Isle of Wight

Safeguarding Adults Board

Annual Report

April 2015 – March 2016

Foreword

The 12months 2015/2016 have been busy ones for the Adults Safeguarding Board. This report summarises the work undertaken by the Board and it's sub groups and includes contributions from different members of the Board about how they have carried out their responsibilities for Safeguarding Adults in 2015/16.

The second annual conference, held in March 2016, sponsored by the Safeguarding Adults Board and the Office of the Police Crime Commissioner highlighted the importance of professionals' listening more, both to those who were in need of safeguarding support and to their Carers. Making Safeguarding Personal, i.e. ensuring people and their Carers are more involved in planning and shaping the support offered to them, is now an important expectation within the work. It is a significant change in emphasis. Professionals in Health and Social Care are still working out how practice needs to change in order to give people the kind of control over how they are kept safe which will enable them to manage the risks they face, more effectively.

There is never any room for complacency in work to reduce risks and improve safety for individuals and specific groups of more vulnerable adults. Some progress has been made in raising awareness of the risks faced and supporting practitioners to identify the lessons that need to be learned from Safeguarding Adults reviews and to introduce improvements. The commitment of partners to work together has been important to the Board's work this year and is vital if we are to build on the progress made.

Margaret Geary,
Independent Chair

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Introduction

This report outlines the activities the Isle of Wight Safeguarding Adults Board (IWSAB) has undertaken to enable it to fulfil its statutory responsibilities regarding the strategic development and oversight of adult safeguarding on the Isle of Wight. This report covers a one year period (1st April 2015 to 31st March 2016) and provides a review of the Board's activities, highlighting key achievements and challenges.

The Board leads the strategic the development of adult safeguarding on the Island and in holding local agencies to account and the core focus of the Board in fulfilling this role is on ensuring service users are kept at the heart of what we do and that we learn from their experiences of safeguarding in order to shape and improve safeguarding on the Island in the future.

The Care Act 2014

In April 2015 the Care Act 2014 came into force, making the Board statutory. Much work had been put in during 2014/15 in readiness for this – particularly focussing on ensuring that staff were working to the principles of 'Making Safeguarding Personal' - and further work continued through 2015/16.

Safeguarding Principles

The following 6 principles laid out by the Government in 2011 are incorporated into the Care Act 14 statutory guidance and they inform our safeguarding practice on the Isle of Wight.

- **Empowerment** –Presumption of person led decisions and informed consent.
- **Prevention** – It is better to take action before harm occurs.
- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented.
- **Protection -** Support and representation for those in greatest need.
- **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** – Accountability and transparency in delivering safeguarding.

Care and Support Statutory Guidance Update 2016

At the end of the financial year, in March 2016 the Department of Health published a refreshed edition of the Care and Support statutory guidance. The statutory guidance supports implementation of part 1 of the Care Act 2014 by local authorities, the NHS, the police and other partners.

Chapter 14 of the guidance covers the adult safeguarding sections 42-46 of the Care Act 2014. Adult safeguarding key amendments within the revised guidance include:

- Reinforcement that a formal safeguarding enquiry (Section 42) is primarily aimed at those suffering abuse or neglect from a third party and is not necessarily appropriate where people are failing to care for themselves. Assessment should be on a case by case basis.
- Additional information in relation to financial abuse to reflect significant increases in internet, postal and doorstep scams and crime.
- Guidance for practitioners to consider the need for criminal investigations and take advice if necessary. Forensic evidence can be lost if a crime is not reported or investigated quickly enough
- Reminder to Local Authorities that they have powers even where they do not have duties – undertaking adult safeguarding enquiries is one area where this may be significant.
- Reinforcing the prevention agenda (better to prevent abuse than act after the event) and reminding practitioners of the importance of identifying and managing risk of abuse and neglect, even where those concerns are not the initial presenting issue.
- New guidance around allegations about people in positions of trust - emphasis that this is a responsibility of Local Authorities and other partners, as well as the large and diverse independent provider sector. Important link made to children's safeguarding and considering risk in the round. The requirement to have a Designated Adult Safeguarding Manager (DASM) has been removed as the introduction of this job title was proving to be confusing strategic and operational roles and distracting from improving practice.
- Encouragement for Local Authorities to use existing tried and tested surveys to understand the experience of carers and service users who have been involved in a safeguarding process.
- Strengthening the role of professional and practice leadership in adult safeguarding to recognise the need to have expertise within an organisation where practitioners and their managers can go for advice and guidance.
- Revised section on strategic leadership, clearly articulating the need for a strategic and accountable lead for safeguarding at a senior level in an organisation to ensure action to implement the Safeguarding Adults Board Strategic Plan.

About the Isle of Wight Safeguarding Adults Board

The IWSAB is a statutory, multi-agency partnership committee, coordinated by the Local Authority, which gives strategic leadership for adult safeguarding across the Isle of Wight.

The primary purpose of the IWSAB is to gain assurance that the safeguarding arrangements locally help and protect adults in the area who meet the criteria set out in Chapter 14 of the statutory guidance of the Care Act 2014.

Section 44 of The Care Act 2014 outlines the three core duties for SABs:

a) It must publish a strategic plan for each financial year setting out how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement, and the SAB must consult the local Healthwatch organisation. The plan should be evidence based and make use of all available evidence and intelligence from partners to form and develop its plan.

b) It must publish an annual report detailing what it has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action taken.

c) It must conduct any safeguarding adult review in accordance with Section 44 of the Act.

Whilst the Isle of Wight Council's Adults Social Care Directorate are the lead agency with responsibility for coordinating adult safeguarding arrangements, all the members of the IWSAB share a responsibility for safeguarding. The IWSAB's remit is to agree objectives, set priorities and co-ordinate the strategic development of adult safeguarding across the Island. It is the key mechanism for agreeing how local agencies will work together effectively to safeguard and promote the safety and well-being of adults at risk and/or in vulnerable situations.

To read the IOWSAB constitution click here.

Membership

Membership will include statutory or core members, as identified through Section 43 of the Care Act 2014 and relevant NHS guidance, and members who are invited on to the IWSAB in order to enhance multi-agency working.

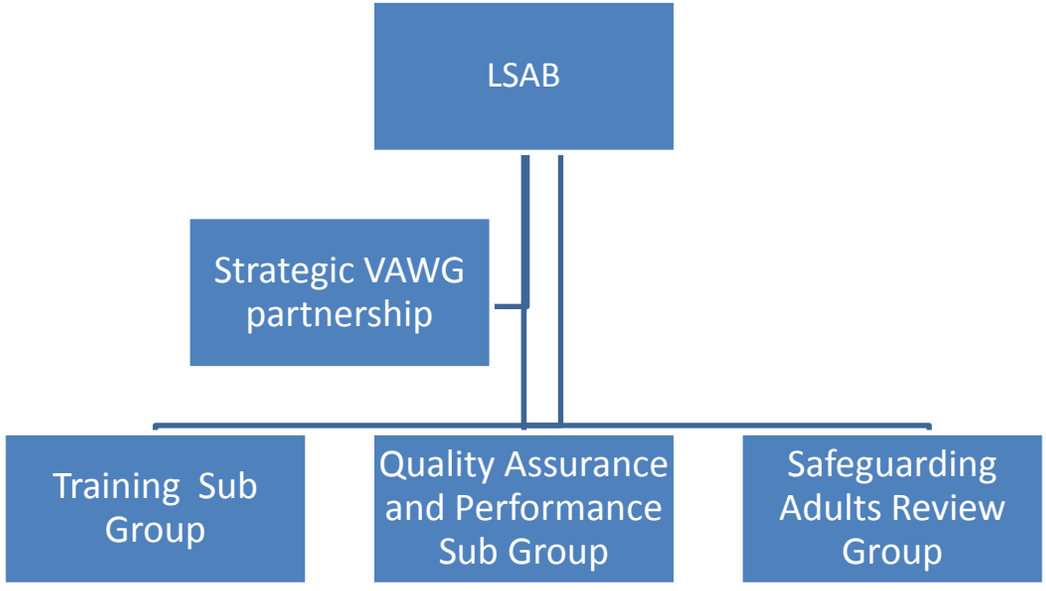
IWSAB member organisations should designate a named person to attend all meetings. The named person must have the required seniority, experience, skills and decision making authority to represent their organisation. A designated person (also of sufficient seniority) should also be identified to deputise for the named person when necessary. The named person (and their deputy) must be able to:

- Contribute to the effective working of the IWSAB in promoting high standards of safeguarding work and fostering a culture of learning and continuous improvement.
- Make decisions on behalf of their organisation
- Hold their organisation to account and hold other members to account for their contribution to the safety and protection of adults
- Commit resources in their organisation to support the work of the IWSAB
- Support access to the multi-agency training made available through the IWSAB for staff in their organisation.

Where members represent a group of organisations they will be expected to communicate effectively within their group to ensure that they have a sufficient mandate to speak on behalf of the whole group at IWSAB meetings.

The full membership of the IWSAB can be seen in Appendix A.

STRUCTURE OF THE ISLE OF WIGHT SAFEGUARDING ADULTS BOARD



The IWSAB Sub Groups focus on the delivery of IWSAB strategic objectives and priorities. The Chair of each subgroup is responsible for providing regular progress reports to the IWSAB. The IWSAB Manager maintains an overview of the work and activities of all the subgroups and is responsible for ensuring the respective work programmes of the subgroups are co-ordinated and consistent with the IWSAB Safeguarding Strategy and Business Plan. Short term task and finish groups may also set up as required to focus on the implementation of specific objectives or projects.

The IWSAB is a member of the 4LSAB Inter-Authority Working Group (IAWG), which brings together the core statutory members of the four local safeguarding boards and acts as a mechanism for coordinating respective work programmes to gain as much consistency as possible.

The IWSAB also maintains links with a range of other strategic forums and partnerships including the Local Safeguarding Children's Board, the Community Safety Partnership, the Modern Slavery Partnership, the Health and Wellbeing Board and the My Life a Full Life (MLAFL) programme. These links

emphasise the strong synergies between the work of the IWSAB and many of these forums and helps reduce duplication - particularly as objectives and membership are likely to overlap.

Strategic VAWG Partnership (The Domestic Abuse Forum)

Over the last 18 months it became apparent that the loss of a dedicated Domestic Abuse Coordinator had impacted on the effectiveness of the Forum. 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. In 2015 the IWSAB agreed to fund a dedicated Domestic Abuse Coordinator to join the Safeguarding Adults Boards' support unit to support the Domestic Abuse Forum, and a new Coordinator was appointed in October 2015. The Coordinator's priorities were to:

- Prepare a 3-5 year Strategic Plan for the delivery of DA services to the Island.
- Introduce' Integrated Commissioning' to ensure that the most effective service is delivered and maximise value for money.
- Review the current performance framework and introduce KPI's which are consistent with the strategic delivery plan
- Ensure joined up working between IWC Departments, statutory and VSO partners to deliver single delivery approach
- Ensure that VAWG training/awareness is a common thread through the strategy.

Training Sub Group

The training sub group plans and coordinates multi-agency safeguarding training which is delivered free to all Board partner agencies and support the conference planning. Training delivered in 2015 /16 included:

Self-Neglect Training
This training was commissioned in response to safeguarding adult's reviews locally and nationally which highlighted the complexity of working with people who self-neglect. Statutory guidance on the Care Act 2014 places self-neglect - in which someone is at risk through extreme neglect of their personal care or living conditions - within adult safeguarding arrangements. Whilst not every case of self-neglect will require S42 response, serious cases of self-neglect will require a multi-agency response, risk assessment and careful monitoring. The training was delivered by Professor Suzy Braye, Emerita Professor of Social Work at the University of Sussex and an expert in the field who also spoke on the subject at the Board's May 2015 Safeguarding Conference.

Mate Crime Workshops
Delivered by Rod Landman (ARC UK), these workshops were commissioned following requests from service users and their families / carers. 2 workshops were delivered – one to service users with learning disabilities to help people to recognise hate / mate crime and to report incidents, and one to

professionals working with this client group to identify how practitioners can work effectively together to raise awareness, support service users and improve the response to hate/mate crime.

Making Safeguarding Personal Training

The Making Safeguarding Personal (MSP) approach is embedded within the Care Act 14 and requires all those partners involved in Safeguarding Adults to consider how practitioners need to change practice in order to better involve individuals in shaping any responses aimed at improving their safety and managing the risks they face. Whilst MSP requires a significant shift in safeguarding culture from 'doing to' to 'doing with', the core principles are not complicated, involving a preventative multi-agency approach with a focus on having & supporting conversations with people - and making those conversations count. This training was delivered by Making Connections throughout 2015 / 16 to ensure compliance with the Care Act requirements.

The Impact of Sexual Violence and Rape

This two day course was presented by CIS'ters, who are a specialist service run by survivors of childhood sexual abuse. This comprehensive 2 day training focused on improving the response to victims/survivors (all ages/genders) of sexual violence and/or sexual abuse.

Domestic Abuse Training

Domestic abuse is clearly identified as a safeguarding issue in the Care Act 2014. This course was commissioned to help define the impact of domestic violence on victims/survivors and to improve responses to victims, increase understanding and awareness of risk assessment, the support available to high risk victims via MARAC and the importance of safety planning.

Safeguarding Adults Review Sub Group

The Safeguarding Adult Review (SAR) sub-group supports the Board's Independent Chair in commissioning and overseeing safeguarding adult reviews (SARs) and other reviews of practice and recommending ways in which the learning and improvement from such reviews can be embedded into practice. The group's objective is to involve agencies, staff and families in a collective endeavour to reflect and learn from what has happened in specific cases in order to improve practice in the future.

New and more robust Terms of Reference were agreed in June 15 to ensure the Group was supporting the Board to meet its statutory responsibilities under Section 44 of the Care Act 14.

Safeguarding Adults Reviews

Section 44 of the Care Act 14 requires Safeguarding Adults Boards to undertake a Safeguarding Adult Review (SAR) in specific circumstances and places a duty on all Board members to contribute in undertaking the review, sharing information and applying the lessons learnt.

The law requires local SABs to arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk.

The purpose of a SAR is not to hold any individual or organisation to account as there are other processes available for that purpose; they are about learning lessons for the future. SARs ensure that SABs get the full picture of what happened, so that all organisations involved can improve as a result

Two Safeguarding Adults Reviews were completed in the period in question and published in May 2016, into the cases of Mrs. X (click here) and Mr W (click here).

Mrs. X

Mrs X was a woman in her mid-eighties, who died several days after being admitted to hospital from a Residential Care Home on the Island in April 2013. A number of practice concerns emerged from the safeguarding investigation undertaken and from the Coroner's inquest that subsequently took place. The IWSAB agreed that this case met the criteria for a Safeguarding Adults Review under the Care Act 2014 and commissioned a review using the 'Learning Together' systems methodology which was developed with the Social Care Institute for Excellence (SCIE).

Findings

The Review found:

- That poorly developed systems and limited access to key IT tools within the District Nursing Service has increased the risk that patients may not be assessed or treated effectively.
- The lack of a joined-up multi-agency approach to the management of patient's health and social care needs has led to a mis-match of expectations between agencies and staff that has affected the quality of service delivery.
- Governance arrangements for the District Nursing Service are lacking effective quality assurance processes to pick up deterioration in service delivery.
- Commissioners and providers of care on the Isle of Wight are struggling to provide a person centred response for older people who can be left stranded when their level of needs rises above a certain point.

Mr W

Mr W was an 86 year old man who died on the 17 August 2013 after having been admitted to St Mary's Hospital from a Nursing Home. The death certificate stated that Mr W died of Septicemia. This subsequently gave rise to questions about the way in which local professionals and services had worked together with Mr W and whether agencies could have intervened earlier.

Findings

The Review found:
Failures in effective multi-agency communication

- Lack of shared risk assessment s and person centered choice
- A combination of poorly developed systems and an overreliance of IT systems impacted upon the professional responses to Mr W.
- The lack of a joint up approach to the commissioning of a multi - agency training strategy has led to silo responses to the delivery of key training and skills development for staff
- A series of notifications of concern about the same person should trigger an escalation and any patterns should be risk assessed by Adult Services and cross checks undertaken with other Emergency Services
- The Safeguarding Adults Board need to have in place robust systems and processes, in particular how they intend to hold agencies to account to ensure that they can meet their Section 44 and 45 duties under the Care Act 2014.

In addition to these 2 statutory reviews, the SAR sub group also undertook a discretionary review into the death of Mr V (click here) because there were clear lessons to be learned about improving practice. Mr V had a long history of not caring for himself very well. He was frequently aggressive and abusive to people who tried to help him. He had a history of schizophrenia, mild learning disabilities and traits of autism. He was also described in affectionate terms by his carers who had built a relationship of trust with him. Mr V died sometime during the night of 10th-11th December 2014 at his warden-controlled flat in East Cowes having been discharged from hospital on the afternoon of the 10th December. Mr V had been adamant that he did not wish to remain in the hospital and declined medical treatment. He was 72 years old. The death certificate gave the cause of death as "acute peritonitis" and "small bowel infarction".

Findings

- If a GP has made a decision that a significant deterioration in a patient's condition would necessitate admission to hospital via 999 ambulance then the GP's notes must be very explicit in stating this.
- That the Ambulance Service link 111 and 999 calls.
- Where a patient with a known or suspected learning disability is admitted, health professionals should liaise with the specialist LD nurse for support and communication with the patient.
- Medical staff should have an easy way of recording an assessment of mental capacity that can be seen and used by any other member of staff dealing
- Where mental capacity assessments are completed they should be fully, recorded and dated clearly in the patient's notes with the patient.

All recommendations from Serious Case Reviews are monitored by the SAR subgroup and are held in a combined SAR Action Plan.

Quality Assurance and Performance Sub Group

The Quality Assurance and Performance Sub Group is responsible for ensuring that robust mechanisms are in place to assure the Board that good practice to Safeguard Adults at risk is delivered consistently by Partner Agencies across the Island in accordance with the Care Act 2014. The Sub Group has a new Chair, Hampshire Constabulary's District Commander for the Isle of Wight, who was appointed in January 2016. The Chair inherited a group that had suffered difficulties in progressing work due to frequent changes of Chair and of attendees, which led to a lack of direction. New Terms of Reference were agreed in January 2016 and work through until the end of this reporting period focussed on re-shaping the group and the development of a new data collection tool. The new Chair is committed to the work of this group and whilst this area of work remains a significant challenge with much to be done, it is anticipated that under this new leadership the group will be functioning far more effectively in the next financial year.

Activity & Data 2015-16 – Safeguarding Adults Collection

The Safeguarding Adults Collection (SAC) records safeguarding activity relating to adults aged 18 and over, with care and support needs in England. During 2015-16 2,631 concerns were raised with the local authority, of which just over 25% (676) required a safeguarding enquiry under S42 of the Care Act 14. The data shows us that a lot of low level concerns are being reported which do not meet the criteria for further enquiry under Section 42 of the Care Act. These cases will be closed as a concern and /or will be signposted to other agencies. It is possible that greater awareness of safeguarding under the Care Act has led to an increase in the reporting of concerns.

Some key points to note are that the majority of safeguarding concerns are in relation to those over the age of 65 which supports the demographic picture of the Isle of Wight, and that the most prevalent type of abuse on the Island continues to be neglect, which mirrors the national picture and this is the same as last year. Neglect covers everything from missed medication and inadequate staffing, to pressure ulcer development and health needs not being met – which is why nationally and locally this is the most common category of abuse.

For the full Isle of Wight Safeguarding Adults Return data please see Appendix B.

Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS)

In 2014/15, following the Supreme Court decision in Cheshire West, a huge increase in DoLS activity was seen on the Isle of Wight – and across the UK, which has continued into 2015 / 16. This has resulted once again in many authorisation requests not being assessed within deadlines and a large number of outstanding requests at year end.

DoLS 2015-16	Hospital	Care Homes	Total
Number of DoLS requests	128	652	780
Assessed approved	16	89	105
Assessed refused	9	6	15
Withdrawn before asst	93	241	334
Out-standing at 31/03/2016	10	316	326

The principle risks remain in line with those detailed in 2014/15 and 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 breech 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 breech) 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. The Local Authority are prioritising DoLS requests that identify high levels of restraint or objection by the person or their relatives.

2. We are supporting care managers to ensure the underlying principles of the Mental Capacity Act are complied with, to avoid substantive breeches of the regulations.

3. We are 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.

Community Engagement

Service Users and Carers

The IWSAB aims to promote the involvement and contribution of service users and carers at the Board. To this end the Independent Chair of the Board met with service user and carers groups over the course of the year to gain feedback on safeguarding. Following feedback from people with a learning disability specific mate / hate crime training was provided this year to service users and to those working with them. This will be repeated in 2016/17.

Festival and Bestival

Joint working between the IWSAB and the Violence Against Women and Girls (VAWG) Strategic Partnership saw a safeguarding presence under the banner 'Reclaim the Night' at the Isle of Wight Festival and the Bestival in 2015. These festivals attract tens of thousands of people to the Isle of Wight and require a coordinated response from the Isle of Wight Council, Hampshire Constabulary, the NHS Trust and other many other partners to ensure the events are managed safely. This year, the team worked in partnership with Hampshire Constabulary and the welfare providers on the sites to provide both awareness raising and advice and a specialist response to anyone who discloses sexual abuse. This is important as we know from research that the majority of victims of sexual assault choose not to disclose to police – but do want someone experienced in the issues to talk to, and it is encouraging that the organisers of both the festivals are willing to openly tackle issues that other festivals might choose to ignore. The team consists of volunteers from Barnardos, the Isle of Wight Youth Offending Team, the Island Women's Refuge and the NHS Trust's Sexual Health Team and used jewellery making as a means of engagement with hundreds of service users to discuss issues around sexual consent and respectful relationships. The initiative appears to be

unique to the Island's festivals and has attracted national media attention as an innovative away to engaging the public with safeguarding. Feedback from festival goers at both events was overwhelmingly appreciative and positive.

Professional Development

During the financial year 2015/16 the IWSAB held 2 major safeguarding conferences at the start and end of the financial year. This was due to late changes to dates which meant that the 2016 conference was held in March 16. The conferences are held in partnership with the Office of the Police and Crime Commissioner for Hampshire and the Isle of Wight.

The first Isle of Wight Safeguarding Adults Board and Office of the Police and Crime Commissioner Conference was held on 15 May 2015. National speakers discussed the implications of the Care Act 2014 on a range of safeguarding issues from self-neglect to so called 'Mate Crime' with a multi-agency audience.

In March 2016 the Safeguarding Adults Board and the Office of the Police and Crime Commissioner joined together again to hold the second annual conference, at which one of the main themes was mental capacity and the linked subject of Deprivation of Liberties (DoLS) work. The conference highlighted the extreme complexity of this area of work and underlined the importance of professionals listening to carers and families.

The presentations from the conferences, together with the full gallery of photos, can be viewed here: SAB Conference.

Partners Contributions to Safeguarding Adults work through 2015/16

The Board's partners were all asked to contribute to this annual report highlighting the work they have undertaken in 2015/16 towards safeguarding adults on the Island. The reports from those partners who responded are included below.

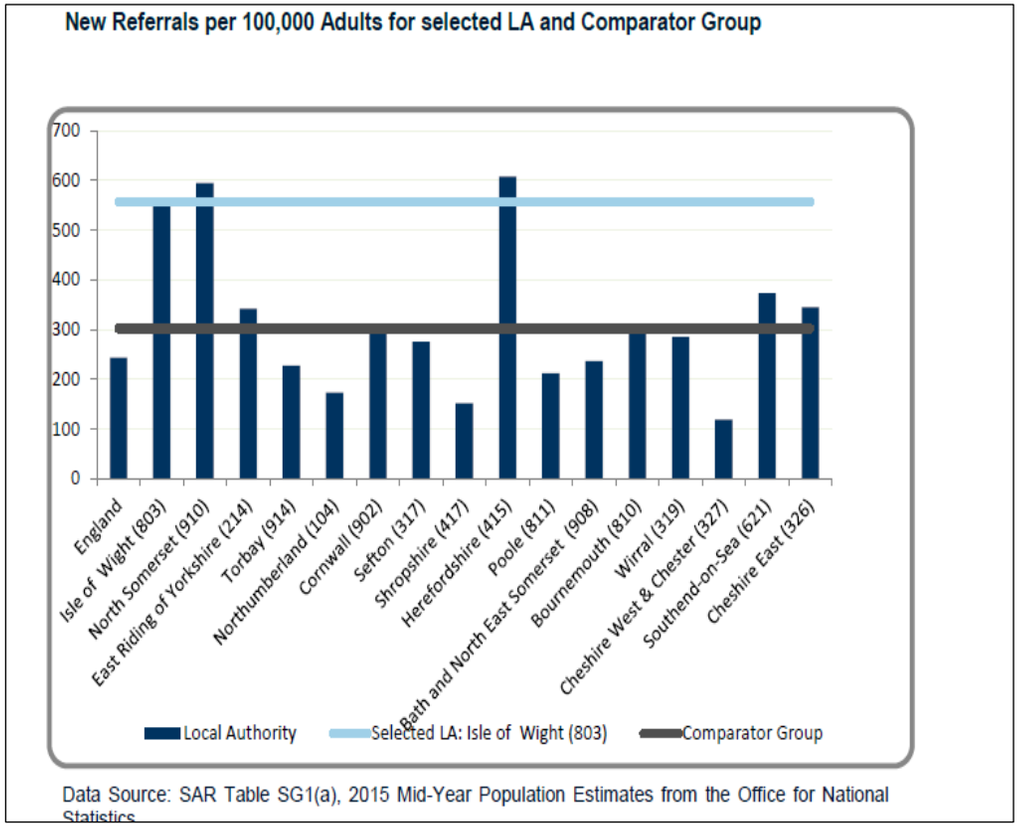
ADULT SOCIAL CARE

Key Developments Achievements in Safeguarding Adults for 2015-16

This year has seen us further embed the principles of the Care Act into all Adult Social Care functions. The focus has been on Making Safeguarding Personal, ensuring that the views, wishes and outcomes for the adults at risk of abuse are captured and acted upon throughout the safeguarding process. The Safeguarding Team has new processes in place to ensure that the adult at the centre of the enquiry (or their family) can be active participants in the process, using advocates as necessary. We have continued to promote use of the local advocacy service for both Independent Mental Capacity Advocates as well as Care Act advocates.

The Vulnerable Adults Panel meets monthly to share information across the Partnership about high risk vulnerable adults and has a monitoring role to ensure action is taken when risk escalates. There is a particular challenge for agencies in managing the risks for people who self-neglect or choose chaotic lifestyles and the Panel provides a forum for monitoring and determining action where appropriate.
We have been exploring how to develop regular integrated locality meetings working with the police, housing, voluntary sector etc. to problem-solve those who are vulnerable in our communities. This is part of the My Life A Full Life plans for developing integrated locality services and will support the work of the vulnerable adult panel.

Adult Social Care has seen a significant rise the number of safeguarding referrals, receiving almost twice the number of most of its comparator group (see table below. This is possibly in part a reflection of training and greater awareness of adult safeguarding risks following the implementation of the Care Act. However, following initial investigations, almost half of the referrals received are not appropriate for moving to a formal safeguarding process which suggests there may be more work to do across the Partnership in understanding reporting thresholds and managing risk in day to day practice.



Applications for Deprivation of Liberty Safeguard (DOLs) are continuing to grow in light of the Cheshire West judgement and additional staff have been recruited to help process these.

This year has also seen a large increase in the number of applications going to the Court of Protection to determine Best Interest decisions in relation to adults lacking capacity.

Training continues to ensure that all staff working across Adult Social care are aware of their duties and obligations in relation to Adult Safeguarding.

Training undertaken in Safeguarding Adults in 2015-16

Safeguarding Training	
Enquiry officer - Refresher	18 Staff
Alerters Training	50 Staff
Managers Updates	3 staff
Section 42 enquiries	3 Staff
Making Safeguarding personal	12 Staff
Reflective support for safeguarding team	5 Staff
Mental Capacity Act training	
MCA Overview and Principles	9 Staff
MCA in Practice	12 Staff
MCA Detailed training	34 Staff

Challenges and Barriers to Safeguarding Adults in 2015-16

- High levels of concerns raised
- Responding effectively in cases of self-neglect
- High volume of DoLS applications

Key Priorities for 2016-17

- Ensure that the Multi Agency Risk Management Framework is understood and embedded in social work practice
- Work with Board Partners to ensure the Vulnerable Adults Panel and the development of integrated locality working provides best practice in supporting individuals who choose challenging lifestyles
- Explore and test the formation of a Multi-Agency Safeguarding Hub (MASH) , or similar, on the Island to improve multi-agency working
- Analyse the reasons behind the large increase in the number of referrals to the Safeguarding Team and
- Work with the Board to improve shared understanding of reporting thresholds and managing risk in day to day practice

In addition we will continue to:

- work towards integration of our practice and processes with partners
- provide high quality training for all staff
- develop the PARIS system to get maximum benefit from its ability to streamline process and improve management information

Isle of Wight CCG

Key Developments Achievements in Safeguarding Adults for 2015-16

The CCG has successfully appointed a Named GP for Safeguarding, a Head of Safeguarding/Designated Nurse for Safeguarding Adults, Children and Looked After Children, as well as a Quality Support Manager who can engage with and support nursing and care home providers as well as domiciliary care providers in their quality improvement endeavours.

Robust mechanisms for information sharing between the Local Authority (LA) and IOW NHST are being further explored, to ensure that all parties are aware of safeguarding incidents and concerns, as well as statutory enquiries. This will enable more detailed monitoring and reporting, as well as support the identification of themes and trends in real time. This data will also enable the monitoring of quality, as well as inform professional challenge where appropriate.

Stronger partnership working is now re-established across the CCG and Local Authority, with clear integrated programmes of care in relation to:

- Quality assurance
- Individual placement reviews
- Care and Treatment Reviews ensuring that individuals living with a disability get the right care, in the right place that meets their needs, and they are involved in any decisions about their care
- An increase in requests for GP encounter information as investigation are undertaken.

What is evident is that there is a need to support Primary Care in improving its capacity to effectively discharge its safeguarding duties. Measures are being put in place which include a Safeguarding Audit undertaken by Dr Ali Robins (Named GP for safeguarding) as an indicative needs assessment – results indicate some support is required in relation to improving Care Act (2014) compliance and understanding. A training needs assessment was also undertaken specifically with Practice Nurses – analysis to be undertaken but crude review demonstrates poor levels of training

Collation of a wide range of support materials for the CCG Intranet Safeguarding page which are to be uploaded. These include:

- Safeguarding referral contact names, numbers, secure email addresses and referral proformas for adults and children
- Threshold documents for children's referrals
- Level 1, 2 and 3 Intercollegiate Standards and Competencies for safeguarding children
- Level 1, 2 and 3 Intercollegiate Standards and Competencies for caring for Looked After Children
- Level 1, 2 and 3 Intercollegiate Standards and Competencies for safeguarding adults
- A training matrix highlighting which member of staff requires which training, at which level, at what frequency and using which format
- A wide range of local, regional and national policies, procedures and protocols
- A summary of the GP responsibilities in relation to Domestic abuse and violence
- Checklist for Care Act (2014) compliance
- MCA (2005) capacity assessment information and checklists

Some targeted training safeguarding training has already been delivered to some practices, with some face to face supportive case reviews taking place following Section 42 enquiries or investigations.

The CCG has undertaken a benchmarking exercise in relation to CCG compliance with PREVENT , LSAB & SEND

Training undertaken in Safeguarding Adults in 2015-16

All CCG and provider staff are required to undertake safeguarding adults training in line with both statutory requirements and their role and function. The CCG has undertaken an audit over summer of all CCG staff in an effort to identify the baseline position moving forward. This is due to be analysed and will inform a CCG wide announcement in relation to current position and statutory requirements (role-specific).

Challenges and Barriers to Safeguarding Adults in 2015-16

The need for provider organisations to fully understand and embed robust systems and processes in relation to their statutory duties under the Care Act (2014), the Mental Capacity Act (2005) and its Deprivation of Liberty Standards (2009) as well as PREVENT under the Counter Terrorism Act (2015). Whilst there are pockets of good understanding in some providers, others require some support to fully appreciate their roles and responsibilities. Given that royal assent was so recent for the Care Act (2014), a more cohesive and supportive approach is required across all providers, with consistent and universal messages, systems and processes and reporting tools and criteria.

Key Priorities for 2016-17

Provider organisations will need to examine how they will deal with the juxtaposition of fulfilling their statutory obligations in line with legal and professional requirements, whilst striving to make safeguarding personal. A clear process for consulting those harmed or at risk of harm needs to be embedded from the very outset of the safeguarding process, with desires and wishes communicated throughout, with a caveat that at times statutory duties and legal requirements may limit the scope for how personalised a response can be. Commissioners need to support providers in understanding and supporting the making safeguarding personal agenda and also in positive risk taking.

MCA and DoLS Priorities include:

- Improving the understanding of the difference between the Mental Capacity Act (MCA, 2005) and the Mental Health Act (MHA, 1983) and how this relates to application in practice
- Improving understanding and practice in relation to when and how to undertake a mental capacity assessment and evidence this, across all provider settings.
- Promoting the use of the Mental Capacity assessment tools using System One across GP surgeries.
- Promoting the use of an NHS Trust endorsed Mental Capacity assessment tools, to be used across the NHST services.
- Improving the understanding of the Deprivation of Liberty Safeguards integral to the MCA (2005) and how

the legislation should translate into practice, particularly in the acute setting.

- Ensure that a registered and non-registered workforce is developed who is fit for purpose for working with and supporting individual with challenging behaviour, in the coming years.
- Ensuring that dementia and training in managing challenging behaviour is targeted at the correct level and not just at the level of awareness.
- Staffing levels reflect the increasing need for constant supervision of people who are at risk of harm due to their dementia in acute care settings.

IW Regulatory and Community Safety Services

Key Developments Achievements in Safeguarding Adults for 2015-16

Having a position on the Safeguarding Adults Board in addition to various sub groups such as the vulnerable Adults Panel, WAWG and SAR group.

Integrating some of the priorities into our wider community safety partnership work plan and sub groups such as DAAT, Joint Action Group and Night Time Economy.

Community Safety Partnership strategic assessment and plan produced with the following priorities;

- Reduce reoffending
- Respond effectively to ASB
- Reduce violent crime
- Protect vulnerable members of the community
- Delivery of prevent (counter terrorism) duty
- Road Safety

Establishing a prevent board on the island and training of Isle of Wight council staff in awareness training to identify vulnerable individuals at risk of radicalisation.

Training undertaken in Safeguarding Adults in 2015-16

LSAB conference
National Centre for Domestic Violence training
ASB new powers training for CSP partners
Offender Management conference
MECC foundation training
Participation in the Trading standards south East Protection of Vulnerable Consumers Focus Group

Challenges and Barriers to Safeguarding Adults in 2015-16

A reduced resource prevents much valued proactive work with partners in providing awareness training for scams etc. This reduction in resource also impacts on availability to tackle all doorstep crime and scam cases on the island.
Lack of housing options for vulnerable adults with alcohol dependency, homeless and offenders
Lack of funding for analytical work

Key Priorities for 2016-17

Reoffending group established and develop a plan to deliver on : housing, skills and priority needs
Road safety priority to address older people vulnerability
Deliver Prevent training to frontline staff and hold Channel panels when required
Conduct 2 Domestic Homicide reviews and share lessons learnt with partners
Carry out community consultation on priorities for 2017 CSP Strategic plan and carry out strategic assessment and review strategic plan.
Undertake training and awareness sessions for partners (resource dependant) for doorstep crime, scams and other types of financial abuse.
Establish a joint working guide for referrals to trading standards.
Deliver the IWASP (Isle of Wight against Scams Partnership) as part of the age friendly Isle.

Hampshire and the IOW Community Rehabilitation Company

Key Developments Achievements in Safeguarding Adults for 2015-16

Between 15-16 the CRC began to mobilise as an organisation. The CRC manages all people who are assessed as low and medium risk of harm to others. It delivers Community payback and accredited programmes. This includes the building better relationships programmes for perpetrators of domestic abuse.

A high proportion of the cases we manage are those who have been convicted of domestic abuse either currently or in the past.

The CRC is also, with the police, the lead agency responsible for the Integrated Offender Management scheme. This scheme targets all of those offenders who commit the most offences in the community.

The CRC also began a new women's group which runs weekly.
Introduction of the Through the Gate(TTG) service which seeks to have a resettlement plan for all service users who leave custody

Training undertaken in Safeguarding Adults in 2015-16

Due to mobilisation phase the CRC training has been predominately on the new delivery model and the new Offender rehabilitation act. In addition our case manager (probations service officer) group undertook some up skilling in working with DA cases.

Challenges and Barriers to Safeguarding Adults in 2015-16

The lack of accommodation from the most difficult who are also vulnerable people on the IOW. The result is that people are going to prison due to lack of stability in the community.

Key Priorities for 2016-17

Develop an offender accommodation strategy for the IOW
Seek to increase the numbers of people accessing BBR programme
Developing links with the TTG in prison to ease people back into the community
Continue to focus on the most difficult people through IOM

NHS England – South (Wessex)

Key Developments Achievements in Safeguarding Adults for 2015-16

Focus on MCA / DoLs. Consulted with Designated Safeguarding Professionals across Wessex via our quarterly Safeguarding Forum to agree priorities and develop a strategy for tackling current issues.

Development and implementation of Webinars presented by Designated Safeguarding Professionals from across Wessex, supported by our team, on various key Safeguarding subjects to include FGM, GP learning from Serious Case Reviews & MCA / DoLs awareness. Webinars accessible to all GP's in Wessex, and MP4 versions are added to the LMC website for future access.

MASH leaflet launched and distributed in Jan 2016 to IOW and rest of Wessex for practitioners and professionals to refer to when they have Safeguarding concerns and are unsure of where to report their concerns

Safer Recruitment - NHS E Wessex in cooperation with the Virtual College, made the online Safer Recruitment training available to all GP practices across Wessex including the IOW. The learning provided an excellent grounding in the essentials of safer recruitment, including the recruitment of those who are employed by GP practices to work or volunteer with children, young people and adults.

Training undertaken in Safeguarding Adults in 2015-16

All NHS E staff now required to complete mandatory Safeguarding training at Level 1. This is done via an online e-learning programme & includes training on both children & adult's safeguarding.

Currently implementing a training programme for 2016/17 in Safeguarding for independent practitioners i.e. dentists, pharmacists and ophthalmologists which will be delivered via a combination of evening workshops and e-learning. Will include key learning from local SARs and case studies along with latest guidance to keep practitioners up to date

Two members of our team attended MCA / DoLs training by SCIE on 23rd / 24th November 2015

Challenges and Barriers to Safeguarding Adults in 2015-16

During 2015/16 NHS England South (Wessex) were able to allocate a small amount of funding to each CCG with a specific focus on MCA/DoLS. As a result CCG's were able to hold a number of educational and training workshops to develop competencies of frontline staff in this area. Whilst these workshops have been successful in training a number of staff to raise awareness of this agenda more work is needed to develop confidence in undertaking meaningful assessments that reflect a change In personal circumstances, for instance a change of care home, or discharge from hospital etc. to ensure compliance with the Care Act 2014.

More focus on a 'think family approach is needed to ensure interface between children and adult services at key points of service delivery such as transition between the two services. There is concern that once in adult services there Is a lack of resources and capacity to offer the same level of support. Ensuring that NHS provider services are fully aware of their responsibilities under the PREVENT agenda.

Key Priorities for 2016-17

NHS England South (Wessex) have developed a safeguarding programme for 2016 / 2017 to allow a focused approach to the NHS England national safeguarding priorities, which are MCA/ DoLS, FGM, PREVENT. Looked After Children (LAC) and Child Sexual Exploitation (CSE).
An initial scoping exercise has been undertaken with key stakeholders including partner agencies and Safeguarding Boards across Wessex, to understand local priority areas and how they align with the NHS England national agenda. The scoping exercise has identified some emerging priorities in relation to the national themes:

MCA/DoL's: The scoping exercise suggests that despite the provision of extensive training to different NHS groups, there is a lack of confidence amongst some staff groups to undertake assessments especially in more challenging environments such as intensive care or end of life placements. This is having an impact on the system in terms of appropriately prioritising cases.

More consideration needs to be given to the content and format of training to ensure MCA / DoLS is fully understood across the NHS and independent provider workforce.

As part of the safeguarding programme a task and finish group has been established to consider future models of support and training needs for differing staff groups to embed sustainable and appropriate use of MCA / DoLS assessment processes In practice.

PREVENT remains high on the national agenda due to the recent international attacks. The Government is seeking assurance that NHS services have the confidence and competence to deliver PREVENT duties. A specific focus is being placed on Mental Health Teams and Primary Care to ensure active participation in this agenda.

Locally, there are pockets of activity in relation to this agenda. Responses from stakeholders suggest a benchmarking exercise is undertaken to ensure all safeguarding leads have received level 3 'Wrap Training' to be assured key messages are cascaded throughout organisations. A focus on Primary care is needed to ensure teams are supported in understanding their responsibilities in this area.

FGM: A focus of the NHS England national sub group is to ensure all frontline staff are confident and have the competencies to identify cases of FGM and that this awareness is sustained in practice so that mandatory reporting for under eighteen year olds reflect the local demographics. A national mapping exercise is being undertaken to ensure clinical services are able to meet the local need, including post abuse services for those that have experienced FGM. Across Wessex we will:

Review local training provision with safeguarding leads

Map current services against population where FGM cases would be expected.

Ensure all provider are registered on the HSCIC database

Other key work streams that are being considered as priority area for 2016/17 are:

Developing the interface between children and adult services- understanding transition pathways
Mapping therapeutic services across the region, specifically in relation to; CSE/CSA, FGM, DVA
Developing workforce capabilities
Implementation of our 2016 / 2017 safeguarding training programme for independent practitioners as highlighted above.
Further focus and resources put towards tackling MCA / DoLs & Prevent?
that CSE work takes into account children who have been the victims of exploitation, as they move into adulthood
Involving patient/ service user voices and perspectives in the developing areas of the programme.

Hampshire Constabulary

Key Developments Achievements in Safeguarding Adults for 2015-16

We are proud to have worked closely with two partnership events which were focused on improving better joint working and information sharing. As a result of the events we now weekly shared vulnerability meetings with partner agencies.
The MARAC is developing well on the IOW with a more focused approach on the cases referred. Adult Services and the development group are working closely to improve the CA 12 referrals, this is making greater progress over the year.
We have maintained our resources within safeguarding showing the commitment we have to this key partnership work.

Training undertaken in Safeguarding Adults in 2015-16

We have maintained our CPD with our front line staff and are now undergoing new training with our new leadership staff including implementation of the Care Act 2014.

Challenges and Barriers to Safeguarding Adults in 2015-16

Managing volume of work and our assessment of risk that meets that of our partners.

More focused time listening to service users and responding their needs.

Key Priorities for 2016-17

Same as the Board.

Sea Gables Residential Care Home- Kelly Pointing Manager- Deputy chair for the IWRCHA.

Key Developments Achievements in Safeguarding Adults for 2015-16

Truly embedding the care act, and re designing the service to ensure that individuals where placed at the centre of any safeguarding concern. Listening to clients and respecting their decisions in relation to their desired outcomes where safe to do so. Developing staff knowledge, and looking at our data in relation to safeguarding concerns raised and whether actually they required a safeguarding response in line with the thresholds for a safeguarding concern. Providing awareness sessions to clients around self-care, and keeping themselves safe.

Training undertaken in Safeguarding Adults in 2015-16

All staff regardless of role have received safeguarding training. This includes subjects such as mental capacity act and DOLS training.
Managers attended Section 42 4 day cohort.
Making safeguarding personal workshops, domestic violence workshops. Mainly managers, with some other key senior staff.
Safeguarding adults conference.
Safeguarding train the trainer for managers

Challenges and Barriers to Safeguarding Adults in 2015-16

Individuals confidence to positively risk manage situations. Individuals in an un recognised professional role worry about blame, and our society is still to some extent a blame culture focused.
Safeguarding should not been seen as a process done to someone, and I feel too many people still have this view.
Comments such as the person was safeguarded, shouldn't been seen as a way to compensate for responsible individuals providing a safe and effective service due to fear of blame. The law is out there to protect staff and individuals when used effectively.
Not being able to have a conversation about a concern due to the lines being so busy.

Key Priorities for 2016-17

To continue to drive up standards in relation to making safeguarding personal. Continue to help clients focus on self-care and keeping themselves safe.
To appoint a safeguarding champion/ client liaison lead member to help build confidence with our clients to self-report issues. Also a key person for families or staff to address direct concerns with to minimise possible harm occurring. Improve conversations
Continue to train and develop staff further in understand the care act and the changes it has brought in relation to safeguarding.
Review the alert forms for reporting in relation to terminology
Build confidence in regards to managing section 42 enquiries, and what the process should include.
Ensure closer is sought on each concern raised, and the outcome is feedback to the person.
Improve knowledge in relation to thresholds for raising a concern, and what will trigger the section 42 duty.
Look at how to monitor are data internally to make most use of it.

SOUTHERN HOUSING GROUP LIMITED

Key Developments Achievements in Safeguarding Adults for 2015-16

Our annual in-house review of our safeguarding policies and procedures has included the following key developments:

- An updated safeguarding toolkit for all staff with revised policies relating to Deprivation of Liberties, Mental Capacity Act, Service User Self-Neglect, Whistle Blowing, Handling Service User Finances and Understanding Mental Health.
- An updated Group wide Policy Statement
- A revised review form for monitoring progress of safeguarding cases
- An organisational safeguarding risk assessment which makes reference to the Care Act 2014 and potential risks in relation to both staff and service users.
- A revised staff handbook specific to safeguarding and relevant to both adults and children
- A revised safeguarding awareness guide for service users
- An updated leaflet for service users
- Care and support statutory guidance in relation to the Care Act

Other developments:

- A review of our Service Level Agreements with partner agencies has provided for the inclusion of safeguarding related information sharing protocols as appropriate
- The implementation of a safer staff recruitment action plan
- Submission of a questionnaire to our insurers specific to our safeguarding operations
- A presentation to the local Adult Safeguarding Board from a Southern Housing Group perspective
- An action plan in response to an independent audit of our safeguarding processes has been implemented and includes a review of e learning training for all SHG employees and relationships with local authorities and safeguarding boards in other SHG regions
- Submission of an SHG self-audit to the LSAB.

Training undertaken in Safeguarding Adults in 2015-16

A mandatory annual training plan is in place for all SHG Care and Support staff on the Island and delivered by our Head of Sheltered and Care Services and Safeguarding Lead

E learning for all other SHG staff is also mandatory.

The Registered Manager for our CQC services has recently completed a Train the Trainer safeguarding course while other staff have attended local training on the process for Adult Safeguarding Reviews, the Level 3 Interagency session, the role of the Designated Officer and Making Safeguarding Personal.

Staff have attended SafeLives training delivered by the LA's Domestic Violence Co-ordinator and Chief Executive of Wight DASH.

Challenges and Barriers to Safeguarding Adults in 2015-16

- Reductions in LA funding which may increase the risks to vulnerable people
- The risk to people with low level support needs who are no longer eligible to receive services
- Lack of Provider and Agency Forums where greater awareness of Safeguarding could be promoted
- Lack of Housing Provider representation on the LSAB

Key Priorities for 2016-17

- To continue to ensure that our services help protect vulnerable people from abuse as far as is possible while promoting independent living
- To embrace the Making Safeguarding Personal initiative
- To learn lessons from safeguarding cases and implement improvements as necessary
- To ensure mandatory training requirements are fulfilled – with this in mind, a full Group wide safeguarding training programme will be implemented commencing January 2017.
- Meet the requirements and recommendations of the SHG independent audit

Appendix A: IOWSAB Membership

Alex	Hyslop	Probation
Amanda	Brady	CQC
Amanda	Gregory	Community Safety Partnership
Bryan	Hurley	Public Health
Chris	Smith	Ambulance Service
Claire	Foreman	Adult Social Care, Isle of Wight Council
Diane	Radcliffe	Wight Home Care
Graeme	Burnett	Southern Housing Group
Jane	Leigh	LSCB
Joanna	Smith	Healthwatch
John	Baxendale	HM Prison Service
Justin	Harden	Fire & Rescue
Kelly	Pointing	Residential Homes Representative
Loretta	Kinsella	CCG
Lynn	Turner	Safeguarding, Isle of Wight Council
Mandy	Tyson	CCG
Margaret	Geary	Independent Chair
Maria	Bunce	Age UK
Nicola	Priest	NHS England
Nikki	Shave	CRC
Rachel	Lovely	Care UK
Richard	John	Hampshire Constabulary
Rida	Elkhier	Public Health
Sarah	Jackson	Hampshire Constabulary
Sarah	Johnston	NHS Trust
Simon	Gerfen	Finance, IOW Council
Steve	Burridge	Hampshire Constabulary
Val	Bell	Housing Services, Isle of Wight Council

Appendix B: SAC Return

Safeguarding Adults Collection (SAC)
2015-16 Collection Proforma version 1 (released March 2015)

Colour coding for this return

Green headings relate to mandatory data items
Grey headings relate to voluntary data items

Section 1: Demographic Tables

The data in these tables should only relate to concerns or enquiries which were raised or commenced during the reporting year.

Only one entry per person is permitted in tables SG1a, SG1b and SG1c

Multiple entries per person are permitted in tables SG1d and SG1e

Only one entry per concern or per enquiry is permitted in table SG1f

Table SG1a	Age Band					
Counts of Individuals by Age Band	18-64	65-74	75-84	85-94	95+	Not Known
Individuals Involved In Safeguarding Concerns	477	158	381	446	65	0
Individuals Involved In Section 42 Safeguarding Enquiries	196	59	149	150	22	0
Individuals Involved In Other Safeguarding Enquiries	1	1	0	0	0	0

Table SG1b	Gender		
Counts of Individuals by Gender	Male	Female	Not Known
Individuals Involved In Safeguarding Concerns	592	935	0
Individuals Involved In Section 42 Safeguarding Enquiries	244	332	0
Individuals Involved In Other Safeguarding Enquiries	0	2	0

Table SG1c	Ethnicity						
Counts of Individuals by Ethnicity	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	Refused	Undeclared / Not Known
Individuals Involved In Safeguarding Concerns	1389	3	6	2	3	2	122
Individuals Involved In Section 42 Safeguarding Enquiries	543	2	4	2	0	0	25
Individuals Involved In Other Safeguarding Enquiries	2	0	0	0	0	0	0

Table SG1d	Primary Support Reason							
Counts of Individuals by Primary Support Reasons	Physical Support	Sensory Support	Support with Memory & Cognition	Learning Disability Support	Mental Health Support	Social Support	No Support Reason	Not Known
Individuals Involved In Safeguarding Concerns	319	7	245	182	81	6	687	0
Individuals Involved In Section 42 Safeguarding Enquiries	150	5	75	84	35	4	223	0
Individuals Involved In Other Safeguarding Enquiries	1	0	1	0	0	0	0	0

Table SG1e				
Counts of Individuals by Reported Health Conditions	Sub-class	Individuals Involved In Safeguarding Concerns	Individuals Involved In Section 42 Safeguarding Enquiries	Individuals Involved In Other Safeguarding Enquiries
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)	23	8	0

Learning, Developmental or Intellectual Disability	Asperger's Syndrome/ High Functioning Autism	2	1	0
Learning, Developmental or Intellectual Disability	Other			
Mental Health Condition	Dementia			
Mental Health Condition	Other			
No Relevant Long-Term Reported Health Conditions	None			

Please note this table collects counts of cases not counts of individuals

Table SG1f	
Counts of Safeguarding Activity	**Count**
Total Number of Safeguarding Concerns	2631
Total Number of Section 42 Safeguarding Enquiries	676
Total Number of Other Safeguarding Enquiries	2

Section 2: Case Detail Tables

All information recorded in these tables should be about cases that concluded during the reporting year.

Multiple entries per enquiry are permitted in all of these tables

Some type of risk categories overlap with each other, please record all types of abuse that apply to each enquiry

Table SG2a	Concluded Section 42 Enquiries			Other Concluded Enquiries		
Counts of Enquiries by Type and Source of Risk	SOURCE OF RISK			SOURCE OF RISK		
	Social Care Support	Other - Known to Individual	Other - Unknown to Individual	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Physical Abuse	33	59	20	0	0	0
Sexual Abuse	4	31	6	0	0	0
Psychological Abuse	26	44	11	0	1	0
Financial or Material Abuse	24	75	38	0	0	0
Discriminatory Abuse	0	1	0	0	0	0
Organisational Abuse	24	3	2	0	0	0
Neglect and Acts of Omission	306	95	13	1	0	0
Domestic Abuse	0	20	1	0	0	0
Sexual Exploitation	0	0	0	0	0	0
Modern Slavery	0	0	0	0	0	0
Self-Neglect		9			0	

Table SG2b	Concluded Section 42 Enquiries			Other Concluded Enquiries		
Counts of Enquiries by Location and Source of Risk	SOURCE OF RISK			SOURCE OF RISK		
	Social Care Support	Other - Known to Individual	Other - Unknown to Individual	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Own Home	113	152	38	0	1	0
Community Service	4	3	1	0	0	0
Care Home	288	57	23	1	0	0
Hospital	2	56	1	0	0	0
Other	10	69	28	0	0	0

Table SG2c	Concluded Section 42 Enquiries			Other Concluded Enquiries		
Counts of Enquiries by Action, Result and Source of Risk	SOURCE OF RISK			SOURCE OF RISK		
	Social Care Support	Other - Known to Individual	Other - Unknown to Individual	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
No Action Taken	132	85	32	0	1	0
Action taken and risk remains	35	71	15	0	0	0
Action taken and risk reduced	167	120	34	1	0	0
Action taken and risk removed	83	61	10	0	0	0

Section 3: Mental Capacity Tables

All information recorded in these tables should be about cases that concluded during the reporting year.

There should only be one entry per enquiry in the first four rows of each table.

The sum of the values in the first four rows of each table should represent the number of enquiries that concluded during the reporting year

Table SG3a						
Mental Capacity Table for Concluded Section 42 Safeguarding Enquiries	Age Group					
For each enquiry, was the adult at risk lacking capacity to make decisions related to the safeguarding enquiry?	18-64	65-74	75-84	85-94	95+	Not Known
Yes	86	26	94	102	22	0
No	209	63	108	114	19	0
Don't know	1	0	1	0	0	0
Not recorded	0	0	0	0	0	0
Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases was support provided by an advocate, family or friend?						

Table SG3b						
Mental Capacity Table for Other Concluded Safeguarding Enquiries	Age Group					
For each enquiry, was the adult at risk lacking capacity to make decisions related to the safeguarding enquiry?	18-64	65-74	75-84	85-94	95+	Not Known
Yes	1	0	0	0	0	0
No	1	0	0	0	0	0
Don't know	0	0	0	0	0	0
Not recorded	0	0	0	0	0	0
Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases was support provided by an advocate, family or friend?						