Analysis of a survey commissioned by the Safeguarding Research Development Group about the current implementation of the Safeguarding Vulnerable Persons at Risk of Abuse Policy and Procedures 2014

Safeguarding Policy Review Survey Analysis

Contents

1.0 Introduction

The HSE is committed to safeguarding people who may be vulnerable from abuse. The HSE launched its safeguarding policy - "***Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures"*** in December, 2014 which is now subject to a review process. The policy has been operational in all CHO areas since 2015 and key operational strengths, as well as challenges, have emerged. The terms of reference for this review covers all aspects of the current policy and its operation, including scope, prevention, definitions and procedural systems.

The Review Development Group was established in January 2016 and comprises of membership across the various sectors involved in adult safeguarding. A key component of the work of the Review Development Group is to consult widely both on the current safeguarding system, in addition to giving due consideration to future models of service delivery. This report analyses the information gathered from phase 1 of the review, with emphasis on the as-is situation, in relation to adult safeguarding in an Irish context. The following sections will outline the methodology of data collection, results generated, representing both qualitative and quantitative aspects and the conclusions, will serve to inform the next phase of the project.

2.0 Methodology

The HSE Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures Review Survey was issued in May 2017 by the National Safeguarding Office, on behalf of the Review Development Group.

The survey was compiled into two parts.

PART 1: Provided general statements requiring a response by anyone who has contact with the policy which encouraged engagement from all staff and volunteers

PART 2: Had additional statements that were directed at Social Care Service Managers and Designated Officers from HSE & HSE Funded agencies. These participants have additional duties and responsibilities under the safeguarding policy as such a more comprehensive selection of questions was presented. Members of the HSE Safeguarding & Protection Teams also completed part two of the survey.

Additionally, all respondents were able to provide qualitative feedback at the end of the survey which afforded contributors an opportunity to document any positive or negative engagement they had in relation to the policy, or indeed, any recommendations for future service development and planning.

Survey monkey Survey Software was used to compile the questionnaires, allowing respondents to complete the survey online. Survey monkey has the additional benefit of analysis tools within this package, allowing our researchers to critically analyse the results and providing visual aids where needed.

The survey monkey questionnaire was piloted with the review development group before being issued and final amendments made. Once finalised, (see appendix 1) the questionnaire was issued to the following stakeholder groups on the 4th May 2017 and a reminder email was issued to maximise the return rate

1. HSE Safeguarding and Protection Teams
2. All HSE Staff through the staff broadcast system
3. Designated Officer Listing
4. Membership of the Reference Group

5. National Safeguarding Committee

6. Review Development Group

The initial closing date was set for the 26th of May 2017; this date was subsequently extended to the 29th May as a consequence of technical issues that resulted in emails being suspended for a number of days across the HSE.

3.0 Results Quantitative Analysis (all participants)

3.1 Profile of Respondents

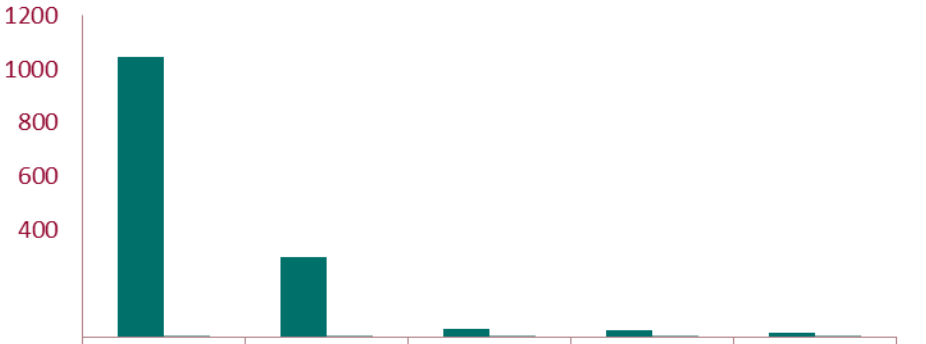
There were 1961 surveys submitted with approximately 1,400 being completed in full. The following is a breakdown of the demographic of the respondents:

- 66% of respondents worked in the HSE, 30% in a funded agency and 4% were members of the public
- 35% of respondents were within the social care division, with primary care and mental health the most significant
- The majority of participants worked both with older people and adults with a disability 31%
- There was an even dispersal across all CHOs with no correlation in the response rate between the level of reporting and/or training in any particular CHO.

3.2 Views on Safeguarding

The participants were asked to rate their level of agreement on statements contained in the survey. In the following section a graphical representation will be presented for each of the questions to summarise the responses provided.

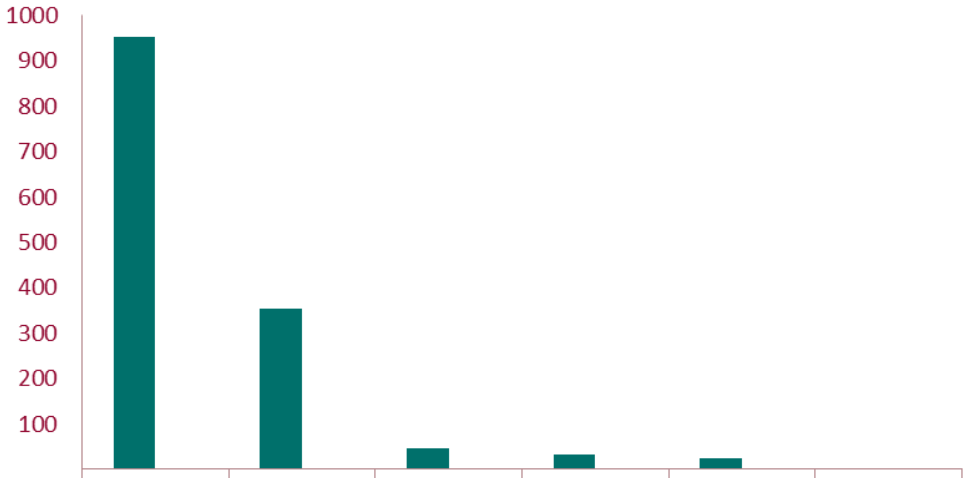
I understand the purpose of this policy



Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Strongly Disagree	Somewhat Disagree
1045	296	30	25	16
74.01%	20.96%	2.12%	1.77%	1.13%

Answered: 1,412 Skipped: 548

I am clear as to who this policy is intended to cover

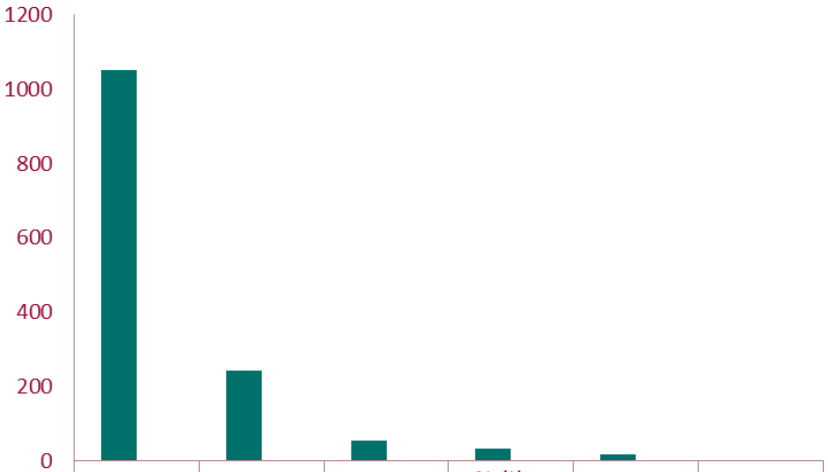


Strongly Agree	Somewhat Agree	Somewhat Disagree	Neither Agree nor Disagree	Strongly Disagree	(blank)
952	355	45	32	23	
67.66%	25.23%	3.20%	2.27%	1.63%	0.00%

Answered: 1,407

Skipped: 553

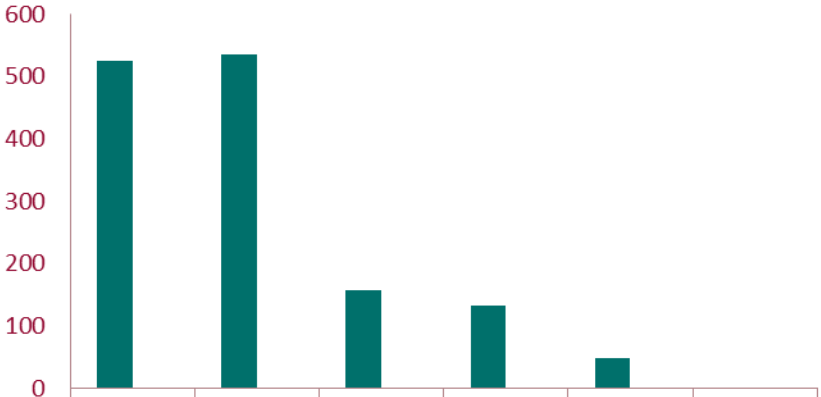
The term zero tolerance is easy to understand



Strongly Agree	Somewhat Agree	Somewhat Disagree	Neither Agree nor Disagree	Strongly Disagree	(blank)
1050	244	56	33	18	
74.95%	17.42%	4.00%	2.36%	1.28%	0.00%

Answered: 1,401
Skipped: 559

Zero tolerance of abuse has has worked to protect people using the service from abuse

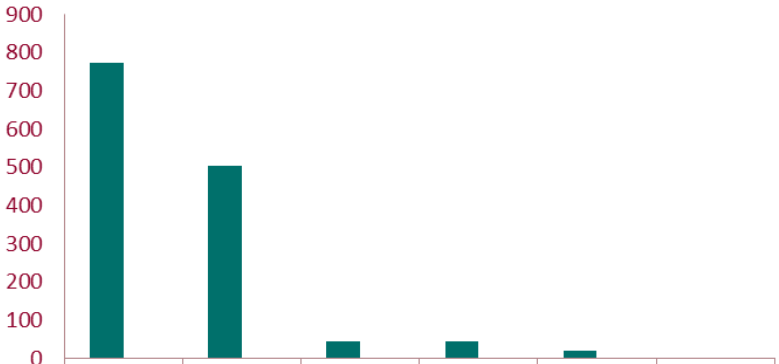


Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree	(blank)
525	535	158	133	49	
37.50%	38.21%	11.29%	9.50%	3.50%	0.00%

Answered: 1,400

Skipped: 560

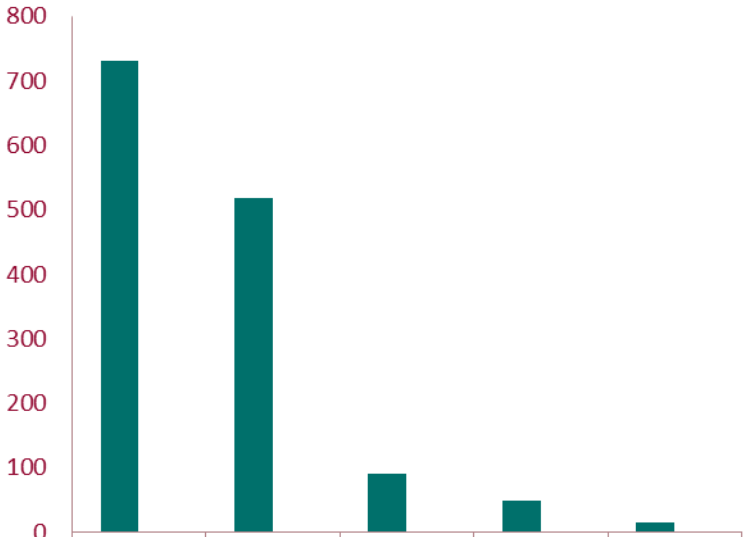
The definitions of abuse in this policy are easy to understand



Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree	(blank)
774	503	45	45	20	
55.80%	36.27%	3.24%	3.24%	1.44%	0.00%

Answered: 1,387
Skipped: 573

The definitions of abuse are correct in their detail

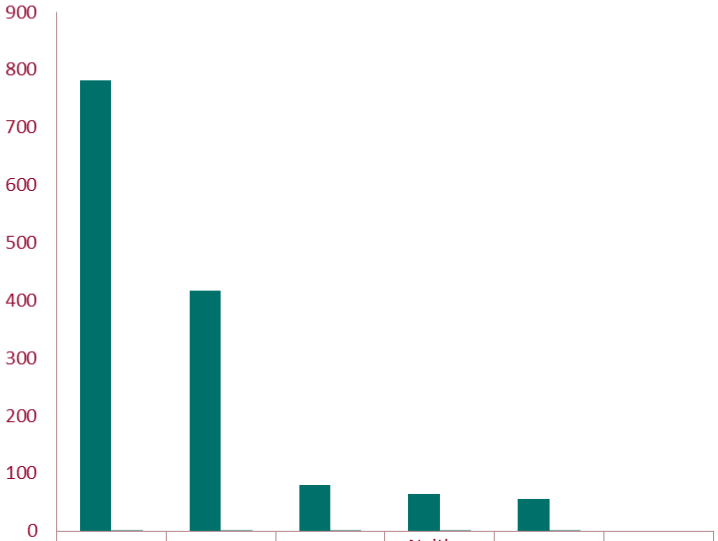


Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
730	519	91	49	15
51.99%	36.97%	6.48%	3.49%	1.07%

Answered: 1,406

Skipped: 554

This policy assists me to be clear on my role and responsibility in protecting service users from abuse

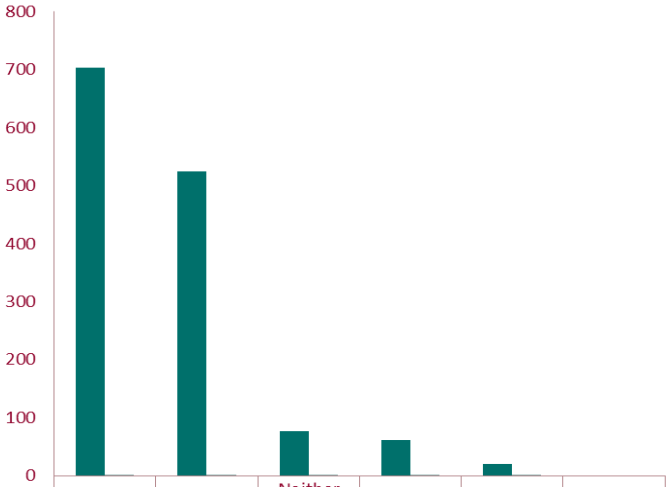


Strongly Agree	Somewhat Agree	Somewhat Disagree	Neither Agree nor Disagree	Strongly Disagree	(blank)
781	416	80	65	55	
55.91%	29.78%	5.73%	4.65%	3.94%	0.00%

Answered: 1,404

Skipped: 556

The human rights of the service users are easy to understand within this policy

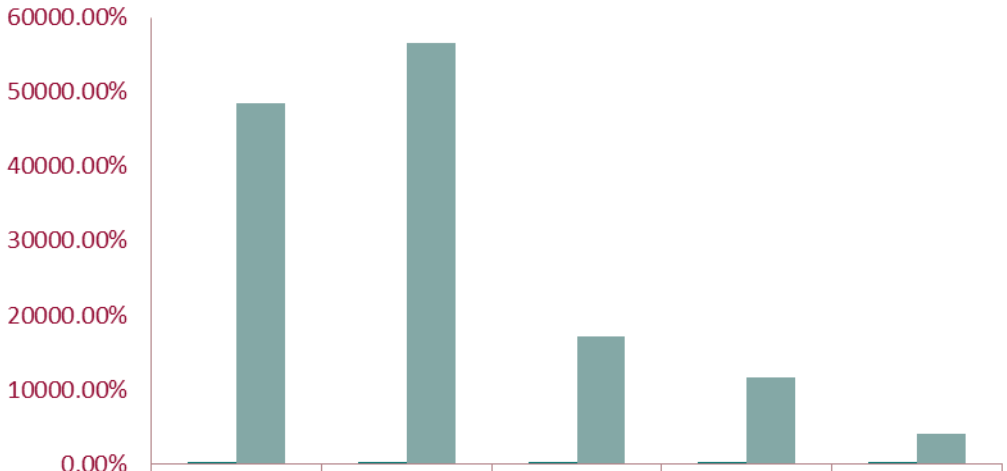


Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree	(blank)
703	524	77	62	21	
50.68%	37.78%	5.55%	4.47%	1.51%	0.00%

Answered: 1,387

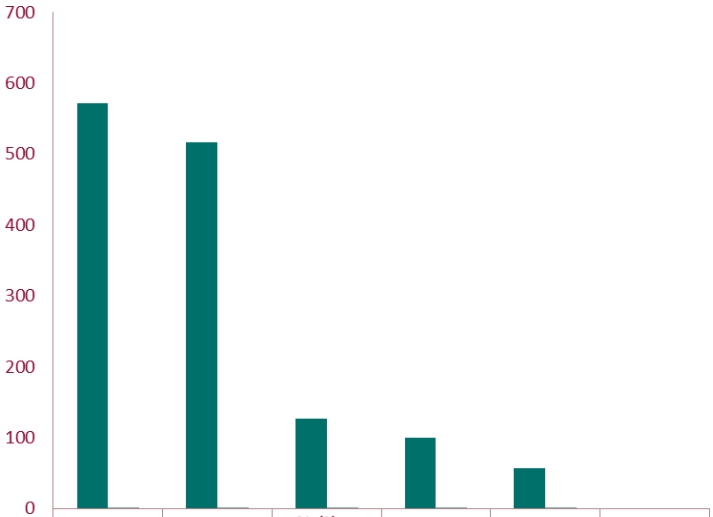
Skipped: 573

In my experience, these human rights principles have helped to protect service users from abuse



	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
Answered: 1,379	35.17%	41.04%	12.47%	8.41%	2.90%
Skipped: 581	485	566	172	116	40

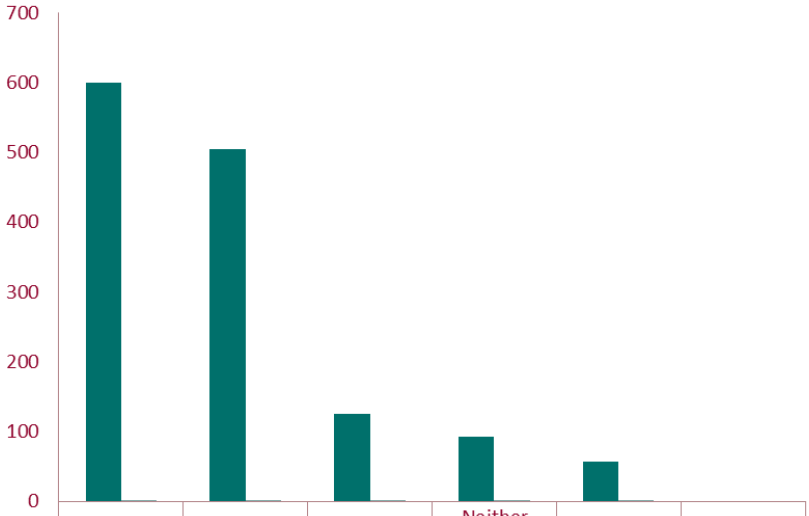
This policy helps my service/organisation to prevent abuse



Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree	(blank)
572	517	126	99	56	
41.75%	37.74%	9.20%	7.23%	4.09%	0.00%

Answered: 1,370
Skipped: 590

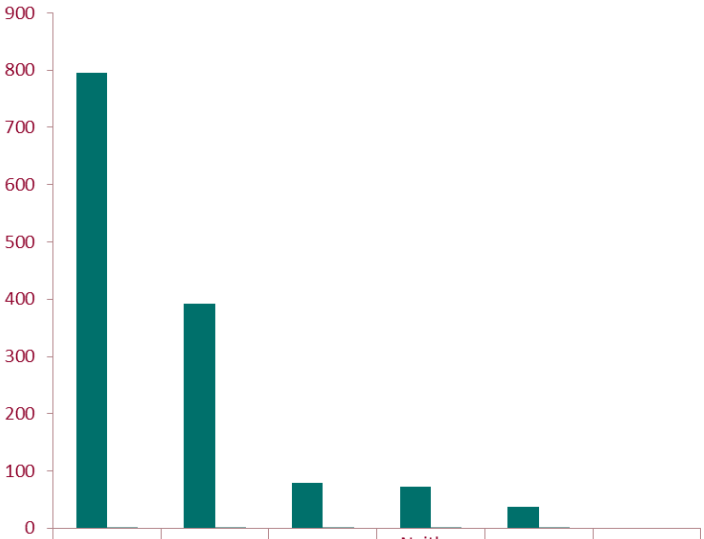
This policy helps my service/organisation to respond effectively to concerns of abuse



Strongly Agree	Somewhat Agree	Somewhat Disagree	Neither Agree nor Disagree	Strongly Disagree	(blank)
599	505	125	92	57	
43.47%	36.65%	9.07%	6.68%	4.14%	0.00%

Answered: 1,378
Skipped: 582

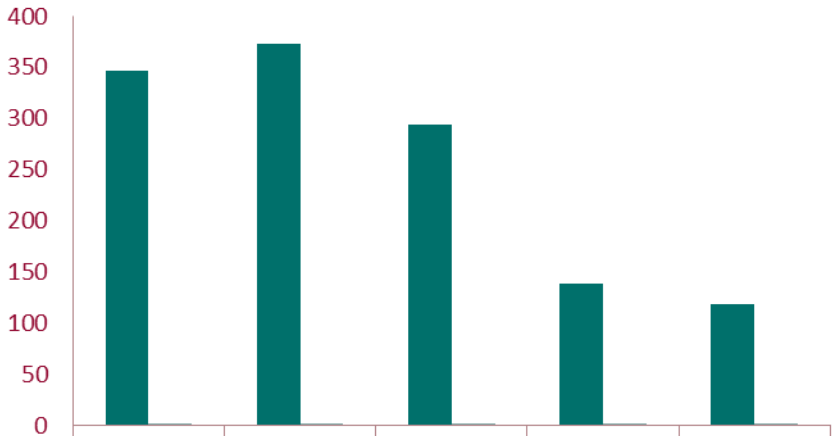
This policy clearly states the steps I need to take if I have a concern of abuse



Strongly Agree	Somewhat Agree	Somewhat Disagree	Neither Agree nor Disagree	Strongly Disagree	(blank)
795	392	79	73	38	
57.73%	28.47%	5.74%	5.30%	2.76%	0.00%

Answered: 1,377
Skipped: 583

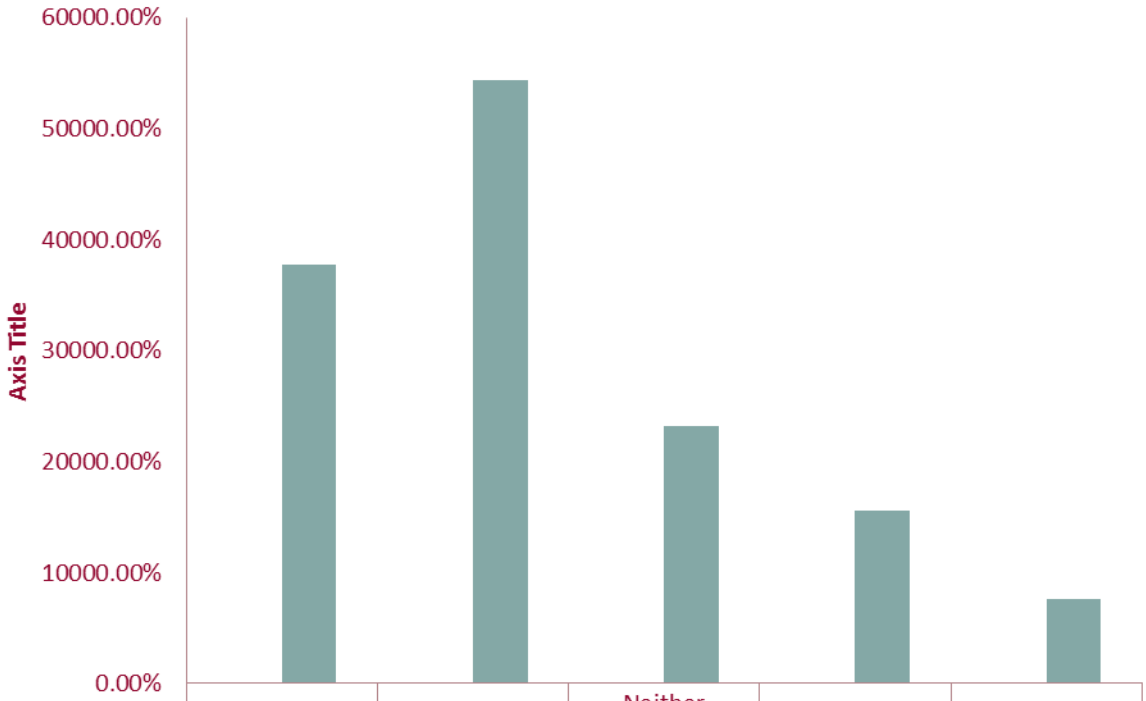
The process of submitting a community based referral is operating effectively



Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
347	373	294	139	118
27.30%	29.35%	23.13%	10.94%	9.28%

Answered: 1,377
Skipped: 583

The policy is clear in relation to the steps to take in relation to the assessment and management of Self Neglect

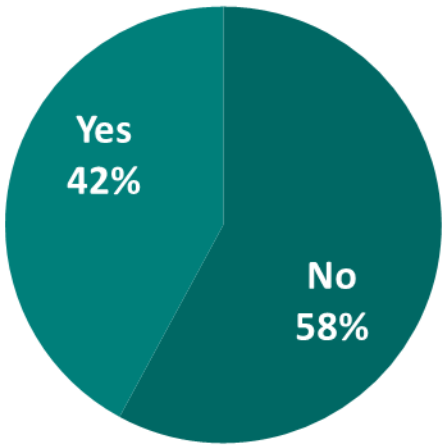


Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
27.22%	39.28%	16.75%	11.26%	5.49%
377	544	232	156	76

Answered: 1,271

Skipped: 689

Are you a Social Care Service Manager, a Designated Officer (HSE & HSE Funded agencies) or a Member of the HSE Safeguarding & Protection Teams?



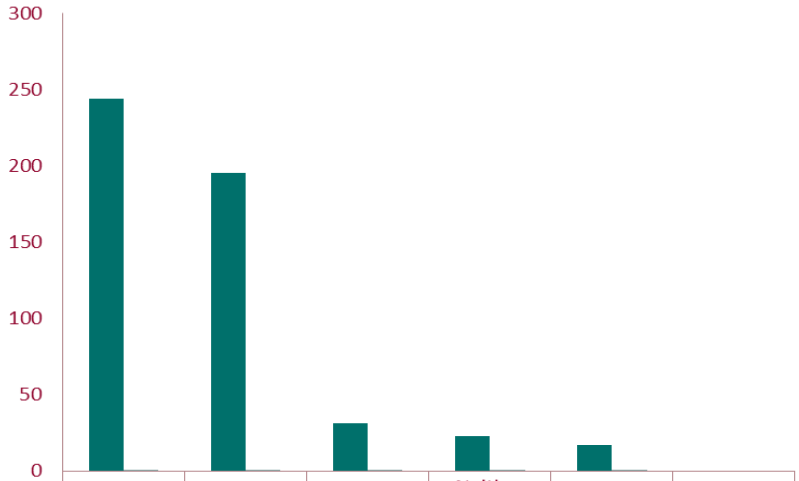
If the respondent answered No at this point the survey directed them to a thank you for completing the survey page.

If the respondent answered yes at this point they were directed to more questions

4.0 Results Quantitative Analysis (part two)

This section was only answered by Social Care Managers, Designated Officers and members of the Safeguarding and Protection Teams.

If I need to carry out a preliminary screening, the policy is clear on the steps to be taken

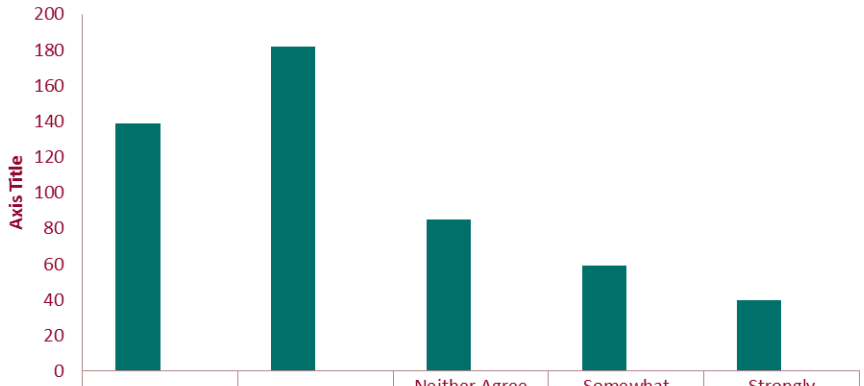


Strongly Agree	Somewhat Agree	Somewhat Disagree	Neither Agree nor Disagree	Strongly Disagree	(blank)
244	195	31	23	17	
47.84%	38.24%	6.08%	4.51%	3.33%	0.00%

Answered: 1,450

Skipped: 510

The system of submitting preliminary screening concerns to the safeguarding teams is working effectively

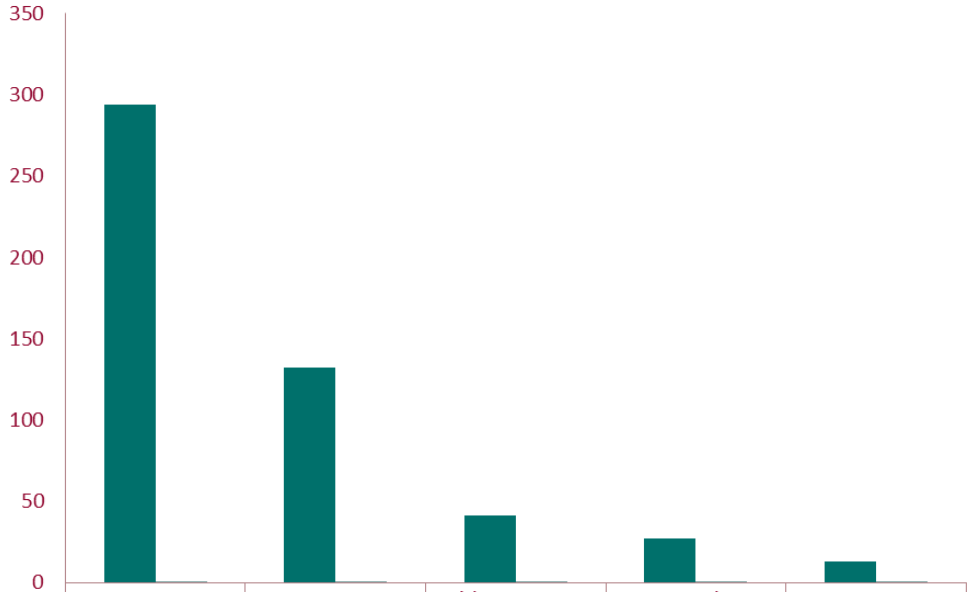


Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
139	182	85	59	40
27.52%	36.04%	16.83%	11.68%	7.92%

Answered: 505

Skipped: 1,455

In my opinion it is vital that the HSE Safeguarding Team has oversight of preliminary screenings from service settings

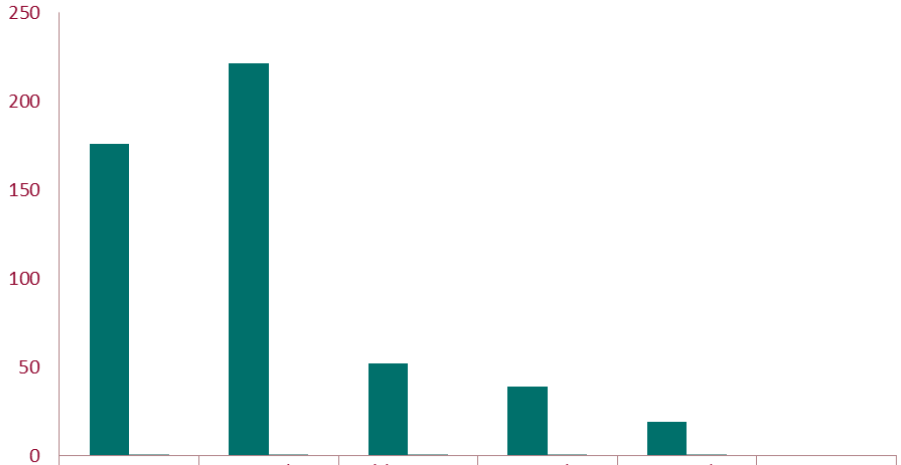


Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
294	132	41	27	13
57.99%	26.04%	8.09%	5.33%	2.56%

Answered: 507

Skipped: 1,453

If I need to draft a safeguarding plan, the policy is clear on the steps to be taken

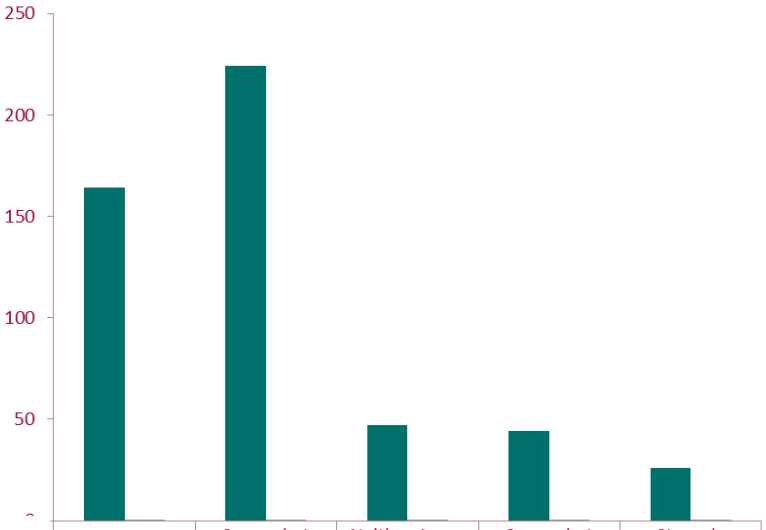


Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree	(blank)
176	221	52	39	19	
34.71%	43.59%	10.26%	7.69%	3.75%	0.00%

Answered: 507

Skipped: 1,453

If I need to coordinate a safeguarding plan, the policy is clear on the steps to be taken

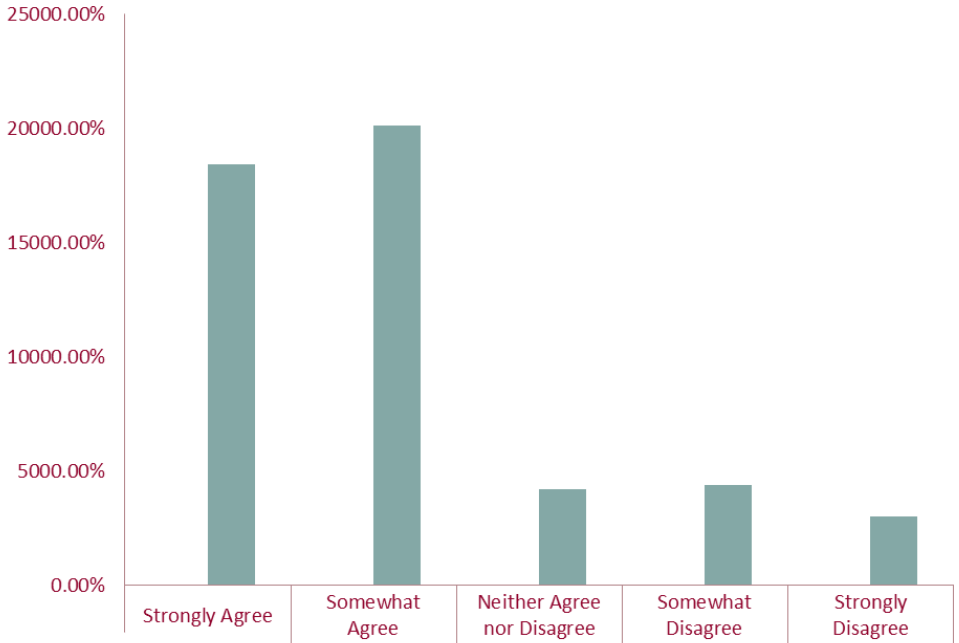


Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
164	224	47	44	26
32.48%	44.36%	9.31%	8.71%	5.15%

Answered: 507

Skipped: 1,457

This policy helps my service/organisation to adequately screen concerns

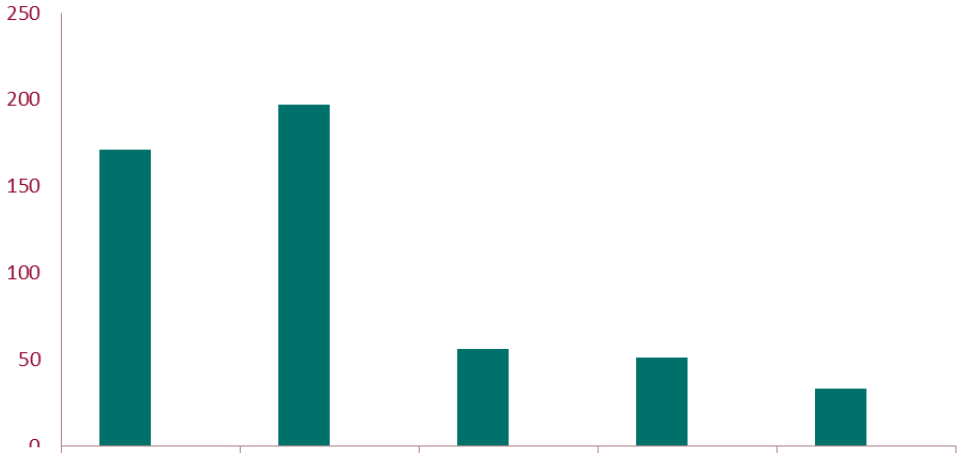


Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
36.73%	40.12%	8.38%	8.78%	5.99%
184	201	42	44	30

Answered: 505

Skipped: 1,455

This policy helps my service/organisation to co-ordinate and review safeguarding plans



Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
171	197	56	51	33
33.66%	38.78%	11.02%	10.04%	6.50%

Answered: 508

Skipped: 1,452

5.0 Results Qualitative Analysis

5.1 Introduction

Survey participants were given an opportunity to provide feedback on any aspect of the policy in a free text section at the end of the questionnaire. While the quantitative feedback provided many positive results in terms of how the policy is being interpreted and managed. The qualitative feedback is predominately providing information on where there are challenges. Some of these issues relate to policy specifics such as:

1. Capacity
2. Definitions

while other stronger themes focused on challenges in the procedural elements most notably in the following areas:

3. Providing Support for Staff
4. Clarity in the Community Referral Process
5. Management of Peer on Peer Abuse
6. Consistency of Safeguarding and Protection Teams
7. Requirement for a Cross Divisional Approach

Each of these individual themes will be expanded on in the following section.

5.1.1 Capacity

Some respondents felt that the policy in its current format is not comprehensive enough to give guidance, particularly following the introduction of the Assisted Decision Making (Capacity) Bill 2015. This is an issue that needs to be addressed as a matter of urgency. As part of this process training is essential, particularly *"on capacity assessment and capacity building with guidance required on for what to do if a person refuses consent for information to be shared with the HSE when that person is considered to have capacity"*

Furthermore respondents felt that *"issues of consent and capacity can sometimes be difficult to assess and therefore have an impact on whether or not a situation is regarded as abusive. Further guidance/ training in this area would be helpful."*

There was a suggestion that the word "capacity" in the definition of a vulnerable person should be changed to "ability" to make it more understandable.

The issue of capacity and self-neglect are inextricably linked. Some respondents reported a non-effective action regarding self-neglect once a person has capacity, which is frustrating. In situations like this, professionals need to provide a capacity assessment, which has been reported as "taking forever and sometimes does not happen at all until there is eventually a major crisis." In this context there was a lot of criticism of the manner in which self-neglect is addressed within this policy, as "*self-neglect issues are particularly problematic to manage. The client has a right to live the way they wish but this may not been seen by professionals as safe. With the new capacity act it will be complex to deal with this matter so this policy will need to take this into account in a clearer way."*

5.1.2 Definitions

In the feedback provided there was general criticism of the definitions included in the policy. Respondents felt that the current definitions were vague, they did not provide a clear definition of abuse types and participants interpreted them more as indicators of abuse. Specifically, the following issues were identified in relation to the categories provided:

- Sexual abuse- there is a need to consider historic abuse, inappropriate sexual language or intimidation via sexual language.
- Discriminatory abuse- this should consider a lack of knowledge of a person's disability specific needs. For example, a younger person who is, inappropriately placed, in an elder care facility due to lack of other options. This facility or the team may not be trained or equipped to understand the needs of a person with physical and sensory intellectual disability.
- Emotional Abuse- is not fully explored, particularly so, in cases of those with mental illness and intellectual disability. People who perhaps are coerced into antisocial acts, such as prostitution, also need to be considered in terms of those who are vulnerable.
- Definition of a vulnerable person- While the types of abuse are explored the actual definition of a "vulnerable adult" is not clear. This lack of clarity can lead to circumstances of people being labelled as "vulnerable" and being referred to Safeguarding Teams as a result.
- More clarity is required in relation to institutional abuse so that historical practices can be challenged
- Mental health professionals in their responses challenged the current definition of a vulnerable person and questioned its application, given their view that it is "paternalistic" and is "not fitting with mental health legislation.
- In relation to the rights of adults who become vulnerable, respondents felt that it is important that the human rights examples presented are contextualized in relation to relevant legislation.

5.1.3 Providing Supporting for Staff

It was evident from a number of responses received that staff feel vulnerable to false allegations, some have reported situations where there is a misuse of power on staff by the management. There is a clear need for greater synergy between the Safeguarding and Trust in Care policies so that all staff are clear in the knowledge that abuse will not be tolerated but due process is clearly defined. Additionally, a HSE National Chaperone Policy was suggested to help protect vulnerable patients and staff from false accusations.

The enforcement of a zero tolerance approach to abuse, particularly in the area of emotional and verbal abuse, presents a challenge for staff members-

"I work in an area where emotional and verbal abuse amongst families is very common and if I am now required to report my experience of this I feel I am in fact putting myself at risk in my workplace. Safeguarding is important, but don't forget that being an enforcer of a safeguarding policy immediately puts the worker in a more vulnerable position, especially in isolated lone worker situations."

Isolation and a lack of staff resources to manage concerns, once reported, have been indicated as a source of increased stress for front line workers.

5.1.4 Administrative Burden

The feeling from the ground is that while the policy is clear in context, the paper burden of separate reporting structures and templates under the Health Act 2007, Regulations 2014, i.e. the NF06 to HIQA along with safeguarding reporting in the form of the preliminary screening is placing a huge burden on the system. Further consideration is needed in respect of the level of paperwork required to adhere to a policy. *"It seems at times a paper exercise, is resource heavy and little emphasis on actual practice."* One respondent stated *"I work with residents that have great sense of humour and have lived here their whole life. I feel HIQA regulations and implementation of excess paper work that does not record anything new other than what is in the plan of care (restrictive practice forms for lap straps/bedrails) has taken from the care we provide, we are spending less and less time with the residents as the weeks go on which is to me is a form of abuse/neglect. it is not sustainable if this is to remain a home"*

Some respondents feel that the paper burden is acting as a deterrent to reporting. That the notification system is not working and is overly administrative, the process is weak for data protection, the language in the policy e.g. *'service users' is not appropriate for a national policy.*

Additionally it was suggested that "an online system of reporting would be more effective as the administration of forms and safeguarding plans."

5.1.5 Training

The importance of training provision is central in the success of any policy with respondents feeling that

"education on this safeguarding policy needs to be rolled out quicker to reinforce all healthcare worker's zero tolerance of any kind of abuse not just the obvious abuse, for example not obtaining the residents consent before proceeding with any care need, isolation, lack of activity, lack of social and many more interactions. "

There was an urgency regarding the requirement for training in other sectors with particular reference to the ambulance services within the acute services and mental health sector.

The current training commitment has been seen as a barrier to recruitment of volunteers

"I manage and recruit volunteers and while I feel it is essential that all volunteers are trained in Safeguarding of Vulnerable adults, the four hour training can be a barrier to recruiting volunteers. If there was a shorter version or on-line version it would help. Also, there is a shortage of trainers which further inhibits the training of volunteers. I have offered to become a trainer, myself, but have not been successful "

The demand for training is far outstripping the supply and this needs to be addressed particularly in the community-it was suggested that safeguarding needs to have a framework for working similar to Children First and should relate to all adults regardless of HSE division. It was felt that the *"Safeguarding policy does not reflect the complexities of this area"…..*when cognitive issues are involved and in its present format…. "is far too simplistic."

Additionally it was strongly stated that training needs to cover all health professionals including those in the private sector.

There was criticism of the roll out of the original training in that it preceded the appointment of some key individuals for example the Heads of Social Care in the safeguarding process and led to confusion in the system

The following ideas were put forward for the future to enhance the training provision

- Use a greater number of case studies

- Do a road show around services
- Have training provided that is specific to the responsibility a person will hold within the safeguarding process including management
- Enhance the training slides in terms of the language and content to focus on the culture, values and attitudes of staff in their everyday practice.
- There needs to be a separate and additional training module for senior management on their role in an organisational culture and how it impacts on the people supported by that organisation.

5.1.6 Clarity in the Community Referral Process

Evidence indicates that on the service side, the Designated Officer and procedural flow is working; however there are many challenges in the less structured, community based referrals. The requirement for greater clarity in relation to community based referrals emerged as a strong theme from multiple respondents from a cross divisional perspective. Specifically, the responses focused on the need for clarity in the following areas, role of Service Manager versus Designated Officer and challenges on case ownership and responsibility in community residing individuals in receipt of services.

The sentiment is that services feel overburdened by their service based referrals and many expressed concern regarding their capacity to also deal with community based referrals,

"As a D.O., I have found the community based referrals difficult to manage and NOT in line with the training (actions and recommendations by trainers). I have been placed in a position of responsibility which does not align with my role/responsibilities and training - the Safeguarding Team are reluctant to take ANY referrals which are community based - in practice, this means as a Line Manager, where my staff come to me to report a person deemed "at risk" I am making a referral which I am then asked to investigate/manage/review/report on - which has no relationship to my professional role. The process therefore will reduce referrals - as DOs will be slow to advise their own staff to make referrals which do not have any relationship to their own area of work. This is a very poor model/process which seems to have been put in place with good intentions but has quickly slipped into a place where the appropriate staff (VA Team) either does not have time/resources or the intention to do what it seemed they would initially be doing - i.e. Managing appropriate Community Based referrals."

"the expectations of funded agencies managing a whole safeguarding process for service users and their families, even where the agency has very limited involvement (e.g. providing 7 or 8hours

support per week out of 168 hours) and the expectation of HSE safeguarding teams that the funded agency will manage the whole safety plan and be responsible for it is unsafe and unreasonable. This policy has been designed to complete safeguarding on the cheap and to save money. A similar model to what happens in children's safeguarding should apply, here the management of cases should be the responsibility of the local equivalent of TUSLA child protection teams. Current vulnerable adult HSE teams are woefully under resourced and can only try to push back responsibility to funded agencies to resolve issues which they don't have the power or resources to manage."

Many services are not willing to take on concerns as contributors have expressed dissatisfaction with the manner in which the community safeguarding services have regressed since the safeguarding policy was established.

"Since the Safeguarding Teams came there is no one on the ground in the community to follow up on identified adults. We do not need 'consultants' who delegate to already overburdened and over stretched services who are struggling to cope with the demands of an aging population. We need case managers in the community to deliver the services to these clients."

While the policy has been complemented on its procedure for reporting a concern, there is a sense that those working in the community feel that there is a complete lack of accountability on the part of the HSE in their role within this policy."

This is evident in the following response-

"In particular I am concerned with responses by safeguarding to clients who are living in the community with significant cognitive impairment and no next of kin. While the policy is quite clear in areas as to the steps that should be taken in reporting a concern of abuse, there very wide gaps and interpretations as to what are the responsibilities of the statutory authorities. My general feeling is that there is a complete lack of accountability on the part of the HSE in their role within this policy. This is very evident in the absolute lack of follow through no the part of the HSE in following up on community referrals and investigating them from their end."

There is an acknowledgment that the policy is too service orientated, requires Designated Officers in the community and is too focused on referring to An Garda Siochána.

5.1.7 Management of Peer on Peer Abuse

There were multiple respondents illustrating the significant issue peer on peer abuse, particularly in residential services for those with an intellectual disability. More information is required on this topic, "*defined guidance would be invaluable".*

There was a wide variation in the consideration of peer on peer abuse from a zero tolerance approach

"Attitudes to peer on peer abuse need to change, and abuse is abuse regardless of who perpetrates it"

to an acceptance that is part and parcel of residential life particularly in the intellectual disability sector,

"those with an intellectual disability do not have the sense to know what is right and wrong and physical and psychological abuse is unintentional."

"Residents become like a family. Family disagreements and differences of opinion are not always abuse - no tolerance does not give space for these areas of disagreement. It could result in over reporting of cases."

"issues of concern arise as a result of people living together in congregate settings and/or as a result of the lack of choice historically associated with vulnerable people in access to residential services. …….safeguarding plans that identify real need to reform those residential services and provide people with real and meaningful alternatives in a timely manner are essential."

The feeling is that *"services are more likely to focus on safeguarding actions that are more local, immediate and ill equipped to address the underlying issue including in which the service provider or the HSE funder are identified as the alleged abuser on the grounds that with this knowledge a subsequent failure to make decisions which create those safer and quality of life based changes constitutes of neglect or institutional abuse*."

A proposed resolution to this issue included the suggestion of the introduction of a "well developed and robust threshold system, which focused on impact on resident being exposed and/or the requirement for careful planning where service users and frontline staff should be involved in the decision making process."

5.1.8 Consistency of Safeguarding and Protection Team

There are nine Safeguarding and Protection Teams in operation since 2015 which consist of a Principal Social Worker and social work staff at Social Work Team Leader and Professionally Qualified Social Work level. The teams link with the National Safeguarding Office on policy related matters while they are managed by the Head of Social Care within their Community Health Care Organisations.

The teams are newly established and comprise of some staff from the former elder abuse service.

At the outset a number of respondents felt that in their area support for elder abuse has been lost in the safeguarding policy/new safeguarding teams and that you had *" better access to services when had Elder Abuse Social Workers solely working on this issue."*

"The previous policy of reporting elder abuse was far clearer and broadening the definition of vulnerable adult and using term of safeguarding has made things more vague and unclear for referrers." How much a team engages with the older person in the community varies from team to team and represents a "huge challenge for vulnerable adults and service users"

While there were some positive responses regarding engagement with the SPTs-

> "*Many concerns are dealt with in a very timely and effective manner."*
>
> *"I have submitted referrals to SPT and I do think they have worked well."*

The majority of responses highlighted issues with the current operation of teams

> *"Teams are overwhelmed with their caseload making their intervention limited."*
>
> *"While responsiveness and delays in processing are key issues, more frustrating is the level of inconsistency"*

Key issues emerging include responsiveness/processing delays and inconsistencies between teams regarding their roles and responsibilities.

A number of respondents reported that they have found it challenging to ascertain the role and function of the teams. For many the introduction of the teams has led to a situation where the service is less, rather than, more accessible. This was summed up in the following submission,

"In the last few years I have found it more difficult to pick up the telephone for an informal chat with a social worker. Prior to this I felt I could more easily approach a social worker for an informal chat. I

strongly believe that it should be possible to do this and to feel supported. While I feel that robust structures must be in place, I do feel that it is essential that staff are warm and approachable so that I can best do my work. Currently I would dread having to contact a social worker because I would be concerned that it would not be supportive. I had one occasion to seek basic information in relation to a client (not to make a formal referral) and at the end of the conversation I felt more confused and unsupported. I think the importance of being able to get informal support and being able to clarify issues is vital and should not be underestimated."

Also respondents reported intra and inter team variation in the management of concerns particularly around the management of community based concerns.

"*While I or my colleagues may have concerns in relation to abuse it really depends what part of the country one refers to, to determine what response one gets! There is never a clear policy on how a suspected case might be dealt with!"*

There appears to be an issue regarding communication between referrers/services and some of the teams,

"The Safeguarding Protection Teams communication is poor following referrals and it is not clear what their role is in terms of providing an actual assessment of referrals to their service."

Responses from Safeguarding and Protection Team staff varies on what constitutes a reportable scenario as well as whose responsibility lies where, with regard to community based referrals. Often organisations are expected to enact safeguarding plans for people they are not funded for.

"Clarity on mental health and how they deal with safeguarding needs to be confirmed…….mental health services adhere to the definitions, principles and values but not the reporting guidelines of the policy. I have found that prior to the onset of this policy I would refer elders at risk of abuse to the elder abuse social worker, e.g. elder parent of a mental health service user at risk of abuse from an adult child; the elder then had their own social worker who advocated for them. Now with the S&PT's - they do not take up these referrals but advise mental health on safeguarding; the elder then misses out on having their own independent social worker who will advocate for them. Less effective service for the elder I believe."

In terms of the responsiveness of the teams, there were a number of respondents that focused on challenges that they faced

" the delay in responding to submissions to the Safeguarding Office is often significant."

"No formal correspondence received in relation to referral status."

"there is poor communication back from the teams" and you are "unsure if concern is being dealt with" often it has taken 6-8 weeks to get a response to a serious concern. Additionally the necessity to have a weekend service was highlighted as a concern

The responses focused on two man areas of resources, staffing to manage concerns and resources available to facilitate safeguarding planning

A. Staffing to manage concerns

"Currently the main issue across age span is the significant impact of National Safeguarding Policy on Social Work time and resources. A policy of zero tolerance has resulted in a considerable growth in referrals. In the absence of clinical thresholds, all referrals require time to process regardless of severity. In addition the time required to prepare and deliver staff training has also risen sharply. This increased demand impacts on the availability of other social work services and practice, i.e., reduced availability for non-safeguarding related work or other crisis work (e.g., general ongoing social work support, home visits, one to one work with service users, group work, planning, training, educational developmental and preventative work, advocacy, and/or frequently not having the time or having to cancel appointments with families to ensure safeguarding work is completed). It is IMPOSSIBLE +++ to cover all the safeguarding referrals in the time allocated, especially as you may get two one week and ten the next. Also social workers no longer have the time to carry out the one to one or group work that is essential in supporting service users and families. ALL of my work now is about filling in the forms and I feel that I may as well work as an administrative civil servant. I feel in SOME cases outcomes are worse for service users as staff and social workers actually have less time for being present with service users and the safeguarding process is in danger of doing the opposite of what it intends."

B. Resources available to facilitate safeguarding planning

There was a strong sense of frustration in the responses received pertaining to safeguarding planning. All too often *"recommendations are not able to be implemented due to lack of funding, which means we recognize a risk but can do nothing about it in any effective manner as we do not have the resources."*

While effective in making people much more aware of what constitutes abuse and acting on any suspicion of the same *"once the referral goes to safeguarding TEAM ,(or person as the case seems to be) they have little or no emergency resources to pull from . No emergency care , no immediate responses for vulnerable adults in the community and no extra funding for Home care if it is needed ."*

5.1.9 Requirement for a Cross Divisional Approach

It is evident from the responses that there is strong desire to have this policy established on a cross divisional basis. In fact, there was a significant contribution to the qualitative feedback provided to the survey from those within other divisions', most notably mental health. The requirement for expansion of the policy was best described in the following submission,

"This needs to be a whole-HSE policy- not just for one division. After all, we deal with patients not categories. If someone is living at home, they may be a service user of primary care, social care (home help) and mental health as well as the acute service- depending on the service that they are using at the time, the current safeguarding policy may or may not apply. We are one organisation!!!!"

From the feedback received there is a strong sense of engagement with the safeguarding agenda within the mental health services however they are faced with challenges. It was suggested that the future policy could consider the expansion of the safeguarding teams remit into mental health to *"ensure specialist skills and sufficient time and resources are dedicated to safeguarding and to the prevent dilution of therapeutic resources in the mental health services or inclusion of the revised policy within the workings of the community mental health teams. "*

Additionally the issue of old age psychiatry cases not being dealt with consistently by the teams was identified as an issue, considering the fact that they were included within the elder abuse service

"Vulnerable adults who have addictions and dual diagnosis may benefit from being clearly framed and highlighted within this policy."

Where mental health services have engaged with the policy, in terms of adopting its principles, they have met with resistance in terms of multidisciplinary shared responsibility. This can only be addressed through education and training on a cross divisional approach,

There has been no training rolled out for the Mental Health Service who are not covered under the existing policy though are required to act in safeguarding capacities. MDT staff are not aware of their responsibilities and expect Social Work staff to take on full responsibility for safeguarding. Social Work staff in Mental Health are being asked to take on the role that a specialised service is dedicated to - without additional staff, staff training, clear procedures, protocols and specified tools at their disposal. This is on top of new and demanding expectations with regard to capacity legislation.

In primary care, the responses received advocated the need for any future policy to require adequate resourcing summed up by the following

"of course the PHN service are competent to deal with safeguarding issues but they cannot be expected to take on this responsibility without resources, considering 95% of older persons live at home. "

"The Policy clearly sets out its aims ,it is the follow through is the confusing part as a clients often bounces between primary care, social work and safeguarding team and all the while the clock is ticking for the client"

The structure and management of concerns in relation to Primary Care was summarised in the following quote:

"The threshold for the assessment of abuse is unclear. Assessments of abuse should be completed by the Safeguarding Team, but where there is a Social Worker in Primary Care, the Safeguarding Team is requesting that these assessments of abuse are completed by the Social Worker in Primary Care. This is not the role of the Primary Care Social Worker, in the same way that assessing allegations of child abuse is not the role of the Primary Care Social Worker and TUSLA would never ask that we would complete this type of assessment as this is outside our remit. The Safeguarding teams should be sufficiently resourced so that they are assessing abuse concerns, not requesting that Social Workers in other roles complete these assessments."

There appears to be a lot of uncertainty around roles and responsibilities within the Mental Health Service and how they interact with the Safeguarding Teams. "*As it stands we work the case as we would normally (as we are led to believe Safeguarding Teams are not working cases where the Mental Health Service works with the alleged victim) This is easier for me as a Social Worker but my concern is that any allegations of abuse or neglect will come to me from my team to look into when the Safeguarding role should be everybody's responsibility. I do understand there is a bill drawn up to place the policy on a more statutory footing as my experience so far is that it can be difficult to*

proceed in any meaningful way with a plan without alleged victim's consent (which is also right and understandable but leaves a person vulnerable to further abuse)."

"As a clinician in the mental health division I am concerned that in the first instance we do not have any policy currently or procedures to manage safeguarding concerns. When a referral goes to the safeguarding and protection team they have outlined that the investigation should be conducted by our service. That is concerning on a few levels. Our clinicians do not have the expertise or skills to investigate allegations of abuse. Our role is to offer mental health treatment and support to service users who have been subject to abuse. The expectation that we have a dual role to investigate and offer mental health service is problematic as a service user can readily then choose to discharge themselves from mental health services thereby leaving their mental health at risk and unsupported and the safeguarding risk outstanding. I strongly feel an independent agency needs to be developed who has the responsibility to investigate safeguarding concerns and our service to feed in to that safety plan accordingly. The real danger is that staff, consciously and unconsciously, will avoid reporting concerns as they do not wish to have the responsibility to investigating abuse (i.e. convening strategy meetings, case conferences etc.) as they do not feel confident to do so and do not wish to have that role."

6.0 Conclusion

From the outset it must be acknowledged that this survey generated a huge response rate which illustrates the level of engagement with the safeguarding agenda across health and social care services within and external to the HSE. There are many positives to take from the responses received in terms of the level of understanding of the purpose of and who the policy is intended to cover. It is clearly educating individuals on their responsibilities to service users, both in recognising and responding to abuse.

The qualitative feedback indicates where there are challenges that need to be addressed, some of which relate to the as-is situation while others link to frustrations in the fact that this policy is not cross divisional in nature. It is essential that the Review Development Group give due consideration to this feedback received, in ensuring that we build on the collective experience of staff who have worked the current safeguarding policy, while addressing the key issues and challenges.