Isle of Wight

Safeguarding Adults Board

Annual Report

April 2014 – March 2015

Contents

Foreword

This report reviews the work of the Isle of Wight's Adults Safeguarding Board over the twelve months from April 2014 to April 2015. It has been the first full year in which the Board has operated in its present form with an Independent Chair.

During this year, work has been undertaken on two Serious Case Reviews, and this report will briefly outline some of the issues highlighted by those reviews. In future, under the Care Act, these reviews will be referred to as Safeguarding Adults Reviews and will be undertaken when someone dies in circumstances in which neglect or abuse may have been experienced. The purpose of these reviews is to learn lessons and improve practice in ways that avoid a repetition of any abuse or neglect. It is not to allocate blame. If there is police action required, then that action will be taken and completed before any Review is undertaken.

This year much work has been completed with colleagues in Hampshire, Portsmouth and Southampton to revise Hampshire- wide policies and procedures in anticipation of the Care Act implementation in April 2015. The support, particularly from Hampshire colleagues who led the re- writing of the policies and procedures, was much appreciated. A list of the policies that have been revised will be provided in the next section of this report.

The partners to the Isle of Wight Safeguarding Adults Board are:-

- The Isle of Wight Council
- Hampshire Constabulary
- The Isle of Wight Clinical Commissioning Group
- The Isle of Wight NHS Trust
- The Ambulance Service
- Isle of Wight Fire and Rescue Service
- Independent Providers from:- Nursing Homes, Residential Homes and Home Care
- A Voluntary Sector representative
- The Prisons Service
- Hampshire Probation Service
- Public Health Service
- The Local Safeguarding Children's Board

Closer links have been developed this year with HealthWatch and Trading Standards, both of whom may join the Board in 2015/16. There are also close links with the Domestic Abuse Forum, the Community Safety Partnership and the Safeguarding Children's Board.

Margaret Geary
Independent Chair

Legal and Policy Background

A number of key developments related to health and social care have had a major impact on adults safeguarding work, both nationally and locally.

The Care Act

From April 2015, the Safeguarding Adults Board will be placed on a statutory footing within a statutory framework outlined in the Care Act 2014. Its purpose continues to be to ensure that adults who are in need of support and care (regardless of whether they receive care services) are effectively safeguarded and to promote actions aimed at encouraging earlier interventions which help to prevent neglect or abuse.

The Care Act received royal assent in May 2014, and came into force in April 2015. It modernises and consolidates the laws on adult care into one statute. Key changes include the introduction of a national eligibility criteria, a right to independent advocacy, and a strengthening of the rights of carers. Most significantly, the Care Act also places adult safeguarding on a statutory basis for the first time.

New Duties include the Local Authority's duty to make enquiries, or cause them to be made, where abuse of an adult with care and support needs is suspected or known to have taken place, and the person is unable to protect themselves. There is a Duty for a Local Safeguarding Adults Board to be established, with statutory members being the Local Authority, Clinical Commissioning Groups and the police. Safeguarding Adults Boards must publish an annual report and a strategic plan, and must arrange Safeguarding Adult Reviews in specific circumstances to learn lessons for the future, with a duty on agencies to cooperate with the review. The statutory guidance for the Care Act replaces the 'No Secrets' guidance, and describes in detail the expectations on all partner organisations in working together to prevent and stop the risk and experience of abuse and neglect, whilst promoting the person's wellbeing and rights.

Local Response to the Care Act 14

The IWSAB has been working with partners over the last year to ensure our local arrangements for safeguarding adults are compliant with the Care Act 2014. A workshop for Board members on the implications of the Care Act 14 and the implementation of Making Safeguarding Personal was held in January 2015 facilitated by Sarah Mitchell from the Local Government Association. Later the same month, the IW Care and Nursing Home Providers delivered a Safeguarding Adults Conference on 16th January 2015 with a focus on the requirements of safeguarding within the Care Act 2014. The conference was deemed a success with 104 delegates attending from across the partnership.

The IWSAB has worked with the other 'SHIP' area safeguarding adult boards in Portsmouth, Southampton and Hampshire over the last year to ensure that the new overarching safeguarding arrangements meet the requirements of the Care Act 2014 and provide consistency across the pan-Hants area. The key activities undertaken by the IWSAB regarding implementation of the Care Act 2014 include the following:

- Involvement in the update of the 4 LSAB (Hampshire, Portsmouth, Southampton and Isle of Wight) Multi-Agency Safeguarding Policy and Guidance
- Involvement in the development of a wide range of 4 LSAB practice guidance covering Information Sharing, Prevention and Early Intervention, Managing Self-Neglect and Safeguarding in Commissioned Services.
- Involvement in the development of a number of Board governance processes which have been adopted across the four LSABs providing consistency of approach for partner agencies. These include the Learning and Review Framework, Quality Assurance Framework and Communication Protocol.
- Involvement in the development and publication of a Multi-Agency Adult Safeguarding Learning and Development Strategy to support implementation of the new Statutory Safeguarding Framework. This was informed by a safeguarding learning and development audit coordinated by Hampshire Safeguarding Adults Board across the 4 LSAB area.
- Strengthening of links with other strategic partnerships and plans including the Domestic Abuse forum, the Human Trafficking Partnership and HealthWatch.

Deprivation of Liberty Safeguards (DoLS)

The Supreme Court Judgment at the end of 2013/14 clarified the criteria for assessing whether a person lacking capacity regarding decisions for their care and support is being 'deprived of their liberty' in a care home, hospital or other care setting. This has resulted in a significant increase in authorised deprivations nationally and locally. The judgment also widened the scope for DoLS to include adults living in the community, requiring such cases to be put to the Court of Protection.

Local Response to DoLS

Following the landmark ruling, a conference on DoLS was organised by the IWSAB on the Island in July 14, with keynote speaker, Barrister Victoria Butler- Cole (39, Essex Street Chambers) and the Island's MCA / DoLS lead, Stephen Ward, outlining the implications of the ruling to a wide range of multi-agency partners.

Feedback from the DoLS Conference

Helped make this minefield a little clearer. Helped me be sure of my own responsibilities as a Care Home Manager. ***(Care Home)***

An extremely well delivered and informative session. Victoria was easy to listen to and put a lot of things into perspective. The reference to case law was very interesting and delivered with a touch of humour, which was very refreshing. I have come away more knowledgeable and clearer on how the IWC is dealing with the DoLS influx. ***(Safeguarding)***

During 2013/14, 29 DoLS requests were received, 3 from the hospital, the remainder from care homes. These were all assessed/completed, 16 resulting in authorisations, 13 declined.

In 2014/15, following the Supreme Court decision in Cheshire West, a huge increase was seen, resulting in many authorisation requests not being assessed within deadlines and a large number of outstanding requests at year end.

DoLS numbers as of 31 March 2015:

	Total Requests	**Completed Granted**	**Completed not granted**	**Withdrawn (moved or deceased)**	**Not yet completed**
As of 31 March 2015	535	70	10	85	365

Following the investment of extra resources a plan has been put in place to recruit two full time Best Interests Assessors, starting on 1 July and 1 September 2015, to assess the outstanding assessments. All requests are now prioritised 1-3 according to the ADASS tool. Outstanding priority 1 requests will be allocated alongside new priority requests (priority 1, some reviews and hospital requests).

The principle risks are:

1. There is likely to be a large number of care home residents and hospital patients who are currently unlawfully deprived of their liberty.

2. This may attract criticism from regulators, in particular CQC.

3. Some affected persons or their family members may seek compensation for unauthorised deprivation of liberty. Where the managing authority has made a request but the supervisory body has not completed assessments, liability will lie with the supervisory body (IWC).

Where an unauthorised deprivation of liberty amounts to a substantive breach of the regulations (i.e. had the correct process been followed the person would not have been detained) any damages awarded are likely to be substantial (£3-5,000 per month). Where the deprivation of liberty is found to be in the person's best interests, necessary and proportionate, but unauthorised due to the DoLS process not having been completed (an administrative breach) costs are likely to be minimal or 0.

4. Some care homes and hospital wards are still not making requests for authorisation in respect of patients/residents who may be deprived of their liberty.

Risk mitigation:

1. Prioritisation of DoLS requests that identify high levels of restraint or objection by the person or their relatives.

2. Care managers are being supported to ensure the underlying principles of the Mental Capacity Act are complied with, to avoid substantive breeches of the regulations.

3. Collaborative working with CQC to support care homes in understanding and complying with the regulations.

4. Where objections to placements remain despite authorisation, these are being referred to the Court of Protection.

Care Quality Commission (CQC)

In 2014/15, the Care Quality Commission started delivering on their planned new approach to regulation and inspection of health and social care providers: NHS acute, mental health and community trusts; adult social care; and GP practices. This includes a sector-specific approach to inspection, including specialist advisors with expertise in the area being inspected. The new approach is a shift in focus from judging only whether providers meet legal standards, to increased professional judgement and encouraging providers to improve, with a focus on services being safe, effective, caring, responsive and well-led. Following each inspection, each service is rated: Outstanding, Good, requires Improvement or Inadequate.

The new standards of care launched on 1 April 2015 include new enforcement powers for the CQC that allows them to go straight to prosecution when they find the most serious failings in care, without issuing a Warning Notice first. They also include new requirements;

the ‘duty of candour’ and ‘fit and proper person’ for directors, to hold leadership to account for poor care. Where they identify serious failures in care CQC will place a provider in special measures, to ensure improvement.

Local Response

The CQC have presented to the IWSAB on the new standards of care and have been invited to return in November 2015 with an update on progress.

Prevent Duties

The Counter Terrorism and Security Bill was introduced in the Parliament on 26th November 2014 and received Royal Assent on 12th February 2015. The Counter Terrorism and Security Act 2015 has created a general Prevent Duty on specified authorities, which ‘must in the exercise of its functions, have due regard to the need to prevent people from being drawn into terrorism’. The Prevent Duty comes into effect in July 2015. The Act creates a new ‘Prevent Duty’ for ‘specified authorities’, which ‘must in the exercise of its functions, have due regard to the need to prevent people from being drawn into terrorism’.
Unitary authorities are included in the list of specified authorities, as are county and district local authorities, schools, colleges, universities, police, probation, prisons, young offenders’ institutions and the health sector.

Local Response

A ‘Prevent’ presentation has been given to board members, and will be repeated in the next financial year. The community Safety Partnership will be working alongside the IWSAB on this agenda.

Modern Slavery

The Modern Slavery Act received Royal Assent on 26th March 2015. The Act consolidates the current offences relating to trafficking and slavery. The act will give law enforcement the tools to fight modern slavery, ensure perpetrators can receive suitably severe punishments and enhance support and protection for victims. The Act establishes an Anti-Slavery Commissioner, appointed by the Home Office, with a UK-wide remit, ensuring that modern slavery issues are tackled in a coordinated and effective manner across the whole of the UK.

Local Response to the Modern Slavery Act

The Assistant Police and Crime Commissioner for the Isle of Wight leads on missing, exploited, trafficked and victims of modern slavery on a pan-Hampshire basis and is a member of the IW Safeguarding Board. The IWSAB’s manager is a member of the pan-Hants Anti-Slavery Partnership and a presentation on the work of the partnership is on the agenda for the IWSAB / OPCC Conference in May 2015.

Serious Crime Act

The Serious Crime Act 2015 received Royal Assent on 3 March 2015. The Act brings in new powers in dealing with organised, serious and gang related crime, and makes a number of changes to the civil and criminal law to enhance the protection of vulnerable children and adults, including strengthening the law to tackle female genital mutilation (FGM) and domestic abuse. It brings in FGM Protection Orders to protect potential victims. These orders will operate in a similar way to Forced Marriage Protection Orders.

The Crime Act also includes criminalising patterns of repeated or continuous coercive or controlling behaviour where perpetrated against an intimate partner or family member, causing victims to feel fear, alarm or distress. The new offence comes after the government ran a consultation over the summer seeking views on whether the law on domestic abuse needed to be strengthened. The Home Office said that 85% of the participants in that consultation said domestic violence law at the time did not provide sufficient protection to victims. Coercive and controlling behaviour can include the abuser preventing their victim from having friendships or hobbies, refusing them access to money and determining many aspects of their everyday life, such as when they are allowed to eat, sleep and go to the toilet.

Local Response

The IWSAB are working alongside Public Health, the IWSCB and Domestic Abuse Forum to develop a local FGM strategy to define a coordinated and effective set of responses to the threat of FGM between strategic organisations and front line professionals across the Isle of Wight. The strategy will be presented to all the Boards' for ratification later in 2015 and members are encouraged to share it widely to raise awareness of the issue.

Clare's Law

The Domestic Violence Disclosure Scheme (DVDS – also known as known as Clare's Law or 'Right to Ask /Know '), a scheme allowing police to disclose details of an abusive partners' past, was rolled out across England and Wales on International Women's Day, March 2014. Clare's Law provides victims with information that may protect them from an abusive situation. The scheme allows the police to disclose information about a partner's previous history of domestic abuse or violent acts.

Domestic Violence Protection Orders (DVPOs) were introduced on the same day. This new power enables police and magistrates' courts to provide protection to victims in the immediate aftermath of a domestic violence incident, by preventing perpetrators of domestic violence from returning to their home for up to 28 days, giving the victim time to consider their options.

Local Response

Under Clare's Law information has been released to 13 members of the public under the 'Right to Ask' and in 15 cases information was given to individuals by police under the 'Right

to Know'. There were a total of 4 DVPN's issued between the end of March 14 and 1st April 15.

My Life a Full Life / Vanguard

The My Life a Full Life (MLAFL) model seeks to deliver new ways of working that focuses on keeping people happy and healthy through self-care, self-management, and active communities. In March 2015 the Isle of Wight was selected as a Vanguard site by NHS England to take a national lead in transforming care for people, families and carers and those using health and social care services. From April, partners will build on the work already carried out under MLAFL, working together with Adult Social Care, Public Health, the voluntary and third sector to deliver integrated care and support on the Island.

Over the next twelve months, the aim is to improve health and wellbeing outcomes, deliver more care in the community, reduce costs per head of population, and be able to better meet future demand within resources. MLAFL has a strong leadership supporting the model of care. Led by the CCG, Trust, Council, and GP Federation, there is also strong representation from the voluntary sector, mental health and services users. The team behind MLAFL are seeking Vanguard support for a total of £8m in 2015-16 to enable the delivery of person centred outcomes supporting whole system integration and change.

One of the main aims of the MLAFL Programme is the development of Integrated Teams within three identified localities on the Island to deliver personalised health and social care. In each locality area the focus will be:

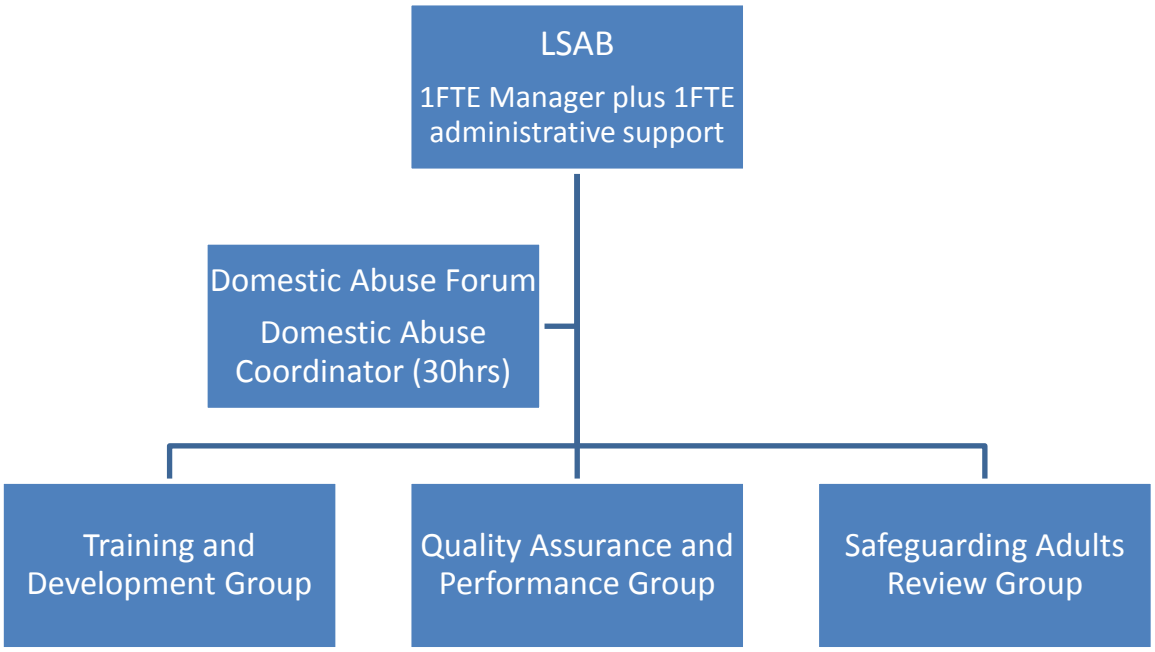
- finding better, appropriate and secure ways of sharing information between professionals about people who need their support;
- developing tools and training which help health, social care and voluntary services to work together more effectively;
- identifying vulnerable people and those with complex care needs and ensuring the services they require are better coordinated;
- developing better support networks in the community to help people returning home from hospital; and
- developing community teams in each locality comprising professionals, volunteers and support services to meet the local community's needs for health, wellbeing and social care.

The IWSAB will receive regular updates on the MLAFL / Vanguard programme over the next financial year.

IWSAB Restructure

Under the Care Act 2014, domestic abuse, sexual violence, trafficking and modern slavery are identified as significant safeguarding issues that require a multi-agency response. It was proposed that to manage this area of work across the partnership a dedicated Domestic Abuse Coordinator be appointed to join the Safeguarding Adults Boards' support unit. It was also agreed that due to the increase in activity and the new statutory requirements of the Care Act 14 that the administrative support to the Board be increased to 1FTE post.

The restructure of the LSAB Support Team was agreed at an Extraordinary Meeting of the IWSAB in March 2015.



Board Activity in 2014/15

Safeguarding Adults Review Sub Group

Serious Case Reviews have been renamed Safeguarding Adults Reviews (SAR's) under the Care Act 14. Under the new arrangements the Board must decide when a SAR is necessary, arrange for its conduct and if it so decides, implement the findings. The purpose of a SAR must be to learn lessons and improve practice and inter-agency working. The Act defines the circumstances under which a SAB must conduct a SAR as:

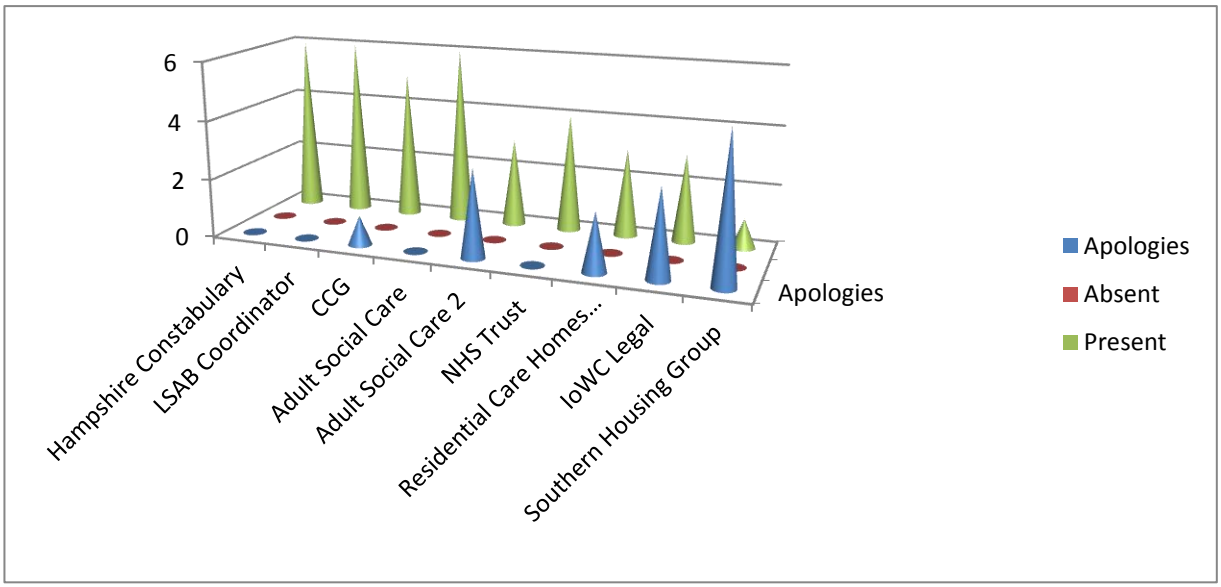
"there is reasonable cause for concern about how the SAB, members of it or others worked together to safeguard the adult and death or serious harm arose from actual or suspected abuse."

The SAR Sub Group works to the IOWSAB Learning and Review Framework that was developed this year in conjunction with the other 4 LSAB's, to support implementation of the new Statutory Safeguarding Framework.

The SAR sub group is responsible for monitoring the recommendations of the SAR's via the multi-agency action plans and for ensuring that learning from the reviews is shared across the partnership.

The SAR sub group membership includes Hampshire Constabulary (Chairing), the Isle of Wight NHS Healthcare Trust, the Clinical Commissioning Group, Adults Social Care, the Nursing and Care Home Association and Southern Housing.

IoW Local Safeguarding Adults Board - Safeguarding Adult Review Group Attendance 2014/2015



During 2014/2015, the IWSAB SAR sub group received a total of 5 referrals for a multi-agency review, one of which met the criteria for a full SAR. This year the Group has monitored the work on two full SAR's – the one referred in the current reporting period and one commissioned in the previous financial year. Both these reviews were completed in the 2015/2016 financial year and so will be reported on in more detail in the next Annual Report. Key themes that emerged from the two reviews included practitioners' understanding and application of the Mental Capacity Act, the challenges of working with cases of self-neglect, the need for a more person centred multi-agency response to older people with rising levels of need and the need for better communication between agencies.

In one of the cases not meeting SAR criteria, the Board felt that there were enough issues of concern in the case to warrant a review process, so a multi-agency reflective workshop was subsequently commissioned and conducted in October 2015.

The SAR group has worked hard to prepare for its new statutory function in April 15, clearing the backlog of actions attached to previous non-statutory reviews and agreeing the new Learning and Review framework and associated policy and templates.

Multi-agency 'Learning Lesson's events were commissioned based on a serious case review, and a smaller partnership review that were both completed in the previous financial year. As many of the cases that are referred to the SAR Group highlight issues around self-neglect and mental capacity, both of these areas will also be a focus of the joint IWSAB / OPCC Safeguarding Adults Conference that is scheduled to be held in May 2015.

It is of concern to members that at the end of this financial year the SAR Group's membership has reduced and that it has thus lost some of the richness and experience that it previously benefitted from. The Group will be revisiting membership in the next financial year. Looking forward, the SAR Group has identified the need for training for partners on Safeguarding Adults Reviews to include the expectations of SAR Group members' roles, and the roles and responsibilities of those involved in undertaking an actual review, e.g. the completion of scoping chronologies, IMR's or narratives and the importance of prioritising attendance at SAR workshops or panels.

Quality Assurance and Performance Sub Group

The Quality Assurance and Performance sub group meets on a bi-monthly basis and has representation from agencies across the Island. The invitation to this group has recently become wider to include representatives from a range of independent providers. The sub group has delegated responsibilities for formulating the performance management information presented to the Board, quality issues linked to practice development from audits and learning from review processes.

There is a standardised performance management framework in place which is also used across Southampton, Hampshire and Portsmouth. This is an ongoing piece of work which will need to be reviewed on a frequent basis to ensure that the data the group is receiving is informing the Board and safeguarding general practice.

There is an absence of analysis of information received from agencies due to having no access to a data analyst. Without this vital support in place, it will be difficult for the sub group to drive improved performance across agencies. The Group uses a Plan, Do, Study, Act (PDSA) approach to its activities and without the vital Study part the PDSA cycle for monitoring and improving the quality and performance agendas of the Board.

Representation from the following agencies made up the Sub-Group Membership for 2014/2015:

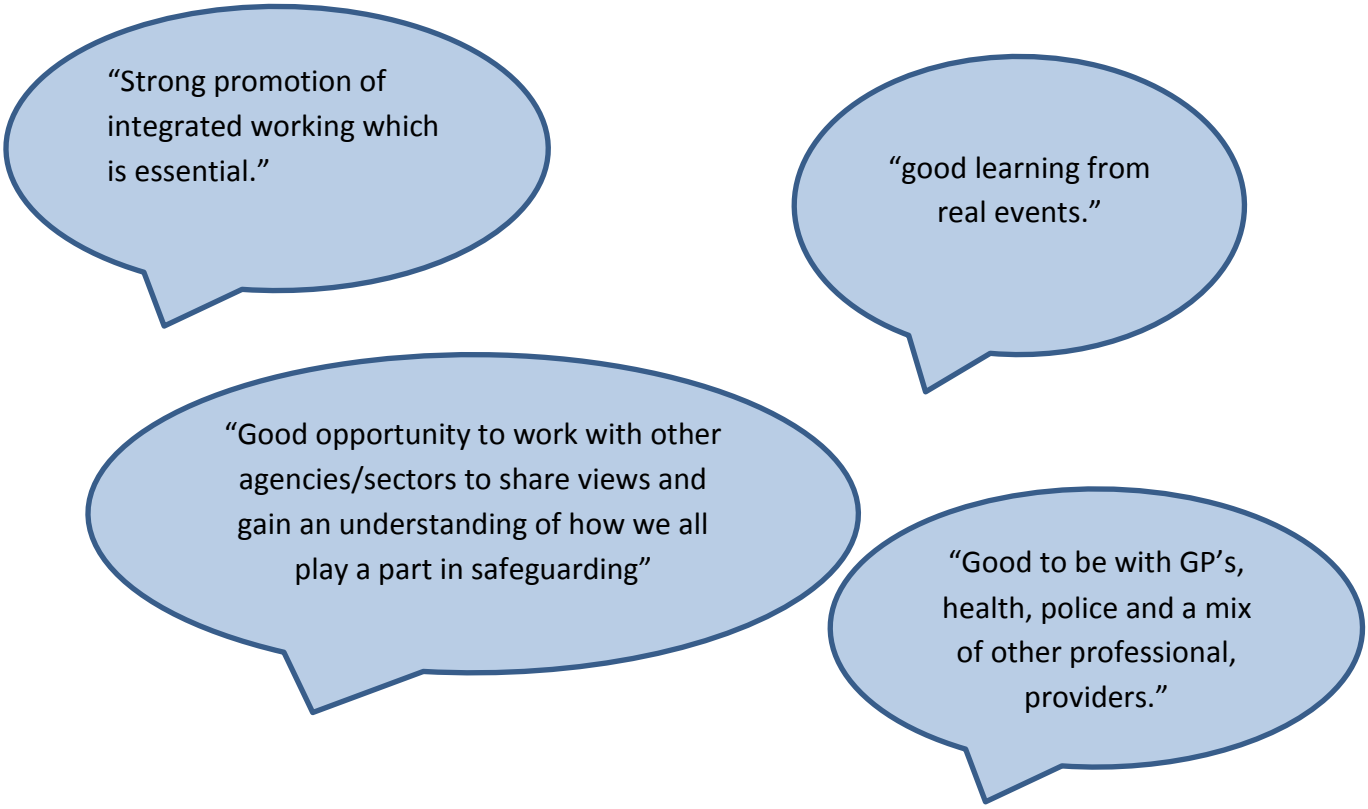
- Adult Social Care
- Ambulance Service
- CCG
- Hampshire Constabulary
- LSAB
- LSCB
- People Matter
- Residential Care Homes Association

Training Task and Finish Sub Group

The Training Task and Finish Group supported the development of the 4LSAB Multi-Agency Safeguarding Learning and Development Strategy, the strategy was agreed by the Board in January 2015. This strategy was informed by a safeguarding learning and development audit coordinated by the pan-Hampshire Workforce Development Group, which members of the Sub Group attend.

The group coordinated the Half-day Board Development Day on the Island for Board Members around the Care Act 2014; this was facilitated by the LGA, with good attendance. The group also helped support the Safeguarding Conference Day for providers, with excellent attendance and coordinated two learning lesson events held in March, with further ones planned for the next financial year.

Feedback from Learning Lessons



Further learning lessons events will be repeated next year following further completion of safeguarding adult reviews and a joint conference with the OPCC is planned for May 15.

The Training Task and Finish group membership includes representation from the following agencies:

- Adult Social Care
- Ambulance Service
- CCG
- LSAB
- NHS Trust

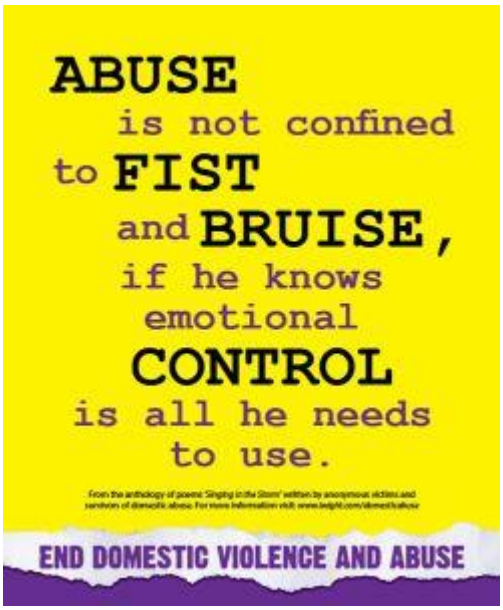
Domestic Abuse Forum

A significant proportion of adults who need safeguarding support do so because they are experiencing domestic abuse – be that in the form of financial abuse from relatives, physical or emotional abuse from their adult children or neglect from the family member who might be their carer. 19 % of safeguarding referrals related to domestic abuse during 14/15; this is likely to be an under-representation as research suggests that domestic abuse will be higher for adults at risk. For example, research into disabled women's experiences has found that the effect of being both disabled and a woman places disabled women at significant and higher risk than women in the general population. This is an area of work that will require further work in 2015/16.

The Domestic Abuse Forum is a multi-agency partnership working to reduce domestic abuse on the Island and ensure that victims and survivors have access to specialist services. The forum has struggled with the lack of a dedicated coordinator during this financial year; however, following the IWSAB's decision to fund this post this gap will be filled next year meaning that there can be a renewed focus on this area of work.

Despite the lack of capacity the forum has undertaken awareness raising during 2014/15 through a variety of activities including a presence at the Isle of Wight Festival 2015 and Bestival 2015 and through two poster campaigns; one on domestic abuse and one on sexual violence / rape.

In November 2014 an anthology of poetry by victims and survivors of domestic abuse was launched at the Quay Arts Centre and lines from some of the poems were used on the domestic abuse campaign posters. The posters have been displayed across the Island on the buses, bus shelters, in GP surgeries, the hospital etc.



Partners Activity in 14/15

Adult Social Care, Isle of Wight Council

Key Developments/Achievements in Safeguarding for 2014/2015

The Care Act 2014 has now put Adult Safeguarding on a statutory footing for the first time and as such has raised its profile. The SHIP Policy has been updated to reflect the changes within the Care Act and this is being used in practice.
The Safeguarding team have reviewed its processes in line with the Care Act and have actively involved partners with this. The emphasis of all safeguarding enquiries now centres on the wishes and personal outcomes of the adult at risk providing they have capacity to give these. The use of independent advocacy has grown and vulnerable adults who require support to understand the safeguarding process and have no one else suitable to support them, are being offered advocacy services
The Cheshire West Judgement has had a huge impact on the amount of Deprivation of Liberty Safeguard applications to the Local Authority and a Consultant Practitioner and Social worker have now been appointed as a dedicated resource to the DoLS process.
A multi-agency vulnerable adult panel has been implemented. The purpose of the Panel is to share information about high-risk vulnerable adults who frequently come to the attention of statutory agencies so that the most high-risk vulnerable adults on the Isle of Wight are effectively monitored and appropriate action taken when risk escalates. These are typically adults who disengage with services.

The Group Manager for Adult Safeguarding will be taking on the role of the Designated Adult Safeguarding Manager which is a role similar to that of the Local Authority Designated Officer in Children's services to manage allegations made about staff in respect of adults at risk.
Approval has been given to recruit a Domestic Abuse Co-ordinator to allow the current post holder to dedicate more time to the management of the LSAB. Alongside this, full-time admin support has been agreed.
A full time consultant has been appointed on a temporary basis to lead on the implementation and processes required in respect of the charges brought about by the Care Act and this includes processes for safeguarding
A new electronic social care record system is being developed to replace the current system which is no longer fit for purpose. This will help to ensure that all electronic information is stored in one place.

Training undertaken in Safeguarding 2014/15

All staff within Adult Social care have received training about the Care Act and how this impacts on the services provided. This has included some reference to Adult Safeguarding. Other training undertaken by Adult Social Care staff is set out below:

Mental Capacity Act in Practice	44 staff
Safeguarding Manager Updates	6 staff
Mental Capacity Act Overview and Principles	32 staff
Adult Safeguarding – Investigating officer	3 staff

Adult Safeguarding – Investigating Officer refresher	13 staff
Adult Safeguarding - alerters	23 staff
Making Safeguarding Personal	16 staff

Key Priorities for 2015/16

- Continue to build on the work already started to embed the principles of the Care Act and particularly Making Safeguarding Personal into all safeguarding work.
- To roll out a new Abuse Alert Form for all partners to use
- To continue to provide high quality training for all staff so that everybody understands their roles in relation to Adult Safeguarding
- Implement the new social care record system (PARIS)in January 2016

Hampshire Constabulary

Key Developments/Achievements in Safeguarding for 2014/2015

Hampshire Constabulary is a key stakeholder in the partnership response to safeguarding the most vulnerable in our community throughout Hampshire. Over the last 12 months, despite financial restraints, the Constabulary has continued to prioritise safeguarding.

The Constabulary structure has had to change to enable it to meet the challenges of a reducing budget and still deliver a quality service. One of the changes to safeguarding is the Safeguarding and Offender Management Teams (OMT) being incorporated into the 'Neighbourhoods and Prevention' strand. The senior officers leading Safeguarding, Offender management and Neighbourhood policing all report back to a single Chief Superintendent, to ensure a coordinated approach. Also, the various Local Safeguarding Adult Board sub group meetings now have selected police attendees, to ensure continuity and consistency across the Hampshire 4LSAB structure.

Incorporating Safeguarding and the OMT into the Neighbourhood and Prevent strand has combined the experience of these teams with the Neighbourhood Policing Teams (NPT - aka Beat Officers and PCSOs) to ensure a truly community focused service. This has encouraged better communication between the teams, which is crucial, having regard to the recognised links between domestic abuse, child abuse and abuse of vulnerable adults. NPT has taken ownership for medium risk domestic abuse incidents by engaging and signposting victims to support networks, thus reducing the risk to both adults and their children.

The effect of the implementation of the Care Act is unknown at this time but it is expected to increase adult safeguarding referrals. This will particularly be in the form of Section 42 Care Act 2014 enquiries. Hampshire Constabulary will work with partners to follow the Safeguarding Policy, Procedure and Guidance document drawn up by the 4LSAB, which includes the Care Act 2014.

The national implementation of Clare's Law (DVDS - Domestic Violence Disclosure Scheme) and Sara's Law (CSOD - Child Sexual Offences Disclosure) has contributed to the safeguarding of both adults and children by the disclosure of the risks an identified person poses to potential victims. It is estimated that there will be over 400 disclosure considerations in the year 2015/16, which will allow a person to make informed decisions around the risk to themselves and their children in respect to their intimate (ex)partners.

Training undertaken in Safeguarding 2014/2015

In the second half of 2014/15, and coinciding with the Force structure change, Hampshire Constabulary has instigated a wide-reaching Safeguarding training programme for staff throughout the Force. This input is provided for staff managing first contact, through to the outcome stage and gives them a better understanding of risk indicators as well as options that put victims at the heart of the police response. This is an on-going training programme.

Specific training in respect to vulnerable adults includes the implications of the Care Act, which is delivered in Investigator and NPT training sessions. The Investigator training schedule is complete and the NPT schedule has already commenced, with completion predicted around October 2015.
NPT officers now also have rotational attachments to the Safeguarding Teams to hone their skills in 'live' cases and attend Adult Safeguarding Conferences.

Key Priorities for 2015/2016

'Vulnerability' is and has been a key priority for Hampshire Constabulary.
1/ Identification of vulnerability - Improve the data produced at a force level in the identification of the high risk vulnerable persons. Improve the assessment of those most vulnerable by enhancing analytical data and better understanding of first and repeat referrals and their causes.
2/ Improve information sharing of all partnership information and IT systems to assist identification of information and intelligence to identify those most vulnerable - Evaluation of benefits, consequences and challenges of safeguarding use of SafetyNet.
3/ To plan / prepare proactive visits to those who are most vulnerable and at risk through pre-planned initiatives with safeguarding, child and adult services, NPT officers, specials and PCSO's and CAIT officers.
4/ Evaluation and review of MARAC process

HMP Isle of Wight/CareUK

Key Developments/Achievements in Safeguarding for 2014/2015

HMP IoW Policy on Safeguarding developed September 2014 and seen by LASB.
LSAB attended by John Baxendale Prison Governor and Rachel Lovely CareUK Service Manager

Training and Development sub group to be attended by Vivien Bush (CareUK safeguarding lead)

Training undertaken in Safeguarding in 2014/2015

CareUk healthcare staff has attended face to face Safeguarding training during January /February 2015.
Due to be updated following implementation of Care Act 2104 and delivered during September for those staff still requiring face to face training.

Key Priorities for 2015/2016

Following successful inspection from HMIP/CQC June 15 a Shared Policy between HMP IoW and CareUK will be developed.

HMP Isle of Wight

Key Developments/Achievements in Safeguarding for 2014/2015

HMP IoW Policy on Safeguarding developed September 2014 and seen by LASB.

LSAB attended by John Baxendale Prison Governor (Head of Public Protection).

Prison Service Instructions introduced within HMP Isle of Wight which identifies practices and procedures to ensure compliance with Safeguarding expectations.

Local Council has commenced Social Care Assessments within HMP Isle of Wight.

Training undertaken in Safeguarding in 2014/2015

Local partner CARE UK has shared their Safeguarding Training package which is being planned for introduction with targeted HMP Isle of Wight Staff.

Key Priorities for 2015/2016

Following successful inspection from HMIP/CQC June 15 a Shared Policy between HMP IoW and key partner CARE UK will be developed.

Isle of Wight NHS Trust

Key Developments/Achievements in Safeguarding for 2014-2015

During 2014-2015 the organisation recognised the need for further resource to deliver the widening agenda for safeguarding. We reviewed our requirements in light of the Care Act, the national agenda, and our local priorities in order to consider what resource we would need for 2015-2016. This was done with the Local Authority and the CCG and has resulted in the development of a small team which is being established during 2015-2016.
We have supported the Domestic Abuse agenda, linking our Emergency Department Ward Manager into our safeguarding team as a lead for this area.

We have developed a process for working more closely with front line staff in a practical way to learn lessons from enquiries. We are able to link enquiries to patient experience and to work with staff to make improvements that will make a difference to others.

Training undertaken in Safeguarding in 2014/2015

Our training focus for 2014-2015 has been for our Ward Managers and Deputy Ward Managers in Mental Capacity Act training and Deprivation of Liberty standards.
In addition to our focus area our staff complete our e-learning module as part of mandatory training and our ongoing compliance with training is monitored through our Joint Safeguarding Steering Group.
We have successfully targeted our temporary staff to ensure they understand the importance of safeguarding in their role.
The Trust has also participated in external training in relation to the Care Act, Prevent, and Adult Safeguarding updates provided by the LSAB and Local Authority.

Key Priorities for April 2015 – March 2016

The Isle of Wight NHS Trust has committed to supporting an adult safeguarding team to ensure a high quality service can be provided for our patients and staff, and we can work more effectively with our partners. The team will be established during 2015/2016 and is a key priority. This will enable us to fully participate in all the LSAB sub groups and be a regular visible presence in partnership forums. This will provide more shared learning.

The implementation of the Care Act will be a key priority for this year. We have a particular focus on ensuring patients and clients achieve suitable outcomes from our enquiries, and our processes for lessons learned for our staff are robust.

We will be improving our compliance with Deprivation of Liberty Safeguards.
We will also be reviewing our training for staff, developing face to face training to support the LSAB and local priorities with a focus on our 'Prevent' training.

Our Joint Safeguarding Steering Group will oversee the two Serious Case Reviews that have been completed and we will ensure that recommendations are reviewed and implemented.

Isle of Wight Registered Care Homes Association – Registered Nursing Homes Association

Key Developments/Achievements in Safeguarding for Care and Nursing Home Providers for 2014/2015

Care and Nursing Home providers continue to be represented at the LSAB and are consistent in their attendance.
One member of the LSAB also sits on the Safeguarding Adults Review sub-group and has been a member of the SCIE review team.

New documentation for providers to report concerns has been issued by the Safeguarding Adult team.

The SHIP Policy and Procedures have been revised to accommodate the safeguarding requirements of the Care Act 2014 and widely circulated to all care and nursing home providers.

Providers delivered a Safeguarding Adults Conference on 16th January 2015 with presentations on the following aspects of Adult Safeguarding with a focus on the requirements of safeguarding within the Care Act 2014:

Safeguarding and the Care Act
The role of the Local Safeguarding Adults Board
My Life in Hospital - a service user perspective
Safeguarding and Domestic Abuse
The Provider Prospective
Safeguarding is our Business – Deprivation of Liberty Safeguards
Safeguarding within an integrated service
The role of the Safeguarding Team

The conference was very successful – attracting 105 delegates from across adult health and social care services.

Training undertaken in Safeguarding for Care and Nursing Home Providers in 2014/2015

Training has been provided in partnership with the IW Council which has been attended by Care Providers across the Island.

Care Providers are responsible for ensuring that their staff are provided with safeguarding training in order to provide evidence that their services are Safe, Caring, Responsive, Effective and Well-led which are the 5 fundamental standards of quality required by the regulator the Care Quality Commission (CQC).

Key Priorities for Care and Nursing Home Providers for 2015/2016

Making Safeguarding Personal and ensuring that providers come together to share learning and develop systems that will ensure quality and safety for all service users and their families on the Isle of Wight.

NHS Isle of Wight CCG

Key Developments/Achievements in Safeguarding for 2014/2015

- Appointment of the Director of Quality and Clinical Services
- CCG safeguarding week in February 2015, including training to the executive board
- Increased integration and information sharing across the CCG safeguarding and quality teams

- Strong attendance, facilitation and participation at the Isle of Wight Safeguarding Adults Board and associated subgroups
- Safeguarding element of the quality schedule for health providers revised and strengthened in preparation for 2015-2016 contracts
- MCA and DoLS funding available across both health and social care which included contribution to the MCA conference and funding additional Best Interests Assessors

Training undertaken in Safeguarding in 2014/2015

- Safeguarding training to the CCG executive board, GP's and primary care
- MCA, including DoLS to GP's and primary care
- Advanced care planning to CCG staff
- Domestic abuse training to CCG staff
- Care Act 2014 and Prevent briefing to GP's and primary care
- Mandatory Safeguarding e-learning training for CCG staff

Key Priorities for 2015/2016

- Continue to develop a close working relationship with NHS England to ensure safeguarding remains a priority in primary care with the introduction of co-commissioning
- Continue to work on improving practice and embedding MCA/DoLS
- Continue to strengthen contracting and commissioning arrangements to include adult safeguarding to ensure that individual rights are protected
- Through the work of the Isle of Wight Safeguarding Adult Board develop outcome focussed, person-centred safeguarding practice – making safeguarding personal
- The impact of the Care Act 2014 for the health economy
- To work with and support the independent sector
- To proactively promote integrated assessments and interventions across both health and social care
- To ensure that robust quality monitoring arrangements are in place for care homes and domiciliary care

Southern Housing Group

Key Developments/Achievements in Safeguarding for Southern Housing Group in 2014/2015

The Southern Housing Group Safeguarding Policy and Procedures have been revised following the introduction of the Care Act 2014.
We have also developed an employee Safeguarding handbook for all staff across the Group which is available on the Group Services Manual, together with the updated policy and procedures. Briefings are being provided across the Group to highlight the changes and how they impact on Providers of social housing. The organisation has a Safeguarding Lead in place who is Island based.

We maintain comprehensive records of all safeguarding alerts incorporating an initial report, incident form and follow up actions including liaison with key agencies and representation at safeguarding case meetings.

Training undertaken in Safeguarding in 2014/2015

A local training plan is in place for all staff within Southern Housing Group working with vulnerable people; the content has been updated following implementation of the Care Act 2014
Our Safeguarding e-learning resource is currently being revised and due to be rolled out across the organisation in late Summer/early Autumn.

Key Priorities for Southern Housing Group for 2015/2016

The Implementation of a training programme for all areas of the Southern Housing Group business.

Overview of Safeguarding Activity on the Island

The Safeguarding Adults Return for 14/15 shows that the referral rate in 2014/5 is almost the same as in 2013/4 with only one more referral received.

Table SG1d 'Primary Support Reason' tallies with the national picture, except that the Island has a higher percentage of abuse against people with memory and cognition needs (21% compared with the national picture of 9%). This is, however, likely to be reflective of the Island's demographics.

Table SG3a details the types of risk (abuse). There is little change from the figures for last year with the largest increase being in the neglect category (33%). Neglect remains the most common abuse type (45%) followed by financial abuse (14%).

It is important to note that the neglect category covers a lot of different forms of abuse including missed medication, inadequate staffing levels, missed care calls, missing persons, poor manual handling, pressure ulcer development and health needs not being addressed – which is why it is the most common type of abuse.

Some work completed for the Quality Assurance and Performance sub group this year has broken down the neglect category further and the results at that time showed that the greatest cause of neglect was care and/or medical needs not being attended to by either carers in a provider setting or by professionals. This was followed by medication errors.

Nationally neglect is the highest type of abuse (32%) followed by physical abuse (27%) and financial (17%)

The Location of Risk category (SG3b)is broken down into 5 locations – care home, hospital, own home, service within the community and other. The highest location is in a Care Home but this is very closely followed by the individual's own home. The largest increase this year is in abuse reported in the hospital with an increase of almost 150%. However, the numbers of incidents remain in line with the national picture and the increase is most likely to be as a result of more robust reporting.

Safeguarding Adults Return 2014/15
For the collection period 1st April 2014 to 31st March 2015

SG1: Demographics - Count of individuals at risk for referrals opened during the reporting period

These tables count the number of individuals split out by each of the below categories

SG1a - By age

SG1b - By gender

SG1c - By ethnicity

SG1d - By primary support reason

SG1e - By reported health conditions

Notes

Individuals should only be included once in each of the tables SG1a, SG1b and SG1c

Individuals can be included more than once in tables SG1d and SG1e

Only two categories in table SG1e are mandatory for 14-15. These are highlighted in yellow.

Table SG1a	Number of individuals by age					
Classification	18-64	65-74	75-84	85-94	95+	Age Unknown
Already known to CASSR	160	57	130	188	38	0
Previously unknown to CASSR	26	8	8	14	3	0

Table SG1b	Number of Individuals by gender		
Classification	Male	Female	Gender Unknown
Already known to CASSR	204	369	0
Previously unknown to CASSR	21	38	0

Table SG1c	Number of individuals by ethnicity					
Classification	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	No Data
Already known to CASSR	552	0	1	1	0	19
Previously unknown to CASSR	54	0	0	0	0	5

Table SG1d	Number of individuals by primary support reason						
Classification	Physical Support	Sensory Support	Support with Memory & Cognition	Learning Disability Support	Mental Health Support	Social Support	No Support Reason
Already known to CASSR	230	6	126	68	35	5	103
Previously unknown to CASSR	24	3	6	14	6	0	6

Table SG1e	Number of individuals by reported health conditions		
Classification	Sub-Class	Already known to CASSR	Previously unknown to CASSR
Long Term Health condition - Physical	Chronic Obstructive Pulmonary Disease		
Long Term Health condition - Physical	Cancer		
Long Term Health condition - Physical	Acquired Physical Injury		
Long Term Health condition - Physical	HIV / AIDS		
Long Term Health condition - Physical	Other		
Long Term Health condition - Neurological	Stroke		
Long Term Health condition - Neurological	Parkinson's		
Long Term Health condition - Neurological	Motor Neurone Disease		
Long Term Health condition - Neurological	Acquired Brain Injury		
Long Term Health condition - Neurological	Other		
Sensory Impairment	Visually impaired		
Sensory Impairment	Hearing impaired		
Sensory Impairment	Other		
Learning, Developmental or Intellectual Disability	Learning Disability		
Learning, Developmental or Intellectual Disability	Autism (excluding Asperger's Syndrome / High Functioning Autism)	5	1
Learning, Developmental or Intellectual Disability	Asperger's Syndrome/ High Functioning Autism	1	0
Learning, Developmental or Intellectual Disability	Other		
Mental Health Condition	Dementia		
Mental Health Condition	Other		

No Relevant Long-Term Health Conditions	None		

SG3: Case details - Count of referrals that concluded during the reporting period

These tables count the number of concluded referrals that involved each of the below categories

SG3a - By type of risk

SG3b - By location of risk

SG3c - By action and result

SG3d - By conclusion

Notes

More than one entry per concluded referral can be entered into these tables

Table SG3a	Source of risk		
Type of risk	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Physical	30	18	20
Sexual	3	7	13
Psychological and Emotional	27	36	19
Financial and Material	11	54	26
Neglect and Omission	202	25	59
Discriminatory	0	0	0
Institutional	2	0	0

Table SG3b	Source of risk		
Location of risk	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Care Home	161	30	29
Hospital	1	5	45
Own Home	97	84	37
Community Service	3	0	3
Other	13	21	23

Table SG3c	Source of risk		
Action and Result	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
No Action Taken	112	77	76
Action taken and risk remains	14	16	18
Action taken and risk reduced	60	19	18
Action taken and risk removed	89	28	25

Table SG3d	Source of risk		
Conclusion	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Fully Substantiated	104	27	29
Partially Substantiate	51	16	27
Inconclusive	42	53	43
Not Substantiated	77	40	37
Investigation Ceased	1	4	1

SG6: Mental capacity - Count of referrals that concluded during the reporting period

This table counts the number of concluded referrals split out by age of the individual at risk and by their mental capacity

Notes

If your council opens separate referrals for each individual at risk, there should be one entry per concluded referral in this table.

If your council has referrals which relate to more than one individual at risk, there should be multiple entries per concluded referral in this table.

Table SG6	Number of concluded referrals					
Was the individual lacking capacity?	18-64	65-74	75-84	85-94	95+	Age Unknown
Yes	57	22	27	46	8	0
No	42	8	25	35	8	0
Don't know	3	1	15	20	4	0
Not recorded	65	26	56	70	14	0
Of the concluded referrals recorded as yes in row 1, in how many of these cases was support provided?						

SG7: Serious case reviews

These tables show details of serious case reviews (SCRs) and indicate whether any individuals died as a result of the abuse that had been investigated

SG7a - Count of serious case reviews

SG7b - Count of individuals at risk involved in serious case reviews

Table SG7a	Number of SCRs
Type	
Where one or more individual died	1
Other	0

Table SG7b	Number of individuals involved in serious case reviews by age					
Type	18-64	65-74	75-84	85-94	95+	Age Unknown
Who died	0	0	1	0	0	0
Other	0	0	0	0	0	0