# **Northern Ireland Adult Safeguarding Partnership**



# 1 APRIL 2017 - 31 MARCH 2018



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# Annual Report

### **EXECUTIVE SUMMARY**

This is the seventh Annual Report of the Northern Ireland Adult Safeguarding Partnership (NIASP) and covers the period 1 April 2017 to 31 March 2018.

Adult safeguarding activity levels have reduced noticeably over the last 5 years. While some of this had been anticipated, the impact of the new policy and procedures is evident as new thresholds are applied and core services respond to more cases of adults at risk.

Prevention activity continues to be led by the Local Adult Safeguarding Partnerships, supported by NIASP. A diverse range of activities and initiatives have continued to develop to advance the prevention agenda.

In 2017/18, NIASP further developed its engagement with service users through the completion of the user feedback audit, which utilised the 10,000 Voices methodology.

The role of the Adult Safeguarding Champion has been enthusiastically embraced by colleagues in the community, voluntary and independent sectors.

NIASP continues to be committed to the identification and sharing of learning. This year, learning focused on supporting an adult victim of modern slavery.

NIASP continues to build on national and international links through university colleagues and developing informal practitioner networks at all levels.



# **WORKPLAN 2017 - 18**

The NIASP Workplan for 2017/18 was based on the three core themes of the Regional Policy, Adult Safeguarding in Northern Ireland: Prevention and Protection in Partnership (DHSSPS 2015).

The Policy does not set out a timetable for implementation or identify specific actions that are required to ensure the Policy is embedded in practice.

#### **Theme 1 PREVENTION**

	Rationale	Target for	Commentary
		Completion	
Continue to develop a	The regional programme will continue	March 2018	Actions complete. Objective achieved
regional programme of	to evolve in partnership with local		
awareness raising and	initiatives.		
prevention activities to			
complement local	Particular attention will be paid in		
prevention plans.	2017-18 to working in partnership with		

	PSNI and Trading Standards to ensure that crime prevention material and training is rolled out to as many front-line staff as possible, whether in specific training sessions or through access to e-learning opportunities such as Friends Against Scams		
Ensure that NIASP and all partner organisations comply with the relevant requirements set out in Adult Safeguarding:  Prevention and Protection in Partnership	The final template for the Adult Safeguarding Champion Annual Position report and associated common data return will be available for use by ASCs for their annual report on adult safeguarding activity in 2017-18	June 2017	Actions complete. Objective achieved

## **Theme 2 PROTECTION**

Ensure that NIASP and all	Information on new roles and	Pilot to be completed	Work in relation to the NIASP website has
partner organisations have	responsibilities and core	by September 2017.	been completed and will go "live" in June
separate internet sections	documentation associated with the		2018.
on adult safeguarding	new policy and procedures are now		
which include easy access	available. It is vital that this		
to core documentation	information is accessible to staff at all		
including referral forms.	levels in an organisation.		
	As a first step, NIASP will pilot a brief	Full audit and	
	questionnaire to ascertain how	associated action plan	
	partner organisations are ensuring	to be completed by	
	this information is widely available	March 2018.	
	and publicised. This will be followed		
	up by a full audit of practice and the		
	development of an action plan to		
	address any outstanding issues.		

Ensure that practitioners	NIASP will continue to ensure that	March 2018	Achieved
have access to relevant,	practitioners are provided with		The Regional Learning Event on a Social
evidence-based	access to relevant interventions		Work Reflection – the recovery of an adult
interventions and	through sharing learning and best		from Modern Slavery took place on the19th
approaches	practice through the annual Learning		October 2017.
	Event.		
	In 2017 19 NIASD will publish a	Contombor 2019	2 orticles have been published in The
	In 2017-18 NIASP will publish a	September 2018	2 articles have been published in The
	minimum of 1 article in a relevant		Journal of Adult Protection:
	peer-reviewed journal on the topic of		"Adult safeguarding in Northern Ireland:
	adult safeguarding in Northern		prevention, protection, partnership" (vol 19
	Ireland.		issue 4)
			"10,000 voices: service users' experiences
			of adult safeguarding" (vol 19 issue 5)
	NIASP will continue to promote the	March 2018	Evidence suggests that SAaRIH continues to
	use of the Social Care Institute for		be well used across the statutory. The site
	Excellence and the Safeguarding		will continue to be available 2018 / 19
	Adults at Risk Information Hub as		

	effective ways of accessing the most		
	up-to-date developments in practice		
	and research.		
NIASP will ensure that the	To consider comments and	March 2018	The review of Operational Procedures is
Manual of Operational	suggestions submitted to NIASP for		ongoing. This work is complex and time
Policies and Procedures is	amendment of procedures and		consuming and will need to be carried
kept up-to-date and	regional documentation		forward into next year's work-plan.
reflects developing			Anticipated timescale for completion
practice in adult			September 2018.
safeguarding.			
NIASP will ensure that the	To consider comments and	Sept 2018	The review of the Joint Protocol is ongoing.
Joint Protocol is kept up-	suggestions submitted to NIASP for		This work is complex and time consuming
to-date and reflects	amendment of the Joint Protocol and		and will need to be carried forward into next
developing practice in	associated regional documentation		year's work-plan. Anticipated timescale for
adult safeguarding.			completion September 2018.
Review the interface with	The complexities in adult	March 2018	Regional workshop took place. All Trusts
Human Resources and	safeguarding investigations have		were represented. Agreement reached that
Adult Protection	resulted in increased challenges in		we would draft regional Joint Principles in
	relation to the interface between adult		relation to Adult Safeguarding/HR joint

	safeguarding and HR processes.		working.
	The new Procedures include further		
	guidance on this but further work is		
	required to secure a regionally		
	agreed pathway and process.		
Develop initial guidance for	NIASP will work with relevant partner	December 2017	Work ongoing. To be carried over to 2018/19
staff in responding to	organisations such as Business		work plan
issues of financial abuse	Services Organisation, Trading		
	Standards etc. to develop		
	introductory guidance for staff in		
	responding to issues of financial		
	abuse or exploitation		

# **Theme 3 PARTNERSHIP**

Clarify the interface	NIASP will work with the Department of	March 2018	While at Departmental level NI is committed	
between adult	Justice to confirm the arrangements to be		to undertake domestic homicide reviews,	ĺ
safeguarding and	put in place to introduce Domestic		discussions about the framework, thresholds	
other public safety	Homicide reviews into Northern Ireland		and processes for these is not yet finalised.	
strategies such as	and clarify the role and contribution of		The Department of Justice are the lead	
	1			

the Domestic and	NIASP in this process. This will include		department on this. While initially a central
Sexual Violence	consideration of any associated costs.		role for NIASP had been anticipated, it is
Strategy			now more likely that the NIASP role will be
			mainly in facilitating the dissemination of
			learning, not oversight of the process.
	Devise a simple operational protocol to	March 2018	The first meeting to consider this was held.
	examine the interface between adult		However, there were concerns within the
	safeguarding and domestic and sexual		group regarding the additional
	violence strategy		responsibilities within the Strategy which
			require further discussion by NIASP.
NIASP will review	NIASP will continue to keep its structures	To be reviewed	On-going
current adult	and operational procedures under review.	annually	
safeguarding			
structures and			
ensure they are fit	NIASP will strengthen its internal	September 2017	Operational Handbook completed and
for purpose	governance arrangements through the		issued at NIASP meeting – September 2017
	production of a Handbook of Operational		
	Procedures.		

	NIASP will work with partner organisations	June 2017	ARC NI has submitted a paper regarding the
	to develop a peer support network for		future of the ARC NI ASC Network.
	ASCs.		Four LASPs have introduced ASC Networks
			in their areas.
NIASP will ensure	NIASP will complete the full audit of user	Full audit to be	Actions completed. Objective achieved
that the experience	experience through the 10,000 Voices	completed by	
of service users is	methodology.	December 2017	
sought at all stages			
of the safeguarding	The findings of the audit will be presented	Action Plan to be	Findings to be presented at NIASP meeting
process	to NIASP and a regional action plan	presented to NIASP by	in September 2018
	developed to address any relevant	March 2018	
	findings		
Review general and	There is a need to ensure that education	December 2017	Training subgroup completed the mapping
specialist training	and training opportunities ae fully		exercise - findings were circulated at the
courses to ensure	reflective of the policy, procedures and		September 2017.
they meet the needs	emerging best practice.		
of practitioners and			
partner organisations	The NIASP Training sub-group will		A final paper was submitted in December
and are responsive	continue to keep this under review		papers. No further actions required at this
to developing policy,			time.

standards and			
practice			
Develop and publish	NIASP will consider the development of a	March 2018	The existing frameworks are to be collated
a suite of standards	small number of Standards for practice in		and areas of duplication highlighted. Key
for adult	relation to the Protocol for Joint		standards that would inform practice
safeguarding in	Investigation of Adult Safeguarding Cases.		improvement are to be extrapolated. It is to
Northern Ireland.			be determined by NIASP is this objective is
	On completion, these Standards will be		to be carried forward into 2018/19
	added to the existing suite.		



# **ACTIVITY ANALYSIS**

This section of the Annual Report is based on activity data collected manually by the Health and Social Care (HSC) Trusts and then submitted to the Health and Social Care Board (HSCB) on a monthly basis. The data is then collated by the Information Team of the HSCB.

The HSC Trusts have agreed that manual collection of data is both inefficient and difficult to quality assure. They are currently introducing a new data collection system, which will be tested in 2018-19 and move to an electronic system in 2019/20

In previous years, analysis of activity information has focused on the number of new referrals into Adult Safeguarding, as a broad indicator of the level and amount of work involved.

Since the first regional report was compiled in 2011, there have been a number of significant developments that mean this is no longer a reliable measure of activity or performance.

- 1. Service re-engineering has resulted in single access points or Adult Safeguarding Gateway Teams being established in each HSC Trust area. In the transition period, Trust practice in recording new referrals has varied, with some recording every new issue or concern communicated to the Gateway Team as a referral. Other Trusts have only recorded those concerns that have been screened into the specialist Adult Safeguarding Teams for formal investigation as a referral;
- Alongside the establishment of Adult Safeguarding Gateway teams, the level
  of adult safeguarding expertise within core teams has also increased. As a
  result, more concerns in relation to adults at risk are being dealt with in core
  services under established Trust procedures;
- 3. The new policy, Adult Safeguarding: Prevention and Protection in Practice (2015) includes new definitions and thresholds for referral to adult

- safeguarding services. This has resulted in changes in practice that make year-on-year comparisons difficult;
- 4. The policy emphasis on finding alternative responses to concerns has also led to a reduction in referrals to specialist teams;
- 5. There is an increased emphasis on developing effective prevention and early intervention programmes eg Keeping You Safe, which appear to be equipping vulnerable service users to avoid risky situations eg in the use of social media or avoiding organised scams;
- 6. HSC Trust community information systems are at different stages of development and implementation. The ability of systems to note the progress of a concern through a screening process to a referral is compromised in some areas. Different recording systems will group these activities together in some Trusts and in some service areas within Trusts, but not in others;
- Adult safeguarding is a unique service in that it works across all adult
   Programme of Care boundaries and systems, with staff often using more than
   one recording system.

In this year's report, analysis of adult safeguarding activity will focus on:

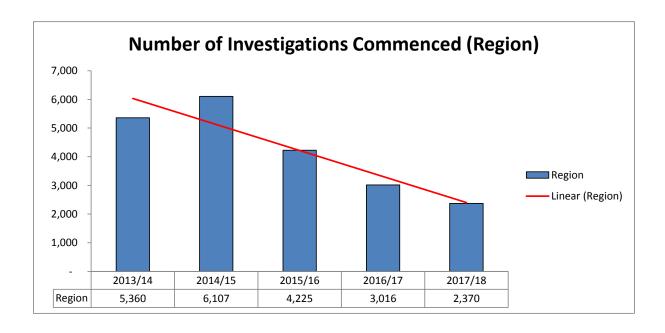
- a) Trends in relation to the number of investigations commenced since 2013/14;
- b) **Trends** in relation to the number of adult safeguarding Care and Protection Plans implemented since 2013/14; and
- c) **Trends** in relation to the number of Joint Protocol Investigations (including Achieving Best Evidence Interviews) since 2013/14.

It should be noted that, as in previous years, most activity related to concerns of physical abuse within the Older People and Learning Disability Programmes of Care.

#### a) Investigations Commenced:

Adult safeguarding investigations commence once a referral to adult safeguarding services has been made and a decision taken that the incident is sufficiently serious to require a full adult protection investigation.

That investigation may be taken forward on a single agency basis (ie the only agency involved is the HSC Trust), or the investigation may be taken forward in partnership with eg a provider organisation or RQIA.



Since April 2013, the number of investigations commenced has decreased significantly from 5,360 in 2013/14, to 2,370 in 2017/18. This is a decrease of 2.990 or 56%.

There are two possible reasons for this decrease:

- The introduction of new adult safeguarding arrangements between 2010 and 2014 resulted in a "spike" in activity as historic concerns were addressed and service users and staff became used to the new arrangements. This "spike" was predicted and a downturn in activity thereafter was also anticipated;
- The phased nature of the implementation of the new procedures since 2015 is reflected in the downward trend. It is anticipated that in future years, this category of information will refer only to investigations where the adult concerned is considered to be in need of protection and that cases involving adults at risk will be dealt with in core HSC Trust activity.

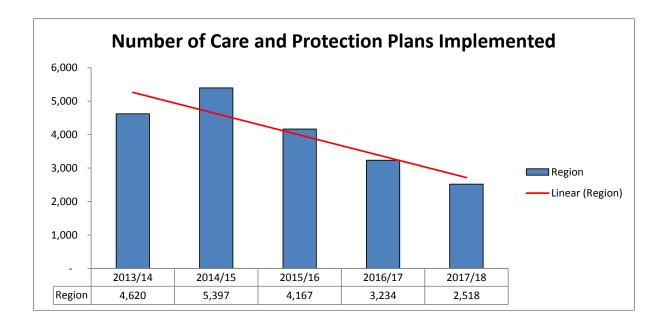
#### b) Care and Protection Plans Implemented:

Care and Protection Plans are the actions taken by HSC Trusts to protect an adult from further harm, where it has been alleged that they may have been subjected to some form of abuse, neglect or exploitation.

For some adults in need of protection, these plans will be the first time they have received support from the HSC Trusts eg victims of modern slavery.

For others, where there is a single agency investigation lead by the PSNI, no additional support from HSC Trusts may be required. In some circumstances, eg where a member of staff is placed on precautionary suspension pending the outcome of an investigation, appropriate arrangements to reduce the level of risk are already in place and no additional support is required.

From April 2013 to March 2018, the number of Care and Protection Plans implemented has declined by 45%, from 4,620 to 2,518.



Possible explanations for this downward trend are the same as the trend in relation to investigations commenced and outlined above.

However, it is also important to note that some investigations will refer to group living situations where one investigative process may include two or more adults, whereas a Care and Protection Plan is associated with an individual adult in need of protection. Consequently, it is not unusual for the number of investigations and the number of Care and Protection Plans initiated to be slightly different.

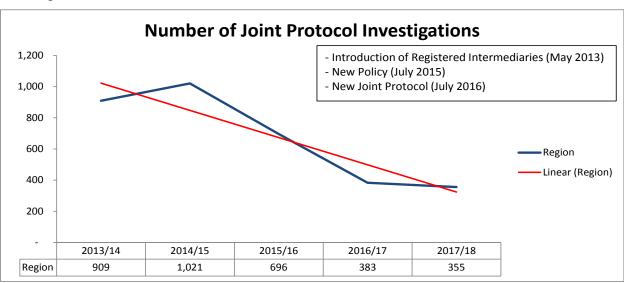
The downward trend in the number of Care and Protection Plans initiated is slightly less marked than the trend in relation to investigations commenced. Again, this may be an indication that new thresholds are being applied and that high-risk situations are being identified and managed appropriately

# c) Joint Protocol Investigations (including Achieving Best Evidence Interviews):

This category of adult safeguarding activity refers to the close co-working and collaboration between HSC Trusts and the PSNI in carrying out investigations where it is alleged or suspected that a crime may have taken place, and to support an adult in need of protection to make a statement of complaint to the PSNI.

These are the most complex and demanding adult safeguarding cases, which require significant levels of resource from both the HSC Trusts and the PSNI to achieve a successful outcome.

In common with other area of adult safeguarding practice, there has been a steady downward trend in relation to the number of Joint Protocol Investigations.



There are three possible explanations for this change in activity:

- The role of Registered Intermediary was introduced on a pilot basis in May 2013 and subsequently rolled out across the region. Registered Intermediaries provide communication support to children and adult witnesses in criminal proceedings, from initial complaints right through to any court hearings and is managed by the PSNI. It is likely that the PSNI are using Registered Intermediaries in some situations where previously they would have moved to joint working with the HSC Trust;
- The new thresholds introduced under Adult Safeguarding in Northern Ireland: Prevention and Protection in Partnership (2015) are also being applied by PSNI personnel;
- Two years ago the PSNI moved to a Central Referral Unit arrangement to manage all adult safeguarding referrals to the PSNI. In much the same way that the introduction of Adult Safeguarding Gateway Teams has concentrated experience in the HSC Trusts, the Central Referral Unit has streamlined decision-making within PSNI systems and processes.

It is also important to note that in 2016 the PSNI and HSC Trusts implemented a new Protocol for the Joint Investigation of Cases of Alleged or Suspected Abuse of Adult. It would appear that the introduction of this Protocol has led to a stabilisation of the number of Joint Protocol cases across the region.

#### **Next Steps:**

In 2018/19, NIASP will oversee the pilot phase of a new data collection system for adults in need of protection which is designed to address some of the data quality challenges addressed above.

In addition, the HSCB will undertake a regional audit in partnership with the HSC Trusts to examine referral practice in more detail and implement any associated improvement plan to ensure that referral criteria are applied consistently across the region.



# **PREVENTION ACTIVITY**

Throughout 2017/18 NIASP engaged in a range of different activities focusing on the prevention of abuse, neglect and exploitation.

- Each local Adult Safeguarding Partnership (LASP) now has an Adult
   Safeguarding Prevention Plan, tailored to address the priorities of the local area and partner organisations:
- Regionally, prevention activity has been led by partners from non-statutory organisations. In particular, faith groups have been very active in raising awareness of the abuse, neglect or exploitation of adults across significant sections of the population.
- Following an audit in 17/18, NIASP has renewed its web presence and a number of changes have been made to ensure individuals and organisations have easy access to relevant information on Adult Safeguarding.
- Further work is required to develop more regional resources to promote prevention activity. In 18/19, NIASP will seek to access sufficient resources to take this work forward.
- Partners continue to seek out ways of addressing concerns of financial abuse. A
  series of multi-agency workshops have been held in the Northern LASP to
  support partner organisations streamline their processes to manage service user
  finances. These have been very positively evaluated by participants and the
  model is being rolled out within the other LASP areas in 18/19.
- LASPs have also continued to roll out various 'Keeping You Safe' initiatives on a local basis. These programmes vary from targeted seminars within specific facilities, to training programmes with service users and various safe place initiatives.
- The development of Adult Safeguarding Gateway Teams continues to pay dividends and provide a safe point of contact for members of the public to raise concerns about an adult at risk. These have also lead to a process of streamlining access criteria to core HSC Trust sources. Further work is required

- to ensure that referrals of a general nature are re-directed to core provision more effectively.
- The South Eastern LASP has developed a suite of information on Adult Safeguarding for the Talking Newspaper organisation which has now been distributed throughout the region.
- A key element of prevention activity is equipping front-line staff to recognise and respond positively to situations where an adult may be at risk. Volunteer now continue to deliver high quality training to front-line staff, managers and now Adult Safeguarding Champions. This training is closely monitored and the sessions are continually evaluated very positively.
- Independent sector employers are also required to deliver awareness raising training to front-line staff. Some organisations will avail of training sessions with Volunteer Now to deliver this requirement. Others will choose to use their own in-house trainers or secure the sources of an independent trainer. Regardless of where the training is secured from, it must reach the standards set out in the NIASP Regional Training Framework (2016). The quality of this training is assured by RQIA.



## PROTECTION ACTIVITY

The majority of protection activity continues to be carried out by the statutory agencies in the partnership ie the HSC Trusts, PSNI, Probation Board for Northern Ireland, RQIA and the Business Service Organisation. However, the impact of the implementation of the new policy is becoming evident as new thresholds are applied requiring core services to respond to cases involving adults at risk. This has diverted significant numbers of referrals from the protection services (see activity analysis, page 14)

As in previous years, NIASP is committed to a process of continual learning and improvement. NIASP has established a single mailbox to receive comments or queries about the policy and related procedures. These are reviewed at every NIASP meeting, and appropriate adjustments made to the regional procedures once a year.

Similarly the protocol for joint investigation is kept under regular review and any emerging issues are addressed as quickly as possible.

Other protection initiatives in 17/18 include

- Collaboration with Woman's Aid and appointment of a specialist development worker for older women living with domestic abuse;
- Piloting the co-location of a specialist adult protection social worker with the local PSNI two days per week;
- Development of a local protocol for across border working with the Health Service Executive:
- Appointment of a dedicated Designated Adult Protection Officer within the Mental Health Programme of Care;
- A service improvement project to streamline the referral process within adult learning disability services; and
- Exploration of how the new role of Community Guardians can support Adult Safeguarding activity.

Work has continued across the partnership to develop new and innovative protection activities. In 2017/18 NIASP partners continued to contribute to highly specialised training programmes for staff working with adults in a need of protection. The specialist social work Professionals in Practice Award in Adult Safeguarding continues to attract high calibre candidates and is consistently well evaluated by participants.

In 2017/18 NIPEC led on the development of a competency framework for nurses undertaking Adult Safeguarding work. This framework is now out for consultation and it is anticipated that staff will begin to work towards achieving these competences in 2018/19.

In relation to issues of domestic violence and abuse, partners continue to be active contributors to multi-agency risk assessment conferences (MARAC) where people at highest risk of serious harm are offered a multi-agency response or support.

MARACs, while playing a vital part in the support and protection of people at high risk of harm, are also very resource-intensive. Adult Safeguarding partner organisations continue to be committed to MARACs but at times it can be challenging to fulfil the obligations associated with them. A recent development has been the introduction of Domestic Violence and Abuse Disclosure Schemes which also require significant contributions from NIASP partners, with no additional associated resources.

In 2017/18 there were a small number of serious adverse incident review reports involving adult safeguarding concerns. These have all now been appropriately reviewed and regional learning eg in relation to recruitment and selection and the management of support to people experiencing difficulties in swallowing, has been disseminated.

At the time of writing, NIASP partners are involved in two significant adult safeguarding investigations. One of these involved an in-patient unit in a statutory setting. The other involves an independent care home. While the outcomes of these investigations have not yet been made public; it is likely that the formal reports will include recommendations to improve protection processes. In 2018/19 NIASP will ensure that systems and processes are in place to implement any regional learning identified from these investigations.



## **PARTNERSHIP ACTIVITY**

Partnership working is central to NIASP and the development of systems and processes to safeguard adults at risk and adults in need of protection. It underpins all NIASPs work.

There are a number of primary partnerships that have helped deliver progress in adult safeguarding practice and improved outcomes for service users. These include the PSNI, local HSC Trusts and RQIA.

Partners in the non-statutory sector have also been instrumental in the development of new procedures and in ensuring that adult safeguarding to central to practice for associated organisations.

NIASPs partnership with service users has developed further in 2017/18 as the audit of user feedback has concluded (see page 29).

There continue to be challenges in working effectively and efficiently with colleagues in Human Resources, particularly where a member of staff is placed on precautionary suspension without prejudice, or disciplinary processes are involved. At present, the processes of a safeguarding investigation, PSNI investigation, Judicial learning, review by a professional regulatory body and any disciplinary investigation all happens sequentially rather than concurrently. This poses significant challenges for employers and employees alike, as well as delaying final resolution for the service user. This situation has improved in recent years, but more work is required to streamline these processes further.

In 2016/17 NIASP undertook a limited review of its membership, which resulted in some new partners joining NIASP. However, it is now over 8 years since NIASP was established, and in 2018/19 NIASP will give consideration to the need for a more fundamental review of membership, in order to refresh and review the partnership.

# HUMAN RIGHTS

### **HUMAN RIGHTS**

<u>Adult Safeguarding: Prevention and Protection in Practice</u> sets out 5 guiding principles for practice and notes that all adult safeguarding activity should be rights-based, empowering, person-centred, consent-driven and collaborative in approach.

Adult safeguarding practitioners engage on a daily basis with the sophisticated task of balancing risk assessment with the protection and promotion of an adult's rights and responsibilities.

The wishes of the adult in need of protection are of paramount importance in all cases of alleged or suspected abuse and the consent of the adult in need of protection should be sought as a first step.

Throughout 2017/18, practitioners have continued to adopt a human-rights based approach to adult safeguarding. While there have not been any new procedures or practice guidance that require a human rights screening, experience from practice eg in the stories and reports from the service user feedback audit, indicates that this approach is ingrained in practice.

NAISP will continue to ensure that human rights are at the centre of practice eg through the development of the new data collection system in 2018/19.



# ADULT SAFEGUARDING CHAMPIONS

The role of the Adult Safeguarding Champion (ASC) is set out in the regional policy, Adult Safeguarding: Prevention and Protection in Partnership (2015). It is a key role in the management of situations where an adult may be at risk. The main elements of the role are:

- to provide information and support for staff on adult safeguarding within the organisation;
- to ensure that the organisation's adult safeguarding policy is disseminated and support implementation throughout the organisation;
- to advise within the organisation regarding adult safeguarding training needs;
- to provide advice to staff or volunteers who have concerns about the signs of harm, and ensure reporting to HSC Trusts where there is a safeguarding concern (see section 10);
- to support staff to ensure that any actions take account of what the adult wishes to achieve – this should not prevent information about any risk of serious harm being passed to the relevant HSC Trust Adult Protection Gateway Service for assessment and decision-making;
- to establish contact with the HSC Trust Designated Adult Protection Officer
   (DAPO) (see section 11), PSNI and other agencies as appropriate;
- to ensure accurate and up to date records are maintained detailing all decisions made, the reasons for those decisions and any actions taken;
- to compile and analyse records of reported concerns to determine whether a number of low-level concerns are accumulating to become significant; and make records available for inspection.

The role has a significant governance function in that, through the provision of annual ASC Reports to the organisation's Management Committee or board, the organisation complies with the regional policy and proactive engagement with the adult safeguarding agenda can be demonstrated.

In 2017/18, NIASP partners in the voluntary, community and independent sectors undertook significant work to introduce the role and to prepare organisations for the responsibilities contained in the regional policy. Work included finalising the template for the ASC Annual Report and agreeing the minimum data set required for inclusion in that report.

This is a role which has been enthusiastically embraced by colleagues in the community, voluntary and independent sectors.

The Association for Real Change (ARC) in particular has provided significant leadership within their network and have organised seminars and workshops to support organisations implement the role of the ASC. These seminars have also been invaluable opportunities for sharing learning and experience with a wider group as well as building a body of knowledge in relation to adults at risk or in need of protection.

The Local Adult Safeguarding Partnerships have also introduced regular support meetings for ASCs in their area and these are proving very popular, with the added advantage of further developing positive working relationships between provider organisations and HSC Trust adult safeguarding teams.



### SHARING LEARNING

This year's shared learning event focused on the role of adult safeguarding in the recovery of an adult victim of modern slavery and in supporting them through an initial rehabilitation phase.

The event was one of several activities hosted by the Department of Justice to mark World Anti-Slavery Day and was opened by the UK Anti-Slavery Commissioner, Mr Kevin Hyland.

At the event practitioners from the Southern HSC Trust shared learning and reflections on their engagement with a victim of modern slavery/human trafficking from the initial point of discovery, through an associated criminal justice process including a trial, and finally to resettlement and rehabilitation for the victim.

The event highlighted the importance of partnership working, with a successful outcome for the user depending on effective contributions from core social work staff, specialist adult safeguarding practitioners, PSNI and independent providers.

The event concluded with a DVD presentation by the victim where she highlighted how her life had changed for the better, describing how she had gone from being a prisoner in a locked room subject to regular sexual abuse and exploitation, to living independently in a supportive environment which she characterised as a situation where she is now "Queen of her own home".

The learning from this event has been further communicated through additional seminars and conferences, eg through lunchtime seminars hosted by the Northern Ireland Social Care Council.



## **AUDIT ACTIVITY**

The Adult Safeguarding 10,000 Voices project provided enhanced qualitative information about the real experiences of service users and their carers. The overall aim of the project was to identify how the adult safeguarding process can be improved to ensure the service users experience is rights based, empowering, consent driven and as person centred as possible.

This will be achieved by adopting the partnership approach which has been successfully applied in the 10,000 Voices Initiative, using a blend of qualitative and quantitative data through the use of Sensemaker® methodology.

#### **Development of the tool**

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

The project asked service users and/or their representatives to consider the following questions:

- 1. To what extent did you feel listened to during meetings and conversations? To what extent did you feel satisfied with how the safeguarding investigation was carried out?
- 2. To what extent were you able to understand the information given to you during the safeguarding investigation?
- 3. To what extent were you given the information you needed at the right time during the safeguarding investigation?

- 4. To what extent were you satisfied with the outcome of the investigation? and
- 5. Do you feel that you are safer now as a result of the safeguarding investigation?

#### The scope of the Project

The project took place across all Trusts from January 2017 – Dec 2017. In total 109 surveys were received. The survey was completed by 76 service users; 16 people acting on behalf of the service users; 16 carers and one other person.

1. Responses to the question "To what extent did you feel listened to during meetings and conversation?"

The majority of respondents (67%) "felt they were listened to in a respected way". (73 out of a total of 109 experiences) A further 16% felt they were listened to but for some their views didn't affect the decisions. This reflects the complex nature of decision making within adult safeguarding

4% of the survey respondents reflected that they felt "judged" in some way. 3 out of 5 of these experiences related to the criminal justice process and outcomes and the other 2 related to experiences involving incidents relating to care staff. This illustrates the importance of supporting individuals to consider their desired outcomes at the beginning of the process and provide appropriate support throughout and after the outcomes of both a judicial and internal HSC safeguarding process.

2. Responses to the question "To what extent did you feel satisfied with how the safeguarding investigation was carried out?"

Again there is a 67% cluster of respondents who felt that they were supported to work things through as the investigation proceeded

Professionals had anticipated that service users and carers would have responded in this question by indicated that the "process dragged on" however only 5% reflected the length of time the process took in their experience. There were indications throughout the narratives that individuals recognised that the investigation process

took time but respondents highlighted they understood the reasons behind this and did not reflect this as a negative experience. However, 29% of the respondents placed their experience between "The Process dragged on" and "I didn't know what was happening". This reflects the need for ongoing effective communication with service users and carers throughout the safeguarding process. This not only provides information but also enables service users and carers to respond to the investigation progress made, preparing themselves for potential outcomes and also to develop personal resilience to strengthen their own safety.

3. Responses to the question "To what extent were you able to understand the information given to you during the safeguarding investigation?"

It is encouraging that 91% of the respondents felt that "the information was clear and easily understood" or that "someone had helped them to understand the information" A small number of experiences reflected that they didn't understand the information during the investigation. The narratives in these 6 experiences reflect the importance of working at the pace of the service user / carer. In one experience a carer reflected that they were so distraught at the time because of what had happened that she could not take in anything and therefore on reflection she felt she did not fully understand what was happening.

4. Responses to the question "To what extent were you given the information you needed at the right time during the safeguarding investigation?"

The responses to this question clearly indicated that 70% of respondents felt that they had the right information at the right time. However, the responses which report that "I was not kept up to date" require further analysis. Of these 9 experiences, 5 reflected in the previous question that the information given by professionals was clear and easily understood DURING the investigation, however, they stated that they didn't get the information that would have helped them understand better at the right time. A further 2 of these individuals reflected that someone had helped them

understand the professional information during the investigation but again reflected that the information was not given at the correct time. This highlights the importance of providing person centred responses during the safeguarding process. This also evidences the importance of working at the pace of the service user / carer to support them through a traumatic experience and a complex system of choices to be made to respond to what has happened.

# 5. Responses to the question "To what extent were you satisfied with the outcome of the investigation?"

It is encouraging to see that the majority of experiences reflected that "people worked together to make things better" encompassing the spirit of the new adult safeguarding policy and procedures. However, it is of concern that 7% of respondents "did not know what the outcome was." It is interesting to note that these experiences do not relate to criminal justice outcomes but rather experiences where there has been a change in practice and the harm has ceased but the service user / carer has not felt that they had "closure" on the safeguarding concerns due to recommendations from investigations not being implemented; communication from agencies to reflect learning and actions taken to improve systems; or actions taken to improve quality of service provision. This was particularly reflected in the experiences of carers of individuals who had a diagnosis of dementia and had complex comorbidities.

# 6. Responses to the question "Do you feel that you are safer now as a result of the safeguarding investigation?"

I feel that I am not at all safer now	4
I feel that I am not much safer now	12
I feel that I am quite a bit safer now	47
I feel that I am completely safe now	46

This perhaps is the most important question in the survey and asks the service user / carer to give their views on how safe they feel after the safeguarding investigation has been completed. 93 out of 109 people felt either quite a bit safer or completely safe. Those whose experience reflected that they did not feel safer or not much safer frequently were situations where service users choose to remain in the relationship where the harm was alleged to have occurred. Many of these were relating to situations of domestic abuse. This is further explained in the analysis below.

#### Overall how would you rate your experience?

Strongly positive	42
Positive	37
Neutral	15
Negative	7
Strongly negative	3
Not sure	7

(Anomaly of 2)

#### **Emerging Themes of Positive Experiences**

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

One service user reported experiencing "a feeling of despair, then hope and eventually light". Another reflected that "People believed me." Experiences commonly reflected the sense of being listened to in a confidential way and being

provided with information to support service users and carers to make decisions about what they wanted to happen next.

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

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

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

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

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

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

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

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

Furthermore there were emerging patterns where 68% of the narratives reflected the partnership working across various agencies and disciplines where service users and carers reflected that working together improved their experience. This included

references to "GP's"; "nursing home staff"; "medical hospital staff"; "day care staff" and "domiciliary care staff"; "Alzheimer's Society".

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

#### **Emerging Themes for Service Improvement**

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

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

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

Some recommendations for improvement from service users and carers include

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

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

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

"Waiting to hear from the PSNI."

"More one to one time with my social worker"

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

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

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

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

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

#### Another

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

Others reported they "found the experience lengthy."

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

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

Many carers reflected actions in seeking out information to support them through the safeguarding process and also prevent harm reoccurring. Using "google", "Age NI",

"Alzheimer's Society", "Carers NI" and the safeguarding teams to provide advice and support was a recurring theme. There is an opportunity to strengthen protection planning, by building on strengths and resilience of service users and carers through the coproduction of protection plans and ongoing social work interventions to support and grow safety.

#### **NEXT STEPS:**

The final report of the Project will be presented to NIASP in the early Autumn. However, where possible the learning from the intermediate report has been shared with HSC Trusts and, where appropriate, incorporated into NIASP's workplan for 2018/19.

Individual HSC Trusts and LASPs will also include implementing the learning form this project into their action plans for next year.



# NATIONAL AND INTERNATIONAL LINKS

Throughout 2017/18, NIASP continued to build on links between adult safeguarding in Northern Ireland and the rest of the UK and Ireland.

The link with the National Centre for the Protection of Older People (NCPOP) in Dublin continues to provide NIASP with access to cutting-edge research on the topic of financial abuse of older people.

NIASP was asked to contribute a paper to a special edition of the Journal of Adult Protection devoted to the legislative and policy context to adult safeguarding across the UK. In the event, NIASP members contributed 2 papers to this special edition,

Following on from publication of an article reporting on the pilot phase of the use of 10,000 Voices to obtain user feedback on adult safeguarding, the article authors were invited to present a paper at the European Social Work Research Conference held in Edinburgh.

NIASP was also asked to contribute to a policy development seminar in Dublin organised by the Irish Government, as they seek to review the legislation underpinning adult safeguarding in Ireland.



### **RISKS AND OPPORTUNITIES**

Looking forward to 2018-19, there are a number of risks as well as opportunities for adult safeguarding. NIASP will continue to work with partner organisations and HSC Trusts to implement Adult Safeguarding: Prevention and Protection in Partnership (2015) and the associated procedures. However, the continued lack of dedicated funding means that implementation of some aspects of the policy and procedures may be delayed. For example, lack of resources to provide enhanced training opportunities has meant that available funding has been targeted at existing Investigating and Designated Adult Protection Officers and it has not been possible to train practitioners new to these roles.

The existing data return is not reflective of the new roles, responsibilities and activity contained in the policy and associated procedures. Adult safeguarding is just one priority among many in terms of the development of an electronic recording system. In 2018/19, NIASP will move forward to pilot a new data return for work with adults in need of protection, with a view to having a final version ready for consideration by the relevant information management governance bodies by the end of the year.

Some aspects of the policy do not require new or additional investment. The new Domestic and Sexual Violence Strategy offers NIASP a number of new and exciting opportunities to address the abuse of adults at risk or in need of protection. The Department of Justice will shortly be starting a consultation on new arrangements to review situations where domestic violence has resulted in a death and it is anticipated that NAISP will make a significant contribution to the identification and sharing of learning from these tragic events.



## **WORKPLAN 2018 -19**

The NIASP Workplan for 2018/19 is again based on the core principles of prevention, protection and partnership. The Workplan focuses on core elements of these principles and assigns the lead role on the objectives to one or more of the NIASP Workstreams.

Regular updates on progress in relation to each objective will be provided at the quarterly NIASP meetings.

THEME / OBJECTIVE	ACTIONS	BY	Completion Date
RAISE AWARENESS	Develop video graphic explaining abuse	Prevention Work	September 2018
OF ADULT	and how to get help.	stream	
SAFEGUARDING			
	Pilot 6 monthly briefing note for Partners		March 2019
Continue to develop a	highlighting developments in Adult		
regional programme of	Safeguarding.		
awareness raising and			
prevention activities to	Partners to include link to NIASP	NIASP	September 2018
complement local	website on their respective		

THEME / OBJECTIVE	ACTIONS	BY	Completion Date
prevention plans.	organisation's website		
Ensure relevant Adult Safeguarding information is easily available to staff, people who use services, their family carers and members of the public.	HSC Trust Adult Safeguarding web page to include LASP member agencies and web links Publicise NIASP Work Plan on NIASP and HSC Trust websites		June 2018
	Promote regional awareness of World  Elder Abuse Awareness Day on 15 <sup>th</sup> June		June 2018
	Establish editorial team to quality assure additions to the NIASP web page, and complete annual review to ensure information is kept up to date.	HSCB	September 2018
GOVERNANCE, AUDIT AND QUALITY ASSURANCE	Test ASC Annual Position Report Template for review in April 2019	Prevention Work stream	March 2019

THEME / OBJECTIVE	ACTIONS	ВҮ	Completion Date
Support NIASP partner organisations to comply	Conduct regional audit of referral activity to Adult Safeguarding Gateway Teams	HSCB	March 2019
with the relevant requirements set out in Adult Safeguarding:	Monitor and Review Adult Safeguarding activity data following implementation of revised Data 4 format	NIASP	March 2019
Prevention and Protection in Partnership (July 2015)	Meet 4 times per year providing a multi- agency forum to co-ordinate the implementation of Adult Safeguarding: Prevention and Protection in Partnership (July 2015)		March 2019
	Develop an Adult Safeguarding Strategic Plan for the next 5 years.		March 2019
	Provide advice and guidance to other statutory agencies to include ASC requirements in their contract; regulation; or quality improvement frameworks.	HSCB	March 2019

THEME / OBJECTIVE	ACTIONS	ВҮ	Completion Date
TRAINING AND	Organise an annual learning event	Prevention Work	March 2019
SHARED LEARNING	focusing on adult at risk of harm and	stream	
	alternative safeguarding responses		
Ensure that practitioners			
have access to relevant	Cascade peer education / self-protection		March 2019
training and opportunities	programmes such as "Keeping Yourself		
to learn from practice	Safe" or equivalent training for Adults at		
	Risk of harm across services and		
	settings.		
	Adapt and implement Department of	Protection Work	December 2019
	Health & Social Care (Jan 2018)	stream	
	Safeguarding Adults Protocol: Pressure		
	Ulcers and the interface with a		
	Safeguarding Enquiry for the Northern		
	Ireland context.		

THEME / OBJECTIVE	ACTIONS	BY	Completion Date
	Review and update Adult Safeguarding	NIASP	March 2019
	Training Strategy and Training		
	Framework 2016 to reflect emerging		
	needs.		
	Support nursing colleagues with the		September 2018
	development and implementation of the		
	Adult Safeguarding Nursing		
	Competence Framework		
	Facilitate Operation Repeat prevention		March 2019
	training to Statutory and Independent		
	Sector domiciliary care workers.		
	Provide a network for taking forward		
	regional learning from reviews and		
	enquiries.		
	Make the SAaRIH web site available to	нѕсв	June 2018
	NIASP Partners for 2018/19	11000	Julio 2010
	THASE I dittiers for 2010/19		

THEME / OBJECTIVE	ACTIONS	ВҮ	Completion Date
	Review the regional adult safeguarding	Protection Work	September 2018
REFINE OPERATIONAL	procedures, 2016	stream	
PROCEDURES			
	Review and refine HSC / PSNI Joint		March 2019
NIASP will ensure that	Protocol arrangements.		
the Manual of			
Operational Policies and	Develop / implement regional principles		December 2018
Procedures is kept up-to-	of practice to support staff when		
date and reflects	coordinating an Adult Protection (and /or		
developing practice in	PSNI) / Human Resources (SHSCT		
adult safeguarding.	guidance shared as good practice		
	example).		
	NIASP will continue to keep its	NIASP	March 2019
	structures and operational procedures		
	and Handbook under review		
	Develop information booklet suitable for	Prevention Work	March 2019
FINANCIAL SAFETY	prevention and alternative safeguarding	stream	Widion 2010
I MANUAL VALETT		Sirvain	
	responses.		

THEME / OBJECTIVE	ACTIONS	ВҮ	Completion Date
Develop initial guidance for staff in responding to	Develop information booklet to support for staff conducting investigations.	Protection Work	March 2019
issues of financial abuse	Tor stair conducting investigations.	Sucam	
ledges of infaritial abase	Continue to circulate Scamwise and	NIASP	March 2019
	Trading Standards information and		
	updates through networks.		
	Support regulated Independent Sector		March 2019
	service providers Improve their financial		
	governance arrangements.		
	Represent AS at interdepartmental DV	Prevention Work	
STREAMLINE	& SV strategy group and identify and	stream	
INTERFACES	raise interface issues	Protection Work	
		stream	
Clarify the interface	Represent AS at interdepartmental	NIASP	
between adult	Modern Slavery strategy group and	HSCB	
safeguarding and other	identify and raise interface issues		
public safety strategies			
such as the Domestic	Represent AS at interdepartmental Hate		
and Sexual Violence	Crime Delivery group and identify and		
Strategy	raise interface issues.		

THEME / OBJECTIVE	ACTIONS	BY	Completion Date
CO- PRODUCTION  NIASP will ensure that the experience of service users is sought	Develop an action plan to implement learning from the 10,000 voices project	Prevention Work stream Protection Work stream NIASP	December 2018
at all stages of the safeguarding process	Integrate outcomes form Adult Safeguarding interventions within work to develop social care outcomes framework	HSCB	March 2019
STANDARDS  Ensure existing standards reflect good governance in Adult	Implement standards associated with the NI Human Trafficking & Modern Slavery Strategy 2016/17 where these intersect with Adult Safeguarding	Prevention Work stream	March 2019
Safeguarding practice	On completion of the review of Joint Protocol arrangements Develop standards for Joint Protocol	NIASP	March 2019

THEME / OBJECTIVE	ACTIONS	ВҮ	Completion Date
	Investigations		
	Ensure that Adult Safeguarding	HSCB	June 2018
	standards are included in Programme of		
	Care Service Frameworks		



## **APPENDICES**

#### **MEMBER ORANISATIONS**

Action for Elder Abuse

**Action Mental Health** 

Age NI

Association for Real Change

Belfast Health & Social Care Trust

**Business Services Organisation** 

Carers NI

Faith Sector - Presbyterian Church in Ireland

**HSCB** (Integrated Care)

**HSCB** (Social Care and Children)

Independent Healthcare providers

Northern Health & Social Care Trust

Northern Ireland Association of Social Workers

Northern Ireland Housing Executive

Probation Board for Northern Ireland

**PSNI** 

Public Health Agency (Allied Health Professionals)

Public Health Agency (Nursing)

**Red Cross** 

Regulation and Quality Improvement Authority

Royal College of Nursing

Social Security Agency

**SOLACE** 

South Eastern Health & Social Care Trust
Southern Health & Social Care Trust
Volunteer Now
Western Health & Social Care Trust
Women's Aid