Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Adult Safeguarding Policy: DHSSPS Officials

15 October 2014

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Ms Paula Bradley (Deputy Chairperson)
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr Fearghal McKinney
Mr George Robinson

Witnesses:

Ms Linda Johnston	Department of Health, Social Services and Public Safety
Ms Eilís McDaniel	Department of Health, Social Services and Public Safety

The Chairperson (Ms Maeve McLaughlin): We have Eilís McDaniel, director of family and children's policy in the Department, and Linda Johnston, from the office of social services. You are very welcome. I invite you to make a 10-minute presentation, then we will it open it up to members.

Ms Eilís McDaniel (Department of Health, Social Services and Public Safety): Thank you, Chair. The Committee has asked officials to provide evidence today in connection with the adult safeguarding policy. At this stage, you should have received a copy of the draft policy and the associated consultation paper. It is our intention to consult on the policy in the near future. The development of the policy is one measure in a package of measures to improve safeguarding outcomes for children and vulnerable adults in fulfilment of a Programme for Government commitment. I would like to give members a sense of what the policy is intended to achieve, describe the key policy themes and set out our plans for publication.

The policy promotes zero tolerance of adult harm. It aims to prevent harm occurring in the first place and, when harm does occur, ensure that effective protection responses are made by police and social services, assisted by other agencies where appropriate or as required. It moves away from current "vulnerable adult" terminology and, instead, introduces definitions of adults "at risk of harm" and "in need of protection". The point being made by the Department is that, while adults may have characteristics that increase their exposure to risk, risks are realised only when others abuse or exploit those characteristics or are neglectful of the needs that they may generate. The policy defines harm and abuse, which includes physical, emotional, sexual, financial and institutional abuse. It also recognises that adults can be at risk of harm due to particular life circumstances; for example, living in isolation, living in poverty or being homeless.

Unlike child safeguarding, safeguarding adults at risk requires consideration of the interlinked concepts of consent and capacity. Assuming that they have the capacity to do so, some adults may choose to act in ways or to consent to things that others may not approve of or may consider unwise. In those circumstances, some adults may or may not want to be safeguarded by others. The best that we might be able to do is to help them to make as informed a choice as possible. Where adults lack the capacity to consent, we need to ensure that they are afforded maximum protections. That is reinforced by the Mental Capacity Bill.

The policy requires that links be made between adult protection processes and other established processes for dealing with victims of human trafficking or domestic violence, for example. As I said, the policy aims to deliver prevention and protection in equal measure. It places lead responsibility for protection with the police and social services but recognises that prevention requires the efforts of us all in our interactions with adults at risk in their homes, in the communities where they live and in places where they go to partake in activities or to access services.

The prevention of adult harm requires effective public health and community safety policies and strategies. It also requires individuals in both community and organisational settings to recognise harm and to know how to report it when it occurs, or, just as importantly, when it is at risk of occurring. In organisational settings, the policy promotes robust internal and external governance arrangements; in care settings, for example, in nursing and residential care homes. There is a key role for bodies such as the Regulation and Quality Improvement Authority (RQIA), for care managers and contract managers, all of whom need to have keeping adults safe firmly on their agenda. Likewise, those responsible for providing or managing care in those settings need to have robust mechanisms in place to ensure that the safeguarding needs of service users are being fully met. All those messages are clearly articulated in the policy, which we aim to publish finally in March 2015. That will require us to issue the draft policy for consultation in November.

We have always considered that the adult safeguarding policy may need to be underpinned by legislation, and the research by the Commissioner for Older People is very timely in that regard. I welcome the commissioner's research. It has coincided very neatly with the development of the adult safeguarding policy, which is a joint policy exercise between this Department and the Department of Justice. We have been engaging with the commissioner in the course of our research, and officials attended a round-table event organised by the commissioner's office. Helpfully, we were given the opportunity to comment on draft research reports. At the same time, drafts of the adult safeguarding policy have been shared with the commissioner's office.

It is intended to seek views on the commissioner's legislative recommendations and those issues that she feels should be given further consideration as part of the consultation on the policy. Question 28 in the consultation paper deals specifically with the commissioner's recommendations. While supportive of what the commissioner is seeking to achieve, we have some reservations about particular recommendations. There is also the issue of recommendations being restricted to older people, which the commissioner's remit clearly limits her to.

We have reservations about some recommendations; for example, the introduction of a power to enter an individual's home or the power to remove an individual where there is a real risk of harm, and the introduction of a tension with an adult's right to autonomy and the right to respect for private and family life. While we have reservations on those grounds, we have to acknowledge that a power to enter already exists in Wales and Scotland, but we understand that it is very rarely used. In addition, the police already have powers of entry in specific circumstances, and social services have the power to remove a person under the Health and Personal Social Services (Northern Ireland) Order 1972. The Mental Health (Northern Ireland) Order 1986 also provides social services with the power to require that an individual who lacks capacity reside in a specific place for the purpose of keeping them safe.

The commissioner also recommends the introduction of a duty on identified relevant organisations to report suspected abuse or harm to the appropriate body. Under the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, which we are still in the process of implementing, there is already a wide-ranging duty to refer to the Disclosure and Barring Service in circumstances where a vulnerable adult has been harmed or placed at risk of harm. The commissioner also recommends the establishment of an adult safeguarding board, empowered by statute, to act as an oversight body to protect older people at risk of harm. This would be the adult equivalent of the Safeguarding Board for Northern Ireland (SBNI).

We already have a non-statutory adult safeguarding partnership for Northern Ireland, led by the Health and Social Care Board (HSCB). It was established under policy direction from the Department and

the Northern Ireland Office, prior to the devolution of justice and policing. We have some reservations about moving to a statutory model at this stage in light of proposals to review the SBNI, which we can learn from, and the changing face of adult safeguarding in Northern Ireland. We recognise that legislative provision, as it relates to adult safeguarding, is contained in a number of statutes, and we appreciate that the commissioner is seeking to bring those together into a single statute.

Just to make the Committee aware, the Northern Ireland Adult Safeguarding Partnership produced a practitioner handbook a short time ago that sets out all the legislation considered relevant to adult safeguarding. Although we have some reservations about what the commissioner is recommending, either because they cut across legislative provision already in place or there are concerns about how they may play out in practice, it is intended to seek views on all the recommendations in the public consultation exercise, which, as I have indicated, should start in November 2014.

Chair, that concludes the presentation. Linda and I are happy to take questions from members.

The Chairperson (Ms Maeve McLaughlin): Thank you for that, Eilís. It is an important piece of work. I want to pick up on a couple of specifics. There is the safeguarding policy, but you have said that you have always considered that that should be underpinned by legislation. I want to tease that out a wee bit more. You went on to say that there were almost reservations about some of the recommendations. Could you expand on that? I noted that you said that it may cut across some legislative processes that are already in place.

Ms McDaniel: We have relevant legislation already in place in a number of different pieces of legislation; I have given a couple of examples today. We have the HPSS Order of 1972 and the Mental Health Order of 1986, which provide powers or duties similar to some of those being recommended by the commissioner. I have also made reference to the safeguarding vulnerable groups legislation, which includes a duty to refer individuals who have harmed a vulnerable adult or placed them at risk of harm to the new Disclosure and Barring Service that operates across England, Wales and Northern Ireland.

I am not discounting moving to an adult safeguarding Bill. However, if we do that we need to consider what other legislative provisions we have elsewhere, possibly with a view to repealing them if necessary. That is the only point that I am making. I appreciate what the commissioner is trying to do by bringing it altogether into a single piece of legislation.

The Chairperson (Ms Maeve McLaughlin): You talked about it being reinforced by the Mental Capacity Bill. Could I explore that with you a wee bit?

Ms McDaniel: One of the key underpinning principles of the policy is that we need to consider the consent of adults to being safeguarded. Consent is very closely linked to capacity. Some individuals may not have the capacity to consent at all. The reference to the Mental Capacity Bill is simply because it is intended to introduce further protections for adults who lack capacity. What we are trying to do in the policy is totally in keeping with the aims of the Mental Capacity Bill.

The Chairperson (Ms Maeve McLaughlin): I go back to the point that this is a policy that is due to go out to consultation. First, do you have timelines for that? Secondly, if a decision is taken that there needs to be a legislative approach, when are we talking about? Are we talking about the next mandate?

Ms McDaniel: Absolutely. The intention is to go out with consultation on the policy in early November, conclude that within 12 weeks of the commencement date, and have a final policy in place by March 2015. We will then need to consider whether we progress an adult safeguarding Bill. It is highly unlikely that that work would be done in time to introduce anything in the current mandate. In our Programme for Government commitment, we refer to the possibility of a piece of adult safeguarding legislation and indicate that it would not be done in the current mandate. It will be for the next mandate. The point that I am making is that it is impossible to do in these timescales.

The Chairperson (Ms Maeve McLaughlin): On a general point, we recently heard media reports here, in England and elsewhere about the abuse of our elderly community taking physical, financial and all sorts of forms. I know that you are talking about the policy, but it is important that the North of Ireland step up on this. There are models of how it has been done elsewhere.

Ms McDaniel: We have been looking very closely at what has been done elsewhere. We have looked at legislation in Scotland and are monitoring legislative developments in other parts of the UK.

The policy is intended to be a starting point for us. It supplements some of what the Department has done in adult safeguarding over the last couple of years. We have engaged in awareness-raising activity, which has led, for example, to the increase in the numbers of referrals to social services. We also thought it essential to put in place what we term the adult safeguarding infrastructure, which includes the Northern Ireland Adult Safeguarding Partnership and five local area safeguarding partnerships that are centred on each of the five trusts.

One of the other more significant things that we did was to work with Volunteer Now to produce a set of adult safeguarding standards for use by the voluntary and community sector and the independent sector. So, we have already put building blocks in place. That will be supplemented by the policy, and legislation would take it to the next stage, if it is confirmed and agreed that that is where we need to go.

The Chairperson (Ms Maeve McLaughlin): So, the door is open in those discussions.

Ms McDaniel: The door is absolutely open. That is why we are seeking views in consultation on the policy.

Mr McCarthy: Thanks very much for your presentation. I offer support for the work that you are doing. Have you any idea of the numbers of vulnerable adults in Northern Ireland or the scale of abuse that they are open to?

Ms McDaniel: We do not have the number of vulnerable adults, but we have the numbers of referrals to social services on the adult protection side. In 2013, we had more than 7,500 referrals to social services of an adult safeguarding nature. That does not necessarily mean that all 7,500 were actually abused, but it represented a 36% increase on the previous year. As I said to the Chair, some of that can be attributed to the awareness-raising activity that has been undertaken both by Departments and the Northern Ireland Adult Safeguarding Partnership. That is a significant number of referrals, and it continues to grow. In the Programme for Government commitment, we set a target based on the numbers increasing over time, and that has proved to be the case.

Mr McCarthy: How does it compare with other regions? Do you know?

Ms McDaniel: I do not know, off the top of my head.

Mr McCarthy: Finally, who are the main partners in the community and voluntary sector that can best assist you in prevention and detection?

Ms McDaniel: There are voluntary and community sector organisations of relevance; Age NI is an obvious example. The Adult Safeguarding Partnership arrangements include representation from the faith sector, for example. The faith sector does very valuable work with vulnerable adults, predominantly in their home or through activities organised by the faith sector. There is a pretty significant membership of both the regional and the local partnerships from among the voluntary and community sectors.

Mr McCarthy: Working together.

Mr McKinney: What is the definition of harm? How is it measured?

Ms McDaniel: I will turn to my learned colleague on the right, but I will start by saying that we define harm as something that consists of abuse, exploitation and neglect. Linda will say a bit more about the different kinds of abuse that the policy refers to. I gave you examples in the opening statement. We are talking about physical abuse, financial abuse, sexual abuse —

Mr McKinney: That is abuse, but how do you define harm?

Ms Linda Johnston (Department of Health, Social Services and Public Safety): We have looked at harm in terms of the impact that it has on the person and how they experience it. It may not be a

major incident, but it may have a major impact on the individual. The criteria of harm and serious harm are very much based on discussion, professional judgement and working with the person in their circumstances to understand how that harm has impacted on them.

Mr McKinney: So, it is about how it impacts. How do you measure that if, for example, two people react differently to what could be recognised as a single act? I may not see it as harm, but someone else might.

Ms Johnston: It is about working with that person through their choices in their circumstances. The response will be determined by what that person wants to see as the outcome of the incident. It is the impact of harm having occurred and then what you do about it together to address it, what the best outcome would be for that person, and who needs to be involved in achieving that.

Mr McKinney: My question centres on how you measure it. How do you satisfy those in authority that, in fact, harm has been caused if, on the one hand, I feel that harm was caused and, on the other hand, a colleague or someone may not feel that way?

Ms Johnston: There are a number of thresholds in the policy looking at the measurement of harm and what might constitute serious harm. It might be about the frequency of an incident or the number of people it affects — whether it is one person or if there is a risk to other people. It is not so much a scale; it is just looking at that whether in that person's circumstances there is a threat to others, what the threat is, and who it is from. Is it from someone close to the person? Is it a family member or a member of staff? So, a range of thresholds would be applied, which would be a matter for discussion between the professional and the person involved.

Mr McKinney: Could harm be caused by neglect through the lack of provision of something?

Ms Johnston: Yes, that is one of things that I am looking at: whether people's needs are being met, how they are being met, and whether they are being met appropriately. If a person is not being provided with a service that they require, or somebody has neglected to provide medications or some aspect of care, that would be deemed neglect.

Mr McKinney: So, in that context, the absence of legislation around goods, facilities and services could, itself, be seen to be the government harming, because we do not have that legislation here.

Ms McDaniel: Under the Health and Personal Social Services (HPSS) Order, for example, there is a duty to provide health and social care and services to people who are deemed to need them. I am not quite certain about where you are coming from.

Mr McKinney: In England, for example, there is the Equality Act 2010, which provides for people to access services as of right. We do not have that legislation here. So, at a certain age, I can be denied facilities, goods, services, education etc.

Ms Johnston: The Health and Personal Social Services Order requires that, where the assessment identifies needs to be met, it is the duty of Health and Social Care to provide for those needs.

Mr McKinney: But we do not have the legislation here to back that up in goods, facilities and services legislation. As I understand it, that exists in England, under the Equality Act 2010. You are legislating for that when harm comes, but, as far as I can see, there is a gap in the market because we can legitimately not provide for somebody. If there are limited cancer drugs, a 75-year-old could be denied them in preference to someone who is younger. Is that not harm?

Ms Johnston: There is a requirement under the Health and Personal Social Services Order to provide for assessed need. If there is an assessment, there is a requirement to provide in order to meet that need.

Mr McKinney: That is, specifically, not the case. We know, for example, on cancer drugs — I do not want to lean on that as the issue but as an illustration — that such drugs are available but are not provided. So, that is not true. There is a gap. Are you not reaching beyond that for harm? I am not saying that that is a bad idea; I am saying that it points out that there is a big gap with respect to our legislation, which, I understand, is sitting in OFMDFM with nothing happening.

Ms McDaniel: I am not familiar with the 2010 Act that you referred to. Maybe that is one of the things that we need to look at. The point that we are making is that there is legislation in place in Northern Ireland that requires us to provide health and social care services to those whom we deem to need them. I do not think that we can disregard that that legislation exists.

Mr McKinney: Do you accept the point that I am making that it is pointing to another gap, in the sense that people can be discriminated against by virtue of their age? You are saying that there is the potential for negligence in that, where a treatment or a facility is not provided, that can constitute harm.

Ms McDaniel: The point that I am making is that it depends on whether it actually constitutes harm.

Mr McKinney: That is why I asked as well.

Ms McDaniel: I now understand your question.

Mr McKinney: That is why I asked what "harm" is and how you define it. If you were taking it right back to refer to a sense of harm to an individual, then you are going to protect someone against potential harm, but, on the other side, that person does not have the right to avail themselves of your service.

Ms McDaniel: The policy has scope, and I think that it is limiting the definition of harm to abuse, exploitation and neglect. We define what we mean by "abuse", and I have given you examples of what that is. I do not think that the policy will be able to deal with any form —

Mr McKinney: No, and it is legitimate to point out a potential flaw in the thinking.

Ms McDaniel: OK.

Mr McKinney: Thank you.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thanks very much for the presentation. According to cases where people have experienced harm, which setting is most likely? Is there one setting from where the majority of cases arise?

Ms McDaniel: We have the statistics based on programmes of care. I will give you that information in the form of a list: in 2013-14, the greatest percentage of referrals to social services — again, this is not necessarily confirming that adults were abused — showed that older people were at the top of the list, followed by adults with a learning disability, those with mental health difficulties, then those with physical disabilities, and the fifth category is referrals from hospital social workers. That does not necessarily answer your question in the sense of where that is happening. It can be happening anywhere. It may be happening in an institution, in a nursing home or a care home, but it could also be happening in an individual's own home. We have a figure for institutional abuse, and the percentage is really very low for the latest published statistics; it is in the order of 1%. However, that does not necessarily mean that, when there is a referral relating to an older person, that older person was not residing in a care home.

The statistics are difficult to read, and we have concluded that we probably need to be a bit more sophisticated about their collection. We may need to collect information in a different way or to collect more information than we are doing.

Ms McCorley: It would be important if you could identify whether there is somewhere where it is more likely to happen, as a greater focus could then be put on that setting.

Probably everybody is aware of the kind of cases that you see on television, and I am reminded of those that happened in a private home where there was a carer who came in. Can your policy stretch to cover those circumstances? It seemed to me that families had to put in photographic equipment to get the evidence to prove what was going on, and I think that that presents difficulties. Will your policy cover that?

There is another aspect. I am talking about a particular case that was brought to my attention by a constituent. It was about a person who is a carer and who was accused by an elderly person of stealing. Now, I know that that can happen when people have Alzheimer's — it is a feature — but that

person was suspended from work and, I would argue, suffered great harm psychologically and emotionally and has not been the same person since. Does your policy cover harm experienced by the carers as well, or by people who are put into vulnerable situations by the nature of their work? They are made vulnerable by the nature of their work. I understand the complexity of it, but there are different kinds of harm and I wonder whether your policy will cover the range of circumstances where in which can experience harm.

Ms McDaniel: It is intended to cover all of those circumstances. The key thing about the policy, which probably sets it apart from policies linked to adult safeguarding in the past, is the emphasis on prevention. There is a range of measures that could be put in place to ensure that harm does not occur in the first place. The key to that will be the empowerment of individuals so that they are facilitated as much as they possibly can be to keep themselves safe. Financial abuse is covered by the policy, although I do not think that it is covered in quite the way that you intend it to be covered. Is there anything that you want to add, Linda?

Ms Johnston: The breadth of the policy means that safeguarding is everybody's business and everybody needs to respond, no matter what the setting. I take your point about carers being suspended. There are very complex and difficult processes that the police and social services manage. It is difficult for everybody working through those investigations, and we are all too aware of their impact on others. In the policy, we do not address the impact on others. It deals with the impact on the person being abused.

Ms McCorley: This person was in a state of shock about what happened as a result. Perhaps, if employees were alerted to what the procedure would be in such circumstances, they would not be as shocked. That woman, after maybe 40 years of working in the sector, was deeply shocked at how she felt that she had been treated. In retrospect, she was probably treated fairly, but she did not see it that way.

Ms Johnston: A range of other policies and procedures will need to be reviewed in light of the direction of this policy. That needs to be addressed operationally when we work through the procedures.

Mr Dunne: Thanks very much for your presentation. Do you see the safeguarding policy being proactive, or will it be reactive to different situations? What is its main objective?

Ms McDaniel: It is both proactive and reactive. As I said in my opening statement, it is designed to deliver prevention and protection in equal measure. I think that we better serve adults at risk by seeking to prevent their being harmed in the first place. However, we need to make certain that protective supports and responses are there when they need them. Principally, protective responses are provided by police and social services.

Mr Dunne: Do you feel that prevention will be made a priority? Is that what you want to come out of the policy?

Ms McDaniel: We certainly want a focus on prevention but without taking our eye off individuals who might have been harmed. The aim of the policy is to put in place a range of measures that delivers a preventative agenda.

Mr Dunne: I think that we were all shocked, distressed and saddened by the institutional abuse cases in the media. It is unbelievable that those things happened in recent years. In this day and age, we feel that there is openness and many ways of reporting. We think that systems and processes are in place in institutions, organisations and government agencies, yet that happened. What kind of assurances can you give to us that such abuse will not recur following the implementation of the policy?

Ms McDaniel: I cannot possibly give you that assurance. I do not think that we could say definitively that, as a result of this policy, no older person or adult with a learning disability will ever be abused again.

Mr Dunne: I appreciate that, but you said that the emphasis is on prevention. The institutional issues are huge. It is so shocking and distressing to think that that happened within our lifetime, and no one knew about it or seemed to take any action. What can be done to stop the recurrence of such cases?

That is an important element of any policy. Of course, the policy is only one aspect of this. How it is actioned and its outworkings are more important.

Ms Johnston: The policy message is that the governance arrangements for all organisations, internal and external, need to be strengthened. The regulation, commissioning, contracting and care management roles — all the professionals involved and all those managing the care — need to make sure that all those processes are pulled together and triangulated in a much stronger way. The policy message is that there are triggers and signs, and we need to pick them up earlier. The early intervention and prevention message is intended to make sure that those issues surface and are disclosed and that the appropriate reporting mechanisms are in place. As I said, the policy needs to be underpinned by more operational policy and procedures to make sure that it takes effect. Our message is definitely that we need to be stronger on picking up the triggers.

Mr Dunne: We need to see openness and transparency. How do we assure the man on the street that that will happen? Will it be through the Regulation and Quality Improvement Authority (RQIA)?

Ms Johnston: The RQIA is one of the key players, as are training and raising staff awareness. The registration of social care workers is a key tenet of making sure that everybody coming into the care sector is appropriately registered and that their professional standards are overseen. If non-registered individuals are detected in the system, they will be referred to the Disclosure and Barring Service, put on its list and prevented from seeking alternative employment. There is a range of measures that, if pulled together, should help to strengthen that.

Mr Dunne: One of your points was about a consent-driven approach. What happens if that consent is not forthcoming? Do we ignore the case? How do we work round it?

Ms McDaniel: Assuming that the individual has the capacity to consent, which is a key consideration, that does not simply mean that you walk away when somebody says that they do not want you to be involved. It is about working with the person to ensure that they understand the choices that they are making and providing them with as much information as possible to help them to make the best possible choice. It is about working with the individual, not just walking away when they say that they do not want social services, for example, to be involved.

Mr Dunne: Finally, how do you inform the public about what abuse really is? How do you make people more alert to the risks to their family and to the public generally? What do you plan to do?

Ms McDaniel: We have already done some work on that. A few years ago, the Department, working with the Northern Ireland Office, produced awareness-raising leaflets. One targeted the general public; the other targeted staff working with adults at risk. I made the point already that some of that work has probably led to the increase in the number of referrals now being made to social services. So, we can say with greater confidence that people are probably more aware of adult harm and its effects and are less willing to walk away when there is evidence that an adult may be being harmed.

Mr Dunne: Will increasing public awareness be part of the implementation of the policy?

Ms McDaniel: We need to consider what else we can do to raise public awareness. Let us get the policy in place first and then supplement that with a range of other measures. The legislation is, potentially, one of those measures, and raising awareness is also part of the picture. The Northern Ireland Adult Safeguarding Partnership has engaged fairly significantly in awareness-raising activities, which is part of its strategic plan.

Mr McGimpsey: Thanks, Eilís, for your very comprehensive presentation. This is a very difficult area, and it is a very difficult ask to promote zero tolerance of harm in order to protect people. Gordon talked about institutions, and I can see that you can put mechanisms and safeguards in place that bear down on abuse there, but you have 7,500 referrals of adult abuse a year. That figure is up 36% on the previous year, which is a huge jump. So, you face a very big task in producing this policy. The hit list of victims are older people, including those with learning disabilities or mental health issues.

You also referred to mechanisms that interface with adult protection arrangements. That interests me. It includes domestic violence, human trafficking and hate crime. What size is that problem as a proportion of the overall problem? How can you impact on that more than the police and the courts?

You have policies on domestic violence and you work with the police, but I am not quite clear how you think that your policy can impact on that.

Ms McDaniel: There is a direct link between this policy and policies governing other issues, including human trafficking and domestic violence. We already have the multi-agency risk assessment conference (MARAC) arrangements in place to deal with the most at-risk victims of domestic violence. Those are police-led. The general messages from this policy are as relevant to victims of human trafficking and victims of domestic violence as they are to adults more generally. That is why the policy says that generic adult safeguarding needs to make certain that it is connected with those more specialist responses to victims of human trafficking or domestic violence, which are the two examples that we give.

There are figures for human trafficking in Northern Ireland, and they are based on referrals to the national referral mechanism. They are relatively small in number compared with victims of domestic violence. I cannot tell you off the top of my head how many victims we have in Northern Ireland, but I can tell you that that information is collected through the MARAC arrangements.

Mr Brady: Thanks for the presentation. I have more of a comment than a question. You talked about statistics earlier. I read an article about three years ago on the abuse of elderly people. It stated that about 4% of the elderly population were in residential homes, but 23% of the calls to the helpline came from residential homes, which is totally disproportionate. You said that you need to be more sophisticated. I take it that, given that disproportionate figure, you will go forward on an evidential basis. As our elderly population increases, there will be a greater need to drill down into the type of complaints and the safeguards and prevention that are put in place. You mentioned that institutional abuse was at 1%. So, it would seem that that is reducing, but there is no evidential basis for that.

Ms McDaniel: I think that I have made the point that our data collection probably needs to be slightly more sophisticated.

Mr Brady: Maybe a lot more sophisticated.

Ms McDaniel: Improvements have been made over the last number of years, with the introduction of the new Adult Safeguarding Partnership arrangements and the establishment of specialist posts in the Health and Social Care trusts. There is probably a bit more work to be done, but my point is that fairly significant progress has been made over the past couple of years.

The Chairperson (Ms Maeve McLaughlin): Thank you for that detail. What you are hearing from the Committee today is that it is important that we advance the consultation on policy but that the focus is on the increasing incidence of abuse, and that is documented by the partnership. These are the figures that I looked at: 1,715 incidents in 2011, rising to 3,023 in 2014. If this is ultimately about prevention and protection, that needs to be underpinned with some sort of legislative framework. We have an opportunity to step up. Thank you for your presentation. We look forward to continuing the conversation as this develops.