rights and freedom of action.

Adult safeguarding essentially comes down to a balance between autonomy and protection.[158] The study states that a rights-based approach recognises this, takes the person's involvement as a starting point and uses existing legal frameworks to assess risk and intervene where there is a serious risk of harm.

One case study highlighted difficulties with taking a human-rights approach to safeguarding.[171] It explored ethical issues around adult safeguarding and the balance between independence and protection. The main challenge in this case was to promote an individual's independence by supporting her relationship with her son, while protecting her from being harmed by him. The author, a trainee social worker, highlights the apparent conflict in trying to carry out safeguarding from a rights-based perspective:

> I began to be aware that social services could violate some of the rights of *[service users' names]* whilst trying to uphold their other rights. Protecting *[service users' names]* from abuse meant upholding their rights under Article 2 (right to life) and Article 3 (freedom from inhuman or degrading treatment) of the European Convention on Human Rights. But this required infringing their rights under Article 8 (right to privacy and family life) by limiting their contact with *[son's name]*.[171]

A study recognises capacity as a key factor in determining respect for autonomy of decision-making, but so too is the concept of a duty of care that may require intervention to be pursued.[172] Dignity is sometimes used as a balancing factor, driving work that sought to empower people to envisage the possibility of choosing safer options for themselves. The rights of carers, care providers and staff were also recognised, along with a duty of care to people who present risk of harm to others. No easy solutions exist when having to balance competing rights, even when practice aspires to empowerment.[172]

According to research with adults with disabilities,[150] Article 16 of the United Nations Convention on the Rights of People with a Disability*********[173] creates an obligation on state parties to take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects [Article 16(1)].

Drawing on the obligations of Article 16 (to protect people with disabilities from abuse) and Article 12 (obligations of the state to ensure that people with disabilities have the opportunity to take legally valid decisions), the study[150] explored adult safeguarding social work practice in one local authority to assess whether these services supported individuals to make decisions around their own safeguarding process. Another study[174] investigated the involvement of parents in healthcare decisions where adult children are at risk of lacking decision-making capacity. Of the 21 parents interviewed, only one parent reported contemplating a son or daughter's involvement in a treatment decision.[174] There was no evidence to indicate that clinicians were following the Convention on the Rights of Persons with Disabilities[173] or the Mental Capacity Act[62] and involving these adult patients in decisions about their own treatment.[174]

Research[175] on safeguarding people with intellectual disabilities has also highlighted that those working with and for people with intellectual disabilities need to balance competing sets of demands. Practitioners have to ask the unanswerable questions: 'What value freedom from abuse if it comes at the cost of losing all independence? What value independence if it comes at the cost of being abused?' This practice dilemma echoes the tensions which exist between different elements of current human-rights legislation. For example, Article 3 of the European Convention of Human Rights provides an impetus for active interventions in order to prevent 'inhuman or degrading treatment'.

At the same time, Article 8 clearly states that 'interference by a public authority' in the private life of an individual citizen should be minimised, and thereby implies that

********* Note the United Nations Convention on the Rights of People with a Disability defines disabilities as including mental health issues.

people with intellectual disabilities should be free to assert their independence and to make choices about how to live their lives — including choices which may expose them to greater risk.[175] Further research[176] with people with intellectual disabilities has considered the consequences of 'powers of entry' legislation for people with learning difficulties who have capacity to consent to sexual relationships. The authors[176] stress that an awareness of the law is important for people with intellectual disabilities; something they state is currently lacking.

One of the challenges for those working with and for people with learning disabilities therefore becomes that of determining what the best level of independence and choice, support and intervention may be for each individual. Human rights as they exist in legislation are a necessary starting point for improving the lives of people with learning disabilities, but by themselves will never be enough. They must be made real in how they are applied to individual circumstances, so that 'independence, choice and inclusion' in the lives of people with learning disabilities does not become abandonment and isolation for the most able; or that 'effective safeguarding' does not restrict people's lifestyles or limit the horizons of the less able. Research states that practitioners need to be aware that one person's freedom may be another person's abandonment to abuse and one person's safeguarding may be another person's restriction of freedom. An awareness and embrace of human rights should lie at the heart of all safeguarding.[175]

In terms of sexual rights, a review[177] of case law in England on consent and sexual relations among adults with an intellectual disability found that capacity assessment is often vital in terms of vulnerable people being able to consent to sexual relations. The authors conclude that the law must strike a balance between two competing interests — protecting people with impaired mental functioning from sexual exploitation, and giving maximum recognition to their sexual rights. Through a review of case law, this review details capacity to consent to the use of contraception and capacity to consent to sexual relations following the introduction of the Mental Capacity Act 2005.[62]

A review article[164] highlighted that mental health is a particularly complex area, as staff in England need to understand the relationship between the Mental Capacity Act 2005[62] and the Mental Health Act 2007[46] when supporting people using services who may lack capacity to make certain decisions. People with mental health problems living in the community should have the same right to adult safeguarding and involvement in addressing the risks as any other group. The Convention on the Rights of Persons with Disabilities[173] gives a new focus on the universal rights of people with disabilities, which includes those with mental illness. The article stated that any new legislative powers on safeguarding should be reconciled with Article 3 of the UN Convention, which emphasises dignity, autonomy and choice. This

approach was reflected in the capacity legislation passed in Ireland; the Assisted Decision Making (Capacity) Act 2015.

Other research[151] reiterates this, highlighting the need to understand the interplay between mental capacity, risk, choice and safeguarding. The UK's Mental Capacity Act 2005[62] and the accompanying Code of Practice[65] make it clear that assumptions should not be made about a person's mental capacity. The starting point is, rather, a presumption that the individual does possess mental capacity to take their own decisions. However, if an individual is assessed as lacking mental capacity for a specific decision, consideration will need to be given to who should be involved in making a 'best interest' decision and also to the court of protection's power under the Mental Capacity Act 2005.[62]

Consideration would also be required in some cases to assess individuals within the deprivation of liberty safeguards, which require practitioners to take a lead role in decision-making to address potential breaches of Article 5 of the Human Rights Act 1998.[67] Although the foundations of this legislation is firmly embedded in the protection of individuals' human rights, research states that to act in the best interests of another person can easily become itself a human rights violation, and such social work must be undertaken only with a deep sense of ethical questioning. A structured approach to decision-making when individuals lack mental capacity can support practice that is consistent with a human-rights approach.[151] A three-tiered decision-making framework has been legislated for in Ireland pursuant to the Assisted Decision Making (Capacity) Act 2015.

Research[178] on safeguarded adults deprived of their liberty in the UK also highlights the need to adopt a human-rights approach to protecting adults at risk, who lack mental capacity to make decisions regarding residence, care and treatment. The author acknowledges that most individuals involved in this work recognise the need to protect individuals' right to liberty and security of person, in line with Article 5 of the European Convention. The critical issue, as cited by the author, is how best to achieve this.

Training for people using services and their families to understand the wider infrastructure of the safeguarding process; capacity and consent; relevant law and regulatory processes has also been proposed by researchers.[179] Advocacy can make a significant contribution to prevention of abuse. It can do this through enabling adults at risk to become more aware of their rights, and more able to express their concerns.[155]

4.5.5 The views of people using services

Regarding what people using services want from the safeguarding process, research[162] has illustrated that they would like to:

- be kept informed
- stop abuse happening again
- experience the least distress possible and no backlash from the abuser, family members, carers and others
- get to the bottom of how issues happen
- feel a bit better about themselves
- move, go home or change care home
- get their money or possessions back
- not be bullied or assaulted at home.[162]

4.6 Theme 2: Effective Care and Support

Effective care and support in health and social care means consistently delivering the best achievable outcomes for people using services. Service providers should aim to deliver care and support outcomes within the context of their service and the resources available. These outcomes can be achieved through regular and timely evaluation alongside use of best available evidence. Individual health, including mental health, and social care needs are all different and change over time and effective care takes account of this. Services should ensure that people using services receive well-coordinated care, and the right care for them at the right time and in the right place.[180] The delivery of health and social care is complex and it must be well planned, organised and managed to be effective. This means that outcomes are clearly described, people using services know who is responsible and accountable for their care, and feedback from people using services and from staff is monitored to plan for improvement.[2]

Articles identified as relevant to the theme of effective care and support are summarised under the following subheadings:

- effective outcome setting and risk assessment
- feedback and evaluation
- integrated care.

4.6.1 Effective outcome setting and risk assessment

An English study[181] found that staff were often so focused on adhering to vulnerable adult procedures that they lost sight of outcomes. Staff often praised the effectiveness of their procedures, even when they failed to safeguard a vulnerable

adult from harm.[181] Other research has noted the need for an effective service to recognise the issue of fluctuating capacity so that decisions can be delayed until such time as the person has regained capacity.[182] Alongside setting outcomes, effective services should also consider how risk is assessed. A systematic review[183] of literature on nine commonly used violence-risk-assessment tools concluded that as risk assessment tools are used to make important decisions in a range of services, it is important that the correct assessment tool is used for the population it was designed for.[183] The authors noted that failure to use the right risk assessment tool can have detrimental consequences for an adult at risk.[183]

4.6.2 Feedback and evaluation

Research demonstrates that organisations need to have systems in place to monitor incidents, complaints and feedback in order to understand what is happening.[184] An effective service uses data from such systems as early warning signs, and to identify systemic problems as quickly as possible.[184] Effective services also regularly self-evaluate the care and support they provide. A key function of self-evaluation is to complement inspection processes by identifying key concerns that require external scrutiny.[185] The outcome of this dual approach is to ensure that inspection is proportionate, and does not demand comprehensive external evaluation.[185]

4.6.3 Integrated care

It is imperative that an effective service is well integrated with other services, organisations and regulators. In terms of prevention work, a model of joint adult safeguarding and quality inspections (called 'Quality in Care') was trialled as a quality assurance model of support in residential care homes in England.[186] The aim of the intervention was to ensure that vulnerable adults were safeguarded and that service standards were improved.[186]

An innovative way of working in this model was the creation of a 'virtual team'. Examples of professionals from community health and social care services that comprised this virtual team included nurses (psychiatric, diabetes, continence); police from the public protection unit; consultant doctors (geriatrician, psycho-geriatrician); and senior practitioners in adult social services. These professionals agreed to be proactive in this preventative model and not just as a response to an incidence of abuse. If an area of practice was identified as requiring support during a visit, the relevant specialists were contacted to assist. Depending on the support required, members of the virtual team offered advice via telephone, email or a visit to the care home. They also offered practical support and staff training.[186] This was an effective way of working with limited resources in adult safeguarding.

Another example of effective care and support through integration comes from a review[187] of 'integrated health and social care teams' supporting older people and

adults at risk. These teams were aligned with GP practice-based commissioning clusters. The co-location of health and social care staff was central to the development and deepening of informal and formal learning and networking across the professions.[187] Key outcomes were an increase in knowledge transfer between nursing and social work staff and improvements in the interventions delivered.[187] Results from this co-location provided:

- simpler and faster access to social services (for example improved performance in response times for assessments and service provision)
- increased efficiency (one point of referral)
- better use of staff time
- clearer understanding of professional roles and better use of resources
- improved patient experience.[187]

However, the authors noted that developing a team ethos and understanding of roles would have helped to overcome early obstacles in inter-professional working between health and social care services.[187]

A third study[188] looked at how safeguarding teams have been organised in different local authorities in England and the pros and cons of specialist versus dispersed models.[†††††††††] In this study, participants practising in a dispersed-generic model highlighted problems with the development of specialist roles and safeguarding teams. Their reservations emphasised their fear that specialist roles dilute the message that safeguarding is 'everybody's business' and may de-skill workers in specialist teams. They also noted that specialist roles can inhibit the development of safeguarding social work skills among mainstream social workers. This article notes the importance of ensuring that regardless of a specialist or dispersed approach, everyone is working with safeguarding in mind, and specialising does not mean that everyone is referring but rather that they work with more complex cases.[188]

A qualitative evaluation[189] of a small, multidisciplinary safeguarding support team in a care home found that the team actively supported services with training, advice and safeguarding actions rather than just inspecting and making judgments. In this case, integration worked well due to the approachability and encouragement of the safeguarding support team, alongside highly interactive sessions, which had direct practical relevance to the day-to-day work of staff.[189]

[†††††††††] In a dispersed-generic model, there is limited or no specialist involvement in response to safeguarding concerns. Safeguarding is regarded as a core part of social work activity. In a specialist model, safeguarding processes are typically completely separate from the care management model and is the responsibility of specialist safeguarding social workers.

One study[190] sets out best practice and referral pathways for general practitioners (GPs) when a safeguarding concern arises. GP practices should implement processes to prevent abuse and foster a culture of vigilance.[190] However, studies note that even within organisations, there are clashes between disciplines due to status, values and roles which creates barriers to multidisciplinary working, including mistrust and misunderstanding of colleagues' expertise and difficulties in developing an explicit knowledge-base and shared language.[191] This study illustrates that, to be effective, services must integrate care both between and within services.

4.7 Theme 3: Safe Care and Support

Safe care and support recognises that the safety of people using services is of the highest importance and that everyone working within health and social care services has a role and responsibility in delivering a safe, high-quality service. However, providing health and social care can never be completely risk-free. Service providers must have systems in place to identify, prevent or minimise unnecessary or potential harm associated with the provision of care and support to people using services. A service focused on safe care and support is always looking for ways to be more reliable and to improve the quality and safety of the service it delivers. Such a service learns from situations where things have gone wrong and makes changes to the service it provides as a result.[180] In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity. Protecting people using services from any form of abuse is integral to this culture. To achieve this culture, everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for people using services.[2]

This theme is subdivided into the following subsections:

- protection of property and finances
- safety in a range of health and social care settings
- open culture
- positive risk taking
- restrictive practices.

4.7.1 Protection of property and finances

Alongside protection from various forms of abuse to a person (verbal, sexual, physical, emotional, neglect), a safe service also strives to protect a person's property, belongings and finances. An article in *The Journal of Adult Protection* [192] highlights the inconsistency of understanding and response to issues of financial

abuse in older people's residential care facilities. This is a complex area which is impacted by a person's cognitive, communication and physical frailty, in conjunction with a fear of retaliation. While there were policies and procedures in place in the facilities surveyed, these mainly related to theft by staff members, other residents or visitors rather than issues around power of attorney or undue influence by family members.(192) According to the authors, a lack of consistency can lead to financial abuse in residential settings being under reported.

Another study(193) highlights inconsistency in staff identifying and addressing financial abuse. The study suggests barriers to safeguarding from financial abuse including:

- bureaucracy and lack of personalisation‡‡‡‡‡‡‡‡‡ in banks and financial institutions
- social barriers that are difficult to challenge (for example, a neighbour overcharging for looking after someone, or a child using parents' money to go on holiday)
- systemic failures (for example, the length of time a criminal investigation takes)
- poverty (a person with very little money is more likely to be quickly affected by financial abuse, as this may be a large part of their income. Also, those with money may have advisors and solicitors to protect their interests).(193)

A survey(194) of voluntary sector dementia staff and their experience of financial abuse highlighted the variance of training and guidance for statutory and regulated service providers versus voluntary and third-sector§§§§§§§§§ organisations. Staff made recommendations including better data sharing between banks and social services if there is an unusual pattern of withdrawals.(194)

A study(195) involving interviews with Adult Safeguarding Coordinators********** in England looked at the issues of personal budgets (budgets paid directly to the person for their care as opposed to an organisation). Respondents identified that paying these to people with dementia could potentially lead to financial abuse but that risks could be minimised through:

- clear safeguarding protocols

‡‡‡‡‡‡‡‡‡ Personalisation means tailoring a service or a product to accommodate specific individuals.
§§§§§§§§§ Third sector organisations are organisations that are neither public sector nor private sector, including voluntary and community organisations such as registered charities, associations, self-help groups, community groups and social enterprises.
********** Safeguarding coordinators are professionals within adult social care or NHS organisations that have overall responsibility for managing the safeguarding process.

- sign off by social work on care plans
- support around money management
- regular check-ins and reviews from social work
- thinking ahead to putting Power of Attorney†††††††††† in place.(195)

4.7.2 Safety in a range of health and social care settings

Much of the literature on adult safeguarding relates to residential services, with less research relating to community settings.(155) However, it is important to consider how all health, mental health and social care services can work to deliver safe care and support. For example, one study(196) undertaken in two local authorities in England, found that safeguarding issues were less likely to be reported by staff in health and mental health services. The authors emphasise this reluctance of mental health professionals to engage in adult protection procedures. This study also highlighted that almost half of safeguarding referrals (46%) were for people in residential or supported living compared to 32% for people living with a family and 17% for people living alone.(196)

A study(197) — looking at the importance of training nurses in busy acute hospitals to challenge attitudes and beliefs about older people — illustrated that specialist needs are more difficult to meet in a generalist environment. The authors argue that nurses care for a growing population of older adults with complex problems without institutional recognition of this.(197) They work in a care context that often does not acknowledge or adequately support the unique healthcare needs of older adults.(197)

To provide a safe service, it is also important to have experienced and relevant professionals undertaking investigations (for example, registered nurses in healthcare settings) so that they are bringing their understanding to the person's physiological, psychological, everyday living skills, behaviour and social assessment and biography.(198) The authors note that knowing a person and their baseline behaviour can help a practitioner identify when something has happened to them, as their behaviour may change.

4.7.3 Open culture

In some services, staff can find it difficult to challenge poor practice, and this in turn threatens the ability of a health or social care service to be able to provide safe care and support. Such cultures can develop due to poor leadership, a focus on finance

†††††††††† Power of attorney can be set up by a person during their life when they are in good mental health. It allows another specifically appointed person to take actions on the person's behalf if they are absent, abroad or incapacitated through illness.

rather than the quality of care, poor quality monitoring systems, lack of acceptance of responsibility at all levels of the organisation and a lack of understanding of adult protection procedures and processes.(198)

Research suggests that a culture of speaking out against poor practice is important. Staff must be supported in raising concerns about practice and action needs to be taken in response.(199)

4.7.4 Positive risk taking

Professionals need to decide how to actively engage in supporting an individual to make informed choices. As stressed in one study,(151) this work requires a particular set of skills. It is not about staff organising and delivering services or medication, it is about skilled practitioners working with the perspective of a person using a service. People should be supported to make informed choices, for example, through the use of aids, such as a diary or video to record a person's thoughts on a particular issue, which can be considered with the person when making decisions that involve the balancing of risk and choice.(151) Defensive risk management strategies or risk-averse front-line practice may result in people using services not being adequately supported to make choices and take control and, therefore, being put at risk.(146) This compromises the ability of a service to provide safe care and support. Supporting risk enablement for people using services is critical.(148)

People should be involved in assessing and managing risk as part of their safeguarding interventions, and a risk assessment should take place alongside the person and their family, maintaining a focus on the person rather than on maintaining a risk-averse environment.(148)

4.7.5 Restrictive practices

A safe service ensures that arrangements are in place to protect each person from harm, promote bodily integrity, personal liberty and the least restrictive environment in accordance with national policy. Safe services minimise harm to the person whereas restrictive practices potentially contribute to this harm. A study(200) on bedrail use proposes an ethical framework to enable nurses to make transparent and defensible decisions about the appropriate use of bedrails, thereby fulfilling professional, moral and legal requirements. This framework is based on the principles of respect for autonomy, beneficence,‡‡‡‡‡‡‡‡‡‡ non-maleficence,§§§§§§§§§§ dignity and justice.(200)

‡‡‡‡‡‡‡‡‡‡ Beneficence is an ethical principle that addresses the idea that a practitioner's actions should promote good and do what is best for the patient or person using services.

§§§§§§§§§§ Non-maleficence is an ethical principle that one should not do harm to patients or people using services.

A legal briefing paper[201] made the suggestion that a more inclusive assessment of capacity is required when assessing whether a person is being deprived of liberty and assessing alternatives to restrictive practices. The article highlights the difference between depriving someone of their liberty and restricting their liberty in a proportionate way to protect them from harm.[201]

4.8 Theme 4: Better Health and Wellbeing

A service focused on better health and wellbeing is one which constantly looks for ways and opportunities to promote, maintain and improve the health and wellbeing of people using its services. The improvement of the health and wellbeing of people using services is not the sole responsibility of people using services or service providers, rather they work together to achieve this outcome and people using services are supported to make decisions.[180]

Practitioners must work beyond making people feel safe, in order to support other aspects of the person's wellbeing, such as feeling empowered and in control.[147]

In the area of adult safeguarding, there needs to be a balance between respect for autonomy and a perceived duty to preserve health and wellbeing.[202] The outcomes framework focuses on the abilities, goals, aspirations, health and wellbeing of people using services. Such an approach is conceptually more empowering, enabling and rehabilitative than care focusing on problems.[165] A study[203] on the findings of a number of serious-case reviews,********** where a person receiving homecare had died and factors contributing to it had been acquired or worsened over the course of care, found failures to follow guidance had been noted among professionals. Its recommendations included:

- greater training for homecare workers
- greater risk communication
- better adherence to clinical guidelines.[203]

The role that district nurses play is key for proactive assessment, treatment, planning and coordinating responses to these factors and ensuring these are reported.[203] Rapid hospital discharge, poor aftercare, lack of resources and person's reluctance to seek help may all contribute to deterioration of health and wellbeing.[203]

Another article[204] looking at the issue of pressure ulcers in a residential care setting discusses how informed professional judgment is critical in preventing and responding to this and other factors that impact on a person's health and wellbeing:

********** Serious case reviews (SCRs) in respect of vulnerable adults are inquiries conducted by English adult protection or safeguarding boards at local level whenever harm or death has occurred.

> Pressure sores are[…] 'not always due to neglect and each individual case should be considered, taking into account the person's medical condition, prognosis, any skin conditions and their own views on their care and treatment. These things, rather than the grading of the pressure sore, should determine whether a safeguarding referral is appropriate. Other signs of neglect, such as poor personal hygiene and living environment, poor nutrition and hydration may help to influence this decision.[204]

The article[204] looked at a range of factors that must be considered in preventing and responding to serious health conditions:

- poor care quality
- responding to pre-existing conditions
- care capacity when a person's needs become more complex
- multi-agency processes and policy
- effective interagency working.[204]

A study[205] on safeguarding adults at risk of harm in Christian faith contexts investigated how those in the Christian faith context understand their responsibilities to protect and safeguard adults. The authors argue that faith-based organisations may constitute an agency involved in safeguarding adults at risk of harm and it is therefore important that practitioners involved in safeguarding develop understanding and awareness of issues of religion and belief and their potential impact upon safeguarding practice.[205] Results highlighted that people were unsure of what safeguarding is, what constitutes a safeguarding issue and how to report a concern.[205]

Participants felt vulnerability was connected to specific conditions, such as a disability or old age rather than life events, such as a stay in hospital or being widowed. Results indicated a lack of clarity about what to do with a safeguarding adult concern; and the need for safeguarding training relevant to the particular needs of faith-based settings. Many respondents who had received safeguarding training obtained this from their work or statutory organisations rather than from their Christian context.[205] This article suggests that faith-based services can be a key point of contact for many people as they provide services such as food banks, homeless projects and debt counselling services.[205]

An evaluation[189] of a 'care home safeguarding support team' found that the team actively supported services with training. Services found that the emphasis the support team placed on meeting the social, mental health and nursing needs of residents contrasted with previous interventions that had prioritised mental health or

nursing care.[189] This suggests the need for more holistic training for professionals working with adults at risk.

4.9 Theme 5: Leadership, Governance and Management

A well-governed service is clear about what it does, how it does it and is accountable to its stakeholders. It is obvious who has overall executive accountability for the quality and safety of the service and there are clear lines of accountability at individual, team and service levels. Leaders at all levels have an important role to play in strengthening and encouraging their services' quality and safety culture. Effective management ensures that a service fulfils its statement of purpose by planning, controlling and organising the service to achieve its outcomes in the short, medium and long term, and organising the necessary resources to ensure the delivery of high-quality, safe and reliable care and support.

A well-governed and managed service also monitors its performance to ensure that the care, treatment and support that it provides is of a consistently high quality throughout the system.[180]

This theme includes articles identified in the literature review, and are presented under the following subsections:

- culture
- multi-agency working.

4.9.1 Culture

Research suggests that it is important for management in health and social care services to create a positive culture that fosters relationships that are trusting, responsive and sensitive.[206] It is also important that management sets a 'zero tolerance' culture regarding adult abuse and neglect. Researchers have emphasised the need for organisational cultures that both encourage and expect professional and public challenges to the quality, resourcing and processes of safeguarding work.[207] Features of such cultures include:

- critical thinking and questioning of practice, resourcing and decision-making at all levels of organisations
- managers who model self-reflective practice (examine his or her own feelings, reactions and motives) and develop it in staff
- managers who require reports of poor practice as well as exemplary work.

This study suggests that, managers in these cultures would ask, regularly, why they received few, if any, reports of poor practice, services or care.[207]

In terms of an open culture, one study[206] proposes that the physical layout of a building can contribute to a sense of belonging. This study argues against segregation of staff and people using services, and promotes shared spaces in services. Other research[146] has stressed the need for social care providers to foster a culture of positive risk taking, in contrast to the current risk-averse culture that predominates health and social care services. Conventional risk management has been characterised by technical approaches, which sometimes treat the person 'as an object' to be assessed by the 'experts', rather than as an agent in their own lives, and part of a family, community and society, with legal rights and choices.[146]

In terms of achieving cultural change in organisations and across organisations involved in adult safeguarding, leadership and champions are key to success.[148] A study on the implementation of 'Making Safeguarding Personal' in England (a national initiative for local authorities to improve safeguarding practice) found that Making Safeguarding Personal was encouraged where there were senior managers or chairpersons of safeguarding adult boards†††††††††† who promoted and supported the approach. Practitioner leadership from social workers was also found to be important and some councils developed and supported Making Safeguarding Personal champions in teams.[148]

Learning from serious-case reviews[208] in the UK also emphasises organisational culture as an important contributor to the adult safeguarding practice environment. A move to personalisation was seen as requiring significant culture change — a move away from eligibility for a service based on diagnosis or IQ towards an approach based on need and risk, which considers the whole person.[208] This article also emphasised the need for a culture of challenge and debate between agencies; they should seek clarity from each other and to follow up on referrals made to others to ensure action is taken.[208]

Many policies and procedures within services, not just safeguarding policies and procedures, can support the prevention of adult abuse. In order to support such policies and practices, it is essential for service providers to display effective leadership.[154] This includes promoting an organisational culture that prevents abuse and ensures that all staff are confident and have the skills to act quickly if concerns are identified.[154] An open culture with a genuinely person-centred approach to care, underpinned by a 'zero tolerance' policy towards abuse and neglect is essential.[155] Good support and training for staff including whistle-blowing policies were also highlighted as being important.[155]

In terms of accountability, a review of research analysing adult protection data concluded that adult protection agencies, administrators, and workers should be

†††††††††† In England, a safeguarding adult board leads adult safeguarding arrangements across its locality and oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies.

willing to risk opening their policies and practices to the scrutiny of research.[209] However, policy and legislation alone cannot protect adults who are at risk, and in circumstances vulnerable to abuse, there also needs to be commitment at an organisational and practitioner level to develop decision-making processes which ensure that safeguarding and personalisation are interwoven as efficiently and effectively as possible.[151]

In terms of a culture of person-centred care and support, interviews[164] with safeguarding leads in England pointed to staff sometimes acting in ways which are not what the person using the service wants:

> We tend to go in heavy handed and we think we know what we should do. Service users often just want the abuse to stop, they don't necessarily want a conviction.[164]

This awareness among managers highlights the need for management to cultivate and promote a person-centred culture in services.[164] To develop such a culture, there must be commitment at an organisational and practitioner level to develop decision-making processes that ensure person-centred care in practice.[151] It is also important to challenge practitioners to look at their own values, perceptions of safeguarding and the influence of organisational culture on practice.[210]

One study[206] described a service's adoption of a compassionate model of practice called 'total attachment': a whole-systems approach to leadership which contributes to the prevention of abuse. The study looks at how staff can become detached from people using services who are challenging and complex and this becomes a culture that needs to be understood and challenged.[206]

4.9.2 Multi-agency working

Multi-agency working involves cooperation between several organisations. Adult safeguarding is a challenging and complex area of practice, and each organisation has its own priorities and drivers, and its own view of what constitutes 'promoting independence' and 'protecting from harm'.[171] This section on multi-agency working will be subdivided into benefits and barriers.

4.9.2.1 Benefits of multi-agency working

Effective multi-agency working in adult safeguarding involves communication and information sharing between front-line workers,[211] sharing of expertise, shared responsibility and a strategically effective approach.[212] Practitioners working within a multi-agency setting aid safeguarding work through the sharing of specialist knowledge and through adopting a transparent investigation process.[154] The sense of shared responsibility that is engendered by working together in adult safeguarding has been cited as important by those working in the field.[213]

Research states that a structured model of multi-agency decision-making can help practitioners to achieve appropriate balancing of risk, alongside empowering people using services to make informed choices.(151) To support a genuine multi-agency approach to decision-making in safeguarding, good communication and leadership skills are needed to encourage less confident or more reflective members to fully engage in the process.(151) Alongside accelerating decision-making, effective multi-agency working reduces duplication of work.(213)

However, having a well-structured interagency communication system through which to share concerns and aid decision-making is important for sharing risk and protecting agencies.(202)

A study with adults at risk, social workers, safeguarding managers and administrators recommended flexible ways of chairing safeguarding meetings to enable participation of adults at risk and manage conflict with alleged perpetrators of harm.(214)

Multi-agency working has worked differently in different jurisdictions. Local Authorities, Local Health Boards, Trusts and Primary Care Trusts across England and Wales have developed their own inter-agency policies and procedures for responding to alleged abuse and inappropriate care of vulnerable adults. Each policy has its own shared definitions and key roles and responsibilities for partner agencies.(215)

In Northern Ireland, a strong multi-agency component to safeguarding work has been achieved through close collaboration between the health and social care trusts, criminal justice sector and the Regulation and Quality Improvement Authority (RQIA) — the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland.(216) In interviews with safeguarding coordinating managers in England as part of one study, one manager particularly praised the police in respect of close collaboration, citing a proactive approach from local police officers and police community support officers to resolve safeguarding concerns and prevent reoccurrence of any abuse.(211)

A study(217) of social service managers in England and Wales found that adult safeguarding managers use negotiation and networking skills across health and police service interfaces. Most of the managers interviewed were highly committed to adult protection developments and derived satisfaction from their ability to contribute to interagency responses at strategic and practice levels.(217)

Safeguarding managers have also emphasised the benefits when different professionals understand each other's roles and the flexibilities and constraints they work under. Views from professionals working outside social services can help managers see the 'bigger picture' in adult safeguarding, both strategically and at an operational level.(217) The ability to consult and work with other agencies over the

course of an investigations at strategic levels brought a broader perspective to their work since other agencies acted as an accessible network of 'critical friends'.[217]

4.9.2.2 Barriers to multi-agency working

Research indicates that there are substantial barriers that hinder organisations from working together effectively, such as different cultures, practices, beliefs and ideologies,[215] alongside lack of clarity of roles and delays in decision-making.[212] Additionally, research has indicated that professionals give precedence to their own professional norms and organisational priorities over partnership working.[181] There must be clarification of roles and responsibilities, integration of processes, and multi-agency training to increase the effectiveness of multi-agency working in adult safeguarding.[215]

A family perspective[218] on an adult safeguarding review highlights the implications of a lack of communication and collaboration between services (in this case, addiction and mental health services). The paper highlighted the lack of coordination across services, where their family member could not get psychological support to address his issues either because he could not engage in those services until he was 'clean', or because he was viewed as not being mentally ill or suicidal.[218]

Research on the consequences of multi-agency work breaking down in the implementation of the 'No Secrets' policy in England highlighted that some disciplines (notably GPs, NHS trusts, independent providers, the voluntary sector and, in some areas, the police) had either abdicated their responsibilities or been excluded from the process of developing and implementing procedures.[181] Respondents noted problems in the demarcation of roles and responsibilities. Social services had no power to insist on the compliance of other organisations, thus its leadership role was undermined.[181]

Similarly, a study on the difficulty of interagency working based on the views of social workers stressed the importance of services focusing on the needs of people using services and not on passing responsibility on to someone else.[219] However, other research has described the 'protective cover' that comes with multi-agency decision-making: rather than one agency (social services) carrying decision-making responsibility alone, joint decision-making can create a 'policy shield' — protection from single agency responsibility for action or inaction.[207]

A study[208] of serious-case reviews noted the absence of overall ownership of any collaborative strategy as a barrier to effective multi-agency working. Practitioners often operated in isolation within their own roles, failing to coordinate services even in circumstances where a case conference would have been warranted or where financial abuse required investigation.[208] The absence of shared understanding, collaborative working or full multidisciplinary assessment meant that not all the risks

in an individual's situation could be identified or addressed holistically, and it was unclear what the key risks were, or who should take responsibility for issues such as capacity assessment.[208]

Professionals were confused about where responsibility lay between, or even within, agencies, and struggled to coordinate.[208] The more agencies that became involved, the more difficult it became to join up their efforts. Specific examples noted include:

- shared multi-agency assessments were absent, and processes for including a comprehensive range of agencies in discussion and shared decision-making were missing
- individual agencies worked separately (and often well) on their own aspects of the situation, assuming other concerns would be addressed by someone else, or perhaps referring perceived problems on to adult social care but failing to follow this up to see what the outcome of the referral was
- agencies failed to respond, for example to missed appointments, or did not sufficiently acknowledge the concerns expressed by others; in one example, a decision that the individual referred did not have a diagnosis that made them eligible for a service, and that they had capacity to choose their lifestyle, influenced other agencies in their own involvement
- joint working or liaison was missing, or complex partnerships (for example, between health, social work, mental health and learning disability services, and between children's and adult services) broke down.[208]

Particular sectors have argued about being left out of multi-agency approaches to adult safeguarding. For example, research from the social housing sector argues for increased strategic and operational joint-working between housing and adult social care.[220] This research identified serious-case reviews where housing staff could and should have played a more active and effective role. This research highlights that negative professional attitudes by adult social care staff towards housing staff can be a factor in the exclusion of housing from partnership working and information sharing. There were references to housing staff being 'outside the loop', not being taken seriously, not treated as professionals, or not having a key role, despite their knowledge and contact with tenants.[220]

Another study[221] on elder financial abuse found there was a need for clarity about the way health and social care professionals and banking professionals and the police make decisions about what constitutes abuse, what is meant by significant harm, how thresholds are established and what are the most appropriate forms of response. Ways of working need to be firmly established and tailored depending on agency partners. For example, it is important to work with statutory services such as

the police for prosecutions, while still maintaining confidentiality in adult safeguarding cases.[222]

Finally, it is stated that multi-agency working can be disrupted by factors including inadequate understanding of legal rules and a clash of cultures, attitudes, priorities and thresholds.[172]

4.10 Theme 6: Responsive Workforce

The theme of responsive workforce relates to planning, recruiting, managing and organising staff with the necessary numbers, skills, and competencies to respond to the needs of a person using a service. People working in health and social care services need supervision, feedback, and appropriate training and support to identify and deal with adult safeguarding concerns in a person-centred and effective manner.[2]

Articles identified as relevant for the responsive workforce theme were analysed and categorised into the following sub-themes:

- recruitment practices, workforce planning and working conditions
- support for staff
- staff training and development
- continuous learning and practice development
- staff experience and competencies
- understanding of role.

4.10.1 Recruitment practices, workforce planning, and working conditions

A review[223] comparing international systems of checking of staff and volunteers working with adults at risk receiving social care in their own homes, day centres or in residential care found a variety of practices, ranging from no checks to substantial checks involving fingerprinting. Reasons for checks identified in different national contexts extend from efforts to stop fraudulent use of government subsidies to minimising the risk of harm to vulnerable adults, and to enhance trust in care providers.[223]

A further study[224] suggested setting up requirements for Criminal Record Bureau checks for care workers and others to see if they have a criminal record that might lead an employer not to take the risk of employing them. Improving recruitment practices reduces the likelihood of previous perpetrators who pose a risk to vulnerable people being hired.[225] Additionally, improving disciplinary practice ensures that people who resign before they are dismissed will also be placed on

appropriate lists or registers, thus reducing the chance of abusers re-entering the care workforce.[225]

Research[226] has highlighted how the social care sector is changing, with staff employed on short or zero hour contracts and high staff turnover. In terms of workforce regulation, it often does not make sense for employers to pay the required employer registration costs which leads to employers taking shortcuts to keep costs low. Equally, staff cannot afford the required staff registration costs because they are often on minimum wage. This is a serious concern in terms of recruiting staff to work with adults who may be at risk of harm. On the other hand, services with a staff group who are supported, supervised and who have better conditions will have a lower turnover thereby reducing the chance of abuse or neglect.[225] Staff who feel they have an investment in service quality are also more likely to report concerns regarding poor practice.[225]

Research on adult safeguarding in England found that vacancies and insufficient staffing levels lead to reactive rather than proactive work.[208] The dangers of having too few experienced care workers and duty managers covering high-risk and urgent situations was highlighted. In addition, the reliance on single or part-time practitioners to manage complex risks and demanding cases over a lengthy period was questioned in terms of workforce planning.[208] From a staff perspective, a study[227] investigating staff responses to accusations of misconduct and abuse while working with vulnerable adults looked at how staff reacted to these allegations made against them, with staff shortages being cited as a key mitigating factor.[227]

Another study[189] describes a multidisciplinary care home support team with statutory responsibility to respond to reports of abuse in long-term care and support services in addressing abuse. The support team looked at the service systemically (evaluating social, mental health and nursing needs of residents) to address the whole culture of care within services.[189] This study highlights that feelings of burnout and conflict between staff are important predictors of abuse, alongside poor training, low salaries, low morale and staff shortages.[189]

4.10.2 Support for staff

Appropriate supervision and management of staff working with adults at risk is paramount.[208] Research points to situations in which staff felt isolated (particularly out of hours and in high-risk situations) without the support or authority to manage cases involving adults at risk effectively.[208] There are also times when front-line workers can experience difficulty deciding whether a case reaches the adult safeguarding threshold and may need management input into a decision to intervene.[208]

Conversely, complex and high-risk cases can also require significant managerial coordination in order to effectively lead the performance of staff, alongside providing appropriate support.[208] In terms of safeguarding cases where access to an adult at risk is obstructed by a third party, support from supervisors and managers is needed by practitioners, as such cases can be distressing.[228] A study[229] looking at the impact of allegations of abuse being made against a staff member cites the importance of having effective supervision, support for and redress to front-line staff who have had unproven allegations made against them.

Focusing on the outcomes of staff work offers a positive approach in contrast to those emphasising competencies, performance and the achievement of specific goals, which can seem punitive. However, it is stated that individual staff who have negative attitudes, inadequate knowledge or who work in procedural ways can be identified and offered support, thus preventing the escalation of poor practice.[165]

Research has shown that the competence of managers in health and social care services is paramount to good adult safeguarding, as supervision, a culture of accountability and an ability to challenge abusive practices, can reduce vulnerability and risk.[189] Providers who properly implement recruitment procedures are less likely to recruit a staff member who may abuse.[225] Providers who correctly implement disciplinary procedures are also more likely to ensure that any record of abuse or misconduct follows the member of staff when they leave, reducing the likelihood of a confirmed perpetrator being able to abuse again.[225] Therefore, it is important that effective management in services is in place to oversee recruitment and disciplinary procedures.

In keeping with the theme of a responsive workforce, it is important that management appropriately supports staff in adult safeguarding roles. A study[229] on the impact of allegations of abuse made against a staff member who was later exonerated, and how this affected that staff member and their wider team, found that effective supervision of front-line staff was important for mitigating against this impact. Another study of staff who had been alleged perpetrators in alleged adult abuse cases highlights that management of allegations of abuse need to be balanced, fair, transparent and addressed in a timely way.[230]

Finally, support for staff in effective adult protection work does not only need to come from management — research finds that it is colleagues, as opposed to supervisors or field trainers (college supervisors), who have the greatest influence on new staff and how they undertake their work in adult protection.[231]

4.10.3 Staff training and development

Adult safeguarding training has received significant attention in the academic literature. This section is presented under two sub-headings:

- training content and methods
- training for specific professions.

4.10.3.1 Training content and methods

A study[232] exploring health and social care professionals' knowledge, detection and reporting of abuse concluded that face-to-face training, including case studies, is more effective than written material alone, and that experience of dealing with abuse increases knowledge and confidence. Training should combine exercises based on case studies, lectures, group work and use of media such as video and film.[215] However, adult safeguarding is not a mandatory part of the pre-registration curriculum or post-registration training in health or social care in England and Wales.[215]

Research in Cardiff[233] found that practitioners and providers' dissatisfaction with adult protection training was linked to the lack of a clear link to national standards; uncertainty around how and when to provide refresher training as well as the difficulties in releasing staff from the workplace to attend training; and, in contrast to other studies, e-learning was suggested as a flexible solution to this.[233] However, perceptions persist that training is primarily an exercise in meeting regulatory requirements. Subsequently, training, practice development and transferring learning can be a low priority.[168,231]

Confusion in adult safeguarding often arises due to differing interpretations (both within and between professions) regarding:

- the concept of a 'vulnerable adult' or 'adult at risk'
- what constitutes abuse (for example, whether it needs to be intentional and recurrent)
- whose judgment on abusive situations should prevail.[181]

These differences are important because they affect the likelihood of abuse being reported, how abuse procedures are used, and ultimately, the outcomes for the person being safeguarded.[181]

Despite the different understandings of risk identified between health and social care professionals, one study found that all professionals were generally content to defer to how the social worker interpreted safeguarding protocols.[234] This study found that questions of professional identity often cause discomfort in the adult safeguarding realm.[234] Feedback[235] from safeguarding managers in the UK indicates that thresholds of harm were more easily understood and responded to by staff where there was a legal definition rather than relying on a policy. Research[222]

in England and Wales highlights the importance of publicising the Care Act[59] more, ensuring staff are trained and know how to engage an independent mental capacity advocate‡‡‡‡‡‡‡‡‡‡‡ in a timely way. Study participants felt that there was little detailed guidance to support practitioners. Sustained training and supervision are essential.[222]

In terms of capacity, research[235] in the UK indicates that thresholds of harm were more easily understood and responded to by staff where the person lacked capacity as opposed to where a person had capacity and wanted to take a risk that went against what a safeguarding practitioner thought they should do. The research found that staff need to be able to integrate the principles of the Mental Capacity Act 2005 in England[62] and equality and diversity, as well as being aware of safeguarding issues.[168] One study looked at how to make training more relevant to social care staff, combining three core multi-agency training strands of adult safeguarding, mental capacity, and equality and diversity under the umbrella of human rights, to create a 'human rights' workshop.[168]

In terms of theoretical approaches to adult safeguarding training, research[236] has compared the 'discovery model' and the 'construction model'. The discovery model delivers clear, basic messages to practitioners about harm and abuse, particularly where time and the potential for interaction is limited. On the other hand, the construction model is about connecting more deeply with practitioners' lived experiences, promoting political engagement and developing professional judgment informed by ethical debate.[236]

The key advantage of introducing construction-model thinking into adult safeguarding education lies in its scope to better connect with practitioners' lived experiences. Rather than implying fault in their understanding of policies and procedures, some practitioners might benefit from an approach that acknowledges the ambiguities inherent in their work, and supports them to work through these in a critically reflective way.[236] According to the authors,[236] a further advantage of embracing construction-model thinking concerns the tools it offers learners to engage politically and to feed their practice experiences back into policy processes over time.

Implications for training approaches can also be drawn from a theoretical paper on how social workers manage the dissonance or conflict that arises from safeguarding work with older people.[207] The paper focuses on the links between:

- macro context (for example, the resourcing and quality of services for older people and ideologies of choice, independence, and personalisation)

‡‡‡‡‡‡‡‡‡‡‡ The Mental Capacity Act 2005 introduced the role of the independent mental capacity advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options.

- meso context (organisations, professional cultures and practices in services)
- micro context (subjective meanings and values the individual brings to their work with older people).[207]

The author[207] suggests that practitioners may know some care homes and health care services are poor but this is accepted by default and not questioned, which is possibly due to poor resourcing and various other issues. Taking a wide-angle view of social, political and cultural factors impacting on how older people are perceived, supported and treated could have important implications for training.

Looking at the field of child protection could potentially generate learning for adult safeguarding training.[237] In child protection, the notion of 'at risk' is a statutory one, but placing a child on an 'at risk' register without other interventions neither increases nor decreases the likelihood of harm.[237] The authors suggest that a different approach to assessing risk and a different paradigm for understanding risk as part of a complex adaptive system is needed.[237] Examples from reports on failures to protect children illustrate that routinely, situations combine and (despite best efforts of services) children are failed by the very services charged to protect them.[237] This is compounded by the fact that practitioners may feel a sense of ease if they feel they have 'followed procedures' or ensured that the correct paperwork is filled in.[237]

The authors note that the misconception here is the belief that the child at risk is part of a linear process of cause and effect. In reality, the child at risk is sited within a network of interconnectedness; which can be conceptualised like a spider's web. Following this analogy, the authors suggest that inquiries into failures to protect children are only looking at one strand of the web. Following their examination of the single thread, there is confusion about why procedures were not followed or how obvious signs were missed.[237] Understanding adults at risk in the context of a complex network is also important for adult safeguarding practitioners to consider.

Research has suggested that more creative methods may be useful in training staff in adult safeguarding. One study[234] sought to understand the diversity of professional and lay attitudes towards adult safeguarding practice using 'forum theatre'.§§§§§§§§§§ Forum theatre offers students and trainees in health and social care a 'safe space' to practice their communication skills and to engage with challenging situations. This study indicates that different professional groups addressed abuse in different ways.[234]

§§§§§§§§§§ Forum theatre as a technique is increasingly being drawn upon within research with marginalised groups. It uses drama techniques to draw a group into discussion and reflection.

Regarding professional decision-making, some studies also indicate that professionals use a superficial black and white approach to decision-making, which fails to incorporate the ethical dilemmas that exist.[238] Professionals can struggle with complex ethical dilemmas created by, for example, elder abuse, particularly when the person who has been abused did not want an investigation. There is some evidence that similar factors influence the decisions of doctors and other health workers.[238]

Adult safeguarding work involves managing uncertainty to address complex ethical dilemmas and the article suggests that agencies should consider how to support staff who are faced with such problems on a daily basis. This may include promoting creative and reflective approaches rather than merely focusing on technical approaches to investigation and resolution.[238] Adult protection will always require an element of autonomous professional decision-making. This process can be supported by training and the development of clear intra- and interagency systems.[238]

Where adult safeguarding legislation has been implemented in a jurisdiction, staff should receive training in adult safeguarding law. The importance of continued professional development in relation to law is highlighted in one study, along with the use of inter-professional education to address clashes in ethics, understanding of law, values and status.[191] Another study[239] found that while all participants had some knowledge of the Mental Capacity Act (2005),[62] not all were confident in assessing a person's capacity and were concerned about the legal consequences of 'getting it wrong'.

4.10.3.2 Training for specific professions

While much of the adult safeguarding literature focuses on training for social work and social care professionals, a much wider range of professionals come into daily contact with adults who may be at risk of harm. These include healthcare professionals (nurses, hospital doctors, GPs and dentists), mental health professionals, housing officers, and staff in banks and post offices. Research suggests that safeguarding training should be common to all agencies, and practice-based to ensure that learning is directly related to the responsibilities of different practitioners.[215] The importance of medical and health professionals, housing staff and emergency duty teams attending safeguarding training was emphasised in one study, and joint training was highlighted to embed a shared safeguarding culture, reinforced by ongoing refresher information, supervision and discussion.[208]

Nurses have a central role in multi-agency working in identifying, managing and preventing abuse in a practice setting so it is imperative that they are adequately prepared to fulfil these key roles.[215] Research suggests that training in identifying abuse should become mandatory for qualified and unqualified nursing staff, as well

as being included in pre- and post-nursing curricula.[215] Further research[240] on the role of nurses in adult safeguarding highlights that community nurses have a central role to play within a multi-agency approach to identify and manage elder abuse, and it is crucial that community nurses are adequately trained to fulfil this key role.[241]

One UK-based study[242] highlights the importance of pre- and post-graduate safeguarding education and training for nurses, and the benefits of face-to-face learning. It identifies that safeguarding vulnerable adults and children is now recognised as a central tenet of nurses and allied health professionals' role globally. The study[242] references the Nursing and Midwifery Council (NMC), which regulates nurses and midwives in England, Wales, Scotland and Northern Ireland:

> Safeguarding is part of everyday nursing and midwifery practice in whatever setting it takes place. You should have the skills to confidently recognise and effectively manage situations where you suspect a person in your care is at risk of harm, abuse or neglect, including poor practice.[243]

A study in the *Journal of gerontological nursing* [197] — which looked at the importance of training nurses in busy acute hospitals to identify delirium versus dementia versus confusion, and to challenge attitudes about older people — argued that care of older adults occurs in the margins of nursing practice; nurses work in a care context that does not acknowledge or adequately support the unique healthcare needs of older adults.

Another study in *The Journal of Adult Protection*[244] measured the impact of adult safeguarding training on community nurses in Scotland working in intellectual disability, mental health, older people's services, acute services, substance misuse, and accident and emergency. Findings indicate that knowledge of Scottish adult safeguarding legislation varies considerably across community nursing and that brief targeted training would be beneficial rather than a 'one size fits all' approach.[244]

In terms of other health and medical professionals, research[190] recognises that GP surgeries play a pivotal role in adult safeguarding as staff come into contact with people who need care and support every day. Therefore, it is essential staff are vigilant, trained and have clear knowledge of how to respond to concerns. This paper outlines the features of a responsive workforce in relation to safeguarding in GP surgeries including:

- proactively following up on people who miss appointments
- understanding of court and criminal justice systems and forensic procedures
- understanding of how vulnerable individuals can be radicalised through grooming techniques

- understanding of the Mental Capacity Act[64] and associated Deprivation of Liberty safeguards, and the Care Act[59]
- awareness of appropriate range of resources
- ability to document and summarise relevant actions and decisions
- audits regarding quality of service
- supporting colleagues in dealing with emotional impact of safeguarding.[190]

Further research[199] indicates that good clinical skills can uncover abuse, but the clinician needs to be alert to this in order to recognise it. Doctors should consider not only the patient, but also the wider context, including environment, family, social networks, and culture. GPs need to raise awareness of safeguarding in their communities and forge links with other services and stakeholders including local service user and carer groups.[199]

A study in the United States[245] evaluating an educational programme to assist clinicians in identifying elder investment fraud and financial exploitation suggests that clinicians (for example, doctors, nurses, social workers) and staff are well positioned to identify possible financial exploitation and signs of elder mistreatment because they evaluate their older patients on a regular basis. Finally, a practical guide in *The British Dental Journal*[246] for dental professionals outlines their responsibilities under the Care Act 2014[59] and highlights that dentists, like GPs, may have long-term relationships with individuals and may see indicators of both neglect and self-neglect which causes concern. As dentists may work across number of sites, they need to be aware of different agencies' roles in safeguarding and their responsibilities.[246]

A national survey[247] of adult safeguarding in NHS mental health services in England and Wales highlighted the need for effective training and understanding of safeguarding measures in mental health services. Staff attitudes and uptake of training are the greatest barrier to achieving best practice. Staff reported viewing training as an 'add on', 'someone else's job' and 'too difficult'. In describing the work as 'too difficult', staff highlighted that patients also fluctuate between having capacity and not having capacity, while those who are perceived to lack capacity are often better able to make decisions, such as those with learning disabilities.[247]

In terms of training for housing professionals, researchers have argued that there is widespread ignorance amongst staff at all levels and in all sectors about the role of housing in adult safeguarding.[248] Given that many vulnerable adults live in social housing, not necessarily in sheltered or supported housing, there is a compelling case for all housing providers to take a multi-pronged and strategic approach to

safeguarding, at the very least ensuring that all staff are trained to recognise abuse and know how to respond to and report abuse and neglect.[248]

At the operational level, internally, safeguarding leads (or service managers) should develop: customer profiling, up-to-date records of vulnerabilities, best methods of communication, tenancy checks and ensure regular and relevant training for all staff.[248]

A survey[194] of community services staff — in relation to risk of financial abuse of older people with dementia — highlights the need for awareness and staff training among banks, post offices and wider sectors. Findings suggest the need for regular auditing of care homes and better data sharing between banks and social services if there is an unusual pattern of withdrawals.[194]

Inter-professional training around adult safeguarding may be useful for a number of professionals. One study[191] using university samples of trainee doctors and social workers looks at the importance of training so that practitioners can connect relevant legal rules with professional practice. The study illustrated the anxiety felt by both samples of students about legal rules. However, social work students expressed markedly higher levels of confidence than medical students in their skills for practising within the legal rules. The confidence of social work students increased as their qualifying education unfolded — whereas the reverse was often the case for medical students.[191]

4.10.4 Continuous learning and practice development

A study[249] evaluating a specialist post-qualifying social work educational programme in the UK highlights the benefits of continuous learning and development, including specialised training, practice applied to learning and shared opportunities for discussion and debate. The paper notes that continuing professional development needs to be supported by a workplace learning environment, and cultural and attitudinal changes need to be encouraged and underpinned with concrete support, such as study facilities, access to research, and administrative support.[249] Further research[250] stresses the need for a more holistic approach to providing care and support which includes the importance of staff staying connected to new ideas and practice. Finally, a study in Wales[233] stresses the importance of lifelong learning for practitioners and of linking formal educational programmes, short training sessions on specific topics and skills development in a work context. This paper emphasises the importance of sharing learning and reflecting on practice.[233]

4.10.5 Staff experience and competencies

Staff must have the required experience and competencies to deliver person-centred, effective and safe care and support. Research[206] suggests that principles of good caregiving should include:

- being available (present in the moment, attentive and listening)
- responding sensitively (consistently interested in the person)
- cooperative care (building a person's own competence).[206]

Research[251] investigating safeguarding documentation and referral screening showed significant differences in activity levels at all stages of the safeguarding process, suggesting variations in the application of thresholds resulting in referrals being screened in by some safeguarding staff and similar referrals screened out by others. Such variation in practice brings the experience and competencies of staff working in adult safeguarding settings into question and illustrates the need for organisations to put professional support and guidance mechanisms in place for staff.[251]

Research in *The Journal of Adult Protection*[156] indicates that a person-centred approach to risk management should assist a social worker working with a person using services to explore the levels of risk that they want to take, empowering the person using services to speak out and enabling them to make informed choices. A personalised approach to risk management can establish a good support plan that can help individuals, and those who care about them, think in a positive and productive way about how to achieve the lives they want, while managing identified risks.[156]

In mental health settings, researchers in England have stressed that it is incumbent on each professional involved in adult safeguarding — whether a carer, social worker, GP, mental health professional, housing officer, police officer or Crown Prosecution Service prosecutor – to build user involvement into their individual working practices.[158] The authors state that people with mental health problems must be respected and valued by the professionals providing their care, and people using services need to feel involved and listened to rather than stigmatised, marginalised and abused.[158]

Finally, if staff do not have the experience or competencies to deal with certain aspects of adult protection, research indicates that bringing in creative professionals may be beneficial to aid adult safeguarding work. For example, in a study[214] with adults who had undergone safeguarding processes, focus groups with creative arts therapists illustrated that creative therapists can use techniques to engage adults with varying levels of capacity to explore meaning of safeguarding.[214]

4.10.6 Staff understand their role in safeguarding people

In practice, different professionals may not fully understand each other's roles and responsibilities and both thresholds and scope of adult abuse are still not universally agreed.[154] Findings from an evaluation[252] of one adult safeguarding authority in England indicates a tendency for respondents to focus on the negative aspects of people using services, while at the same time emphasising the positive aspects of fellow professionals. Negative assumptions about people using services may contribute to poor safeguarding outcomes, particularly where staff do not fully embrace safeguarding as an integral part of their professional remit.[252]

In this research, safeguarding was often portrayed as a professional 'problem' to be solved, in the course of which people using services may sometimes cause irritating additional difficulties, rather than being constructed as a role which was gladly undertaken on behalf of, and in collaboration with, wider society.[252] Further research[151] illustrates that agencies and professionals may view their participation and responsibility in safeguarding as being at an end once they have made a referral. However, making a referral alone is not enough — partner agencies need to own and work with the issues until they have been formally resolved.[151]

4.11 Theme 7: Use of resources

The theme 'use of resources' relates to how resources are planned, managed and delivered as part of delivering safe and high-quality care and support. Resources include human, physical, financial and natural resources. Service providers use the resources available to them to deliver the best possible health and personal outcomes for people using services. The resources available for health and social care are finite, whether publicly or privately funded. Improving the quality and safety of care requires making the best use of the resources available, not necessarily using more resources.

A well-run service knows how it is using its resources, and, as new evidence and technologies emerge, continually seeks opportunities to provide better care with the same or fewer resources. Service providers maintain the quality of the care they provide at all times, even when they are managing fewer resources or when they are looking for ways to make the care they provide more efficient.[180]

A critical analysis[252] of outcomes following safeguarding alerts in one local authority in England found that while the policies and procedures involved in safeguarding activities were generally perceived to be effective, there were wider organisational factors, particularly access to human and other resources, which created difficulties. However, the most frequent theme raised by respondents in the study was the amount of time which safeguarding assessments took up. Balancing safeguarding against other care coordination was reported as a challenge. The difficulty with

safeguarding was not simply the amount of staff time which some cases demanded, but also the fact that safeguarding alerts occurred at unpredictable rates, required a rapid response, and generated large amounts of paperwork.(252)

A pilot programme(48) of adult safeguarding arrangements in four English local authorities proposed that councils may need to think imaginatively about how to make best use of resources across agencies, for example, by:

- establishing a 'virtual' team of safeguarding leads
- greater pooling of resources across agencies
- considering the balance of specialist and mainstream services
- considering whether local referral thresholds should be recalibrated.(48)

Other UK-based initiatives have innovatively managed resources and maximised knowledge sharing in adult safeguarding through their use of a structured rolling secondment, whereby, experienced assessment and care managers moved into one of five posts on an adult safeguarding team for a six-month period.(212) Further research in England has reviewed(187) the implementation of 'integrated health and social care teams' supporting older people and vulnerable adults in teams aligned with GP practice-based commissioning clusters.********** Results from the co-location provided:

- simpler and faster access
- increased efficiency as there was one point of referral
- better use of staff time
- clearer understanding of professional roles
- better use of resources through improved information sharing, decision-making and risk management
- improved patient experience.(187)

In terms of financial resources, one study highlighted that the lack of agreed or pooled budgets for local service development and resources was a major concern for social service managers in England and Wales, where local authorities generally fund local adult protection work. Some respondents said that the absence of joint-funding was the result of the lack of a legal requirement for agencies to participate in adult

********** Practice based commissioning can be undertaken by individual GPs or GP practices, but is most often done by groups organised into 'consortia', 'clusters' or 'localities'.

protection. This was a majority view, although some respondents were not so convinced of the need for compulsion.(217)

While improving the quality and safety of care requires making the best use of the resources available, and not necessarily using more resources, it must be acknowledged that some adult protection studies have highlighted resources as seriously lacking.(181) Scarce resources may lead to risk-avoidance strategies as outlined in a journal article on the use of bedrails.(200)

Some research has highlighted the risk of resources being 'unnecessarily wasted' on vulnerable adult protection, for which demand was limited, unknown or unpredictable.(181) Some interviewees in this English study depicted vulnerable adult mistreatment as an 'elastic phenomenon' which could expand or contract depending on the breadth of its definition and the propensity to report it. Some participants remarked that abuse was only as real as the statistics generated; that statistics were the product of arbitrary decisions on record-keeping; and that such records could misleadingly suggest that an increase in resources was not warranted, including resources to track abuse. This issue has resulted in some disparities in the perceived need for resources across organisations.(181)

One study noted that barriers(253) to effective planning and management of resources in adult protection services can also include:

- lack of communication skills
- lack of a desire to get involved
- liability concerns
- concerns regarding the time it takes to get involved and the resulting consequences to workload and other patients
- discomfort with issues related to violence or family dynamics.(253)

4.12 Theme 8: Use of Information

High-quality, safe and reliable healthcare is informed by and uses all types of information. Information is an important resource for service providers in planning, managing, delivering and monitoring services. Information should be accurate, valid, reliable, timely, relevant, legible and complete. It is important that service providers have systems in place, including information and communications technology (ICT), to help them ensure that the information they collect and report is of high quality and relevant to meeting the needs of the person they are working with. Service providers protect and manage personal information which is shared between services in a sensitive and responsible manner.(180)

Articles identified as relevant for this theme were analysed and categorised into the following sub-themes:

- the use of information and data to plan, manage and deliver services in line with best practice in adult safeguarding
- the sharing of information pertinent to adult safeguarding within and across organisations
- information governance.

4.12.1 Use of information and data to plan, manage and deliver services

Given the general move towards person-centred practice in health and social care, local authorities in the UK are increasingly keen to measure their performance using data provided from people who have experienced safeguarding interventions.[167] Research into adult safeguarding legislation in Scotland found insufficient expertise is available concerning audit and evaluation; data on case conferences and post-intervention feedback is generally poorly gathered.[53]

One study on the recording of safeguarding-related information highlighted missing or inadequate records, or divergent accounts of discussions between professionals, making it difficult to identify escalation of risk or to account for practice.[208] There were cases highlighted in this particular study in which:

- communications from other agencies were not placed on file
- written records did not routinely evidence what concerns were expressed
- what help was offered and accepted or declined by the individual
- what referrals were made and later followed up
- or what information was shared with others and what decisions were taken.[208]

According to 'No Secrets',[58] agencies should routinely gather information on the outcomes of investigations and users and or carers' views on how the policy has worked for them.[164] Having consistent and reliable data means that trends can be identified and services can identify what causes abuse as well as ways to address it and prevent it.[225] This means that people using services are less likely to experience abuse in the future, thereby creating safer services.

One study[196] indicated the potential for adult-protection monitoring data to explore the efficiency and effectiveness of adult protection case management and safeguarding activities. This was achieved by examining associations between

interventions (such as investigations) and outcomes (such as post-abuse work with victims and perpetrators or successful prosecutions).[196]

4.12.2 Sharing of information within and across organisations

Information sharing and reporting are necessary to protect adults at risk. In England, The Care Act[59] put a spotlight on the need to share safeguarding information. Research[248] emphasises the importance of a wide range of practitioners understanding the basic legal framework that supports information sharing in England.

One study point out that some health and social care practitioners may think that the law (including the common law duty of confidentiality, the Data Protection Act [1998] and the Human Rights Act 1998) prevents the sharing of information when, in fact, it enables the appropriate sharing of information to help keep people safe.[248] The authors[248] argue that it is important for health and social care employers to emphasise this in safeguarding training and to point to the fact that there are very few safeguarding scenarios where it would be acceptable not to share information within the appropriate legal boundaries.

The study noted that not sharing information may only be acceptable whenever the person at risk has the mental capacity to make the relevant decision and:

- nobody else is at risk from the abuse or the abuser
- no serious crime has been committed
- no staff or other people with care and support needs are involved
- there is no evidence of coercion or duress.[248]

The article[248] argues that all UK workers must also understand the basics of the Mental Capacity Act 2005[62] so that they can support people who lack the capacity to make particular decisions about safety, risk or sharing information.[248] For example, housing officers may shy away from assessing mental capacity, thinking that it is not for them to do, but in reality they are doing it all the time. It is a matter of deciding whether someone has a mental impairment that is affecting their decision-making and, if it is, then housing officers should know how to help the individual to access the right support.[248]

The authors recommend that there should be clear local guidance for staff on when to share information where there are concerns about coercion or duress.[248]

In terms of inter-agency communication, confidentiality and data protection rules can be perceived as impeding the sharing of information across agencies.[181] This is particularly evident in the quotes below taken from interviews with staff who

develop multi-agency procedures in local authority departments, health authorities, the police and the voluntary sector in England:

- we do share quite a lot of information. But it's getting tougher because you suddenly realise, "Well I wonder what their data protection policy is — are we working along the same lines and are we doing the same things?" (voluntary sector respondent)[181]
- Very poor link and communication with the hospital in assault cases, they tend to hide behind the Data Protection Act (police respondent).[181]

Whenever ethical considerations did not hinder information sharing, staff in this study[181] highlighted the technical hindrances in data systems to collating data effectively across agency boundaries. Even if ethical and technical barriers were overcome, there still remained confusion over who should be informed about a case, how often, and in how much detail. Some agencies or their staff felt inappropriately excluded, while others dismissed the need for their participation, and the system of communication between agencies was reported to be ad hoc rather than standardised.[181]

A study[202] which gathered the views of a wide range of practitioners (safeguarding leads, practitioners from social services, police and health services) in England, reported that many practitioners considered sharing of information an essential element in deciding whether a duty of care could be exercised. Others viewed it as an unjustified intrusion in breach of the right to respect for private and family life under Article 8 of the European Convention on Human Rights. Recording the rationale for decisions to intervene or not intervene in any given situation was considered essential.

Data protection and confidentiality safeguards have been cited by managers as reasons why information could or would not be shared by another agency with social services.[217] Managers had experience of this arising in relation to the NHS, the police and, to a lesser extent, the inspectorates of social care services.[217] Professionals must be aware of when the need to share information outweighs the right to confidentiality.[184]

In England, there is an absence of formalised mechanisms through which professionals can share information in a timely and consistent way, or raise concerns visibly to others.[208] In a case highlighted in a paper,[208] information was not effectively shared even between different parts of the same agency. Participants in this study[208] commented that sharing accurate information would have led to better coordination and joint working, or that its absence led to fragmentation.

Serious-case-reviews have found that inadequacies in recording contributed to the inability of services to recognise the escalating risks:

> Overarching problems will remain if the wider problems of the sector are not addressed especially those which make communication, information sharing, accountability and resource provision difficult.[203]

One article highlighted how the family of an adult going through the safeguarding process was 'horrified' by the lack of information across organisations responsible for his care.[218] It highlighted that information from organisations such as the NHS regarding health, drug use and mental health difficulties was rarely passed on to social services.[218] Furthermore, the family of the adult at risk was not informed of relevant incidents.[218] A family member, who subsequently became the advocate, was not given appropriate information or included in conversations surrounding his care.[218]

4.12.3 Information governance

Issues of privacy and confidentiality regarding how information relating to adult safeguarding is documented, stored and shared are important. Research[213] points to the uncertainty of some organisations when it comes to disclosing information. One study identified problems with general practitioners (GPs) in information sharing.[53] The research found significant variation in how information-sharing protocols translated into improved practice, especially between GPs and banks, due to different interpretations of ethics and data protection legislation.[53] Multi-agency training helped to improve information sharing and the appropriateness of referrals, but this training was not mandatory, leaving significant gaps in the system regarding the sharing of relevant adult safeguarding information.[53]

Research has found that, in adult protection cases, information was being shared with others without their knowledge or permission.[149] Sharing information without the individual's consent, where that person has capacity, raises significant legal and ethical concerns.[202] In line with a person-centred approach to providing services, people using services should be appropriately informed and made aware whenever their information is shared across or within organisations.

4.13 Summary of the systematic literature review

The Project Team carried out a systematic literature review to retrieve and document evidence published over a 10-year period (2007–2017) in relation to adult safeguarding, as it relates to the eight-theme standards development framework used for nationally mandated standards. The results were documented by theme and then subsequently by sub-themes, as outlined in the previous sections.

Evidence from the literature review found greater focus being placed on the themes of person-centred care and support; effective services; safe services; use of information; responsive workforce; and leadership, governance and management. Less evidence was available in relation to the themes of health and wellbeing; and use of resources. Additional input will be sought from the project Advisory Group and other stakeholders (including focus group participants) for these themes.

The systematic literature review found that adult safeguarding should be viewed from a human-rights perspective. It is important to empower adults to protect themselves from harm and include people in making decisions about their care was also highlighted. The research points to the need for effective communication within and between services when managing safeguarding concerns and the need for services, organisations and agencies to work together and share information as needed. The research indicates that staff need to be skilled and trained as well as being supported by management to create an open, transparent and safe culture within services. The need for strong leadership within services and clear governance arrangements was also evident in the literature reviewed.

5 Summary, conclusion and next steps

This background document outlines the literature that was reviewed by the HIQA and MHC Project Team to inform the development of national standards for adult safeguarding for Ireland. This included:

- a review of adult safeguarding in Ireland
- an international review of adult safeguarding in six jurisdictions
- a systematic literature review on adult safeguarding.

Information and findings from each of these three reviews will be used to inform the development of national standards for adult safeguarding.

The key findings from national and international evidence include:

- the importance of approaching adult safeguarding in a person-centred way
- the importance of empowering adults to protect themselves from harm and including them in making decisions about their care and support
- the importance of viewing adult safeguarding from a human-rights perspective
- the need for effective communication within and between services when managing adult safeguarding concerns
- the need for services, organisations and agencies to work together and share information and expertise appropriately
- the importance of cultivating an open, transparent and safe culture within services
- the need for strong, clear leadership, management and governance structures
- the need for a skilled and trained workforce supported by management.

The evidence reviewed tells us that adults at risk of harm should be treated with dignity and respect at all times. They should be supported to participate in decision-making and their views should be considered when making decisions that affect them. This is in line with a general trend in health and social care toward empowerment and participation of the people using services, and a move away from an approach where services assume the 'best interests' of adults at risk of harm. It is important that adult safeguarding focuses on prevention; supporting people to take action before harm occurs.

The research reviewed indicates that for adult safeguarding to work effectively, it is paramount that organisations, services and agencies supporting and caring for adults, work together in a cooperative manner. This includes sharing expertise and information appropriately, and working together to find the best solutions for people using services on a case-by-case basis.

This document will inform an initial draft of the national standards for adult safeguarding in conjunction with:

- detailed discussions at meetings of the Standards Advisory Group
- individual meetings with relevant informed and interested parties
- focus groups with:
    - — people who use health, including mental health and social care services
    - — front-line staff and management in these services
    - — relevant advocacy groups.

When the draft standards are developed, a public consultation will be held. Submissions received during this consultation will be reviewed and carefully considered, and the standards may be revised and improved based on the feedback received. The main amendments will be published in a related statement of outcomes document along with the final national standards when they have been approved and mandated by the Minister for Health.

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Appendices

Appendix 1—International experts in adult safeguarding

Name	Country	Affiliation	Position
Dr Amanda Phelan	Ireland	University College Dublin	Associate Professor, School of Nursing and Midwifery
Dr Gloria Kirwan	Ireland	Trinity College Dublin	Assistant Professor of Social Work, School of Social Work and Social Policy
Kathryn Mackay	Scotland	University of Stirling	Lecturer, School of Applied Social Science
Paul Comley	Scotland	University of Stirling	School of Applied Social Science; National Adult Protection Co-ordinator, Scotland
Saartje Drijver	Scotland	Care Inspectorate Scotland	Senior Inspector
Professor Michael Preston-Shoot	England	University of Bedfordshire	Professor Emeritus (Social Work), Faculty of Health and Social Sciences
Professor Jill Manthorpe	England	King's College London	Professor of Social Work at King's College London, Director of the Social Care Workforce Research Unit and NIHR Senior Investigator Emeritus
Dr Sheila Fish, Beth Anderson and Hugh Constant	England	Social Care Institute for Excellence (SCIE)	Senior Research Analyst, Associate Director, Practice Development Manager
Professor John Williams	Wales	Aberystwyth University	Professor, Law
Dr Lorna Montgomery	Northern Ireland	Queen's University Belfast	Lecturer, School of Social Sciences, Education and Social Work

Appendix 2—Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13: Safeguarding service users from abuse and improper treatment

Component of the regulation	Providers must have regard to the following guidance
13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.	▪ All providers must make sure that they have, and implement, robust procedures and processes that make sure that people are protected. Safeguarding must have the right level of scrutiny and oversight, with overall responsibility held at board level or equivalent.
13(2) Systems and processes must be established and operated effectively to prevent abuse of service users.	▪ As part of their induction, staff must receive safeguarding training that is relevant, and at a suitable level for their role. Training should be updated at appropriate intervals and should keep staff up to date and enable them to recognise different types of abuse and the ways they can report concerns. ▪ Staff must be aware of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. This includes referral to other providers. ▪ Staff must understand their roles and associated responsibilities in relation to any of the provider's policies, procedures or guidance to prevent abuse. ▪ Information about current procedures and guidance about raising concerns about abuse should be accessible to people who use the service, advocates, those lawfully acting on their behalf, those close to them and staff. ▪ Providers should use incidents and complaints to identify potential abuse and should take preventative actions, including escalation, where appropriate. ▪ Providers should work in partnership with other relevant bodies to contribute to individual risk assessments, developing plans for safeguarding children and safeguarding adults at risk, and when implementing these plans. This includes regularly reviewing outcomes for people using the service. ▪ Providers and their staff must understand and work within the requirements of the Mental Capacity Act 2005 whenever they work with people who may lack the mental capacity to make some decisions.
13(3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.	▪ Providers must take action as soon as they are alerted to suspected, alleged or actual abuse, or the risk of abuse. Where appropriate, this action should be in line with the procedures agreed by local Safeguarding Adults or Children Boards. ▪ Providers and staff must know and understand the local safeguarding policy and procedures, and the actions they need to take in response to suspicions and allegations of abuse, no matter who raises the concern or who the alleged abuser may be. These include timescales for action and the local arrangements for investigation. ▪ Staff must be aware of, and have access to, current procedures and guidance for raising and responding to concerns of abuse. Staff should have access to support from line management when considering how to respond to concerns of abuse. ▪ Managers and staff must understand their individual responsibilities to respond to concerns about abuse when providing care and treatment, including investigating concerns. ▪ Staff must understand their roles and associated responsibilities

	in supporting the actions the provider takes in responding to allegations and concerns about abuse. ▪ Providers should make sure that staff are kept up to date about changes to national and local safeguarding arrangements. ▪ Where appropriate, staff must follow local safeguarding arrangements to make sure that allegations are investigated internally or externally. Providers must make sure that they respond without delay to the findings of any investigations. ▪ When people who use services make allegations of abuse, or actually experience abuse, they must receive the support they need. ▪ Where allegations of abuse are substantiated, providers must take action to redress the abuse and take the necessary steps to ensure the abuse is not repeated. This may involve seeking specialist advice or support. ▪ When required to, providers must participate in serious case reviews. Any changes to practice and/or recommendations relating to the provider must be implemented.
13(4) Care or treatment for service users must not be provided in a way that–	
13(4)(a) includes discrimination against a service user on grounds of any protected characteristics (as defined in Section 4 of the Equality Act 2010) of the service user,	▪ Staff must understand their individual responsibilities in preventing discrimination in relation to the protected characteristics set out in s.4 of the Equality Act 2010. These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; and sexual orientation. ▪ Providers should have systems for dealing with allegations and acts of discrimination regardless of who raises the concern or who the allegation is against. This includes policies and procedures that describe the required actions and the timescales in which to take action. ▪ Providers must support people who use services when they make allegations of discrimination or actually experience discrimination. They must not unlawfully victimise people who use services for making a complaint about discrimination. ▪ When allegations of discrimination are substantiated, providers must take corrective action and make changes to prevent it happening again. This may involve seeking specialist advice or support.
13(4)(b) includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,	See Regulation 13(7) for the meaning of restraint in relation to this regulation.As part of their induction, staff must receive training that is relevant to their role and at a suitable level to make sure any control, restraint or restrictive practices are only used when absolutely necessary, in line with current national guidance and good practice, and as a last resort. The provider should make arrangements to keep staff up to date at appropriate intervals. If using restraint, providers must make sure that restraint: ▪ Is only used when absolutely necessary. ▪ Is proportionate in relation to the risk of harm and the seriousness of that harm to the person using the service or another person. ▪ Takes account of the assessment of the person's needs and their capacity to consent to such treatment. ▪ Follows current legislation and guidance. ▪ Providers and staff should regularly monitor and review the approach to, and use of, restraint and restrictive practices. ▪ Where a person lacks mental capacity to consent to the arrangements for their care or treatment, including depriving

	them of their liberty, providers must follow a best interest process in accordance with the Mental Capacity Act 2005, including the use of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards, where appropriate.
13(4)(c) is degrading for the service user, or	Providers and staff must take all reasonable steps to make sure that people who use services are not subjected to any form of degradation or treated in a manner that may reasonably be viewed as degrading, such as: ▪ not providing help and aids so that people can be supported to attend to their continence needs, and ▪ making sure people are not: — left in soiled sheets for long periods — left on the toilet for long periods and without the means to call for help — left naked or partially or inappropriately covered — made to carry out demeaning tasks or social activities — ridiculed in any way by staff. This list is not exhaustive. Providers should consult and consider the views of people using their service when defining the meaning of 'degrading'.
13(4)(d) significantly disregards the needs of the service user for care or treatment.	▪ Care and treatment must be planned and delivered in a way that enables all a person's needs to be met. This includes making sure that enough time is allocated to allow staff to provide care and treatment in accordance with the person's assessed needs and preferences. There should be policies and procedures that support staff to deliver care and treatment in accordance with the requirements detailed in the plan(s) of care. ▪ When a person lacks the mental capacity to consent to care and treatment, a best interests process must be followed in accordance with the Mental Capacity Act 2005. Other forms of authority such as advance decisions must also be taken into account. ▪ Staff should raise any concerns with the provider about their ability to provide planned care. When concerns are raised, the provider should respond appropriately and without delay.
13(5) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.	▪ Providers must act at all times in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice and the Mental Capacity Act 2005 Code of Practice. ▪ Hospitals and care homes must follow the Deprivation of Liberty Safeguards. ▪ Other types of services must ensure that any deprivation of the liberty of a person who lacks mental capacity is authorised by the Court of Protection.

Appendix 3—Summary of literature review concepts and search results

Summary of search results across eight academic search databases

		ASSIA	PubMed	PsycInfo	EMBASE	CINAHL		Social Sciences		Social Services Abstracts	Social Sciences Citation Index	TOTALS
Date		6/12/2017	29/11/2017	30/11/17	29/11/2017	6/12/2017		5/12/2017		7/12/17	11/12/17	
Search option		Title/abstract	Title/abstract	Title/abstract	Title/abstract/author keywords	Abstract and title searched separately (no joint option)		Abstract and title searched separately (no joint option)		Title/abstract	Title article	
Limits		English, 2007-2017, scholarly journals, excluding duplicates (ProQuest)	English, 2007-2017, Species: human, Journal article	Language: English, Years:2007-2017 Source type: scholarly journals	English, 2007-2017, articles, reviews, articles in press	English, 2007-2017, academic journals		English, 2007-2017, scholarly journals		Language: English, Years:2007-2017 Source type: scholarly journals	Years: 2007-2017 Source type: Articles	
Concept 1	"adult* at risk" OR "adult* at risk of harm" OR "adult* abuse" OR "vulnerable adult*" OR "adult* protection" OR "protecting adult*" OR "adult* safeguarding" OR "safeguarding adult*"	347	90	427	783	Abstract 630	Title 365	Abstract 121	Title 40	307	168	**3,278**
	AND											
Concept 2	"guideline*" OR "practice" OR "standard*" OR "best practice" OR "guidance" OR "principle*"	183	23	121	177	193		18		164	5	**884**
	AND											
Concept 3	"health" OR "healthcare" OR "social care" OR "social" OR "community care" OR "mental health" OR "homecare" OR "home care"	118	10	66	94	84		7		103	0	**482**

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