MOVING FORWARD: ADULT SAFEGUARDING IN THE HEALTH SERVICE EXECUTIVE

A high-level review of the HSE safeguarding policy, procedures, structures and options for the future of safeguarding across all settings.

JACKIE MCILROY
INDEPENDENT REVIEWER

Acknowledgements

I am deeply indebted to all the people who assisted this Review by giving their time to attend engagement events, to share their knowledge and expertise and to tell their stories. These include people who have experience of safeguarding services, families, practitioners, managers, voluntary and community sector, educators, trade unions and professional bodies and Government Departments.

I am grateful to the National Safeguarding Office for their support, gathering of information and planning of stakeholder events and Safeguarding Ireland for their input and expertise.

My thanks also to Dr Sarah Donnelly, University College Dublin who provided an excellent summary of key messages from international research on adult safeguarding which is attached to this report.

This Review relied on the brilliant organisation and administration provided by the Office of the CEO for the HSE, led by Paula McShane. I would like to say a massive thank you to Paula and Suzanne Hannigan for all their assistance.

Table of Contents

1.0	Executive Summary	5
2.0	Introduction	10
3.0	Background	11
4.0	Remit of the Review	13
5.0	Engagement	14
6.0	Data on Safeguarding Activity	16
7.0	A Culture of Safeguarding	17
8.0	Amplifying the Voice of the Person	20
9.0	A Focus on Wellbeing and Prevention	21
10.0	Governance that Matters	25
11.0	A Structure for Going Forward	31
12.0	A New Model of Safeguarding	34
13.0	Workforce	37
14.0	Moving Forward Recommendations	39
Appendix 1	Engagement Groups	43
Appendix 2	Critical Considerations for Adult Safeguarding in Ireland, Dr Sarah Donnelly, UCD	44
Appendix 3	Extract from N. I. Adult Safeguarding Policy	59
Appendix 4	List of Acronyms	60

"If everyone is moving forward together, then success takes care of itself."

Henry Ford

1.0 Executive Summary

Background

On 3rd July 2023, an independent external reviewer was commissioned by the Health Service Executive (HSE) to provide professional advice in respect of two elements of work.

The terms of reference for the work are as follows:

1. To review the relevant reports 'Emily' (specifically National Independent Review Panel (NIRP), Community Healthcare Organisation (CHO) Safeguarding, NIRP Summary) and conduct any engagements necessary to advise the Chief Executive Officer (CEO) of the HSE on the specific question as follows;
2. Based on the material available and considering best practice is a further examination of individual records warranted such as would likely identify past harm, and if so, is that examination limited to particular scope and time or full lookback?
3. Against the backdrop of the examination but not limited to that, to conduct a high level review of the HSE safeguarding policy, procedures, structures and advise the CEO on possible options for the future of safeguarding recognising that the HSE has roles in safeguarding in both the community and alternative care settings for adults.

The report on Part 1 and Part 2 of the Terms of Reference was published in September 2023. This report relates to Part 3.

The Need for Reform

In the course of the work of this Review, there has been a broad consensus among those it has engaged with that there is a need for transformational change in the way adult safeguarding is delivered and the way the system is organised. The procedures that are currently in place are outdated and there remains a need for cultural change to embed safe practice and promote an open environment where safeguarding concerns are taken seriously and abuse of any nature is not tolerated.

Too often the Review heard that there has been acceptance of poor quality care, defensive practice, tolerance of abusive behaviours, putting organisational reputation above the needs of the individual and how the very institutions set up to care for people became instead unsafe environments. Yet most managers, staff and volunteers are working tirelessly to provide the best care they can and the Review saw many excellent examples of good practice but what we do know is that culture can transform services or it can be a barrier to change.

These issues will not come as a surprise to those working across the system or those who use its services. Indeed, many of these issues were plainly articulated from a number of different sources, who also made clear their concerns with regard to factors such as rising demand, variability of services across the country, lack of investment, workforce planning and a lack of clarity as to roles and responsibilities.

Although there are committed and talented people at all levels of the health and social care system, safeguarding and protection so often seems to be a world apart from everyday practice and viewed as an add on rather than the core business of health and social care.

This Review has a vision for adult safeguarding that places safeguarding at the heart of all that the HSE and all public, private and voluntary agencies funded through public monies to provide a health and/or social care services (henceforth to be described as funded agencies) do:

- by embedding a culture which recognises every adult's right to respect, dignity, honesty and compassion in every aspect of their life
- working collaboratively across sectors and professions to prevent or minimise harm whilst recognising the adults right to self determination
- establishing clear guidance, processes, and services when there are safeguarding concerns

To achieve this, the Review suggests the following elements are needed:

A Culture of Safeguarding

Having a positive organisational culture is vital when delivering high quality care and support. The HSE must embrace a culture which promotes genuine openness, does not tolerate poor practice or behaviours and responds to safeguarding concerns as soon as they arise.

Amplifying the Voice of the Person

Truly listening to the voice of those who have experience of services and working in partnership with them to achieve the best outcomes for them as individuals and collectively to improve services, will lead to cultural change and transformation.

A Focus on Wellbeing and Prevention

Safeguarding in its widest interpretation is about safe services and core to all that the HSE does. Crucial to people's wellbeing and to them feeling and being safe are:

- the services that are provided
- the way in which care is provided
- the quality of care provided
- how safe services are
- how safeguarding concerns are responded to

Good governance, compassionate care, education and training, addressing health inequalities, raised awareness of abuse and knowing how to minimise the risk of abuse are all key to prevention.

Governance that Matters

Safeguarding and protection can be a messy business, by its nature abuse is conducted covertly, it can involve difficult family dynamics, unhelpful allegiances and complex decisions so there is no one solution that ensures that we get it right. Instead what is required is clear guidance on what is expected of staff and volunteers, clarity on who is responsible for decision-making when there is a concern and a patchwork of checks and balances that collaboratively can provide some level of assurance.

These include policies and procedures, recording mechanisms, learning from data, regulation, audits, information sharing agreements, multi-agency protocols, commissioning and contractual arrangements.

A Structure for Going Forward

Effective leadership, clarity on roles and responsibilities and accountability is key to driving improvement and creating the environment that supports safe practice and effective responses to people at risk of abuse.

Although this review will recommend a separate structure for safeguarding and protection services, that does not negate the responsibilities of all management and staff to ensure safe services and concerns of abuse are taken seriously and responded to effectively.

Moving Forward Recommendations

The Irish health and social care system has a great opportunity to bring about meaningful change in how it supports and protects some of the most vulnerable members of the population. It is an opportunity that should not be wasted but it will require energy and commitment from the organisation. It is vital that leaders at all levels of the health and social care system promote and embed a culture of safe services so that safeguarding becomes part of the fabric of health and social care.

To do this, this report makes recommendations to support the following four key actions:

1. Embedding a safeguarding culture.
2. Increasing the visibility of safeguarding.
3. Supporting a strong change management process.
4. Embedding a culture of learning and improvement.

Embedding a Safeguarding Culture

Cultural change takes time but it can be hastened by robust leadership, clear guidance and understanding of what is expected and prompt action when things go wrong. It can also be supported by listening to the voice of those who have experience of services and who know best what is or isn't working.

To support this culture, it is recommended that:

- A change programme for adult safeguarding and protection is commenced. This should be co-produced with staff, people with experience of safeguarding services, family carers and other key stakeholders.
- The HSE and all funded agencies should document the roles and responsibilities of Boards, senior managers, and staff in respect of safeguarding and provide clarity as to who is responsible for what and how decisions are made.
- Meaningful co-production with people who have experience of services should be implemented across services.
- Outcomes based supports/approaches are to be designed alongside people who have experience of safeguarding services.
- Making Safeguarding Personal (MSP) approaches should be rolled out across the HSE.
- People who are at risk or have been subject to abuse should be offered the services of an independent advocate as routine. An analysis of demand and capacity for advocacy should be undertaken to ensure that this recommendation is implemented.
- In recognition of the social and structural issues that can increase the likelihood of abuse, the HSE should review resources and practice with individuals and groups who may be marginalised and/or require additional support.
- The culture of the HSE should ensure that people who use services are empowered to make informed decisions for themselves and to have control over how their care is provided and the decisions that affect their lives. The implementation of the Assisted Decision-Making (Capacity) Act (ADMCA) 2015 will greatly assist this.

Increasing the Visibility of Safeguarding With Well-defined Lines of Accountability

- A new safeguarding structure with clear lines of accountability should be created. This should be led by a Chief Social Worker at a national level and a Director of Safeguarding within each Health Region.
- The Chief Social Worker should have responsibility for strategic and professional oversight, governance, performance management and accountability in relation to the exercise of adult safeguarding functions. The post holder should also have operational oversight of serious and significant safeguarding concerns within service provision and where necessary have the authority to allocate a safeguarding team, independent of the Health Region, to assess and implement a safeguarding plan and/or put in place other safeguarding processes as required.
- The Director for Safeguarding should have sufficient seniority within the organisation that they can make authoritative and final decisions and support, advise and provide direction to the senior management teams on safeguarding across all services within that region. They should also have management responsibility for the Safeguarding and Protection Team and provide professional leadership for all social workers within that region.
- The National Safeguarding Office (NSO) should become part of the strategic arm of the Office of Chief Social Worker.
- There is merit in maintaining the Safeguarding and Protection Committees that are currently in place and these should be strengthened to support operational practice, multi-agency collaboration and to have a more visible leadership role.
- A pathway to the Safeguarding and Protection Team should be developed that provides clarity as to their role, the circumstances in which Designated Officers (DO) should notify the team based on significant harm and/or complexity of the case, when co-working is appropriate or when the protection team should hold responsibility for the case.
- The competences and training for DOs should be determined to provide clarity of role function and accountability.
- An out of hours social work service to respond to safeguarding concerns should be developed.
- The HSE and the Department of Health should consider the viability of an adult safeguarding helpline for the public.
- Consideration should be given to the value of introducing safeguarding lead posts across adult services to support a culture of safeguarding similar to those recently introduced within acute services.

Supporting a Change Management Process

The change programme should be an intense period of activity that sends a strong message that safeguarding is everyone's business, and that poor practice or tolerance of abuse is not acceptable. It will also increase the visibility of safeguarding services and structures.

The implementation plan must be championed across services and blockages to implementation need to be urgently addressed.

It is recommended that initially the change programme is conducted through the medium of task and finish groups reviewing and agreeing on key areas for improvement and led by senior leadership.

These include

- The development of a new HSE operational policy and procedures that support the implementation of the Department of Health Adult Safeguarding Policy, embeds the change in culture that is required and provides clarity as to process and roles and responsibilities. There should be a greater emphasis on professional decision-making for safeguarding in all services. The new operational policy should cover the HSE and all funded services, treat people equitably regardless of residency status and be in line with Assisted Decision-Making principles.
- The HSE should review policies and procedures to ensure synergy with the future direction of adult safeguarding and promote best practice in safeguarding. These include but are not confined to:
  a. The Confidential Recipient
  b. The complaints process
  c. HSE Open Disclosure Policy 2019
  d. The Incident Management Framework 2020
  e. Risk management policy and procedures
  f. The Trust in Care Policy 2005
- The HSE should retain oversight and responsibility of the quality of the care that is provided in commissioned or contracted services and all contracts or service level agreements should ensure robust governance arrangements are in place within provider organisations to ensure effective leadership, good safeguarding practice and high quality service.
- A new form of data collection should be developed and included in the development of an electronic solution.
- The NSO should review all safeguarding documentation.
- The NSO should produce guidance on good safeguarding practice across settings and provide information for people who are purchasing their own care on important considerations for safe practice. These should be easily accessible to the public.
- A Joint Agency Policy should be developed with An Garda Síochána (AGS).
- Policy and procedures for the management of self neglect should be developed separately but in parallel with the Adult Safeguarding Policy.
- A serious case management approach should be rolled out across the country building on the learning from the evaluation of the experience in Community Healthcare West.

Embedding a Culture of Safeguarding, Learning and Improvement

- Further public awareness campaigns should be developed that help the public recognise signs of abuse and to know where to go if they are concerned.
- A communication strategy that includes key messaging, the use of social media and other communication mediums should be developed on an annual basis.
- The NSO should ensure an inter-agency and inter-disciplinary approach to adult safeguarding training and practice development.
- NSO will develop and agree a regional adult safeguarding training framework which will specify learning outcomes and core content to meet a range of identified training needs within the HSE and partner organisations.
- Professional education providers should be consulted as to how safeguarding can be included in undergraduate and post graduate education programmes.

- Joint training sessions with AGS should be developed at a local level to promote relationship building and understanding of each other's roles and responsibilities. Also, consideration should be given to specialist interviewing training for social workers as provided within Túsla.
- The Department of Health should provide funding for NSO to conduct an annual commissioning process for academic research in adult safeguarding that informs process and practice.
- The NSO should also encourage research and audits of adult safeguarding practice within the HSE.
- The NSO should be responsible for the dissemination of learning from reviews of significant failures of care within the HSE to support change and good practice.
- The NSO should organise an annual conference on adult safeguarding that promotes good practice and shares learning from international research.

This Review was specifically to review the policies, procedures and structures of the HSE in respect of safeguarding and protection. However it is clear that there are matters outside the remit of the HSE and therefore outside of this Review that will inform and influence future practice. This Review recommends that consideration be given to the following:

- Using the new National Adult Safeguarding Policy (Department of Health) as a catalyst for change.
- The development of safeguarding legislation that clarifies the roles and responsibilities of agencies and puts practice on a statutory footing.
- Regulation of services across all services and settings should be considered in any future review or development of legislation.
- The Government should build on the creation of a register of social care workers in November 2023 by introducing professional regulation of health assistants and care workers in all care settings.
- A duty to co-operate across agencies should be mandated.
- If a separate agency for safeguarding is being considered, then workforce planning would need to commence and should include increasing the numbers of student social work places and other relevant professional groups if required across all sectors.

2.0 Introduction

2.1 Safeguarding is a broad continuum of activity. It ranges from enabling people to keep themselves safe within their communities and community safety approaches, through prevention and early intervention, to risk assessment and management, to interventions that support and protect.

2.2 Safeguarding is not a separate entity but is influenced by the culture, leadership and the society in which it occurs. Societal attitudes, particularly biases to gender, sexual orientation, race, disability, older people and any other marginalised people within that society are replicated in how society responds to supporting those who may be vulnerable and less likely to be able to protect themselves.

2.3 Ireland's history like so many other countries have shameful examples of how those who required help and compassion were instead subject to exploitation and abuse. The Magdalene Laundries in Ireland is one such example from the past but today there remains many examples of how societal views can influence the care and support it provides. How sometimes abuse of an older person's pension by family members is accepted as it is viewed as 'only a family matter'; how peer to peer abuse is a feature of life within some institutional settings as challenging behaviour 'is just to be expected'; and how abuse of people who are socially excluded is considered inevitable as 'it's is a result of lifestyle choices'. If we do not see abuse, then how can we safeguard those who require it?

2.4 This Review in the HSE cannot address these wider societal issues but it is important to be mindful of the unconscious bias that exists within every organisation as it will affect the decisions that are made, the support that is provided and how the system truly embeds safeguarding in all that it does.

3.0 Background

3.1 The HSE adult safeguarding policy, Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures, was developed rapidly in 2014 in response to service failures and institutional abuse exposed at the Aras Attracta Residential Campus. This led to the development of Adult Safeguarding and Protection Teams, Safeguarding Ireland, the NSO and the introduction of DOs in funded services. Previous safeguarding failures also led to service initiatives such as elder abuse social workers and indeed the commissioning of this report was prompted by concerns regarding how a community nursing home managed concerns of the sexual assault of residents in what is commonly known as the 'Emily' case.

3.2 In the course of the work of this Review, there has been a broad consensus among those it has engaged with that there is a need for transformational change in the way adult safeguarding is delivered and the way the system is organised. The procedures that are currently in place are outdated and there remains a need for cultural change to embed safe practice and promote an open environment where safeguarding concerns are taken seriously, and abuse is not tolerated.

3.3 Too often the Review heard that there has been acceptance of poor quality care, defensive practice, tolerance of abusive behaviours, putting organisational reputation above the needs of the individual and how the very institutions set up to care for people became instead unsafe environments. Yet most managers, staff and volunteers are working tirelessly to provide the best care they can, and the Review saw many excellent examples of good practice but we know that culture can transform services or it can be a barrier to change.

3.4 These issues will not come as a surprise to those working across the system or those who use its services. Indeed, many of these issues were plainly articulated from a number of different sources, who also made clear their concerns with regard to factors such as rising demand, variability of services across the country, lack of investment, workforce planning and a lack of clarity as to roles and responsibilities. Although there are committed and talented people at all levels of the health and social care system, safeguarding and protection so often seems to be a world apart from everyday practice and viewed as an add on rather than the core business of health and social care.

3.5 Ireland is not alone in facing these challenges. Adult safeguarding is a relatively new concept compared to safeguarding and protection practice in children services. There is no clear evidence that one model of adult safeguarding works better than another and the evidence for safeguarding interventions is in its infancy. Adult safeguarding is complex but this should not be used as an excuse for doing little or to limit the ambition to do better.

3.6 Overall, the Review found an appetite amongst those whom it engaged with for change and for improvement. Many called for radical reform to put in place structures and processes for safeguarding across all Irish society. Others suggesting that the health and social care sector should get its house in order first.

3.7 There is a wider debate on the need for a national safeguarding service across all sectors and a cross government approach which is pertinent but outside the remit of this Review as it applies only to the HSE and funded services.

So Why is the Time for Change Now?

3.8 There are a range of drivers coming together at one time that hopefully will create an impetus for transformation:

- The HSE is going through a period of reform. New health regions and population health networks provide an opportunity to do things differently.
- There have been very public failures to protect people who are receiving HSE or funded services and this has led to greater political and public concern that services are not safe and that change is required.
- The call for legislative measures to support how people are protected has strengthened and it is understood that the Law Reform Commission will report in the near future.
- The Department of Health are currently producing a National Adult Safeguarding Policy for all public, voluntary and private providers in health and social care. This will drive change in practice across the system.
- The Assisted Decision-Making (Capacity) Act 2015 was recently implemented in April 2023. It provides a framework for supported decision-making and has implications for how the health and social care sector support adults who have challenges with their decision-making capacity.

3.9 Change and reform are always difficult, they create uncertainty, and they require us to give up long held patterns of behaviours and ways of working, it can challenge our beliefs and with respect to safeguarding it can force us to face the unpleasant side of society where abuse is a reality.

3.10 It is important that the case for change is clearly understood by those who use and those who deliver services, and that keeping people safe is at the very core of what the health and social care sector does.

4.0 Remit of the Review

4.1 On 3rd July 2023, an independent external reviewer was commissioned by the CEO of the HSE to provide professional advice in respect of two elements of work.

4.2 The term of reference for the work are as follows:

1. To review the relevant reports 'Emily' (specifically NIRP, CHO Safeguarding, NIRP Summary) and conduct any engagements necessary to advise the CEO of the HSE on the specific question as follows;
2. Based on the material available and considering best practice is a further examination of individual records warranted such as would likely identify past harm and if so is that examination limited to particular scope and time or full lookback.
3. Against the backdrop of the examination but not limited to that, to conduct a high level review of the HSE safeguarding policy, procedures, structures and advise the CEO on possible options for the future of safeguarding recognising that the HSE has roles in safeguarding in both the community and alternative care settings for adults.

The report on Part 1 and Part 2 of the Terms of Reference was published in September 2023. This report relates to Part 3.

5.0 Engagement

5.1 Between starting and producing its final report, this Review had relatively a short period of time. However from the reading of documents and written submissions to the Review, extensive meetings with staff, families, people who have used services and key stakeholders across health and social care there were consistently key messages heard on the need for change and the solutions required so it is unlikely that a longer review would have very different outcomes.

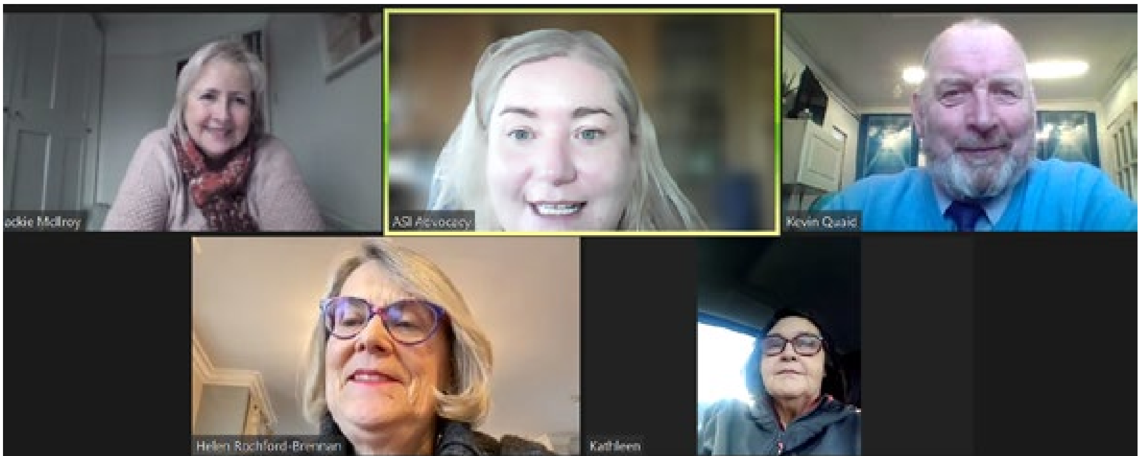
5.2 The Review heard:

- The unsustainable nature of the 'status quo'. The current policy does not apply to most of the health and social care sector and is not keeping the people it serves safe.
- The number of organisational failings within the HSE in respect of safeguarding individuals would indicate a lack of understanding of adult safeguarding and protection and a culture which allows minimising and reframing of safeguarding concerns.
- Safeguarding is everyone's business and yet it is no-one's business.
- There is a lack of accountability and clarity as to roles and responsibilities.
- There is a compelling need for legislation to support safeguarding interventions.
- How General Data Protection Regulation (GDPR) has been interpreted is allowing it to be used to as an excuse not to share information both within organisations and across agencies.
- There is resistance to moving to a social model of disability which promotes independence for people who are older or have a disability.
- The voice of the person with experience of services and their families is often not heard.
- There is significant regional variability in practice.
- There is a lack of investment in safeguarding and protection services.

5.3 The Review also heard that there had been improvements in recent years:

- There have been excellent public information campaigns.
- Education and training programmes have been developed.
- There is greater awareness of safeguarding since the 2014 policy was implemented.
- Safeguarding and Protection Teams are in place to provide support, advice and intervention.
- Assisted decision-making legislation will be helpful.
- Collaborative relationships have been developed.
- Multi-disciplinary approaches to safeguarding are in place.

Photographs from a Selection of Engagement Events

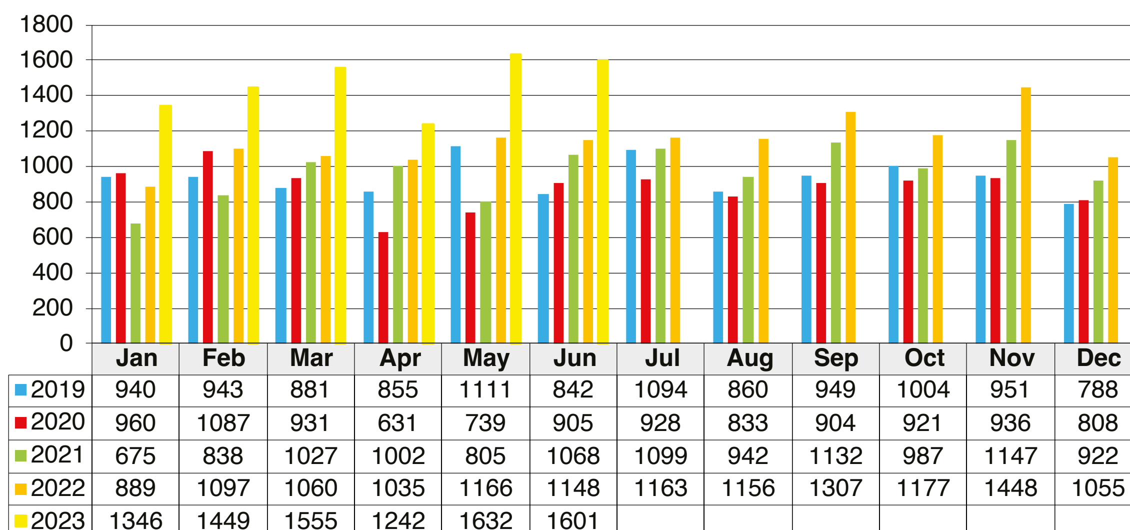


6.0 Data on Safeguarding Activity

6.1 This data has been provided by the NSO. The data for 2023 is provisional from the quarterly Quality and Patient Safety (QPS) internal reporting and will only be finalised in June 2024 when the Annual NSO Report is published.

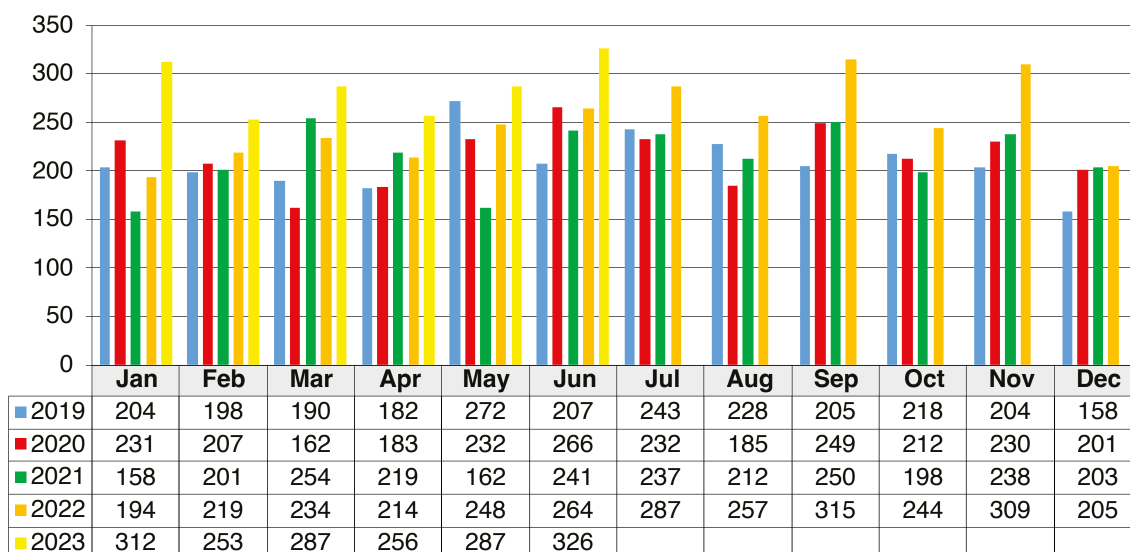
Total Notifications Across the Months of the Years 2019 - 2023

Notifications Received by Month 2019 - 2023



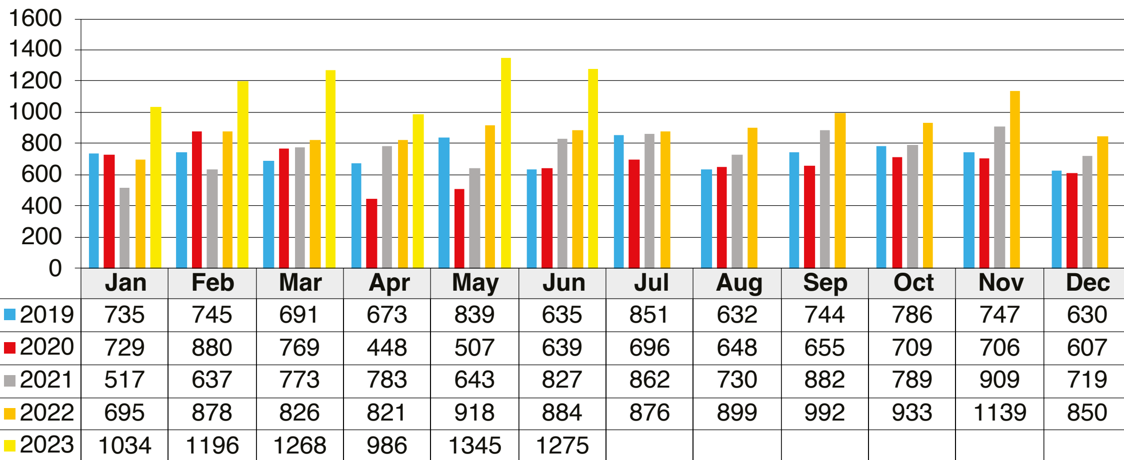
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	940	943	881	855	1111	842	1094	860	949	1004	951	788
2020	960	1087	931	631	739	905	928	833	904	921	936	808
2021	675	838	1027	1002	805	1068	1099	942	1132	987	1147	922
2022	889	1097	1060	1035	1166	1148	1163	1156	1307	1177	1448	1055
2023	1346	1449	1555	1242	1632	1601						

Community Notifications Received by Month 2019 - 2023



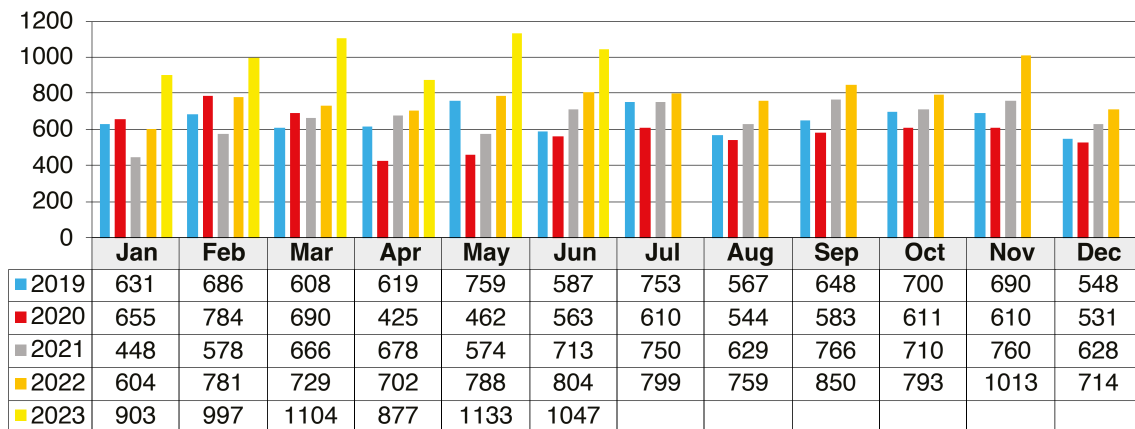
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	204	198	190	182	272	207	243	228	205	218	204	158
2020	231	207	162	183	232	266	232	185	249	212	230	201
2021	158	201	254	219	162	241	237	212	250	198	238	203
2022	194	219	234	214	248	264	287	257	315	244	309	205
2023	312	253	287	256	287	326						

Service Notifications Received by Month 2019 - 2023



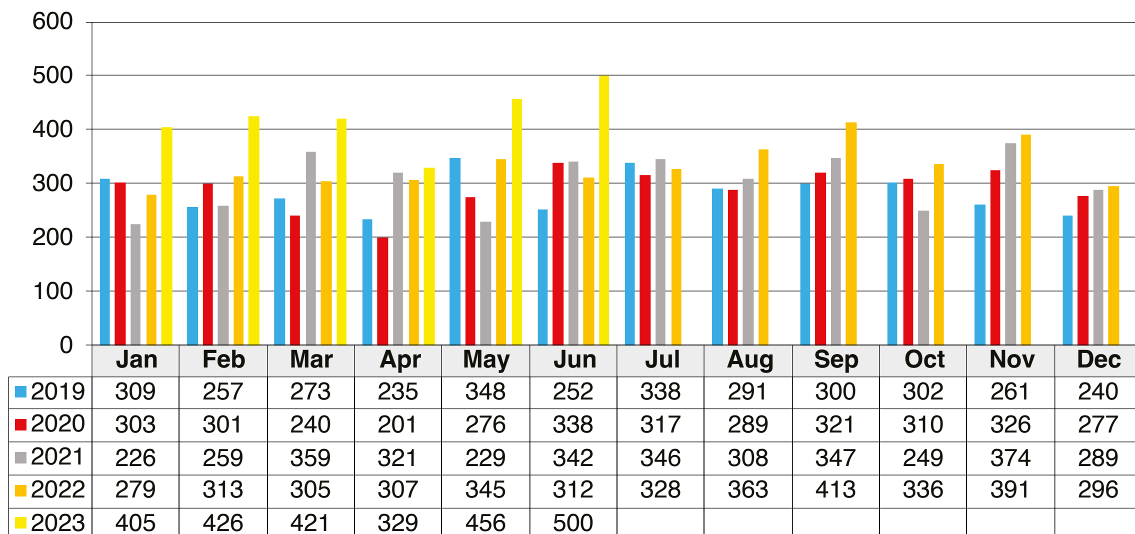
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	735	745	691	673	839	635	851	632	744	786	747	630
2020	729	880	769	448	507	639	696	648	655	709	706	607
2021	517	637	773	783	643	827	862	730	882	789	909	719
2022	695	878	826	821	918	884	876	899	992	933	1139	850
2023	1034	1196	1268	986	1345	1275						

Notifications Received for Under 65's by Month 2019 - 2023



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	631	686	608	619	759	587	753	567	648	700	690	548
2020	655	784	690	425	462	563	610	544	583	611	610	531
2021	448	578	666	678	574	713	750	629	766	710	760	628
2022	604	781	729	702	788	804	799	759	850	793	1013	714
2023	903	997	1104	877	1133	1047						

Notifications Received for Over 65's by Month 2019 - 2023



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	309	257	273	235	348	252	338	291	300	302	261	240
2020	303	301	240	201	276	338	317	289	321	310	326	277
2021	226	259	359	321	229	342	346	308	347	249	374	289
2022	279	313	305	307	345	312	328	363	413	336	391	296
2023	405	426	421	329	456	500						

6.2 Key Commentary:

From the above graphs and other sources, the following key trends are noted:

- Notifications for Q2 2023 are in excess of 4,400 concerns representing a 34% increase on Q2 2022.
- Broken down by service/ community, the first half figures for 2023 indicate that concerns originating from services have risen by 41% and 25% increase in community. The growth in Q2 is more evident in service referrals. Increase in staff levels and targeted training could account for some of this increase.
- For those under 65 years there was a 38% increase in the YTD reporting when compared to the same period last year. When reviewed by service/community - YTD shows an increase of 76% in community referrals and 35% in service referrals. Note a proportion of the community concerns reported would be in receipt of services.
- For those over 65 years there was a YTD 36% increase in the reporting level - when considered in terms of whether the cases were referred in a service or community - there has been a 7% increase in community and just over 74% in service concerns.
- Based on a projected one third increase in safeguarding notifications in 2023, there are currently significant challenges with the current recruitment embargo impacting on response capacity for Safeguarding and Protection Teams.

7.0 A Culture of Safeguarding

7.1 Culture is made up of the organisation's leadership, values and practice and the behaviours and attitudes of the people who work there. Having a positive organisational culture is vital when delivering high quality care and support.

7.2 In engagements, the reviewer was struck by the appetite for change and the desire to do better. There are excellent staff within the HSE and the Review witnessed excellent practice, yet too often people who contributed to the Review talked of being aware of defensive practice and how safeguarding issues could sometimes be reframed or safeguarding responses tempered to fit with organisational priorities. The focus so often appears to be on process rather than outcomes for the individual who is at risk of or has been abused. So a significant change programme across the HSE is required that drives a culture where the voice of the individual who requires support is truly placed at the centre of decision-making and safeguarding is seen as core to everyone's job rather than an add on or a process set side.

7.3 The CEO through his staff presentations and his decision to appoint a Chief Social Worker has made it clear that safeguarding is a key priority for the organisation. This needs to be replicated at all levels of the HSE and the services that are funded to provide health and social care.

7.4 Effective leadership is key to driving improvement and creating the environment that supports safe practice and effective responses to people at risk of abuse. Although this Review will recommend a separate structure for safeguarding services, that does not negate the responsibilities of all management and staff to ensure safe services and concerns of abuse are taken seriously and responded to effectively. Most concerns or issues will not meet the threshold for a safeguarding investigation and are best managed within existing service provision. **The HSE needs leaders and champions for safeguarding at all levels in the organisation and funded organisations.**

7.5 Safeguarding Ireland provided this Review with information on how the Central Bank of Ireland developed an Individual Accountability Framework[1] for retail banks as a means of changing culture and improving internal accountability by clarifying the roles of senior management and boards. This was achieved by the creation of individual statements of responsibility, together with a management responsibility map documenting the wider governance and management arrangements. It is understood that this was mandated through legislation. Such an approach is applicable to health and social care even in the absence of safeguarding legislation. To ensure clarity in respect of accountability, the HSE and each of its funded agencies should as a minimum document the roles and responsibilities of boards and senior management regarding safeguarding and oversight and decision-making arrangements.

7.6 The Care Quality Commission (CQC) in the UK[2] found that failing organisations tend to have cultures where staff are afraid to speak out, don't feel they have a voice and aren't listened to. The report went on to identify services which had shown significant improvements in their overall inspection rating because they prioritised the development of an open and positive workplace culture.

7.7 So what does this look like in practice? This following list is not comprehensive but provides a minimum requirement:

- Each organisation within health and social care makes clear the roles and responsibilities of the Board, senior management and staff in respect of safeguarding.

1 Behaviour and Culture Report into Irish retail banks, The Central Bank of Ireland

2 Rapid Literature Review: The Characteristics of safety culture, Care Quality Commission 2023

- Leadership makes it clear through its actions and behaviours that poor practice is not acceptable and that all safeguarding concerns are taken seriously and responded to appropriately.
- People with the right values and attitudes for this work are recruited through effective recruitment processes.[3]
- Safeguarding is seen as part of everyone's job.
- It is talked about at team meetings and staff supervision sessions.
- Staff are trained to identify and respond to concerns of abuse.
- Staff feel able to report poor practice or concerns of abuse and know that they will be listened to.
- Support is made available to anyone raising concerns.
- Best practice in safeguarding and learning from reviews is disseminated and more importantly implemented.
- Practice audits are routinely conducted as part of service improvement.
- Progress is informed by thematic reviews of incidents, complaints, service user experience surveys etc.
- Safeguarding services are invested in.
- Change management informed by implementation science is applied to how services can be led and transformed.

7.8 **Staff engagement is key to meaningful change in practice and culture.** Often during this Review, staff articulated not only the problems but also the solutions. Embracing their enthusiasm, willingness to change and listening to their ideas will support a collaborative approach to improvement. Leadership top down and bottom up.

7.9 The HSE must embrace a culture which promotes genuine openness and a willingness to call out practice and management styles that are defensive. It should support whistleblowers and provide a safe environment that encourages challenges to poor practice. Mistakes will happen, safeguarding concerns will occur, so it is important that the HSE move beyond a blame culture to recognising that identifying weakness in service provision is a strength that requires skill. **The HSE needs leadership that is brave and progressive.**

7.10 **A positive culture is also about enabling people to be independent and to be able to protect themselves.** People, families and carers should be empowered to make meaningful and individualised choices about care, helping them to plan and make informed decisions regarding their care, to involve friends and family if they so wish, and to maintain independence. Choice and control are enabled by access to information and are underpinned by a rights based approach; by knowing your rights and by the actions of others being based on your rights. This leads to truly person-centred care.

7.11 The NSO is currently supporting the implementation of MSP approaches. MSP means that safeguarding should be person-led and outcomes focused. This approach was included in the Care Act 2014 in England and requires staff to engage with *"the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety."*[4] The aim of the NSO is that by the end of 2024, the MSP guidance resources in adult safeguarding practice will be developed and utilised across HSE and funded services[5]. This is to be welcomed and will support staff with practical tools to engage with people during a safeguarding process in a meaningful way.

3 Choosing with care, The Warner Report, 1992

4 The Care Act, DoH England, 2014

5 Advancing the use of Making Safeguarding Personal, (MSP) resources in adult safeguarding, T Hanley 2023

8.0 Amplifying the Voice of the Person

8.1 **Co-production** with people who have experience of health and social care services is a powerful way of transforming service delivery. *"Where new relationships between staff and people who draw on care and support are created, and people who draw on care and support are recognised as experts in their own right. There is respect for the assets that everyone brings to the process and an emphasis on all the outcomes that people value, rather than just those - such as clinical outcomes - that the organisation values."*[6]

8.2 Although this review was able to engage with families who had experience of safeguarding processes and representative organisations for families, it was more difficult to identify and hear directly from those who have experience of services. The review did meet with some experts by experience identified through advocacy organisations, had access to surveys of service users conducted for the Department of Health to inform the national adult safeguarding policy and attended the Irish Association of Social Workers (IASW) safeguarding event at which two contributors talked eloquently about their experience of services and challenged social workers to ensure a rights based approach was central to their practice. However, hearing the voice of service users and families does not appear to be a regular feature of the planning and delivery of service provision in the HSE. Voluntary and community organisations are more advanced in the development of co-produced practice.

8.3 Viewing services through the lens of others is challenging but ultimately will help improve services. It is the view of this Review that **co-production should be integrated in the planning, design and delivery of safeguarding and protection services.**

8.4 The current policy rightly states that *"Advocacy assumes an important role in enabling people to know their rights and voice their concerns."*[7] **Advocacy also has a key role** in supporting an individual to have their wishes and preferences heard and acted on.

8.5 This Review was informed that often there are tokenistic referrals to advocacy services to tick a box on a safeguarding plan, but then no meaningful engagement when an advocate wants to work with the person regarding safeguarding issues. Advocacy should not be viewed as a threat or an inconvenience but seen as an important resource. It is vital that the voice of the person is heard and that they are supported in the best way possible and that can require the skills of different professionals including advocates.

People who are at risk or have been subject to abuse **should be offered the services of an independent advocate as routine** and their involvement should be evidenced within the safeguarding plan and subsequent reviews.

8.6 Truly listening to the voice of those who experience services and working in partnership with them to improve services will lead to cultural change and transformation.

6 Co-production: What it is and how to do it, Social Care Institute for Excellence (SCIE), July 2022

7 Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures, HSE, 2014

9.0 A Focus on Wellbeing and Prevention

9.1 As safeguarding is such a broad concept, it is sometimes difficult to grasp exactly what we mean by safeguarding adults. It is much clearer when we apply the same concept to children.

9.2 The Health Information Quality Authority (HIQA) and Mental Health Commission's (MHC) National Standards for Adult Safeguarding 2019 define safeguarding as *“measures that are put in place to reduce the risk of harm, promote and protect people’s human rights and their health and wellbeing, and empowering people to protect themselves.”*[8]

9.3 So what do we mean by prevention and protection?

Safeguarding as a concept implies the use of macro level intervention to prevent abuse. At the macro level, a range of mechanisms including legislation and policy are used to promote overall safeguarding of adults, including challenging societal attitudes and social inequalities. Safeguarding at the level of the individual includes policies, procedures and interventions ranging from minimum interventions such as the provision of home care support to compulsory measures such as the detention of individual in hospital without consent under mental health legislation. Protection on the other hand tends to focus on the needs of individuals who are experiencing harm and/or abuse or at risk. This involves identifying existing harm and the promotion of welfare, preventing continuation of abuse and/or harm or neglect. (Stewart 2016[9])

Within this report the term ‘safeguarding’ is used in its widest sense, that is, to encompass both activity which prevents harm from occurring in the first place and activity which protects adults at risk where harm has occurred or is likely to occur without intervention.

Safe Services

9.4 The role of health and social care services is to promote the health and wellbeing of the population. Health is easily understood but it is by supporting people’s wellbeing that we will help them to stay healthy, feel valued, maintain supportive relationships, be as independent as they can and be safe.

9.5 **Safeguarding in its widest interpretation is about safe services and core to all that the HSE does.** Crucial to people’s wellbeing and to them feeling and being safe are:

- the services that are provided
- the way in which care is provided
- the quality of care provided
- how safe services are
- how safeguarding concerns are responded to

Good quality, compassionate care is key to prevention.

8 HIQA and MHC, National Standards for Adult Safeguarding (HIQA and MHC 2019)

9 Stewart, Ailsa E, The implementation of Adult Support and Protection (Scotland) Act (2007), 2016

Good Governance

9.6 Governance will be discussed later in the report but it worth noting that effective commissioning of services, clear guidelines of what is expected within services, proactively seeking the views of people who use services to hear how good they are, reviewing and acting on complaints, risk and incident management are all preventative strategies.

Supporting Families and Communities

9.7 A zero tolerance approach to abuse is essential but sometimes it is important to look outside the culpability of the individual to consider the factors that may impact on abuse. These factors are multi-faceted:

We know that:

- *"More than 1 in 4 carers reported moderate to severe burden, making them over 13 times more likely to report that they engaged in potentially harmful behaviours towards an older person when compared to carers who experienced little or no burden."*[10]
- People with care and support needs may be particularly vulnerable to the impact of poverty and may be less able to protect themselves from abuse. It brings additional stressors for families and relationships and can adversely affect a person's health, mental wellbeing and sense of worth.
- Social exclusion, isolation, disabilities, mental health and previous experience of abuse all increase the risk of abuse and neglect.
- The supply of healthcare services tends to be lower in areas of higher deprivation.[11]

9.8 This Review heard of numerous examples where overcrowded housing, addiction and debt played a role in abusive situations that had arisen.

9.9 The HSE in partnership with other key state agencies has an important role in **tackling social inequalities as part of a preventative strategy for improving both health and wellbeing.** The impact of discrimination, marginalisation, poverty, isolation, inadequate housing and loneliness can profoundly impact on the quality of life and life opportunities for individuals, families, family carers and communities.

9.10 It also has a duty to provide support to people who are may be vulnerable to abuse, just as child protection services will provide support to families to minimise the risks, the same is true for adult safeguarding. This Review often heard that when a person was identified as being at risk of abuse, very often staff could not access the resources necessary to keep that person safe. This could be as simple as being able to provide a one off financial payment to support the safeguarding plan such as providing a train fare to take the person to a family member where they could be safe or it could be a lack of respite for a carer who is at the end of their capacity to cope.

9.11 Statutory services alongside local communities, voluntary and community organisations, faith groups etc. all play a role in recognising and addressing the stressors that may exist as this is an important aspect of prevention but the HSE has a specific role and it should review the supports/resources that safeguarding and protection staff can access in order to prevent or minimise the risk of harm.

10 Lafferty, A., Fealy, G., Downes, C. and Drennan, J. (2014) Family Carers of Older People: Results of a National Survey of Stress, Conflict and Coping. NCPOP, University College Dublin". in Donnelly, S and O'Brien, M (2023). 'Understanding Carer Harm' Research Report. UCD/Family Carers Ireland, Dublin.

11 Area level deprivation and geographic factors influencing utilisation of GP Services, Barlow et al, ESRI,2021

Training and Research

9.12 Effective adult safeguarding requires a specific level of knowledge, expertise and skill and understanding. It also requires an all-system approach so if safeguarding is to be embedded in all services, the HSE **must create a culture of learning and improvement.**

9.13 Prevention includes improving awareness in the public who have poor understanding of safeguarding adults. There are existing public awareness campaigns and Adult Safeguarding Day is a great opportunity to raise awareness across the country. These and other opportunities should be exploited as they arise. **A communication strategy** should be developed on an annual basis to ensure year round communication and messaging.

9.14 Adult safeguarding is complex and must be delivered by a confident, competent and trained workforce, which includes those working in a voluntary or unpaid capacity.

9.15 Although the NSO has a number of training programmes, they need to be built upon. **A national training framework for safeguarding and protection should be developed.** The framework will provide a number of levels of training which reflect the varying levels of expertise required and the differing needs of organisations across the safeguarding continuum. The appropriate level of training will be determined by the roles and responsibilities of the individual staff member.

9.16 Service providers should use the framework to identify and set out training and development pathways for their staff and volunteers, to ensure they have the appropriate skills and knowledge to engage in preventative activity and respond to safeguarding concerns appropriate with their role. This may involve a combination of formal training events, and time for staff to reflect on their own practice and the practice of others.

9.17 Staff in roles that require a more detailed knowledge of adult safeguarding should have specific training commensurate with their role and function. This should be across all professional groups.

What Would this Look Like?

- Professionals who may be required to make a professional judgement or input to safeguarding and protection assessments should have specific training as to their role with regard to assessment of abuse. Examples include tissue viability nurses who may be called upon to determine if there has been neglect in care; speech and language therapists who support people with communication difficulties; doctors who may have to determine if an injury is non-accidental. The list is too long to name all. This could include training provided by the HSE and/or modules on adult safeguarding included in their unidisciplinary professional training programmes.
- Although safeguarding is everyone's business, safeguarding and protection is a core social work function. In order to develop expertise within the HSE and partner agencies, a post qualification training framework on adult safeguarding for social workers should be developed.
- This should include specialist training for Safeguarding and Protection Teams particularly in respect of the management of significant risk of abuse and multi-agency approaches to adult protection.
- Although DOs already have specific training, this should be enhanced to support their role and professional decision-making.
- Joint training sessions with AGS should be developed at a local level to support relationship building and understanding of each other's roles and responsibilities.
- The NSO should collaborate with the HSE Human Rights and Equality group to ensure that a human rights approach is incorporated into all training.

9.18 Education is important, but **the learning must be embedded in practice.** The NSO has developed a useful tool for teams to reflect on safeguarding at team meetings or forums. This should be promoted further.

9.19 Adult safeguarding must be on the agenda for team meetings, there should be journal clubs or peer support groups that encourage reflection and learning from discussion of case studies, it should be discussed at professional supervision and included in every member of staff's learning and development plan.

Research

9.20 This Review is thankful to Dr Sarah Donnelly who provided a summary of some key learning from international research on adult safeguarding and this is attached as Appendix 2 to this report. **Learning from evidence** as to what works and what is unhelpful is vital to the development of a learning organisation.

9.21 There is limited research on adult safeguarding within the Irish context. Yet every review, every failing raises issues that require further research and evidence. The Department of Health should fund the HSE to commission research that supports the local context. The identification of priorities and commissioning of research should be part of the role of the NSO.

9.22 Research that helps the system learn from the experience of people who have received safeguarding and protection services and staff that deliver them should be conducted.

9.23 In addition the NSO should support and encourage a culture of learning from practice throughout the HSE. This includes dissemination of learning from reviews, conducting audits of practice and sharing good practice examples.

9.24 It is also important that the HSE learns from data as to how the system is working. Monitoring trends in incidents, safeguarding notifications, complaints etc. will provide an ongoing picture of the culture of safeguarding and identify areas for improvement.

10.0 Governance that Matters

10.1 Safeguarding and protection can be a messy business, by its nature abuse is conducted covertly, it can involve difficult family dynamics, unhelpful allegiances and so there is no one solution that ensures that we get it right. Instead, what is required is a patchwork of checks and balances that collaboratively can provide some level of assurance.

10.2 The governance of adult safeguarding has been identified by research[12] as having five components:

1. Clarity of goals, scope of activity and purposes, including shared principles, multi-agency commitment and strategic leadership.
2. Structures, including clear divisions of responsibility and mechanisms for communication, and explicit linking between functions or activity.
3. Membership, including a clear rationale for inclusion of agencies, understanding of roles, responsibilities and commitments, evidence of engagement and protocols for chairing, quoracy, resource contributions and business management .
4. Functions, including strategic planning and operational oversight, appreciation of the difference between governance and executive management, and a strong developmental and improvement agenda which embraces audit, performance management and quality assurance.
5. Accountability, including standards for and assessment of committee performance, clarity about decision-making authority and reporting channels and explicit links to other partnerships.

Policies

10.3 The HSE adult safeguarding policy, Safeguarding Vulnerable Persons at Risk of Abuse - Policy and Procedures 2014, is part of a wide range of measures to protect the welfare and safety of adults who may be at risk of abuse and unable to protect themselves sufficiently. These measures also include the Confidential Recipient, the complaints process, Open Disclosure, Incident Management Framework and Risk Management policy and procedures and Trust in Care policy.

10.4 The 2014 policy appeared to have been brought in quickly in response to a specific concern regarding abusive practice within a HSE setting and was successful in raising awareness of abuse and establishing processes for responding to adult safeguarding concerns across HSE and funded social care settings. It was a policy that was needed at a point in time as this Review has been informed that there was a cultural acceptance of low level abuse and a lack of understanding of the need to respond and how to respond that needed to be addressed. As a result the policy is prescriptive, procedurally driven and does not allow for professional judgement and proportionality. However it is now over eight years since it was implemented and it is outdated in responding to the current needs of the HSE. This was recognised in 2017 and after much consultation, a draft policy was developed in 2019 but was not implemented.

10.5 The Department of Health are currently consulting on a new adult safeguarding policy and it is understood that the scope of the policy will be across all public, voluntary and private settings within the HSE, older people, disability services, primary care, acute and community. This is to be welcomed as the HSE has a duty of care to people within hospitals, private nursing homes, mental health services in the same way as they have in older and disability services.

12 Braye, S., Orr, D. and Preston-Shoot, M. (2012) The governance of adult safeguarding: the findings from research The Journal of Adult Protection 14 (2), 55-72

10.6 This policy will set the strategic direction for national adult safeguarding practice and it provides a wonderful opportunity to reset current practice in safeguarding by building on the work that has been achieved to date, addressing current deficits and driving further change across the HSE. It will be important that the HSE develops a new HSE operational policy and procedures to reflect the future direction of safeguarding.

10.7 The new policy and procedures need to have a focus on wellbeing and prevention, ensuring compassionate, high quality care that is open and transparent and learns from mistakes and failures. It should support professional decision-making, placing a responsibility on practitioners to respond to each individual and their unique circumstances. Each response should be tailored to meet the needs of that individual, working towards supporting them to achieve their preferred outcome. There is no role for paternalism in modern safeguarding but a partnership approach that works with the person to achieve what is best for them.

10.8 The work of the NSO in supporting and promoting MSP[13] is important in that it will help to develop an outcomes focus to safeguarding but also sets the tone for the culture in which safeguarding decisions are made. It shifts the focus from process to people and aligns with the Assisted Decision-Making (Capacity) Act 2015[14] and positive risk taking considerations.

10.9 The language of vulnerability within the existing policy disenfranchises groups of people who may require support or be at risk of abuse but do not view themselves as vulnerable. Not everyone with a mental health problem is vulnerable but there may be times in their life that they are less able to protect themselves and for that period of time however long or short may need support and intervention to feel safe. Although there is no evidence that one term is more effective than another most countries appear to describe the person requiring support as a 'person at risk of abuse' or 'in need of protection' or variations of this. The new National Safeguarding Policy should provide a descriptor that will be applied across all settings in Ireland.

10.10 ***'Safeguarding is everyone's business'*** is often cited as it recognises the role of all staff, volunteers and services have in keeping people safe and when an issue arises such as a quality of care issue or an allegation of abuse, knowing how to respond. It is true that at each stage in the spectrum of safeguarding, people will require different responses provided by different people, organisations and professions and as the risk of harm increases, the safeguarding response required to mitigate it also increases. However, too often in engagements, this review was advised that ***'safeguarding is everyone's business'*** means in reality that it is ***no-ones business or responsibility.***

10.11 The new policy, whilst promoting a culture where safeguarding is core to the work that everyone does in caring, treating and supporting a person, must also **establish clear roles and responsibilities for decision-making** when there are concerns of harm or abuse. This will be discussed further under structures.

Recording Templates

10.12 Effective recording is an important element of good governance, however, the current reporting templates are too long and cumbersome. The NSO should review all documentation to ensure that it supports recording of assessment and decision-making whilst aiming for a more streamlined and simpler format. Safeguarding should be integrated into other reporting templates such as incident reporting and risk management. Any recording system should be amenable to easy data collection, collation and analysis.

13 The Care Act 2014, England.

14 Assisted Decision-Making (Capacity) Act 2015 (Section 10(4), Regulations 2023, Ireland

Data

10.13 It is important that there is an accurate data system to inform workforce planning, securing investment and identifying risks or trends across the region.

10.14 The current data does not provide a full picture of safeguarding and protection. It relies on the notifications that are sent to the Safeguarding and Protection Teams. It is known that there is underreporting across the system.

10.15 There has been concern expressed that if all safeguarding concerns are not sent to the Safeguarding and Protection Teams that it will impact on the collection of data. This should be managed through a simpler recording format preferably via an electronic solution or at least an administrative process. A simpler process may encourage more reliable reporting that can inform learning about types of harm and ways of preventing harm.

10.16 Therefore, there should be an overhaul of the current data collection and reporting system to support more reliable reporting.

Information Sharing

10.17 Throughout the Review, concerns about information sharing were expressed. The Review heard how GDPR legislation was often used as a reason not to share pertinent information relating to a safeguarding concern. This was within the HSE and funded agencies and with other agencies such as AGS and Túsla.

10.18 Not only is this a misunderstanding of the legislation but it goes against all logic and risk management requirements. How can the system risk assess and safeguard a person without knowing all the pertinent information?

10.19 It is understood that Safeguarding Ireland working alongside a number of stakeholders is engaging with Data Protection Commissioner to produce guidance on information sharing and safeguarding. This is most welcome and very much needed.

Joint Working with An Garda Síochána (AGS)

10.20 Although at a local level there is often a good working relation with AGS and the HSE, this can be dependent on individual relationships and interpretation of roles and functions. It is strongly recommended that the Office of the CEO formally makes a request to AGS to collaborate with the HSE in the development of a joint agency policy for adult safeguarding.

This will provide clarity in respect of the roles and responsibilities of the two agencies where the nature of the harm to the adult in need of protection constitutes a potential criminal offence and develop agreement on the sharing of information.

Regulation

10.21 There are a broad range of regulators (both professional and service), auditors and those who monitor contracts and services which are relevant to adult safeguarding in Ireland. Each has a specific role in measuring and ensuring that organisations comply with their own particular service or quality standards and the regulatory framework within which they operate. Regulation needs to be responsive and proportionate, with the aim of ensuring public confidence in the services provided. They do this by requiring providers to meet relevant quality standards, detect failings in provision of care or services early, and take appropriate action when sub-standard care is found.

10.22 HIQA and the MHC, in particular, have a key role in adult safeguarding as their inspections can and do evidence poor practice that could amount to abuse. These organisations receive complaints from service users, families and the public and therefore have intelligence from a range of sources and they have powers to require provider organisations to report and comply with safeguarding standards. However their regulatory role does not cover all services.

10.23 Identifying Risks Sharing Responsibilities, The Case for a Comprehensive Approach to Safeguarding Vulnerable Adults 2022[15] provides a sound analysis of the regulatory framework in Ireland that support adult safeguarding. It is not the intention of this Review to replicate their work but there are a number of key points in the report that are worth highlighting.

- There is a clear need for a new and overarching legislative and regulatory approach to adult safeguarding in order to adequately protect people's human and legal rights.
- There is currently no uniform framework for regulating safeguarding across all settings or contexts.
- There is no provision for independent inspection of home care service providers, or investigation of complaints relating to safeguarding concerns.
- There is no statutory provision for HIQA, the HSE or independent advocates to investigate individual safeguarding complaints in nursing homes.
- There is an absence of legislative provision for the detection, investigation and prevention of abuse, other than by way of reporting criminal offences and pursuing prosecution.

10.24 It is also worth noting that healthcare assistants, homecare workers, daycare staff and other social care staff who have a key role in supporting older people and those with a disability are not subject to professional regulation as nurses, medics, social workers and allied health professionals are. In England, Scotland, Wales and Northern Ireland, staff who work in social care settings, including nursing homes, are required to register with the social care regulator. This has led to improvements in care, more investment in training and importantly staff whose practice is harmful cannot move from working in one provider to another.

10.25 All of the above issues are outside the remit of this Review but are worth noting for future consideration.

15 Identifying Risks, Sharing Responsibility. The Case for a Comprehensive Approach to Safeguarding Vulnerable Adults, Safeguarding Ireland, May 2022

Commissioning/ Subcontracting Arrangements

10.26 The HSE commissions or sub-contracts services to a range of organisations across the statutory, voluntary, community, independent and faith sectors. These include GP and other primary or health care services, such as private hospitals, nursing or residential care, day care or homecare services.

However, although accountability for poor care or service provision sits with the provider, the HSE should retain oversight and responsibility of the quality of the care that is provided. This review has been told on numerous occasions that when a person is admitted to a nursing home, under the Fair Deal arrangements the contract exists between the person and the provider of the service. That may be the case, but it does not negate the responsibility of the HSE to ensure that the service is safe and of a high quality. There is a duty of care to all people who require services from the HSE irrespective of the setting or whether the service is directly provided by the HSE or provided by another organisation.

10.27 A condition of all contracts or service level agreements should ensure robust governance arrangements are in place within those provider organisations to ensure good safeguarding practice, that adults at risk are safe from harm and that they receive a high-quality service. Safeguarding concerns that are identified as part of the contract review should be notified to the Safeguarding and Protection Team for assessment.

Advice and guidance on safeguarding when purchasing care should be provided to adults who commission their own care and should be accessible to all adults as part of 'planning ahead'.

Other Policies

10.28 As the new policy is implemented it will be important to review all HSE policies to ensure that they support adult safeguarding or, at least, do not undermine it.

10.29 There are policies which have a specific relationship to safeguarding and require particular attention. These need to be reviewed to ensure synergy with the future direction of adult safeguarding, the inclusion of common language and to streamline processes where possible. These include:

a. The Confidential Recipient

b. The complaints process

c. HSE Open Disclosure Policy 2019

d. The Incident Management Framework 2020

e. Risk management policy and procedures

f. The Trust in Care Policy 2005

Although there will be a level of overlap between some of the policies, every effort should be made to ensure clarity as to function and to avoid duplication of effort where possible.

10.30 In addition, all services providing services for the HSE should have robust policies that support good practice in safeguarding such as:

- recruitment, selection and vetting procedures
- management, support, supervision and training of staff
- procedures for responding to and reporting safeguarding concerns in a timely manner
- procedures for cooperating within the organisation and with others as required to address safeguarding concerns
- procedures for assessing and managing risks

- management of reporting and escalating untoward/adverse incidents
- procedures for managing complaints
- procedures on recording, the management of records, confidentiality, and the sharing of information
- a disciplinary policy, including referral to regulatory bodies where relevant
- a policy for staff who wish to confidentially report concerns

Self Neglect Policy

10.31 The 2014 policy includes self neglect. This is problematic as research would indicate that to work alongside an individual whose circumstances amount to self neglect takes time and persistence, relies on relationship building and often the resources of different agencies. It is also complex as the autonomy of the individual can often be at odds with the views of society that their way of living is not appropriate. Sir Munby's famous quote in the UK Courts said, "*What is the point of making someone safe if in doing so you just make them miserable,*" and highlights the dilemma between care and control.[16]

10.32 Assessing and supporting people for whom there are concerns of self neglect should remain with services who know the person best or are able to provide a longer term intervention and are more likely to have a longer term relationship. The assessment to determine the appropriate response should consider if there are any underlying factors that require a protection response. For example, self neglect may be the manifestation of harm which has been perpetrated by a third party and which the adult feels unable to disclose and impacts on their ability to care for themselves.

10.33 It is not to say that safeguarding and protection social workers do not have a role in supporting colleagues who are managing a situation in which self neglect is a feature however so do mental health professionals, primary care, housing agencies, voluntary and community organisations and others depending on the needs of the individual.

The Review was impressed by the approach taken within HSE Community Healthcare West (CHO 2) which operates a serious case management model to support staff in their decision-making and intervention. A panel of key professionals sits on a regular basis and staff with such a case can attend, discuss the issues, reflect on the action taken to date and seek advice from the panel as to how the situation could be progressed. It is understood that this approach is to be evaluated however early indications are that staff find it very helpful.

10.34 Self neglect is complex and requires a range of assistance over time. This can include emotional, practical and financial support. The Review does not believe that self neglect should be included in the safeguarding policy but deserves a policy of its own that details how staff should respond and the support that is available. To ensure that this important issue does not fall under a policy vacuum, the policy on self neglect should be developed in parallel with adult safeguarding policy and procedures.

16 Judge Munby on Local Authority X v MM &Anor (No1) (2007)

11.0 A Structure for Going Forward

Current Position

11.1 This Review has found that there is generally a lack of understanding of adult safeguarding and protection. Much of this is caused by a lack of visibility, leadership and clear structure. Too often referrals for people who may be in need of protection are sent backwards and forwards between services as it is not always clear as to who has key responsibility. A strong message from this Review is that unless and until issues of accountability are addressed, then practice will remain fragmented and inconsistent.

Leadership is Currently Manifested in Different Ways

11.2 A Safeguarding and Protection Committee is established within each Community Healthcare Organisation. These multi-agency Committees are appointed by the Chief Officer and are chaired by the Head of Quality, Safety and Service Improvement (QSSI). Although there is variability in how they practice, they all aim to promote a culture of adult safeguarding within the area and have oversight of the area plan to promote the welfare of vulnerable persons

11.3 Under the current policy, adult Safeguarding and Protection Teams provide a specialist safeguarding service and have oversight of DOs decision-making. They also assess and put in place safety plans for community referrals which are usually not known to other HSE services. This accounts for approx. 40% of their work with 60% accounting for the oversight function within their role, duty, advice, training and other safeguarding activity.

11.4 Safeguarding and Protection Teams are currently managed within QSSI structures which report to the Chief Officer within each Community Healthcare Organisation (CHO). It would appear that the decision to place teams within this new structure was pragmatic at the time and there have been benefits in the teams being aligned closely to incident management and service improvement processes. It would be important that these links are maintained within any new structure however the visibility of adult safeguarding and protection work is often concealed within the realms of patient safety and all its wider guises. Safeguarding and protection services needs a higher profile if it is to have any influence and impact on practice across the HSE.

11.5 The highest dedicated management grade for social work and adult safeguarding is Principal Social Worker. Therefore, there are no social workers at the senior management team at CHO or national level who can offer senior operational leadership, advice and support in respect of adult protection and more generally adult safeguarding other than the NSO that sits outside of operational arrangements. This needs to be addressed so that there is clear accountability and governance within HSE operations.

Proposed New Safeguarding Structure

11.6 It is welcomed that a Chief Social Worker post with accountability for adult safeguarding and protection will be appointed. This will provide leadership at the highest level of the organisation. The post holder should have strategic oversight of how safeguarding and protection is implemented across all HSE and HSE funded services. However, they also need to have operational responsibility for serious and significant safeguarding investigations. They should be able to direct a health region as to how an investigation should be conducted and to bring in a different protection team from outside the region, if required, to assess the

safeguarding concerns, develop and have oversight of the safeguarding plan and work with multi-agency partners as appropriate. This will provide a level of independence from local operational decisions.

11.7 The NSO should become part of the strategic arm of the Office of Chief Social Worker. Its role will be to drive a culture of safeguarding across the organisation, developing a training framework, disseminating learning from safeguarding reviews and leading initiatives that support good practice in safeguarding.

11.8 Adult protection by its very nature is a high-risk activity for the person at risk, the professional managing their concerns and the HSE as a corporate entity. As such adult safeguarding and protection services would benefit from a structure of its own with clear lines of accountability. Also, the Office of the Chief Social Worker will need to have a structure at national level and within each of the new health regions to ensure that the policy is being implemented consistently and to promote a culture of adult safeguarding and protection.

11.9 It is disappointing that safeguarding operations appear to be an afterthought in respect of the Draft Paper for the Regional Health Areas (RHAs) Implementation Plan 2023.[17] However, this structure can provide a remedy.

11.10 There is merit in continuing to have a multi-agency Safeguarding and Protection Committee in each health region. Consideration should be given to how the role of the committees can be strengthened to support multi-agency working and processes. The committees have a key leadership role and so it is important that the committee has the right membership with sufficient seniority within the organisation they represent in order that decisions can be made.

11.11 This Review recommends that each health region should have a separate safeguarding and protection structure with a Director of Safeguarding that can make authoritative and final decisions and support and advise the senior management teams on safeguarding across all services within that region. This should be a dedicated social work post.

11.12 The post holder will be accountable to the health region but will have a professional line to the Chief Social Worker. This will provide both leadership in safeguarding at a local level as well as support a regional, more consistent delivery of safeguarding services. This will also help to address the limited social work expertise at senior management level within the HSE.

11.13 The postholder will have management responsibility for the Safeguarding and Protection Teams and provide a professional structure for all social workers in adult services for professional supervision, learning and development. They should also ensure that all professionals who have a role in safeguarding and protection have supervision and opportunities to reflect on their practice and have the appropriate competence and training required to fulfil their role.

11.14 It may seem contradictory to say that safeguarding decision-making should be integrated into all services and yet argue for a separate structure for adult safeguarding social work. This Review has found that safeguarding and protection does not have a clear identity within the current structures and there is a lack of clarity as to where the leadership for this lies. Having a separate safeguarding structure has the potential to promote integration within services and with other services in the health region as it will promote a stronger focus on strategic leadership, provide capacity for shared multi-agency agendas and increased support to senior management and other professional groups managing safeguarding concerns.

17 Draft Paper for the Regional Health Areas (RHAs) Implementation Plan, Department of Health, 2023

12.0 Model of Safeguarding

12.1 Much is talked about in respect of the different models of adult safeguarding and the merits or otherwise of each. Different countries have applied different models but there is not clear evidence that one model works better than another.

"The assumed benefits of specialism appear to relate to consistency in approach and practice. It has been argued that specialism provides greater objectivity in decision-making processes and promotes better relationships with providers. On the other hand, the assumed benefits of a generic model are related to the fact that safeguarding is regarded as everyone's business, mainstream social workers can acquire specialist skills whilst maintaining a sense of continuity of service for the client."[18]

Dr Donnelly in her presentation on Critical Considerations for Adult Safeguarding in Ireland[19] describes the most common models used internationally. The Semi-centralised Model is the closest to the model envisaged by this Review whereby most safeguarding concerns are managed within multi-disciplinary teams and high risk and more complex referrals are assessed and managed by the Safeguarding and Protection Team.

Model C	Description	Rationale
Centralised Specialist Model **Three types of centralised models were prominent.** **In these sites, centralised specialist teams took varying roles in coordinating and investigating safeguarding concerns** **Represented in 14 sites**	**C1 – Semi-centralised** Central specialist safeguarding team manage all 'high risk' referrals. Senior practitioners or team managers manage 'low risk' referrals Allocated or duty social workers investigate all referrals alongside their normal duties. **C2 – Semi-centralised (6 sites)** 'High risk' referrals are managed and investigated by the central specialist safeguarding team. 'Low risk' referrals managed by team managers/senior practitioners and investigated by social workers alongside normal duties. **C3 – Centralised (3 sites)** All safeguarding alerts managed + investigated by central safeguarding team.	• Consistent approach to decision-making • Effective multi-agency working • Development of expertise • Objectivity

18 McCreadie, C., Mathew, D., Filinson, R., & Askham, J. (2008). Ambiguity and Cooperation in the Implementation of Adult Protection Policy. Social Policy and Administration,

19 Critical considerations for adult safeguarding in Ireland, 2023, Dr Sarah Donnelly, School of Social Policy, Social Work and Social Justice, University College Dublin

So How Will This Work in Practice?

12.2 Most safeguarding activity is carried out within services and by multi-disciplinary teams for individuals who are known to their service. Decisions on the actions required and whether the threshold for abuse has been met sits with DOs who hold this role in addition to their core function, usually as a senior manager within a service such as the Director of Nursing or even if there is a social worker who acts as DO, often the time available to do this is limited. They are therefore often trying to manage competing priorities at a time when decisive action is required. As part of a change programme for adult safeguarding, the role of DO should be reviewed to develop criteria and competences for undertaking the role.

12.3 Under the current policy, notifications are sent to the Adult Protection teams who have oversight of the concern and the safety plan which if agreed they sign off. However, it is for the DO to ensure that the plan is put in place.

12.4 Whilst there may have been a purpose to this in 2014 in order to support good safeguarding practice, it also has the effect of disempowering DOs from taking responsibility for decision-making in their service. As the role of the Safeguarding and Protection Team is only one of oversight of the paperwork provided, they are not able to provide assurance that the safeguarding plan has been implemented or that the person is any safer than before. It is therefore recommended that a greater emphasis is placed on professional decision-making in all services.

12.5 It is intended that responsibility and accountability for ensuring that a thorough assessment of any safeguarding concerns has been completed and that appropriate action has been taken will normally remain with the DO and the management of the service. Instead, the Safeguarding and Protection Teams will provide advice, support, co-working with the service or take responsibility for management of the assessment and intervention as /or if required.

A pathway will be developed that informs the circumstances in which the Safeguarding and Protection Team should be notified. It is anticipated that notification will be required where there is significant harm and complexity.

12.6 Although DOs need to have sufficient seniority to be able to make decisions as to how to respond to safeguarding concerns, it needs to be recognised within their work plan to ensure that sufficient time is allocated to this work and they need to be trained and skilled to make defensible professional judgments, including whether the concern should be managed under safeguarding procedures or responded to in another way such as through a complaints process, training or disciplinary procedures. Safeguarding is about the management of risk and knowledge and skill is required to distinguish mistakes, accidents and poor care practice from negligence, abuse and suspected crimes. All require immediate action to address the issue but not all require a protection intervention.

12.7 New IT systems should help to align processes between reporting incidents, complaints and safeguarding concerns so that information does not have to be duplicated across different reporting templates.

12.8 Much of adult safeguarding activity remains within multi-disciplinary services as they know the person and their situation best and will be able to provide ongoing support to the person after the safeguarding concern is addressed.

12.9 The role of social workers within multi-disciplinary services should be developed and adult safeguarding should be included within their job description so that it is recognised within their role. They can support the team and other professions to manage safeguarding concerns and seek advice or liaise with the adult Safeguarding and Protection Team if required.

12.10 A relatively new post has been created within the acute sector for Principal Social Workers with responsibility for promoting a culture of safeguarding and assisted decision-making. Consideration should be given to the value of introducing similar posts, particularly in areas where the safeguarding policy did not previously apply. However, all of these posts need to have a reporting line to the Chief Social Worker if they sit outside of the health region safeguarding structure.

Safeguarding and Protection Service

12.11 There should be a pathway to the Safeguarding and Protection Team that provides clarity as to their role, the circumstances in which DOs should notify the team based on the circumstances and complexity of the case, when co-working is appropriate or when the protection team should hold responsibility for the case.

12.12 The Review has found impressive examples of safeguarding activities and services however they are not consistent across the country. The service provided by Safeguarding and Protection Teams is variable depending on where they are based and the services and structures within which they work. Although there will always be some regional variability in respect of how services are provided depending on the local context, there should nevertheless be greater consistency across the country than currently exists as to what services are provided and by whom.

12.13 The Safeguarding and Protection Teams should:

- Provide a point of access for the public who have safeguarding concerns.
- The service should be provided out of normal working hours, either as part of a wider emergency social work service or as a discrete safeguarding and protection service.
- In addition to community assessment and safeguarding interventions, they should manage larger and more complex cases and all cases where there is a concern relating to a service or where an assessment is required independent of a service.*
- They will also undertake assessments in other health region areas as required by the Chief Social Worker.
- Contact AGS if a crime is alleged or suspected, or there is an immediate risk of harm to an adult at risk.
- They will continue to provide advice and support on safeguarding and protection across the HSE and will co-work with multi-disciplinary teams as required. They will make key decisions including whether the threshold for protection intervention has been met.
- They should adopt a serious case management approach when appropriate.
- Promote multi-agency working and chair multi-agency case conferences to support and lead safeguarding interventions as required.
- The teams should continue to promote good practice across the health region through training and mentoring.

*Appendix 3 references Northern Ireland's description of complex and large scale investigations that must be referred to the adult protection service. The HSE should provide their own definition so that there is clarity and consistency across the country.

13.0 Workforce

13.1 The current Safeguarding and Protection Teams are mostly social workers with the recent addition of nursing. This is not unusual as across the world safeguarding is key function of social work based on their training, knowledge and skills. However, it is a misnomer to suggest that this negates a multi-disciplinary approach to safeguarding.

13.2 A social work assessment of concerns of abuse relies heavily on not only their own expertise but also that of other professionals. The expertise required is dependent on the needs of the person at risk. In one case it may require a psychologist, in another it may require a speech and language therapist. The teams advise that they often rely on the local knowledge and relationships that public health nurses have within families and communities but equally they may need the opinion of a mental health nurse or one with expertise in tissue viability. Sometimes only a social work assessment is required. In short, the social worker will assess and access and co-ordinate the professional opinions of others to provide an holistic assessment of the specific needs of the case.

13.3 To support the role of relevant professions who will contribute to assessments, the HSE should begin a dialogue with undergraduate and post graduate education providers as to how safeguarding can be integrated into their professional training.

13.4 Most safeguarding decisions are made with the multi-disciplinary team that supports the individual and with whom they usually have an existing relationship. DOs are the key decision makers and although the Safeguarding and Protection Teams provide support and guidance, the safeguarding plans and implementation normally remains with the multi-disciplinary team. As discussed previously, it is important that DOs are fully supported to fulfil their role.

13.5 In circumstances where there is not multi-disciplinary opinion that can be readily drawn upon, particularly in complex adult protection cases, consideration should be given to how some key professional staff could have an attachment to the teams with safeguarding included within their job description.

13.6 It is welcome that there was some investment in Business Managers in 2021. Sufficient administrative support is vital to support the work of Safeguarding and Protection Teams and an effective use of finite resources.

Investment

13.7 There has been an investment in workforce development of €6,956,620.82 since 2021.

	CFO Strengthening Services Initiate 2021	Expert Panel on Nursing Homes 2022	National Service Plan 2023
Social Work Team Leaders	18	9	17 (15 have not been recruited to)
Professional Qualified Social Workers	3	9	
Principal Social Workers	1		
Safeguarding Business Managers	10		
Director of Nursing	1		
Clinical Nurse Managers	9 (8 have not been recruited to)		

13.8 This Review has seen documentation that shows that although the National Service Plan in 2022 highlighted the risk associated with the under resourcing of safeguarding operations, business cases to expand operations were not successful in 2023. To manage this, Community Operations sought funding outside of the usual service planning route.

13.9 Although the investment is welcome, it should be noted that of 26 posts to be recruited in 2023, 23 remain vacant as a result of the HSE recruitment embargo and there is concern that they may be decommissioned at year end.

13.10 Also the funding does not reflect the increased demand for services. Quarter 2 of 2023 shows that there was 34% increase in notifications to the teams from the previous year yet the financial allocation appears to be less than €1.5m for the year.

13.11 There needs to be a fully costed workforce plan developed, particularly taking account of how these services will be provided in the future health regions.

In Conclusion

This Review has a vision for adult safeguarding that places safeguarding is at the heart of all that the HSE and its funded agencies do:

- by embedding a culture which recognises every adult's right to respect, dignity, honesty and compassion in every aspect of their life
- working collaboratively across sectors and professions to prevent or minimise harm whilst recognising the adults right to self determination
- establishing clear guidance, processes, and services when there are safeguarding concerns

14.0 Moving Forward Recommendations

The Irish health and social care system has a great opportunity to bring about meaningful change in how it supports and protects some of the most vulnerable members of the population. It is an opportunity that should not be wasted but it will require energy and commitment from the organisation as a whole. It is vital that leaders at all levels of the organisation promote and embed a culture of safe services so that safeguarding becomes part of the fabric of health and social care.

To do this, this report makes recommendations to support the following four key actions:

1. Embedding a safeguarding culture.
2. Increasing the visibility of safeguarding.
3. Supporting a strong change management process.
4. Embedding a culture of learning and improvement.

Embedding a Safeguarding Culture

Cultural change takes time but it can be hastened by robust leadership, clear guidance and understanding of what is expected and prompt action when things go wrong. It can also be supported by listening to the voice of those who have experience of services and who know best what is or isn't working.

To support this culture, it is recommended that:

- A change programme for adult safeguarding and protection is commenced. This should be co-produced with staff, people with experience of safeguarding services, family carers and other key stakeholders.
- The HSE and all funded agencies should document the roles and responsibilities of Boards, senior managers, and staff in respect of safeguarding and provide clarity as to who is responsible for what and how decisions are made.
- Meaningful co-production with people who have experience of services should be implemented across services.
- Outcomes based supports/approaches are to be designed alongside people who have experience of safeguarding services.
- MSP approaches should be rolled out across the HSE.
- People who are at risk or have been subject to abuse should be offered the services of an independent advocate as routine. An analysis of demand and capacity for advocacy should be undertaken to ensure that this recommendation is implemented.
- In recognition of the social and structural issues that can increase the likelihood of abuse, the HSE should review resources and practice with individuals and groups who may be marginalised and/or require additional support.
- The culture of the HSE should ensure that people who use services are empowered to make informed decisions for themselves and to have control over how their care is provided and the decisions that affect their lives. The implementation of the Assisted Decision-Making (Capacity) Act 2015 will greatly assist this.

Increasing the Visibility of Safeguarding With Well-defined Lines of Accountability

- A new safeguarding structure with clear lines of accountability should be created. This should be led by a Chief Social Worker at a national level and a Director of Safeguarding within each health region.
- The Chief Social Worker should have responsibility for strategic and professional oversight, governance, performance management and accountability in relation to the exercise of adult safeguarding functions. The post holder should also have operational oversight of serious and significant safeguarding concerns within service provision and where necessary have the authority to allocate a safeguarding team, independent of the Health Region, to assess and implement a safeguarding plan and/or put in place other safeguarding processes as required.
- The Director for Safeguarding should have sufficient seniority within the organisation that they can make authoritative and final decisions and support, advise and provide direction to the senior management teams on safeguarding across all services within that region. They should also have management responsibility for the Safeguarding and Protection Team and provide professional leadership for all social workers within that region.
- The NSO should become part of the strategic arm of the Office of Chief Social Worker.
- There is merit in maintaining the Safeguarding and Protection Committees that are currently in place and these should be strengthened to support operational practice, multi-agency collaboration and to have a more visible leadership role.
- A pathway to the Safeguarding and Protection Team should be developed that provides clarity as to their role, the circumstances in which DOs should notify the team based on significant harm and/or complexity of the case, when co-working is appropriate or when the protection team should hold responsibility for the case.
- The competences and training for DOs should be determined to provide clarity of role function and accountability.
- An out of hours social work service to respond to safeguarding concerns should be developed.
- The HSE and the Department of Health should consider the viability of an Adult Safeguarding Helpline for the public.
- Consideration should be given to the value of introducing Safeguarding Lead posts across adult services to support a culture of safeguarding similar to those recently introduced within acute services.

Supporting a Change Management Process

The change programme should be an intense period of activity that sends a strong message that safeguarding is everyone's business, and that poor practice or tolerance of abuse is not acceptable. It will also increase the visibility of safeguarding services and structures.

The implementation plan must be championed across services and blockages to implementation need to be urgently addressed.

It is recommended that initially the change programme is conducted through the medium of task and finish groups reviewing and agreeing on key areas for improvement and led by senior leadership.

These include:

- The development of a new HSE operational policy and procedures that supports the implementation of the Department of Health Adult Safeguarding Policy, embeds the change in culture that is required and provides clarity as to process and roles and responsibilities. There should be a greater emphasis on professional decision-making for safeguarding in all services. The new operational policy should cover the HSE and all funded services, treat people equitably regardless of residency status and be in line with Assisted Decision-Making principles.

- The HSE should review policies and procedures to ensure synergy with the future direction of adult safeguarding and promote best practice in safeguarding. These include but are not confined to:
  a. The Confidential Recipient
  b. The complaints process
  c. HSE Open Disclosure Policy 2019
  d. The Incident Management Framework 2020
  e. Risk management policy and procedures
  f. The Trust in Care Policy 2005
- The HSE should retain oversight and responsibility of the quality of the care that is provided in commissioned or contracted services and all contracts or service level agreements should ensure robust governance arrangements are in place within provider organisations to ensure effective leadership, good safeguarding practice and high quality service.
- A new form of data collection should be developed and included in the development of an electronic solution.
- The NSO should review all safeguarding documentation.
- The NSO should produce guidance on good safeguarding practice across settings and provide information for people who are purchasing their own care on important considerations for safe practice. These should be easily accessible to the public.
- A joint agency policy should be developed with AGS.
- Policy and procedures for the management of self neglect should be developed separately but in parallel with the Adult Safeguarding Policy.
- A serious case management approach should be rolled out across the country building on the learning from the evaluation of the experience in Community Healthcare West.

Embedding a Culture of Safeguarding, Learning and Improvement

- Further public awareness campaigns should be developed that help the public recognise signs of abuse and to know where to go if they are concerned.
- A communication strategy that includes key messaging, the use of social media and other communication mediums should be developed on an annual basis.
- The NSO should ensure an inter-agency and inter-disciplinary approach to adult safeguarding training and practice development.
- NSO will develop and agree a regional adult safeguarding training framework which will specify learning outcomes and core content to meet a range of identified training needs within the HSE and partner organisations.
- Professional education providers should be consulted as to how safeguarding can be included in undergraduate and post graduate education programmes.
- Joint training sessions with AGS should be developed at a local level to develop relationship building and understanding of each other's roles and responsibilities. Also, consideration should be given to specialist interviewing training for social workers as provided within Túsla.
- The Department of Health should provide funding for NSO to conduct an annual commissioning process for academic research in adult safeguarding that informs process and practice.
- The NSO should also encourage research and audits of adult safeguarding practice within the HSE.
- The NSO should be responsible for the dissemination of learning from reviews of significant failures of care within the HSE to support change and good practice.
- The NSO should organise an annual conference on adult safeguarding that promotes good practice and shares learning from international research.

This Review was specifically to review the policies, procedures and structures of the HSE in respect of safeguarding and protection. However, it is clear that there are matters outside the remit of the HSE and therefore outside of this Review that will inform and influence future practice. This Review recommends that consideration be given to the following:

- Using the new National Adult Safeguarding Policy (Department of Health) as a catalyst for change.
- The development of safeguarding legislation that clarifies the roles and responsibilities of agencies and puts practice on a statutory footing.
- Regulation of services across all services and settings should be considered in any future review or development of legislation.
- The Government should build on the creation of a register of social care workers in November 2023 by introducing professional regulation of health assistants and social care workers in all care settings.
- A duty to co-operate across agencies should be mandated.
- If a separate agency for safeguarding is being considered, then workforce planning would need to commence now including increasing the numbers of student social work places and other relevant professional groups if required across all sectors.

Appendix 1

Four engagement events were held:

1. Key stakeholder event which included state bodies, representative organisations, private providers, staff representative bodies, advocacy organisations and HSE staff
2. Social work representation across all programmes of care
3. Representation from range of funded organisations
4. Two workshops were conducted at a learning and development event for Safeguarding and Protection Teams

In addition the Review engaged with:

- Care Champions
- Dementia Working Group
- Safeguarding Ireland
- National Safeguarding Office
- Health Information Quality Authority, HIQA
- Mental Health Commission
- Safety, Quality and Service Improvement Managers (HSE)
- Senior management representation (HSE)
- Internal Audit Division (HSE)
- Principal social workers in adult Safeguarding and Protection Teams Individually and as a group (HSE)
- Visited HSE Community Health Care West Safeguarding and Protection Team
- Department of Health
- Department of Children, Equality, Disability, Integration and Youth
- Irish Association of Social Workers
- Fórsa
- Nursing Homes Ireland
- An Garda Síochána
- National Independent Review Panel
- Community Healthcare Cavan, Donegal, Leitrim, Monaghan, Sligo Strategic Working Group
- National Advocacy Service

The Review also met individually with family members and nursing, medical and social work staff and received written submissions from individuals and organisations.

Appendix 2

Critical Considerations for Adult Safeguarding in Ireland

Dr Sarah Donnelly, Associate Professor of Social Work, School of Social Policy, Social Work and Social Justice, University College Dublin

This appendix is based on an invited presentation by Jackie Mc Ilroy as part of the Independent Review of Adult Safeguarding in Ireland commissioned by Bernard Gloster, CEO of the HSE.

Methodological Approach for the Review

A rapid review and synthesis of the existing literature on adult safeguarding legislation, models, and practice was carried out utilizing the analytic framework developed by Professor Michael Preston Shoot and colleagues for Serious Adult Reviews in the English context (Preston Shoot et al.2020; Braye and Preston-Shoot, 2017; Braye, Orr and Preston-Shoot,2015).

Figure 1: Domains for Analysis

As part of this review, key experts and academics in the jurisdictions under examination were contacted to ensure all key literature, particularly grey literature, had been identified and reviewed. This step also enabled the researcher to access articles and documents currently in press or which are at the draft/pre-publication stage. The experts consulted were:

- Prof. Jill Manthorpe, Kings College London, England
- Dr Lorna Montgomery, Reader in Social Work, Queens University, Belfast
- Dr Kathryn Mackay, Lecturer in Social Work, University of Stirling, Scotland
- Dr Sarah Lonbay, Senior Lecture in Social Work, University of Sunderland, England

Domain 1: Direct Practice with the Individual

(Donnelly et al.2017)

It is important to establish the aims of relevant legislation or policy when considering how best they could be used for safeguarding adults at risk of harm or abuse. As a first step, consideration should be given to whether the focus of the policy will target primary prevention, as in Australia and Canada, or at a secondary level, as in Scotland which seeks to stop the continuation of harm. Adult Safeguarding is conceptualised as encompassing both macro-level and micro-level activities to prevent abuse and/or harm in society at large and for the individual.

At the macro level, a range of mechanisms including legislation and policy are used to promote the overall safeguarding of adults, including challenging societal attitudes, discrimination, and social inequalities. Safeguarding at the level of the individual includes policies, procedures, and interventions ranging from minimum interventions such as the provision of home care support to compulsory measures such as the detention of individuals in hospitals without consent under mental health legislation.

Protection on the other hand tends to focus on the needs of individuals who are experiencing harm and/or abuse or who are at risk. This involves identifying existing harm and the promotion of welfare as well as preventing the continuation of abuse and/or harm or neglect. This is achieved through the development of frameworks for intervention, often underpinned by a statutory mechanism to enable the provision of support. Less attention is generally paid to prevention, by changing societal structures or attitudes. The culturally relative nature of a government's responses to abuse often determines their responsibility and some jurisdictions choose to set higher thresholds than others or to target certain groups of people or types of harm but exclude others.

Defining Abuse

The concept of abuse and associated language such as 'vulnerable' can stigmatise and disempower and lead to paternalistic interventions. Scotland concluded that the alternative concept of 'harm' avoided moralizing and stigmatising effects and could be applied more broadly (Donnelly et al.2017). Harm is understood in the widest possible way, in that "no category of harm is excluded simply because it is not explicitly listed" (Scottish Government, 2014, p.15). Abuse often involves the violation of human rights. This is particularly evident in countries that use a human rights-based approach to underpin policy and legislation. In a number of jurisdictions, the alternative concept of exploitation is emerging as a theme that links the different types of abuse commonly referenced (DOH UK, 2017).

Fundamental pillars

Underpinning safeguarding practice across jurisdictions are core concepts and fundamental pillars including but not limited to the Duty to Share Information; the Duty to Work together and cooperate and Codes of Practice. Serious Adult Reviews (SARs) in England have repeatedly highlighted the importance of multi-agency cooperation. The top five recommendations from SARs include information sharing and communication within and across agencies, holistic multi-agency assessment, planning, monitoring, and review (Aylett, 2016, p.32). Many jurisdictions also recognize the importance of police, financial and legal safeguarding expertise, and collaboration.

A strong evidence base exists for the 'Making Safeguarding Personal initiative' (MSP). MSP is a personalised, outcomes-focused approach that enables safeguarding to be 'done with, not to, people'. The approach is based on principles of co-production, enabling conversations about what matters to people, asking the right questions and focusing on desired and negotiated outcomes and how people wish to achieve them (Ahuja et al.2022). Making safeguarding 'everybody's business' by awareness raising, educating the wider public, and people in receipt of support about their human rights helps to empower people to challenge organisational norms, and take action to safeguard themselves or someone else they know (Donnelly et al.2017).

Responses to alleged abuse should also be made in the context of the person's decision-making capacity to make an informed choice, including the choice about whether to accept help (Preston-Shoot and Cornish, 2014). In Scotland for example, interventions might be seen as infringing on a person's autonomy in the short term for example, by making them subject to investigation processes, case conferences, and protection orders. However, the longer-term benefits can often address the harm being experienced and improve an adult's quality of life with greater autonomy than before. For success, this requires transformational leadership, transparency, and accountability (Lawson, 2018). Strong case management systems have also been found to improve safeguarding where geographical location issues are present (i.e. remote or rural areas vs urban) (Alliance for the Prevention of Elder Abuse: Western Australia, 2017; Mazars, 2020).

Social Work- The Lead Profession

> *'We must ensure that the right people with the right expertise are making the right safeguarding decisions at the right time'.*

Social work is the central profession in adult safeguarding practice (BASW, 2014) underpinned by a core set of values (CORU, 2019; BASW, 2014). Social workers have unique skills and knowledge base (DOH, 2014). The everyday experience of social workers involves working with individuals and managing positive interventions that help them manage risks and protect themselves. There are specific social work interventions that can be applied in adult safeguarding work. These include but are not limited to family systemic work; social and community-based development; task-centred approaches; solution-focused approaches and crisis resolution.

Social workers can also apply therapeutic skills, working with people who have been abused or neglected, as well as those causing the abuse or neglect. Psychosocial/cognitive behavioural theories underpin social work practice and provide insights into how to support emotional recovery from abuse. Approaches such as attachment-based social work with adults or family group conferencing can also be useful. Central to all aspects of this work is anti-discriminatory, anti-oppressive practice. Social workers bring communication skills to engage and create rapport, give professional empathy, develop relationships built on trust and understanding, and agree on expectations in a co-production mode on both sides. In adult safeguarding, as elsewhere in social work, using a multi-agency approach is essential to achieve the outcomes of enablement, empowerment, and protection.

Domain 2: Organisational Features Affecting how Practitioners and Teams Work

Several potential key factors in Adult Safeguarding service configurations are helpful to consider when examining organisational features affecting how practitioners and teams work. This domain will examine models of adult safeguarding and critically analyse their effectiveness drawing on the existing evidence base. This section concludes with an overview of Adult Protection Legislation and Reporting Systems.

Figure 2: Potential Key Factors in Adult Safeguarding Service Configurations (adapted from Norrie et al.2014)

Who makes initial decisions about whether a concern is safeguarding alert or not – a qualified social worker or another worker?
Where are decision-makers based – at first contact, local teams or specialist Safeguarding and Protection Teams?
Who manages and coordinates and who investigates safeguarding alerts at various stages?
What documentation and recording system are adopted and how do these relate to the general running of adult health and social care services?
Who chairs safeguarding meetings or case conferences – and at what level of risk are these instigated?
Who investigates regulated providers?
Who receives training to undertake safeguarding investigative work? What formal training is required to undertake safeguarding investigative work and is it mandatory?
Who audits safeguarding work, using what tools? How are workers performance managed? Are Service Users experiences captured?

Models of Adult Safeguarding

Establishing a lead agency that coordinates all aspects of adult safeguarding is identified as the ideal approach. This should include structure and governance which is inter-disciplinary and inter-agency founded on collaboration, in order to develop care and support plans under the ethos of human rights (Donnelly et al.2017). A caveat of implementing such services and structures is the need for adequate funding and resources (Mazars et al.2020; Age UK, 2018; Dow et al.2018; SWID, 2018; Boersig & Illidge, 2018).

Many jurisdictions (Ireland, England, Wales, Scotland, Australia, and Northern Ireland) have regulatory authorities independent from the government, that have a legislative mandate for quality and safety. In Ireland, HIQA and the Mental Health Commission (MHC) developed joint standards for adult safeguarding for health and social care providers. In addition, HIQA developed guidance on restrictive practices and ethical decision-making based on human rights principles (HIQA, 2019a; 2019b; 2019c).

Overview of Adult Safeguarding Models (Donnelly et al.2017)

This section provides an overview of the multi-agency, single-disciplinary model with variations in responder as seen in England that include the Dispersed Generic Model, the Dispersed Specialist Model and the Centralised Specialist Model (Graham et al.2016). This section also provides some international examples of Adult Safeguarding Models for consideration.

Table 1: England. Multi-agency, single-disciplinary model with variations in responder (Graham et al, 2016)

Model A	Description	Rationale
Dispersed Generic Model **Represented in 5 areas**	• Limited or no specialist involvement in response to safeguarding concerns. • Safeguarding is regarded as a core part of social work activity. • Strategic safeguarding team likely to be involved in investigations relating to multiple concerns within a particular setting such as a care home.	• Safeguarding is everybody's business • Maintaining skills throughout social work as a profession • Consistency of worker for the person perceived to be at risk.

Model B	Description	Rationale
Dispersed Specialist Models **Specialist safeguarding social workers are based in operational rather than a central safeguarding team.** **Represented in 4 areas** **Two variations of this model were identified.**	**B1 – Dispersed specialist - coordination for high risk referrals** • Specialists based in local operational teams manage 'high risk' investigations. • 'Low risk' investigations are managed by locality team managers alongside normal duties. • Allocated or duty social workers undertake all investigations alongside normal duties. **B2 – Dispersed specialist coordination for all referrals** Specialists manage all safeguarding investigations. Locality social workers investigate, alongside normal duties	• Specialists offer consistency in approach • Experts in policies and process • Experienced social workers other professionals • Strong links with mainstream social work practice • Independence and objectivity

Model C	Description	Rationale
Centralised Specialist Model **Three types of centralised models were prominent.** **In these sites, centralised specialist teams took varying roles in coordinating and investigating safeguarding concerns** **Represented in 14 sites**	**C1 – Semi-centralised** Central specialist safeguarding team manage all 'high risk' referrals. Senior practitioners or team managers manage 'low risk' referrals Allocated or duty social workers investigate all referrals alongside their normal duties. **C2 – Semi-centralised (6 sites)** 'High risk' referrals are managed and investigated by the central specialist safeguarding team. 'Low risk' referrals managed by team managers/senior practitioners and investigated by social workers alongside normal duties **C3 – Centralised (3 sites)** All safeguarding alerts managed + investigated by central safeguarding team.	• Consistent approach to decision-making • Effective multi-agency working • Development of expertise • Objectivity

Table 2: Examples of International Models of Adult Safeguarding

Australia	Canada	Northern Ireland	Scotland
Interagency model with various responders **Example** **Victoria-** elder abuse response integrated into Primary Care Partnerships framework, ensuring that allegations of abuse were treated as "core business" when providing services to older people.	**Single agency, single disciplinary model with dedicated responder** **Example-BC** Social Worker-Adult Protection acts as the designated responder coordinator (DRC) across the services where the adult is known. Criminal cases are reported to the police. Community Response Networks are also an integral.	**Collaborative Partnership Approach** Northern Ireland Adult Safeguarding Partnership (NIASP) and five Local Adult Safeguarding Partnerships (LASPs) were established. Adult Protection Gateway Services: single point of contact for referrals in each HSC Trust. Designated Adult Protection Officers (DAPOs) in both with Adult Protection Gateway Service, and within core service teams.	**Interagency model with dedicated responder** ASPSA(2007) requires Adult Protection Committee (APC) in each local authority. Ensures Interagency cooperation. must have an independent chair, be a multi-agency committee with representations from Council, Police, GPs and Health Boards plus other agencies.

Which Safeguarding Model works best? (Donnelly et al.2017)

The model adopted reflects the philosophy of legislation, policy, and practice, the more specialized safeguarding is, the more likely it is to be perceived as the 'condition' that affects a particular group of people in society and not safeguarding as everybody's business.

Specialist Model

The importance of maintaining safeguarding specialism has been identified and there is some evidence of productive outcomes when this occurs (Cambridge, Beadle-Brown, et al.2011). Specialism is important in terms of quality-assuring processes through independent chairs; a clear lead in investigations and centralised decision-making (Cambridge and Parkes, 2006). Specialist social workers undertaking safeguarding work can facilitate the maintenance of good relationships between mainstream social workers and social care or other providers. The assumed benefits of specialism relate to consistency in approach and practice. Specialism has been shown to provide greater objectivity in decision-making processes and promote better relationships with providers. The creation of specialist teams has also been viewed as sometimes problematic however in organizational terms and in terms of survivor experiences.

Mainstream Model

Continuity has been highlighted as an important feature of social work practice for survivors of abuse, especially in times of crisis (Fyson and Kitson, 2012). The Specialist model may lack continuity, which may in turn negatively impact upon the adult at risk. Concerns have been raised about the workload implications of a mainstream model if not properly resourced; as safeguarding work is unpredictable and therefore can impact on long-term casework (Preston-Shoot & Wigley, 2002). Campbell (2016) highlights the difficulty however in demonstrating causality between interventions and outcomes. For example, it is a difficult task to demonstrate that harm has not happened by the enacting of legislation rather than other related variables such as multi-agency working. Instead, Campbell suggests that we ask different types of research questions such as: "Do those at risk of harm feel safer because of this activity?" (p.101).

Conclusions

The putting in place of a lead agency who is responsible for referrals is evident across jurisdictions. Whilst professionals identifying and responding in the first instance to suspected harm or abuse can vary, in the majority of models, social workers are the lead investigating professional. The importance of capturing service user experiences for evaluation and quality improvement has also been identified in the literature.

Central to the majority of models is interagency working, particularly between those tasked with adult protection, including mental health, health and social care services, primary care agencies and the police. This approach seeks to ensure access to comprehensive skills and expertise enabling a holistic approach to adult safeguarding to be taken. However, effective mechanisms for cooperation need to be in place to achieve interagency working in practice. Serious Case Reviews identified as vital the need for clear lines of accountability and oversight to be invested in a single independent agency. The need for guidance documents such as Codes of Practice that clearly set out the roles, responsibilities, and accountability of the different bodies involved in safeguarding has been highlighted. Clear procedures for addressing safeguarding issues including guidance on thresholds are also required. Actively engaging adults at risk in the safeguarding process is imperative with the success of the Making Safeguarding Personal approach of particular note. The introduction of a similar initiative would be an important development for Irish safeguarding policy. Benefits and challenges of both a specialist vs mainstream organisational model have been found with no clear conclusion as to which model is most effective (Donnelly et al.2017).

Adult Protection Legislation and Reporting Systems

Policy and practice in adult safeguarding is characterised by competing debates about how regulators define core concepts and reporting systems. Adult Safeguarding legislation is relatively new and is largely restricted to Europe, North America, Australia, and New Zealand. Such specialist laws can enhance consistency of understanding and response as they set out the overarching principles and scope of adult safeguarding, clarifying response pathways and a duty to respond or cooperate or share information (Anand et al. 2014).

The appointment of an independent body to oversee the implementation of the legislation and codes of practice on the ground ensures transparency and accountability and supports the inclusion of wider society in safeguarding. Unintended outcomes can occur however, including potentially intrusive government involvement in adults' lives with or without their consent, undermining the rights and autonomy of individuals (Harbison et al. 2012; Keeling, 2017). Protection and autonomy are not essentially conflicting as protective action may promote a person's autonomy in the longer term (Preston-Shoot and Cornish, 2014). The Scottish Adult Support and Protection Act (2007) is a good example of the benefits of primary legislation for example, the formalisation of practitioner roles and its robust framework improved practice and decision-making, increased support, and shared responsibility within agencies but also from other agencies. There is also a provision for powers under the Act such as the right to request access to records e.g. financial harm (Mackay and Notman, 2017).

Domain 3: Inter-professional and Interagency Collaboration

Of all the domains examined, the strongest evidence base relates to the benefits of inter-agency and interprofessional working. Serious case reviews have concluded that a lack of information sharing between agencies has resulted in vulnerable individuals being unnecessarily exposed to harmful or abusive situations (Preston-Shoot et al.2020). Firm consensus on the benefits of multi-agency working has been evidenced - Ireland should therefore consider the introduction of a statutory duty/ obligation for agencies to work together and share information. There is also a need for guidance documents such as Codes of Practice that clearly set out the roles, responsibilities, thresholds, and accountability of the different bodies involved. Actively engaging adults at risk in the safeguarding process is also imperative. However, the cultural challenge of empowering "at-risk" adults while respecting their liberties, and balancing the need for professional interventions, when they are perceived as making choices that put them at risk of harm, cannot be understated.

Interagency approaches require clear and easily understood processes, careful management, and well-trained staff to be executed correctly (Mazers et al.2020). In England, Wales, and Scotland, multi-agency cooperation is mandated, and this provides an increased professional onus on engagement. It is also essential to have coordination in responses across the agencies involved who work together in partnership with the adult to mitigate risk. Robust governance, accountability, and transparency from the level of front-line case management to more strategic governance of oversight committees, boards, or networks is required (Donnelly et al. 2017). The Law Reform Commission (2019) suggests that non-statutory cooperation protocols may be sufficient, but there may be a need to have a statutory obligation to work together.

Conclusions on Interagency Working

There is a clear link between good multi-agency working relationships and effective investigations leading to positive outcomes. Safeguarding Adult Reviews frequently indicate the absence of information-sharing and agencies working in silos. Analysis suggests that safeguarding referrals could have been made but were not, including from ambulance services, police, GPs, and district nurses (Preston-Shoot et al.2020).

Priorities for attention and improvement include case coordination, leadership, use of complex case management frameworks, information-sharing, interagency referrals, safeguarding processes, strong role differentiation, out-of-area placement, and organisational disconnect (Preston-Shoot et al.2020). Multi-agency safeguarding Hubs (MASHs) have been introduced in some local authorities in England to facilitate closer working between professionals in adult social care, the police, and the NHS. They aim to make multi-agency working, particularly information sharing, more efficient and thereby make safeguarding more effective (Norrie et al.2015).

The literature suggests that the extent of multiagency collaboration may impact outcomes and is affected by different ways of organising safeguarding; co-location of other agencies is anticipated to minimise some of the challenges of multi-agency working (Graham et al.2016). It is a key duty of the authorities to cooperate in inquiries (Scotland, England), particularly in relation to information sharing. This, along with the power to access records, was identified as having contributed most to the effectiveness of safeguarding in Scotland.

Some Challenges Identified

1. Lack of resources for developing interagency partnerships (Penhale et al.2007; Cambridge & Parkes, 2006).
2. Poor communication between agencies (Flynn, 2012)
3. Lack of clarity about different professionals' roles and responsibilities (Penhale al. 2007).

Domain 4: Leadership, Oversight and Governance

In Ireland, Section 3(1) of the European Convention on Human Rights Act 2003, imposes a statutory duty on every 'organ of the State' to perform its functions in a manner compatible with the State's obligations under the Convention provisions. There is a significant benefit to adults in vulnerable circumstances of legislation that enshrines duties on public bodies to provide services and interagency cooperation.

At the highest level, legislation and/or policy sets out the overarching principles of Adult Safeguarding. At the next level, committees, or boards (in Scotland the Adult Protection Committees, in England Safeguarding Adult Boards, and in Northern Ireland Adult Safeguarding Partnerships) have a remit to oversee the implementation of legislation and/or policy and structures. Committees normally have an independent chair and representatives from the relevant NHS/Council Board, police, and other organisations who have a role to play in adult protection (Donnelly et al.2017).

Leadership (Preston-Shoot et al.2020)

The failure to coordinate and share information between services has been identified in Serious Adult Reviews (SARs); this included a lack of leadership where multiple agencies were involved. In several cases examined by Preston-Shoot et al. (2020), no agency held responsibility and ownership for the management of the risks presented by the individual. The absence of case management meant that there was no coordinated approach to understanding the full risk picture and agreeing on a shared strategy that could then be monitored by a lead practitioner.

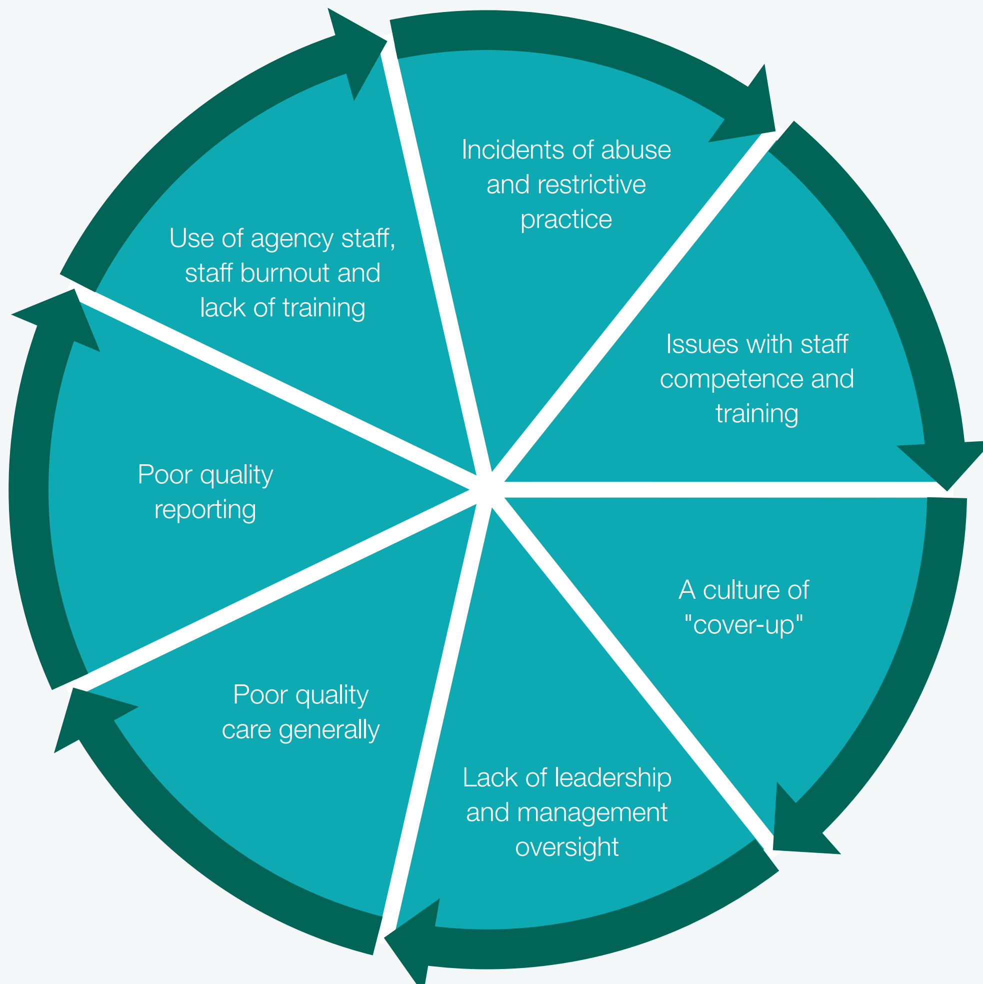
The system for convening multiagency risk management meetings, or the threshold for doing so, was not well known, or understood. "Only by using an approach of active leadership, supported by evidence from internal audit and responsive escalation routes, can an organisation ensure that the needs of adults at risk can be responded to with timely approaches consistent with agreed policies and procedures" (p.155)

Organisational Behaviour and Agency Culture (Preston-Shoot et al.2020)

Preston-Sheet et al.(2020) concluded that it was imperative that Safeguarding Adult Boards and their partners can evidence the difference that Safeguarding Adult Reviews have made to practice, organisational culture, policies, and procedures. They noted that workload pressures: stretched resources, finances, staffing, and services were seen to have a negative impact on frontline decision-making, with services overwhelmed and the workforce fatigued.

Blurred boundaries were evident between senior and operational decision-making, with managers overriding staff and creating a culture of fear and frustration. A culture of openness to learning from incidents including self-assessments and peer reviews should therefore form part of adherence to the principle of accountability.

Figure 3: Factors Impacting on Closed Culture in Institutional Abuse



Governance and Closed Culture in Institutional Abuse (Montgomery and Cooper, 2023 in press)

When presenting the mantra, “Safeguarding is everybody’s business” the people being safeguarded may not necessarily be the service-users. Conflicts of interest often exist between the needs and priorities of the commissioners of services, practitioners, and those of service users. It has been argued that governance and culture issues are an ‘inescapable feature’ of every aspect of the health and social care sector (Marsland et al. 2015; p.142) and are therefore of fundamental importance.

Making Culture Change Happen (Mannion,2022)

Healthcare scandals in the NHS and elsewhere have highlighted the vital role of employees in raising concerns and speaking up about poor quality care, as well as the importance of organisations responding appropriately when such concerns are raised. Critical issues for consideration include:

1. Crises as a trigger and opportunity for significant organisational change.
2. The role of leadership in detecting the need for change and shaping that change by recognising the nature of the problem to be addressed, establishing new roles and responsibilities, and mediating in conflict situations.
3. ‘Re-learning’ and ‘re-education’ as a means of embedding and helping to explain the assimilation of new cultures and the search for new cultural possibilities
4. Success in consolidating the new order and countering natural resistance to change. As one of the key functions of organisational culture is to establish and stabilise ways of organising and interacting, resistance is inherent to any culture change efforts.

Frequently a ‘culture of fear’ pervades the organisation, with individuals holding positions of power colloquially known as ‘untouchables’ who engage in transgressive or disruptive behaviour with apparent impunity. Often there are widely held perceptions about the likely response to concerns that discourage staff from speaking up. The challenge is to devise strategies for cultural transformation that successfully achieve a degree of cultural fit between healthcare professionals and managers.

Culture may lie at the root of many of the service failings of complex organisations however it may also be key to improving quality and safety. Culture change cannot be assumed to follow managerially espoused values; rather, culture change arises spontaneously from everyday social interaction. Divergences between espoused cultures and cultures in practice may explain why so many organisational cultures appear paradoxical, and contradictory, both to employees and service users.

Moving to an Independent Safeguarding Authority? (IPA, 2017)

From a governance perspective, difficulties arise whereby an agency is both a provider and regulator of services creating the potential for a conflict of interest or competing loyalties. The Institute of Public Administration (IPA) has advised that as a regulatory body, it would be vital that any new Safeguarding Agency would be and would be perceived by users of the service to be *impartial and independent*. The need for a separate body where independence in the performance of its functions is therefore deemed to be necessary.

There is also the need for robust performance management arrangements to ensure good governance and accountability. The government’s guiding principles on agency rationalisation and reform (DPER, 2014) are also an important reference point. They emphasise the primacy of the relationship between the citizen and the State and the importance of public bodies being designed in a manner that will ‘respect and enhance this relationship’. This guideline is particularly pertinent when considering the future of Adult Safeguarding in Ireland, which will be required to respond sensitively and efficiently to concerns about the safety and wellbeing of those who are at risk of harm or abuse in our society.

Ensuring the new agency is separate from both the HSE and the Department of Health would therefore seem essential. This suggests that the most viable options are either an independent safeguarding agency or that it would form part of an existing agency. The IPA argues, however, that there should be a strategic imperative for a merger rather than motivation by a desire to avoid the establishment of a new agency.

Overall Conclusions

The promotion of legal and civil rights of adults at risk is best underpinned by a human rights approach to prevent discrimination and abuse and to ensure social inclusion. Legislation and reorganisation of adult safeguarding systems can offer jurisdictions the opportunity to consider the introduction of measurable outcomes, comprehensive adult safeguarding provision, and an opportunity to reprioritise service provision across the preventative-protection continuum (Anand et al.2014; Donnelly et al.2017). For professionals working in Adult Safeguarding, primary adult safeguarding legislation has the potential to enable them to use powers to take action when all other avenues of intervention have failed. In doing so, such interventions can provide adults at risk, victims, and survivors additional legal protections, as well as clearly defined reparation processes.

Safeguarding legislation alone will not bring about organisational culture change to one of rights-consciousness. Making safeguarding 'everybody's business' through awareness raising and educating the wider public and people in receipt of support about their human rights empowers people to challenge organisational norms and take action to safeguard themselves or someone else they know (Donnelly and O'Brien, 2018). A move to a culture of rights-consciousness requires the voice of the adult at risk to be central (Donnelly and O'Brien, 2022). As observed by the Áras Attracta Review Group, an understanding of abuse, the ability to communicate and the presence of a trusted adult in the lives of adults at risk are perhaps the best protections a person can have against abuse. Community networks such as those in Canada, have been shown to be effective in raising awareness about adult abuse in local communities (Donnelly and O'Brien, 2018).

Legislation is not a panacea for poorly resourced services and has the potential to restrict actions to that defined by law undermining the autonomy and other rights of adults. Critical features of safeguarding organisations include robust governance and accountability, leadership and cultural change, defined and appropriate levels of decision-making and thresholds, multi/inter-agency working, a mandated duty to cooperate and share information, Codes of Practice and learning from mistakes through Serious Adult Reviews. Ultimately, meaningful change will only be possible if underpinned by significant cultural change in the Irish context.

Bibliography

Age UK (2018) *Adult Safeguarding (England),* London: Age UK. Available: https://www.ageuk.org.uk/globalassets/age-uk/documents/policy-positions/health-and-wellbeing/adult-safeguarding-policy-position-nov-2018-final.pdf

Ahuja, L., Price, A., Bramwell, C., Briscoe, S., Shaw, L., Nunns, M., O'Rourke, G., Baron, S and Anderson, R. (2022). 'Implementation of the Making Safeguarding Personal Approach to Strengths-based Adult Social Care: Systematic Review of Qualitative Research Evidence', *The British Journal of Social Work*, Volume 52, Issue 8, Pages 4640–4663, https://doi.org/10.1093/bjsw/bcac076

Alliance for the Prevention of Elder Abuse: Western Australia (2017) *Elder Abuse Protocol: Guidelines for action*, Victoria Park: Alliance for the Prevention of Elder Abuse: Western Australia. Available at: https://publicadvocate.wa.gov.au/_files/Elder-Abuse-Protocols-2018.pdf.

Anand, J, Taylor, B, Montgomery, L, Bakircioglu, O, Harper, C, Devaney, J, Lazenbatt, A, Pearson, K, Mackay, K & Nejbir, D. (2014). *A Review of the Adult Safeguarding Framework in Northern Ireland, the UK, Ireland and Internationally*. Commissioner of Older People Northern Ireland.

Áras Attracta Swinford Review Group (2016) The Report of the Áras Attracta Swinford Review Group. Available at: http://www.hse.ie/eng/services/ publications/Disability/Disability_Services_.html

Aylett, J. (2016) 'Universal learning: findings from an analysis of serious case review executive summaries', *Journal of Adult Protection*, 18(1), 28–39.

Boersig, J. and Illidge, D. (2018) 'Addressing Elder Abuse: Perspectives from the Community Legal Sector in the Act', *Macquarie Law Journal,* 18, pp. 93-113.

British Association for Social Work (BASW). (2014). *The code of ethics for social work: Statement of principles*. Birmingham, UK: BASW. Retrieved from https://www.basw.co.uk/codeofethics/

Blundell, B. and Warren, A. (2019) 'Reviewing the extent of rural and remote considerations in elder abuse policy: A scoping review', *Australian Journal of Rural Health,* 27(4), pp. 351-357.

Braye, S. and Preston-Shoot, M. (2017) Learning From SARs: A Report for the London Safeguarding Adults Board. London: ADASS. http://londonadass.org.uk/wpcontent/uploads/2014/12/London-SARs-Report-Final-Version.pdf

Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Serious Case Review Findings on the Challenge of Self neglect: Indicators for Good Practice'. *Journal of Adult Protection*, 17, 2, 75-87.

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., and Whelton, B. (2011). 'Adult protection: The processes and outcomes of adult protection referrals in two English local authorities.' *Journal of Social Work*, 11(3), 247–267

Cambridge, P. and Parkes, T. (2006). 'The tension between mainstream competence and specialization in adult protection: An evaluation of the role of the adult protection co-ordinator'. *British Journal of Social Work*, 36(2), 299–321.

Campbell, M. (2016). 'Adult Protection in Scotland in 1857 and in 2015: what have we learned?' *Journal of Adult Protection*, 18(2), 96-110.

CORU (2019), *Social Workers Registration Board Code of Professional Conduct and Ethics.* Available: https://coru.ie/files-codes-of-conduct/swrb-code-of-professional-conduct-and-ethics-for-social-workers.pdf

Department of Health (DOH) (2017) *Care and support statutory guidance. Issued under the Care Act 2014*, available: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Department of Public Expenditure and Reform (2014). *A Report on the Implementation of the Agency Rationalisation Programme*, Dublin: Department of Public Expenditure and Reform

Department of Health (DH) (2014), "One year on", annual report by the Chief Social Worker for Adults, Department of Health, London.

Donnelly, S and O'Brien, M (2022). 'Adult Safeguarding Legislation—The Key to Addressing Dualism of Agency and Structure? An Exploration of how Irish Social Workers Protect Adults at Risk in the Absence of Adult Safeguarding Legislation'. *The British Journal of Social Work*, Volume 52, Issue 6, September 2022, Pages 3677–3696.

Donnelly, S. and O'Brien, M (2018). Speaking Up About Adult Harm: Options for Policy and Practice in the Irish Context. University College Dublin, March 2018. Available at: https://researchrepository.ucd.ie/server/api/core/bitstreams/01900f8a-4958-49c9-8d59-f61791b36853/content

Donnelly, S., O'Brien, M.; Walsh, J.; McInerney, J.; Campbell, J. and Kodate, N. (2017) *Adult Safeguarding Legislation and Policy Rapid Realist Literature Review*, Dublin: Health Services Executive. Available at: https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults / safeguarding%20literature%20review%20%20.pdf

Dow, B., Gaffy, E. and Hwang, K. (2018) *Elder Abuse Community Action Plan for Victoria February 2018*: National Ageing Research Institute Available: https://www.nari.net.au/files/files/documents/elder_abuse_community_action_plan_for_victoria_feb_2018.pdf.

Flynn, M. (2012). *Winterbourne View Hospital: A Serious Case Review*, Bristol, South Gloucestershire Safeguarding Adults Board.

Fyson, R., & Kitson, D. (2012). 'Outcomes following adult safeguarding alerts: A critical analysis of key factors'. *Journal of Adult Protection*, 14(2).

Graham, K., Stevens, M., Norrie, C., Manthorpe, J., Moriarty, J., & Hussein, S. (2016). 'Models of safeguarding in England: Identifying important models and variables influencing the operation of adult safeguarding'. *Journal of Social Work, 17*(3), 255- 276.

Harbison J., Coughlan S., Beaulieu M., Karabanow J., Vanderplaat M., Wildeman S. M., Wexler E. (2012) 'Understanding 'elder abuse and neglect: A critique of assumptions underpinning responses to the mistreatment and neglect of older people', Journal of Elder Abuse & Neglect, 24(2), pp. 88–103.

Health Information and Quality Authority (2019a) *Five years of regulation in designated centers for people with a disability*, Dublin: Health Information and Quality Authority. Available: https://www.hiqa.ie/sites/default/files/2019-08/HIQA-DCD-5-Year-Regulation-Report-2019.pdf

Health Information and Quality Authority (2019b) *Guidance on promoting a care environment that is free from restrictive practice: Disability Services*, Dublin: Health Information and Quality Authority. Available: https://www.hiqa.ie/sites/default/files/2019-03/Restrictive-Practice-Guidance_DCD.pdf

Health Information and Quality Authority (2019c) *Guidance on promoting a care environment that is free from restrictive practice: Older People's Services*, Dublin: Health Information and Quality Authority. Available: https://www.hiqa.ie/sites/default/files/2019-03/Restrictive-Practice-Guidance%20_DCOP.pdf

Institute of Public Administration (2017). *Discussion Paper: The establishment of Cosáint, The National Adult Safeguarding Authority.* Available: https://www.ipa.ie/_fileUpload/Documents/National_Safeguarding_Authority_Options_Paper.pdf

Keeling A. (2017) 'Organising objects: Adult safeguarding practice and article 16 of the United Nations Convention on the Rights of Persons with Disabilities', *International Journal of Law and Psychiatry*, 53, 77–87.

Law Reform Commission (2019) Issues Paper: A Regulatory Framework for Adult Safeguarding, Dublin: Law Reform Commission. Available: https://www.lawreform.ie/_fileupload/ Issues%20 Papers/LRC%20IP%2018 2019%20A%20Regulatory%20Framework%20For%20Adult%20 Safegaurding.pdf.

Lawson, J. (2018) *Making Safeguarding Personal*, London: Local Government Association. Available at: https://www.brent.gov.uk/media/16411199/making-safeguarding-personal.pdf.

Mackay K. and Notman M. (2017) 'Adult Support and Protection (Scotland) Act 2007: Reflections on developing practice and present-day challenges', *The Journal of Adult Protection*, 19(4), pp. 187–98.

Mannion, R. (2022). *Making Culture Change Happen* (Elements of Improving Quality and Safety in Healthcare). Cambridge: Cambridge University Press.

Marsland, D.B., Oakes, P.M., & White, C. (2015). 'Abuse in care? A research project to identify early indicators of concern in residential and nursing homes for older people'. *The Journal of Adult Protection, 17*, 111-125.

Mazars, Phelan, A., O'Donnell, D. and Stokes, D. (2020) *Evidence review to inform the development of a national policy on adult safeguarding in the health and social care sector: An evidence review*, Dublin: Mazars. Available: https://www.gov.ie/pdf/?file=https://assets.gov.ie/123612/49a98685-4361-4679-b8b9-93a2ea0d801b.pdf#page=null

Norrie, C., C. Cartwright, P. Rayat, M. Grey, and J. Manthorpe. (2015). 'Developing an Adult Safeguarding Outcome Measure in England.' *The Journal of Adult Protection* 17 (5): 275–286.

Norrie, C., Stevens, M., Graham, K., Manthorpe, J., Moriarty, J. and Hussein, S. (2014), 'Investigating models of adult safeguarding in England – a mixed-methods approach', *The Journal of Adult Protection*, Vol. 16 No. 6, pp. 377-388

Penhale, B., Perkins, N., Reid, D., Pinkney, L., Hussein, S., & Manthorpe, J. (2007).' Partnership means protection? Perceptions of the effectiveness of multi-agency working and the regulatory framework within adult protection in England and Wales.' *Journal of Adult Protection*, 9(3), 9–22.

Preston-Shoot, M., Braye, S., Preston, O., Allen, K. and Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for Sector-Led Improvement.* London: LGA/ADASS.

Preston-Shoot, M. and Cornish, S. (2014) 'Paternalism or proportionality? Experiences and outcomes of the Adult Support and Protection (Scotland) Act 2007', *The Journal of Adult Protection,* 16(1), pp. 5-16.

Preston-Shoot, M., and Wigley, V. (2002). 'Closing the circle: Social workers' responses to multi-agency procedures on older age abuse'. *British Journal of Social Work*, 32(3),

Romeo, L. (2015), 'Social work and safeguarding adults', *The Journal of Adult Protection*, Vol. 17 No. 3, pp. 205-207.

Scottish Government (2014a) *Adult Support and Protection (Scotland) Act 2007: Revised Code of Practice* (Edinburgh: Scottish Government), available at: http://www.gov.scot/Publications/2014/05/6492/1

SWID (2018) *SWID Submission on Draft HSE Adult Safeguarding Policy*, Dublin: Irish Association of Social Workers. Available: https://www.iasw.ie/download/513/SWID%20submission%20%20Safeguarding%20of%20VA%20policy%20Review%20Sept%2018%202.pdf

Appendix 3

Descriptor for Large Scale and Complex Cases in Northern Ireland

Large Scale and/or Complex Investigations A large-scale adult protection investigation may be initiated when a number of adults at risk have allegedly been abused or patterns or trends are emerging which suggest serious concerns about the quality of care, which put the safety of service users at risk. This could include any of the following:

- multiple concerns within one service provider;
- one person is suspected of causing harm to multiple adults and/or in a number of settings;
- a group of individuals are alleged to be causing harm to one or more adults;
- where care arrangements are complicated by cross-boundary considerations.

A large-scale adult protection investigation is likely to involve a range of organisations, and potentially a number of individual adult protection interventions.

Complex (i.e. organised or multiple) abuse is defined as abuse involving one or more abusers and a number of related or non-related adults at risk. The abuser concerned may be acting with others to abuse adults at risk, may be acting in isolation, or may be using an institutional framework or position of authority to access adults at risk for abuse. Such abuse can occur both as part of a network of abuse across a family or community and within institutions such as residential or nursing homes, supported living facilities, day support settings and in other provisions such as voluntary groups. There may also be cases of adults at risk being abused through the use of the internet. Such abuse is profoundly traumatic for the adults at risk who are involved. The investigation of large scale and/ or complex abuse requires specialist skills from PSNI and HSC Trust staff. Every investigation will require careful and thorough planning, effective inter-agency working and attention to the needs of the adult(s) involved. Some investigations become extremely complex because of the number of people or places involved and the timescale over which the abuse is alleged to have occurred.

Adult Safeguarding: Prevention and Protection in Partnership, Department of Health 2015.

Appendix 4

ADM	Assisted Decision-Making
ADMCA	Assisted Decision-Making Capacity Act
AGS	An Garda Síochána
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHO	Community Healthcare Organisation
CQC	Care Quality Commission
DO	Designated Officer
DoH	Department of Health
GDPR	General Data Protection Regulation
GP	General Practitioner
HIQA	Health Information Quality Authority
HSE	Health Service Executive
IASW	Irish Association of Social Workers
IT	Information Technology
MHC	Mental Health Commission
MSP	Making Safeguarding Personal
NIRP	National Independent Review Panel
NSO	National Safeguarding Office
QPS	Quality and Patient Safety
QSSI	Quality, Safety and Service Improvement
RHA	Regional Health Area
SCIE	Social Care Institute for Excellence
UCD	University College Dublin
UK	United Kingdom of Great Britain and Northern Ireland
YTD	Year to Date