Annual Report

April 2018 – March 2019

Foreword

The 2014 Care Act made clear that Safeguarding Adults should be everyone's business. It is certainly in everyone's interests to improve our awareness of adults in need of care and support who may be at risk either from others' treatment of them, or from their own lifestyle choices. Given the nature of the Island communities, it is likely that most people know of someone who needs care and support and for many of us, as we age, assurance that we can live free from abuse and get the kind of help that means we are not written off because of our lifestyle, becomes more important.

During this last year the cases brought to the attention of the Safeguarding Adults Board have highlighted again the challenges services experience in keeping in touch with the care and support needs of individuals who, for a variety of reasons, are unable to keep appointments or to be more proactive in seeking help for themselves. The Safeguarding Adults Board's Safeguarding Review Sub-Group continues to play an important role in commissioning case reviews, ensuring action plans based on the lessons learned are produced and agreed, and monitoring the progress of any improvement action. Communication about Safeguarding concerns could be significantly improved if the relatively new Multi-Agency Risk Management Meetings and Multi Agent Safeguarding Triage meetings can be embedded and effectively used by practitioners and their managers. Both these initiatives have generated some improved approaches, but some services find that capacity issues make it difficult to maintain adequate involvement.

Data and evidence of what works are clearly important in identifying the action needed and trying to continuously improve practice. Getting the data into a more meaningful, coordinated format from a range of agencies, some of whom operate at a County rather than a local level, is difficult. The Quality Assurance and Performance Sub-Group receives arguably too much data from the partners to each of its meeting and could spend all its time trying to analyse it. Efforts are being made to avoid this risk and to prioritise data and audits that focus on specific aspects of the work such as Making Safeguarding Personal and the Safeguarding Adults Thresholds guidance. Work over the next year should reflect this more focussed approach and may also develop a clearer understanding of how Health's work on Serious Incident Reviews links to the Safeguarding Adults Team's work. At present the Annual Report does not reflect all the data that comes to the Sub-committee, but relies almost entirely on the data generated by Adult Social Care.

It is also really important that, in addition to data, the Safeguarding Adults Board is able to take account of the experience that local people have of the support they are offered. The Safeguarding Adults Board benefits from regular reports from the Isle of Wight's HealthWatch and from their Chief Executive's contributions to the Board and to other aspects of the work. The involvement of HealthWatch in the Safeguarding Adults work is vital and hopefully can be maintained in the future. In 2018/19 HealthWatch and People Matter were commissioned to lead a project aimed at improving the awareness and involvement of voluntary sector organisations in Safeguarding Adults work on the Island. Funding has also been identified for a Safe Places Project. Initial progress on both projects is outlined in the Annual Report. Both are likely to continue into 2019/2020.

Margaret Geary,
Independent Chair

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2. Board Structure

The Board has three sub-groups:

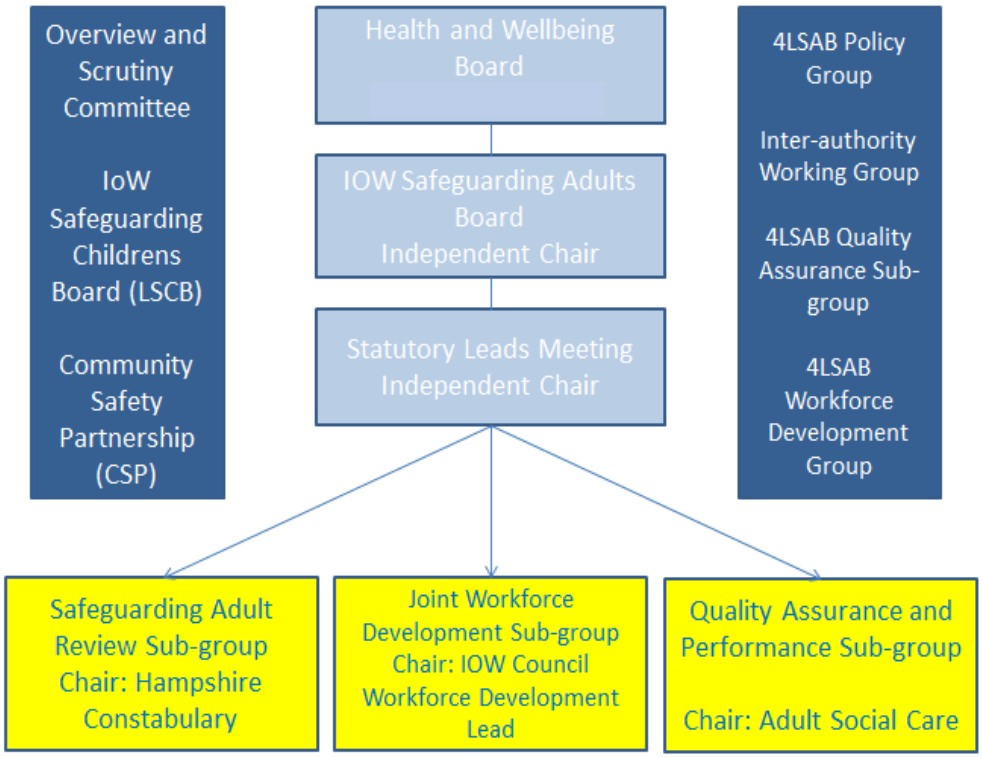
- **Safeguarding Adults Review Sub-Group**
- **Quality Assurance and Performance Sub-Group**
- **Training Sub-Group**

Much of the work of the Board is undertaken by members of the three sub-groups in collaboration with the Board Manager and her Administrative Support. Across its work, the Board maintains close links with the Local Safeguarding Childrens Board and the Community Safety Partnership. In 2018/2019 the Violence Against Women and Girls work was transferred from the Safeguarding Adults Board to the Community Safety Partnership, along with the funding linked to that work.

The Board also has a Statutory Leads group, which meets a few weeks before Board meetings to check on progress against some key actions, raise and discuss any concerns, and agree how best to put forward proposals to the Board to address those concerns. This group involves the Isle of Wight's Police Commander, the Clinical Commissioning Groups Deputy Director of Quality, the Director of Adult Social Services and the Chair of the Safeguarding Adults Board.

The Safeguarding Adults Board chair and Board manager also contribute to regular meetings involving the other 3 Safeguarding Boards in the Hampshire area i.e. in Hampshire County, Southampton and Portsmouth.

Isle of Wight Safeguarding Adults Board Hierarchy



2.1 Change of Board Manager

In 2018/2019, the SAB Board manager, Fleur Gardiner, resigned to move to another role within the IOW Council. The Board expressed their appreciation for all her hard work over the last 4 year and wished her all the best for the future. The post of Board Manager was held by Emma Coleman on an interim basis throughout 2018/2019, to allow for decisions about the role to be made within the next year in accordance with the IOW Recruitment Policies. Emma Coleman applied for, and was successful in being appointed to, the role of Board Manager from April 2019.

3. Safeguarding Adults Reviews

3.1 Cases reviewed, and lessons learned

During 2018/19 the Safeguarding Adults Review Sub-group on the Isle of Wight undertook 1 Statutory Review, and 3 discretionary reviews in cases which did not meet the criteria for a full Safeguarding Adult Review, but took place in circumstances which led the Sub-group members to agree that a review would generate important lessons for partners in the services involved with the case. The main findings in the cases reviewed in 2018/19 were:

Case A: The Statutory Review

Case A involved a person with a fairly chaotic lifestyle, who had experienced homelessness and who eventually was found dead in a bus shelter. The lesson's learned included the importance of ensuring effective communication between health service, housing and social care when someone is having difficulty in keeping appointments and is difficult to locate. The need to understand each service's legal responsibilities and ensure that they are met as fully as possible. How services communicate across local authority boundaries also needs to be improved. In case A, the individual did not manage to keep a number of the appointments offered and the absence of any follow up impacted on opportunities that might have arisen to intervene with effective support. The family asked that this review be published on the website under the individuals first name of Howard.

Case B:

This individual was found dead at home in 2015, sometime after her death. The lessons learned were the importance of ensuring that individuals receiving primary care services were involved in regular reviews and their circumstances regularly assessed. In this case, Primary Care was the main source of contact with the individual. Issues about the capacity of the individual's son who was the main carer were not picked up. This case is now the subject of a DHR.

Case C:

This person shot himself and left a note which implied he had not received the services that he felt he needed. The review made clear that this person had had numerous visits by Carer's and by other professionals, but he found it increasingly difficult to manage at home. He did not want to move to receive care elsewhere. Towards the end of his life he made declarations to a few people that he had a gun. There was some evidence that these were not taken as seriously as they should have been and the lessons learned from this case focus on this failing. The Coroner's verdict recorded death by suicide.

Case D:

This person had multiple substance misuse issues and died as a result of this misuse. This case will be the subject of an independently facilitated workshop for practitioner's in 2019.

3.2 Learning Lessons from SARs – University of Sussex Project

In early 2018, the University of Sussex proposed to develop a project investigating how existing research and review findings on self-neglect can more effectively be implemented through organisational learning, and the outcomes of this tracked.

The project originated in the Sussex Social Sciences Impact Fund, which aims to enhance the impact of existing research. The core focus was on self-neglect, however, learning from this project will in many respects be transferable to other aspects of adult safeguarding.

The initial meeting in May focussed on the existing activities, current priorities, and systems for measuring learning in each area. Most areas had common themes:

- Difficulty knowing what training SAB partner agencies are offering on self-neglect
- Most of the SABs involved offered self-neglect training in some form. Attendance at these training courses was good, but feedback rates were very low
- Concern that SARs have a limited shelf-life and the learning is not long term
- Each area carries out regular audits

A number of challenges were identified for work on self-neglect and safeguarding more generally, including thresholds for safeguarding referrals, commissioning of SAR's, training not reaching senior managers and overcoming a silo mentality within agencies. It was noted that there is a need to move safeguarding, mental health awareness and mental capacity awareness beyond being an 'add-on' to usual practice, and make them core to the everyday work of adult social care and partner agencies.

Learning from this project will be disseminated and monitored through all 3 sub-groups of the SAB. David Orr from University of Sussex will present the findings at the SAB in September 2019.

3.3 Multi-Agency Safeguarding Triage (M.A.S.T.)

Unlike Southampton, Hampshire and Portsmouth, the Isle of Wight does not have a Multi-Agency Safeguarding Hub (MASH). The Safeguarding Adults board has long considered that there is a need for a multi-agency approach to early sharing of information and decision making about how best to engage with and support adults at risk. The messages from local and National Safeguarding Adults Reviews have highlighted the value of such an approach.

In 2017 the Safeguarding Adults Board supported proposals to form a Multi-Agency Safeguarding Triage process.

MAST Highlights

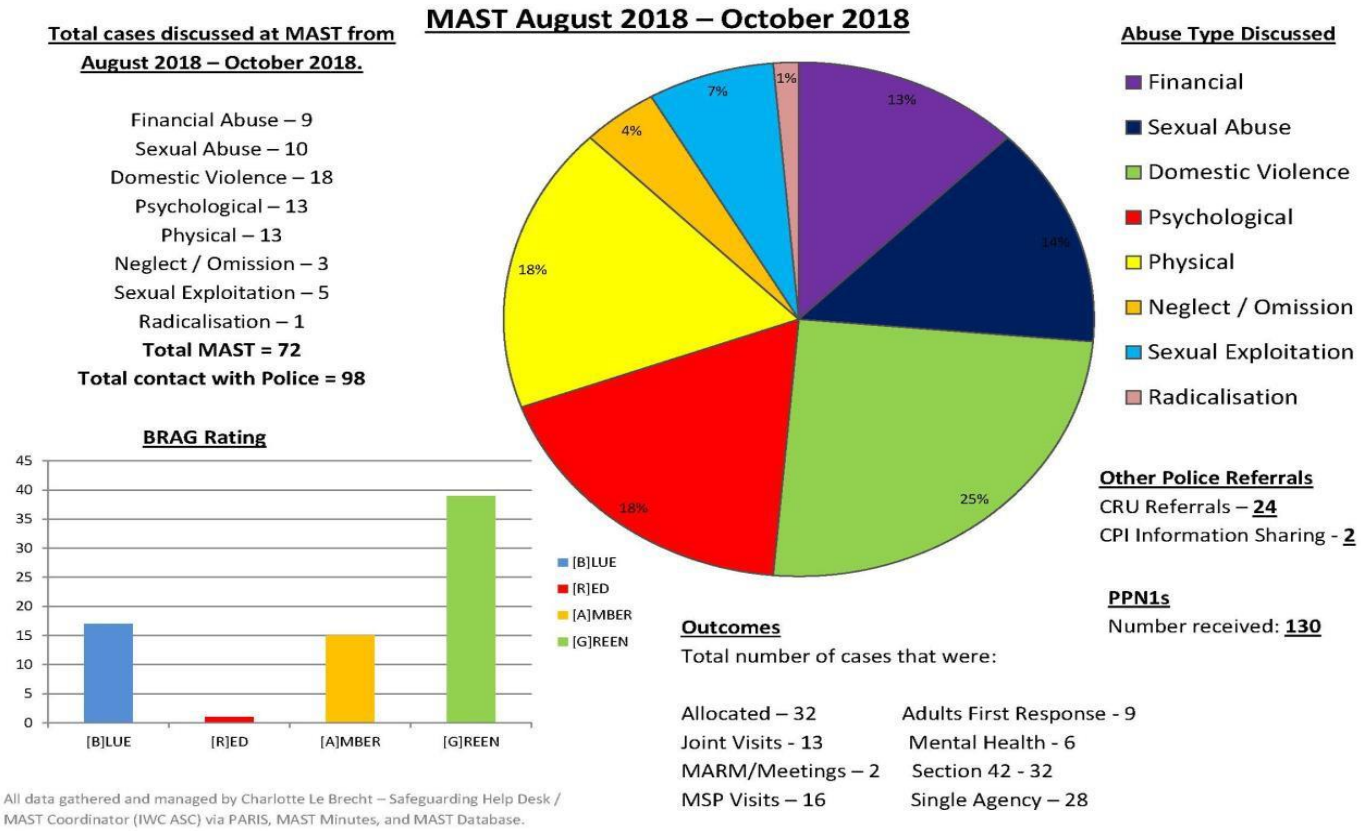
The MAST undertakes a multi-agency adult safeguarding triage function about adult safeguarding concerns. MAST partners are Police, Adult Social Care and Health.

The MAST partners meet face to face 3 times a week. Urgent cases outside of these meetings are fast tracked to the Central Response Unit (CRU).

Benefits include:

- Early information sharing
- Facilitates information sharing with other partner agencies
- Joint working
- Identification of high-risk cases
- Early identification of most appropriate referral pathway
- Effective use of resources.
- Victim focussed responses.

The below diagram shows:



CRU – Central Response Unit

CPI – Community Partnership Information Sharing Form

Future opportunities could include:

- High risk domestic abuse strategy discussions and actions
- All PPN1 (Public Protection Notice) coming into the MAST for triage
- MARM referrals coming through MAST triage.

On the days where no face to face meetings were held the triaging would be virtual; the adult social care safeguarding team would liaise if necessary with the Clinical Commissioning Group and or the central referral unit in Fareham, Hampshire to request Police information/response.

Due to Police resources, between December 2018 and May2019 the face to face meetings ceased. However the Police have maintained a commitment to the MAST approach and will be providing Police representation at the face to face MAST meeting starting again in May 2019.

3.4 Multi-agency Risk Management Meeting (M.A.R.M.)

In order to further embed the 4LSAB Multi-agency Risk Management Framework, a series of workshops took place in 2018. They were aimed at adult safeguarding professionals whose organisations work with adults experiencing circumstances which create a risk of harm, and where it is judged that a multi-agency response is needed. The kind of themes that could lead to a MARM being convened are:-

a) Vulnerability factors placing them at a higher risk of abuse or neglect including mate crime, network abuse
b) Self neglect, including fire safety
c) Refusal or disengagement from care and support services
d) Complex or diverse needs which fall between agencies
e) On-going needs or behaviour leading to lifestyle choices placing the adult and/or others at significant risk
f) Complex needs and behaviours leading the adult to cause harm to others
g) Domestic violence, mental health and substance misuse.

These half day workshops aimed to provide an overview of the existing 4LSAB MARM Policy, share experiences of working with adults whose circumstances place them at risk of significant harm and also to consider how the MARM framework could provide a multi-agency approach to working with and supporting the adult at risk. The content of these workshops was informed by a multi-agency survey carried out by the Board in the summer of 2018, with the aim of gauging knowledge and confidence in partner agencies around MARM meetings.

Feedback from participants in the Multi-Agency Risk Management meetings suggest that they are useful in enabling care plans to be agreed and put in place around individuals who may face risks that could escalate to a more serious level. Further work is needed to embed these multi-agency meetings and encourage partners other than Adult Social Care to convene them. The Isle of Wight Adult Social Care Service have led in introducing this process and have been asked to outline the usefulness of MARMs in national workshops.

The key messages from the survey were:

- Only 20% of those agencies surveyed had called a MARM meeting
- Of those who had called a MARM, around 17% advised it had been difficult to call
- over 40% report that not all relevant agencies attended
- 30% of agencies surveyed advised that there were no clear actions given. Reasons cited were ownership issues, weak chairing and no new input at meeting
- 45% of agencies felt that MARMs were not embedded, 30% thought they were somewhat embedded, and 25% felt they were very or extremely embedded

However,

- Over 75% of agencies surveyed said that the risk to the individual had been removed or reduced as a result of the MARM
- Only 20% of those surveyed felt MARMs were not effective

A MARM workplan locally and across the 4 Safeguarding Adults Boards covers the following:

- A set of supporting documents contained within an online toolkit are being developed. Documents such as agenda templates, guides to chairing meetings, letter templates, minute templates, risk assessments and chronology template will be available for any agency to utilise if they need it.

- A set of 'One Minute Guides' to subjects such as MARMs, Making Safeguarding Personal, Mental Capacity etc. have been developed
- There will be a future proposal for an IOW MARM Coordinator post
- Both e-learning and face-to-face will be developed in 2019/2020 for the Island

The 4 LSAB Data Set requires data to be collected in relation to MARM meetings, and discussions are taking place on the IOW to identify the best way to gather this data. Currently data is collected by Adult Services in relation to the number of MARM meetings they have held.

4. Quality Assurance and Performance Sub-Group

4.1 Data Collection and Analysis

This is important as it provides some of the evidence that should underpin improvement action. Adult Services produce monthly reports on the number and type of referrals received by the Safeguarding Adults Team. The data includes information about timescales for the action taken, and the nature of that action and the outcomes. The joint lead for the Clinical Commissioning Group and the Health Trust produces a Universal data report which includes information about Children & Adults Services Incident Reports and other information linked to Safeguarding Concerns. Additional data is currently received from Police and Healthwatch.

The proposed audit plan for 2019/2020 is below:

- May 2019 – Making Safeguarding Personal case file audit
- August 2019 – S42 and Decision Support Guidance case file audit
- November 2019 – MARM audit
- February 2020 – Escalation Policy Audit

4.2 Hilary Corricks Report and Subsequent Work

In September 2018 the Safeguarding Adults Board were updated on the progress made in acting upon the recommendations made in Hilary Corricks review in 2017 of the Adult Social Care Safeguarding arrangements. Since this report, the Safeguarding Team has changed the way they interact with people who contact the team. They have improved their communication with the partner agencies, providers and professionals. New practice guidance, templates and prompt tools have been developed and implemented by the team to ensure consistent decision making, clear recording of the 6 statutory principles and MSP outcomes.

1. There should be clear timescales, terms of reference and ownership of multi-agency work to develop a threshold agreement for safeguarding.

   The team worked closely with Jane Hughes, Independent Safeguarding Consultant to implement new threshold document and change the way referrals are processed. New documents have been developed and implemented to ensure consistency of practise and recording.

2. The Adult Safeguarding Team and First Response should be merged, creating one point of access for referrals in to ASC.

There is ongoing work led by Liz Hughes, Service Manager to transform the front door of Adult Social Care, this will be implemented to coincide with the move to County Hall.

3. Meds alerts should all go to the CCG Medicines Management Team.

   Threshold document includes flowchart for medication related incidents and decision making guidance for safeguarding referrals. This has been fully implemented by the Safeguarding Team.

4. Falls should continue to be reported to CQC. Provider managers should also log them, stating what happened and what action they have taken including a new risk assessment. They should report figures to ASC quarterly. Social workers and auditors undertaking visits to provider units should look at the register.

   There is a new process for the falls monitoring led by Caroline Robertson, Fall Prevention Co-ordinator, Integrated Quality team and the Safeguarding Team are working closely to ensure that the falls reporting is consistent and safeguarding concerns are recognised.

5. There is a need to reinforce Senior Management at Service Manager Level.

   Liz Hughes has been appointed as the new service manager for the Safeguarding team.

6. An IOW MASH should be set up, to meet daily, with clear terms of reference, agreed thresholds and a shared Multi-Agency Risk Assessment.

   MAST policy is in place and MAST meetings are taking place 3 times a week. Multi-agency triage meetings restart in May 2019. We will be able to review this process and provide new data for the LSAB.

7. The Independent Reviewing Officer role should be improved and possibly relocated.

   The role of the Independent Reviewing Officer has extended to 30 hours per week, main focus of the role in chairing of safeguarding meetings.

8. The ASC Quality Assurance officers should build on their close relationship with their opposite numbers in the CCG, improve information sharing, coordinate inspection programmes and develop joint audit tools.

   Quality Assurance Leads are now part of the Integrated Quality Teams Isle of Wight Council/ Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups with close links to the Adult Safeguarding Team.

9. Monthly data reports should be provided with commentary

   This was fully implemented by the Safeguarding Team.

10. Action plans should be coordinated, progress checked and where relevant plans signed off.

    Safety plans have been developed and implemented by the Safeguarding Team.

11. The practice of holding client information on the I-drive should be reviewed and ceased.

    The data stored on the I-drive is GDPR complaint.

12. When a Safeguarding Plan is made in respect of a service user, an alert should be placed on the CRS, and removed when there is no longer need for the plan.

Safeguarding referrals and concerns are always recorded on PARIS.

Not all agencies have access to PARIS, even when they do have this the access to the safeguarding section is very limited. More work needs to be done to improve this.

4.3 Adult Safeguarding Decision Support Guidance

During the year, after fairly extensive consultation with providers, a policy was agreed about the issues that should be considered before a referral is made to the Adult Safeguarding Team. The policy is now known as the Thresholds policy. Guidance on how to adhere to the policy was also produced. Training for practitioners in all the services involved in safeguarding adults has been delivered. This training will continue in 2019/2020. This is important work for the SAB because there is substantial evidence that practitioners do not understand when cases should be referred to the Adults Safeguarding Team. Only between 20% - 30% of the cases referred result in a section 42 safeguarding enquiry but all referrals have to be assessed. This means that the limited staff resources in the Adult Safeguarding Team are involved in assessment work which is not appropriate for a safeguarding enquiry. There has also been particular concerns about the referral of all medication incidents and falls to the team even though it should be clear that these do not all raise a safeguarding concern. Health and Social Care colleagues have worked together to resolve these particular concerns.

The work carried out by the DASS with CQC to ensure that the regulator understand the decision support guidance has been important in clearing the way to embed this policy.

The IOW has taken a lead in producing the Thresholds policy and a version of this policy is being adapted and adopted across the other 3 authorities in Hampshire.

4.4 Hospital Discharge

Over the years there have been concerns raised about inappropriate hospital discharge. Healthwatch Isle of Wight has had health specific concerns reported to it and undertook to produce a report on local peoples experience of discharges, particularly to care and nursing homes. The IOW NHS Trust is well aware of the concern raised and has been undertaking work to improve hospital discharge for local people. Implementation of the Red Bag scheme was a vehicle to improve communication between the hospital and care providers. Monitoring the progress of this improvement work will continue to be a focus of the SABs quality group.

5. Workforce Development Sub-Group and Raising awareness

5.1 Decision Support Guidance (Thresholds) Training

In order to support the implementation of the new Decision Support Guidance and Toolkit, a series of multi-agency training sessions were delivered in 2018. The full day sessions gave nominated safeguarding leads the opportunity to delve deeper into the procedures and learn the essential information from them, so that they could disseminate

them throughout their own agencies. In addition, a series of short 'lunch and learn' sessions were delivered to groups of both multi-agency and single agency staff.

5.2 Lessons Learned Workshops

This series of workshops enabled participants to hear about the findings and lessons learned with respect to the safeguarding adult review on 'Howard' which was published in October 2018. They included an update on implementation of the action plans. The findings of the review were presented alongside a model of good practice for working with adults who self-neglect. This model was built up from research findings and from safeguarding adult review reports. Thereafter there were opportunities for participants to identify and discuss policy and practice strengths and on-going risks or shortcomings, based on their experience on the Isle of Wight. The Safeguarding Adults Board received feedback from the workshops that will further inform their implementation of the action plans which were developed from the recommendations of this SAR review.

5.3 ACEs Training

This one-day course provided a working background to the subject of Adverse Childhood Experiences (ACEs), focussing on how these experiences can affect individuals as adults. The course highlighted how an individual's reaction to ACEs depends on that person's own biological stress reactions, the person's own protective characteristics, the intensity and duration of the ACE, and the strength of the person's childhood bond to a stable, responsive, and nurturing caregiver. It went on to explain the importance of 'normal stress' and how to recognise how the accumulation of stress becomes toxic. In addition, it highlighted the role of resilience in terms of protective behaviours. The day also included a screening of an award winning documentary on the topic of ACEs.

5.4 Self-neglect Training

This ever-popular course has now been offered by the Board every year for 4 years. The Care Act 2014 has placed self-neglect clearly within adult safeguarding arrangements. This workshop aims to support good practice in work with people who self-neglect, drawing on evidence from research into approaches that produce positive outcomes. Using a mix of presentation, groupwork and discussion, the workshop seeks to build on participants' own experience and to explore how the research evidence can support local policies and practices.

5.5 LSAB Annual Conference

IOW Safeguarding Adults Board Conference, Thursday 7th February 2019

The Isle of Wight Safeguarding Adults Board annual conference was held on Thursday 7th February 2019 at Northwood House in Cowes. The focus for this year's conference was 'Safeguarding Individuals with Chaotic Lifestyles', and referenced a recent Safeguarding Adult Review: Howard.

The conference was attended by around 115 delegates from a variety of sectors across the Island.

Dr Carol Tozer, Director of Adult Social Care, led the programme with her presentation 'What Have We Learned from Howard'. This presentation referenced the recent SAR published by the Safeguarding Adults Board. Howard's legacy is one of organisational change – an established MARM process, development of wet provision on the Island, Temporary Accommodation Meetings, bids for additional funding to support rough sleepers and seeking an

extension of temporary housing offer. Carol finished by reminding delegates that there are currently other 'Howards' on the Island, and we all owe it to Howard not to repeat mistakes.

The second speaker, Mark Poingdestre from the new substance misuse provider, Inclusion, introduced the service to Island professionals. He advised delegates of their model of intervene early, reduce harm and achieve recovery.

Following Mark was Jamie Brenchley, the new Housing Needs and Homelessness Team Leader for Isle of Wight Council. He pointed out that numbers of homeless people on the Island have been rising, and described the devastating effects homelessness can have on an individual's health and wellbeing – life expectancy decreased by 30 years, 9 times more likely to die by suicide and 17 times more likely to be a victim of violence.

We had a workshop delivered by Lisa Smith, Assistant Director of RiPfa (Research in Practice for Adults). The workshop was around balancing risks and rights, and showed that the concept of risk varied across agencies. Key messages were that risk is dynamic, and it can never be eliminated, but it can be assessed and minimised. Assessment of risk should always include service user and carer perspectives.

Our afternoon session kicked off with Megan Karnes, the founder and CEO of Hoarding UK. We used this opportunity to launch the new 4LSAB Hoarding Guidance, which will be rolled out across the Island and will provide practitioners with guidance about responding to evidence that individuals hoarding has become problematic. Megan highlighted that hoarding is not a 'lifestyle choice', it is a recognised disorder which can cause individuals great levels of stress if not tackled properly.

Our last speaker was Melba Gomes, who was speaking about mental capacity, with a focus specifically on fluctuating capacity and executive and decisional capacity.

6. Task and Finish group focussed on Safeguarding and People with Learning Disabilities

The Board chaired and organised Resilient Communities Task & Finish Group continued to meet throughout 2018/2019, and its members were successful in securing a one-off grant of £25,000 in late 2018 in order to fulfil the following criteria:

<u>Awareness Raising focused on Hate-Mate Crime</u>

This work will be for organisations across the Isle of Wight. It aims to raise awareness of hate/mate crime through a series of training sessions. These sessions will be for multi-agency professionals, individuals with learning disabilities and their carers, prison staff and residents and local businesses who sign up to be 'safe places'. The training will be delivered by Inclusion Outright, and will also include promotion of the existing Healthwatch video on mate crime, featuring local members of Johns Club and Haylands farm. In 2019/2020, part of the funding will be used to develop an e-learning package on hate/mate crime, which can be incorporated into partner agency basic training for employees. HMP IoW has been keen for their staff to be involved in this training as it has relevance to their work with prisoners.

Setting up Safe Places Network

Part of the funding has been used for a 5 year membership into the National Safe Places network. This network is well established across England, with major retailers such as HSBC, Morrisons, Co-op and McDonalds already signed up to be registered 'safe places' for individual with learning disabilities. The first Isle of Wight Safe Place – the Isle Help Hub – was secured in Spring 2019, and will be the first of many across the Island. This part of the project is being led by People Matter.

Evaluation and Reporting of Progress

Evaluation of the project will be carried out by Healthwatch. This will start around 2 years after the first Safe Place was established. In the meantime, Healthwatch are actively promoting and raising awareness around Safe Places.

7. Project with Healthwatch and People Matter

In September 2018, the Board approved a proposal from HealthWatch and People Matter around the Voluntary & Community sector's role in safeguarding adults. The purpose of the proposed work is:

- To provide paid staff and volunteers in the voluntary /community sector with the support and information they need to identify concerns about the safety of individuals they meet who cannot support themselves.
- To identify the ways in which the Voluntary/ Community sector contribute to keeping adults in need of support safe and the kind of support from the statutory sector that they need to continue to do this.
- To ensure that the word 'Safeguarding' is known more widely in the Voluntary/ Community Sector. It's meaning is better understood and there is more knowledge about whose responsibility it is to report

There is an extensive network of Voluntary/Community organisations on the Isle of Wight. Anecdotal evidence from discussions with some of these organisations and with some of the service user forums suggests that local people are more ready to engage with and confide in voluntary / community sector staff and volunteers than they might do with statutory service providers.

Safeguarding Adults Reviews have identified that individuals - particularly those who have chaotic lifestyles and/or have a tendency towards self-neglect - become increasingly isolated from and invisible to statutory services. Work is

needed to improve how statutory services respond to this. The Voluntary/ Community sector, in reaching out to some of these people, need to have better links to other service providers. It may then be able to provide better links across to statutory providers when this is appropriate.

Voluntary/ Community sector staff and volunteers in a number of organisations are often involved with individuals who have either given up on statutory providers have been discharged from service and have nowhere else to go. One example given was when people were discharged from mental health services and arrived without warning at a voluntary organisation whose staff had no information about the person, about the risks they s/he faced or about the risks the staff might face in trying to offer support.

The outcomes for this project are:

- Adult Safeguarding Champions being identified in the voluntary /community organisations with a focus on Adults
- A commitment of an initial programme of regular meetings of these champions with statutory leads for Adult Safeguarding
- The production of a bi-annual News Update focussed on adult safeguarding users, polices and professionals for voluntary/community organisations
- Improvements in communication between the key voluntary/community organisations working with adults and the statutory services for when Adult Safeguarding is important, building on the feedback from the canvas on what is working at present and what obstacles there currently are to this communication. This may mean developing specific protocols which should be followed.
- Evidence that voluntary/community organisations are using the thresholds guidance to make appropriate referrals to Safeguarding
- evidence of MSP and the 6 principles in the way in which the voluntary sector engage with adults at risk and this is evidenced in the safeguarding concern referrals to the safeguarding team
- Bespoke safeguarding training to be provided to community and voluntary sector organisations.

From January to March 2019, Healthwatch Isle of Wight and People Matter developed a survey for voluntary and community sector organisations around their understanding of safeguarding, reporting procedures and training. The survey was shared with town and parish councils and through the voluntary sector community. The results of the survey and analysis will lead to a better understanding of the needs of the voluntary sector and will enable the barriers to reporting to be identified and addressed.

This project will continue in 2019/2020.

8. Joint Work with the LSCB

8.1 Family Approach Protocol

In 2018/2019, the 4LSCB and 4LSAB's across Southampton, Hampshire, Isle of Wight and Portsmouth began jointly developing a 'Family Approach' protocol and online resource centre for practitioners and managers. The proposal for this work followed discussions between the 4 Local Safeguarding Children Boards (4LSCBs) and the 4 Local Safeguarding Adults Boards (4LSABs) across Hampshire & Isle of Wight.

In response to both the Family G Serious Case Review on the Island, and several other cases in Hampshire, it was suggested that a high level Protocol should be developed, which defines what is meant by 'a whole family approach',

and outlines a set of principles that the Safeguarding Boards, Agencies, and front line professionals could commit to. This document will replace the Joint Working Protocol currently in place.

The protocol will be supported by practical information, guides and tools that would be of value to frontline professionals. An online resource library / toolkit holds all the information in one place and acts as a central portal for staff to access. Information will include:

- checklists and prompts for staff working with children and adults.
- a shared resource library linking to quick briefing guides, and relevant local policies and procedures for both children and adults.
- referral pathways and threshold charts for children and adults in each area.
- A section on Adverse Childhood Experiences (ACEs).

This protocol is due to be launched on the Isle of Wight in May 2019, with a series of joint adults and Childrens workforce training sessions scheduled for June 2019.

8.2 Joint Training

During 2018/19 we delivered the following joint training:

Training - Unveiling the psychology that underpins interpersonal trauma and effective professional response to such

This course, delivered by Zoe Lodrick who previously spoke at an LSAB Domestic Violence conference, was offered jointly to multi-agency professionals in both the adults and children's workforce, with costs and admin shared by the 2 Boards.

There is also a Joint Learning Event scheduled for April 2019 between the Community Safety Partnership (CSP), LSAB and LSCB looking at common themes in Domestic Homicide Reviews (DHRs), Safeguarding Adult Reviews (SARs) and Serious Case Reviews (SCRs).

There continues to be regular liaison meetings between the LSAB and LSCB Business units to discuss shared approaches and common themes and issues, as well as attendance at each other's board and QA meetings where possible. In 2018/2019, a new joint Health sub-group and joint Workforce Development Group were formed with the LSCB, meaning greater opportunities for shared training and events.

9. 4 Local Safeguarding Adults Boards Work (4LSAB)

4LSAB Quality Assurance Sub-Group

The 4LSAB QA Sub-group was established in 2018, starting with a 4LSAB multi-agency workshops, where terms of reference and a workplan were devised. A further meeting and workshop was held on the 28th February 2019 at Portsmouth City Council.

The following common themes were identified across the 4 areas:

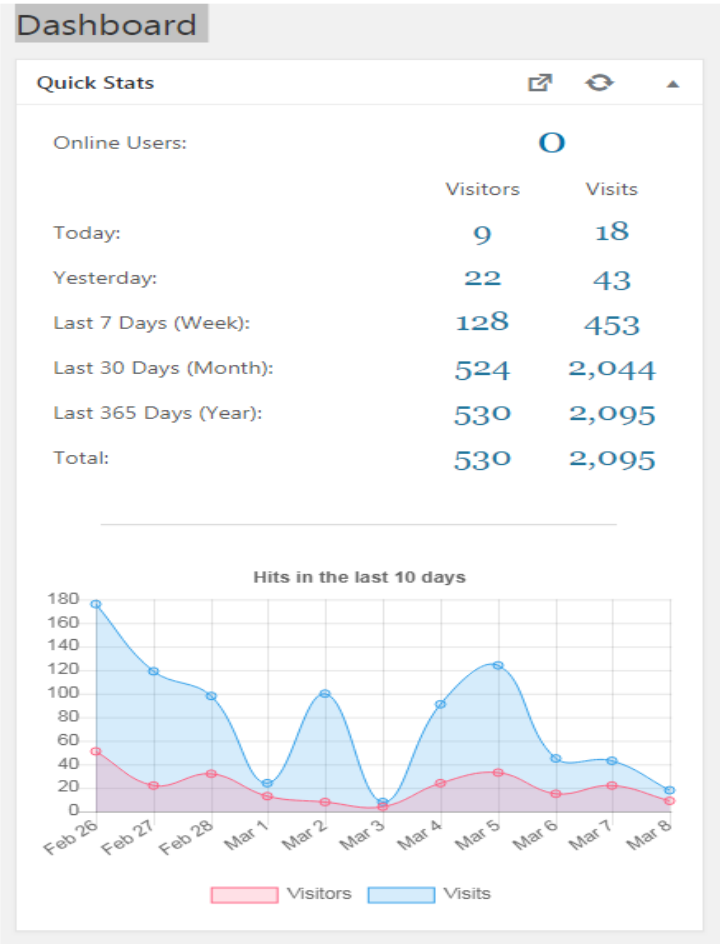
- Awareness of Safeguarding Adult Concerns
- Service users/Making Safeguarding Personal
- Learning review and Safeguarding Adults Reviews
- Data relating to Safeguarding Adults Priorities

It is the role of the QA sub group to gain assurance on behalf of the individual boards, including evidencing the impact of learning on the experience of service users. 3 workshops were completed based on the 4 LSAB QA sub-group workplan – data, MSP and methodologies. The group will aim to carry out 1 audit per year. Single agencies would continue to carry out their own audits. The MCA and organisational safeguarding self-audits will be considered by this group.

10. LSAB Independent Website

New Independent Website

The LSAB new Independent Website was launched live at the annual conference. The website features our safeguarding posters on the main page, as well as having a clear 'traffic light' system for making a safeguarding referral. The page has proved to be quite popular, and has the following pages:



Home Page:

- Safeguarding posters on a rolling banner. This will also have additional slides for events such as World Elder Abuse Day, National Safeguarding Week etc.
- Traffic light system for making a safeguarding referral, which has a guide to 'what makes a safeguarding concern', 'I'm concerned about an adult what should I do?', 'Report a concern'.
- Information about who the Board are
- News items
- Live twitter feed

Keeping Adults At Risk Safe:

- Space for 'animated scribe' video
- The aims of adult safeguarding
- Types of abuse and neglect
- Making Safeguarding Personal

Events and Training:

- Current training courses, with booking links and course information
- Information about 'coming soon' courses
- Conferences (past and present) and resources

News:

- SAB news items – publication of new polices, events, new legislations, publication of SARs
- Partner agency news – events, policies, guidance
- National news – national SAR's of interest, new government legislation

Information for Professionals:

- All 4LSAB policies, toolkits and guidance
- National guidance
- Guidance on making a referral

SARs

- All published SARs
- SAR policy
- Information on making a referral to the SAR sub-group

The website will be reviewed and upgraded regularly.

11. Adult Social Care – Safeguarding Adults Collection Data 2018/2019

A safeguarding concern is where there is reasonable cause to suspect that an adult with care and support needs is at risk of or is experiencing abuse or neglect and due to their care and support needs is unable to protect themselves from the abuse or neglect. A safeguarding concern can be raised by anyone. In 2018/19, 3307 safeguarding concerns were recorded, which is a small decrease from 3421 recorded in 2017/18.

	2016/17	2017/18	2018/19
Initial Referrals to Safeguarding	3529	**3421**	**3307**
Initial Referrals not meeting Concern criteria	1631 (46%)	**1436 (42%)**	**1492 (45%)**
Commenced Safeguarding Concerns	1898	**1985**	**1815**
Closed at Concern Stage	1302	**1466**	**951**

'Other' Enquiries (commenced during year)	26	**19**	**17**
S42 Enquiries (commenced during year)	570	**500**	**847**
Concluded S42 Enquiries	417	**621**	**717**
Conversion Rate (Concerns/Enquiries) (England 16-17: **41%**)	31%	**26%**	**48%**

What is a Section 42 enquiry?

This is set out in Section 42, Care Act (2014)

The Section 42 duty requires consideration of the following criteria under Section 42 (1) and (2) of the Care Act (2014):

S42 (1) Whether there is "reasonable cause to suspect" that an adult

i. has needs for care and support

ii. is experiencing, or is at risk abuse or neglect, and

iii. as a result of their needs is unable to protect themselves S42 (2)

iv. Making (or causing to be made) whatever enquiries are necessary

v. Deciding whether action is necessary and if so what and by whom.

What has commonly been known as the 'three-point test' set out in S42(1), is covered in points i. to iii. above. In this framework we should refer to these as the statutory criteria for decision-making. These criteria, and working out whether there is "reasonable cause to suspect" that these are met then inform any decision identifying a duty to make enquiries. The local authority is responsible for that public law decision as to whether or not to proceed with the duty to make enquiries under S42 (2).

The last two points (iv. and v. above) under S42 (2) support an understanding that activity attached to that duty is required - to inform the decision on what action needs to be taken and by whom.

The duty to make enquiries under S42(2) is not a prescriptive process in the way it was before the Care Act (2014) but consists of activity to inform decision-making and the actions to be taken.

In deciding what the LA thinks is necessary the LA must consider and reflect in their decision making the 6 statutory safeguarding principles:

The 6 principles are:

- Empowerment
- Preventing
- Proportionality

- Protection
- Partnership
- Accountability.

The purpose of the enquiries is for the LA or others to:

- Gather more information and establish the facts
- Establish views and wishes of the adult at risk or their representative
- Establish the adults needs and risks and confirm causes for concern
- Ascertain the desired outcomes of the adult
- Establish whether the LA has a duty to act or another agency.

In 2018/19 45% of reported safeguarding concerns were assessed by the adult safeguarding team as not meeting the S42 enquiry duty, (this is a small increase of 3% from the 2017/18 data).

The number referrals that are assessed as not safeguarding concerns (S42 (1) are still significant, (from a prevention point of view, conversations within this early information gathering S42(1) can themselves make a valuable contribution in informing and empowering people to keep themselves safe and therefore is an important part of adult safeguarding work, even if S42 (1) is subsequently not met). The LA adult social care and SAB work on embedding the Decision Support Guidance will help to ensure that partners take a more active role in determining what constitutes a safeguarding concern, a quality issue, an incident, accident, and concerns for welfare and make informed decisions about referral pathways.

There is a range of organisational structures and processes across the country for receiving and acting on safeguarding concerns. Almost half of local authorities have a triage process for evaluating concerns initially and NHS Digital have calculated that about 50% of concerns go no further than this stage. In many councils, concerns will go to a generic team (usually one which deals with all enquiries about social care and support) who will determine whether it is a safeguarding matter and therefore whether it should be referred on. For instance, in many areas, concerns that relate to care quality will be referred to the team dealing with care contracts and commissioning rather than being treated as a safeguarding concern.

In 2018/19, 847 individuals were supported by the adult safeguarding team, following a S42 decision. The current conversion rate 2018/19 from safeguarding concern to S42 enquiry is 48%, which is higher than the national average and is a significant increase from 26% in 2017/2018. This reflects the current work to increase understanding of safeguarding concerns and enquiries via the SAB Decision Support Guidance.

Appendices

Appendix A – SAC return

Table SG1a	Age Band						
Counts of Individuals by Age Band	18-64	65-74	75-84	85-94	95+	Not Known	Total
Individuals Involved In Safeguarding Concerns	521	169	277	311	82	0	1360
Individuals Involved In Section 42 Safeguarding Enquiries	215	86	170	185	51	0	707
Individuals Involved In Other Safeguarding Enquiries	6	3	3	4	1	0	17

Table SG1b	Gender			
Counts of Individuals by Gender	Male	Female	Not Known	Total
Individuals Involved In Safeguarding Concerns	540	820	0	1360
Individuals Involved In Section 42 Safeguarding Enquiries	280	427	0	707
Individuals Involved In Other Safeguarding Enquiries	6	11	0	17

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	Total
Individuals Involved In Safeguarding Concerns	1196	4	4	4	1	0	151	1360
Individuals Involved In Section 42 Safeguarding Enquiries	639	1	2	2	0	0	63	707
Individuals Involved In Other Safeguarding Enquiries	16	0	0	0	0	0	1	17

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	Total
Individuals Involved In Safeguarding Concerns	484	6	181	168	102	33	0	545	1519
Individuals Involved In Section 42 Safeguarding Enquiries	277	2	97	76	42	14	0	204	712
Individuals Involved In Other Safeguarding Enquiries	6			1	2	2	0	6	17

Table SG2a	Concluded Section 42 Enquiries			Other Concluded Enquiries				
Counts of Enquiries by Type and Source of Risk	Source of Risk			Source of Risk				
	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Total Section 42	Total Other
Physical Abuse	24	103	5	0	1	0	132	1
Sexual Abuse	2	22	1	0	0	0	25	0
Psychological Abuse	27	51	4	0	2	0	82	2
Financial or Material Abuse	13	93	4	1	2	0	110	3
Discriminatory Abuse	0	1	0	0	0	0	1	0
Organisational Abuse	16	2	2	0	0	0	20	0
Neglect and Acts of Omission	206	79	15	3	3	0	300	6
Domestic Abuse		36			2		36	2
Sexual Exploitation	0	2	1	0	0	0	3	0
Modern Slavery	0	1	0	0	0	0	1	0
Self-Neglect		17			0		17	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				
	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Total Section 42	Total Other
Own Home	42	203	5	1	5	0	250	6
In the community (excluding community services)	4	14	4	0	1	0	22	1
In a community service	9	4	2	0	2	0	15	2
Care Home - Nursing	61	37	2	2	0	0	100	2
Care Home - Residential	154	76	2	1	1	0	232	2
Hospital - Acute	9	28	12	0	1	0	49	1
Hospital - Mental Health	4	11	1	0	0	0	16	0
Hospital - Community	1	2	1	0	0	0	4	0
Other	4	32	3	0	0	0	39	0

Table SG2c	Concluded Section 42 Enquiries			Other Concluded Enquiries				
Risk Assessment Outcomes: Was a risk identified and was any action taken / planned to be taken?	Source of Risk			Source of Risk				
	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Total Section 42	Total Other
Risk identified and action taken	240	314	29	2	9	0	583	11
Risk identified and no action taken	4	7	0	0	0	0	11	0
Risk - Assessment inconclusive and action taken	13	23	1	0	0	0	37	0
Risk - Assessment inconclusive and no action taken	3	11	2	0	0	0	16	0
No risk identified and action taken	13	8	0	0	0	0	21	0
No risk identified and no action taken	13	13	0	2	0	0	26	2
Enquiry ceased at individual's request and no action taken	2	31	0	0	1	0	33	1

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	Total
Yes, they lacked capacity	73	21	100	114	26	0	334
No, they did not lack capacity	126	58	81	57	17	0	339
Don't know	9	8	11	11	5	0	44
Not recorded	0	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?	68	19	88	103	26	0	304

Table SG4a							
MSP Table for Concluded Section 42 Safeguarding Enquiries	Age Group						
For each enquiry, was the individual or individual's representative asked what their desired outcomes were?	18-64	65-74	75-84	85-94	95+	Not Known	Total
Yes they were asked and outcomes were expressed	138	70	111	104	27	0	450
Yes they were asked but no outcomes were expressed	52	13	57	55	20	0	197
No	10	3	21	15	1	0	50
Don't know	8	1	3	8		0	20
Not recorded	0	0	0	0	0	0	0
Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases were the desired outcomes achieved?	18-64	65-74	75-84	85-94	95+	Not Known	Total
Fully Achieved	81	47	74	67	18	0	287
Partially Achieved	52	19	33	32	9	0	145
Not Achieved	5	4	4	5		0	18

Table SG5a	
Counts of Safeguarding Adult Reviews	**Count**
Count of SARs where one or more individual died	2
Count of SARs where no individuals died	0

Appendix B - Attendance at sub-groups and SABs

SAB Main Board 2018-2019		
Attendance List	**Meeting total**	**Staff Attendance for Meetings**
Police	4	6
Adult Social Care		13
NHS Trust		6
NHS England		2
Vol Sector		8
LSCB		2
LSAB		12
CCG		9
CSP		2
Public Health		5
HMPS		2
CQC		1
Southern Housing Group		2
Fire & Rescue		4
Community Rehabiliation Company		1
Care Home Association		3
Probation		0
	Totals:	**78**

Health Sub-Group 2018-2019		
Attendance List	**Meeting total**	**Staff Attendance for Meetings**
LSCB	5	7
NHS England		4
LSAB		7
Vol Sector		7
Public Health		7
GP		1
NHS Trust		8
CCG		14
	Totals:	**55**

SAR Sub-Group 2018-2019		
Attendance List	**Meeting total**	**Staff Attendance for Meetings**
Police	9	9
Adult Social Care		10
NHS Trust		9
CCG		7
Southern Housing Group		7
Care Homes Association		5
Community Saftey Partnership (CSP)		6
LSAB		17
	total:	**70**

QA&P Sub-Group 2018-2019		
Attendance List	**Meeting total**	**Staff Attendance for Meetings**
Police	3	2
Public Health		1
Adult Social Care		6
LSCB		2
Vol Sector		4
Care Home Association		2
LSAB		5
NHS Trust		2
Southern Housing Group		0
CCG		2
	Totals:	**26**

Isle of Wight
Safeguarding Adults Board

Business Plan
2019 -2020

Our purpose

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.

Section 44 of the Care Act 2014 sets out the statutory objectives of Local Safeguarding Adults Boards, which are:

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.

Everything we do is underpinned by the 6 safeguarding principles:

- **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

Implementation and Monitoring

- The IWSAB Business Plan gives the detail about how the IWSAB Strategic Plan will be implemented over the next year, including how we evidence the outcomes.
- Implementation of this Strategic Plan will be achieved through the work of IWSAB's subgroups and through the Board partners work which will focus on specific objectives. Progress against the Plan will be reported to the Isle of Wight Safeguarding Adults Board at regular intervals and the IWSAB Annual Report will provide an overview of the achievements made and will identify any areas for further development.
- Any queries about this Strategic Plan can be directed to: LSAB@iow.gov.uk

This plan outlines the focus for the Isle of Wight Safeguarding Adult Board over the next year.

8 areas of focus were agreed by the LSAB Statutory Leads. These areas of focus are also informed by feedback from HealthWatch and from service user and carer groups. In addition to the 8 areas of focus the Board's 'business as usual' includes undertaking Safeguarding Adults Reviews, monitoring the quality and performance of safeguarding on the Island, commissioning training and promoting awareness of the Board's work via conferences, events and publicity.

The 8 areas of focus for 19/20 are:

- Follow up work with partners as a result of the Making Safeguarding Personal Audits and to identify and agree the data needed to track the progress of this work.
- Developing a framework for how the MAST and the MARM should be working together and supporting both to become embedded as good practice on the Island.
- Convening a Task and Finish Group with the Children's Safeguarding Board to scope what work we might want to do on contextual safeguarding and transition between adults and children
- Oversight of the Safe Places and Voluntary Sector Projects
- Ongoing monitoring of the work linked to the Thresholds guidance.
- Responding to individuals with Chaotic Lifestyles
- Joint work with Health services around boundaries between SIRI's and SARs
- Oversight of the refreshing of mental health services on the Island

Other work:

- Work with East Sussex on the review of themes coming from SARS and lessons learned and any follow up from the joint event in March
- To work together with the Childrens Board to further embed the Joint Family Approach Protocol
- Ongoing work on assessing referrals in respect of the need for reviews and in overseeing reviews when these are necessary.
- Maintaining a watching brief on discharge practices across Health and Social Care
- Any other Audit work
- Continuing the lessons learned workshops for practitioners after Serious Case Reviews
- Ongoing training linked to the Thresholds guidance
- A fresh look at what might be needed in respect of Mental Capacity Assessment and Liberty Protection work
- Support for practitioners in understanding the changes needed to Make Safeguarding Personal.
- Planning for the next Safeguarding Adults Conference
- Linking to the Hampshire- wide Safeguarding Adults Training work
- The Board will also receive a report on the Safeguarding issues identified through the new multi - agency work focussed on better supporting individuals identified as being homeless, in need of care and support, and unsafe discharges. This group has been recently convened by Adult Social Care.

These areas of focus will be managed through the Sub Groups of the Board and by the LSAB Business Unit as detailed below:

Sub Group: Quality Assurance and Performance

Core Business: to provide the IWSAB with appropriate information to be assured that all partners are consistently safeguarding adults across the Island and are working in accordance with the Care Act 2014, Statutory Guidance and the SHIP Multi Agency Safeguarding Procedures

Areas of Focus:

- **Follow up work with partners as a result of the Making Safeguarding Personal Audits and to identify and agree the data needed to track the progress of this work.**
- **Developing a framework for how the MAST and the MARM should be working together and supporting both to become embedded as good practice on the Island.**
- **Convening a Task and Finish Group with the Children's Safeguarding Board to scope what work we might want to do on contextual safeguarding and transition between adults and children.**
- **Oversight of the project work with the Voluntary Sector.**
- **Ongoing monitoring of the work linked to the Thresholds guidance. Follow up work on the Thresholds guidance, if necessary, after receiving feedback from the DASS's meeting with CQC.**
- **Maintaining a watching brief on Discharge practices across Health and Social care**
- **Any other Audit work**

Outcome	Action required	Lead	By when	Evidencing the outcome	Red/Amber/Green rating
Follow up work with partners as a result of the Making Safeguarding Personal Audits and to identify and agree the data needed to	Implementation of the recommendations and actions from the May 2019 audit. Group to receive regular assurance from agencies with	QA&P Chair	July 2019		

track the progress of this work.	actions.				
Developing a framework for how the MAST and the MARM should be working together and supporting both to become embedded as good practice on the Island.	Action required will depend on the outcome of the current MAST and MASH review being undertaken by Hampshire Constabulary.		TBC		
Convening a Task and Finish Group with the Children's Safeguarding Board to scope what work we might want to do on contextual safeguarding and transition between adults and children					
Oversight of the Resilience project focussed on Safe Spaces for people with learning difficulties	Regular reports to be presented to the QA&P sub-group on progress	SAB Coordinator	Quarterly reporting		

Oversight of the project work with the Voluntary Sector.	Regular reports to be presented to the QA&P sub-group on progress	SAB Coordinator	Quarterly reporting		
Ongoing monitoring of the work linked to the Thresholds guidance. Follow up work on the Thresholds guidance, if necessary, after receiving feedback from the DASS's meeting with CQC.	Section 42 and Decision Support Guidance audit scheduled for August 2019	QA&P Chair and SAB Coordinator	October 2019		
Maintaining a watching brief on Discharge practices across Health and Social Care	Regular reporting on the Red bag Scheme and other related project by NHS Trust. Regular updates from the Adult Social Care Assistant Director.	NHS Trust Adult Social care	6 monthly reporting		
Any other Audit work	To develop an audit schedule for 2019/2020 containing 4 audits with different	QA&P Chair and SAB Coordinator	March 2020		

	themes to include MSP, S42 and DSG, MARM and Escalation				

Training Sub-Group

Core Business: ensuring that the training and development of the local workforce in relation to safeguarding adults meets high quality standards and reflects the issues and themes identified by the Board and required by statutory guidance.

Areas of Focus:

- To work together with the Childrens Board to further embed the Joint Family Approach Protocol
- Continuing the lessons learned workshops for practitioners after Serious Case Reviews and Safeguarding Adult Reviews.
- Ongoing training linked to the Thresholds guidance.
- A fresh look at what might be needed in respect of Mental Capacity Assessment and Liberty Protection work.
- Support for practitioners in understanding the changes needed to Make Safeguarding Personal.
- Planning for the next Safeguarding Adults Conference
- Linking to the Hampshire- wide Safeguarding Adults Training work

Outcome	Action required	Lead	By when	Evidencing the outcome	Red/Amber/Green rating
To work together with the Childrens Board to further embed the Joint Family Approach Protocol	To jointly develop e-learning with the LSCB on a range of subjects e.g. domestic abuse, family approach to safeguarding etc.	Sub-group Chair, SAB Coordinator, LSCB Manager	March 2020		

	To embed this training in partner agency basic e-learning packages				
Continuing the lessons learned workshops for practitioners after Safeguarding Adult Reviews	Half-day training sessions to be delivered following completion of every SAR. Feedback to be shared with the sub-group and recommendations made for further work where appropriate.	SAB Coordinator	Where appropriate		
Ongoing training linked to the Thresholds guidance.	Assurance to be sought from partner agencies that this is embedded in their basic training package. Feedback from observation sessions to include information on whether Thresholds	Sub-group Chair	December 2019		

	guidance is being adequately included.				
A fresh look at what might be needed in respect of Mental Capacity Assessment and Liberty Protection work.	Liaise with RiPfa regarding training and information available as part of package Work with DoLS leads to develop training where appropriate around MCA in 16+	Sub-group Chair	December 2019		
Support for practitioners in understanding the changes needed to Make Safeguarding Personal	Ensure this is a 'golden thread' through current safeguarding training being offered by the SAB and partner agencies Ensure MSP is included in the newly developed 'working with risk' course Receive feedback, actions and recommendations	Sub-group Chair, SAB Coordinator	December 2019		

	from the scheduled MSP audit being carried out by the QA&P sub-group Ensure the new MARM tools being developed are person centred				
Planning for the next Safeguarding Adults Conference	Planning for the next SAB Conference, which will be in November 2020 to coincide with the National Adult Safeguarding Awareness Week	Sub-group Chair, SAB Coordinator	March 2020		

IWSAB Business Unit
Core Business: • Ensure IWSAB meetings are convened, support agenda setting for board meetings and arrange accommodation. • Arrange secretariat to the IWSAB and the circulation of appropriate papers. • Advise and update IWSAB on the policy and practice implications of any new legislation, government policy or guidance. • Attend all of the IWSAB subgroups, support the chairs in setting the agenda. To also maintain an overview of the work of all the subgroups and ensure respective work programmes and activities are co-ordinated and consistent with the IWSAB Safeguarding Strategy and Business Plan. • Provide advice to the IWSAB and subgroups on professional issues. • Co-ordinate the production of the Business Plan, undertaking reviews of progress and reporting to the IWSAB. • Co-ordinate the production and publication of the Strategic Plan and Annual Report. • Refine and maintain strategic links with agencies whose function supports adult safeguarding work and the protection of adults at risk but who do not sit on the Board. • Act as the first point of contact to receive and triage for learning review referrals.

Attendance and Involvement in the following 4LSAB Sub-Groups:

Inter-authority Working Group:

1) To provide strategic leadership and direction across the area on adult safeguarding issues.
2) To promote consistency and collaborative working across the four Local Safeguarding Adult Boards and their core statutory member agencies.
3) To provide strategic oversight and coordination of the implementation of the Local Multi-Agency Safeguarding Adults Policy and Guidance.
4) To act as an executive and oversight group, drawing in the Senior Managers of partner organisations

4LSAB Policy Group:

There is a 4LSAB Policy Implementation Group, currently chaired by HSAB which has a remit to coordinate the implementation and on-going development of multi-agency safeguarding policy for Southampton, Hampshire, Portsmouth and the IOW.

4LSAB Quality Group:

To develop and maintain the Quality Assurance Framework across the 4LSAB area to ensure consistency of a common framework in order to ensure that the following points actions are discharged:

1. To test that the learning from SARs and other multi-agency audits / reviews are evaluated post implementation and are focused on the outcome for the service user.
2. To develop links with other sub-groups across the 4LSAB in order to identify common areas of assurance work by means of a business plan. Following a SAR, assurance work is required to ensure that the learning points are embedded within organisations' ways of working – this could incorporate a peer review process.
3. To create an audit plan for the 4LSAB group to include statutory and non-statutory reviews and to assist organisations to complete a self-assessment every other year.
4. To ensure that the needs and the priorities of each board are understood and allow equal opportunity for each board to have a thematic audit completed. The strengths of each board should be used effectively to assist in this process.
5. To ensure that Making Safeguarding Personal (MSP) is a cross cutting theme across all organisations and to drive its implementation within those organisations. MSP is not a safeguarding team / department responsibility.

6. To report back to the Inter-Agency Working Group initially, ensuring that there is parity in work across all four Boards before distribution to individual boards.
7. To develop a Think Family approach to adult work and identify common themes with the 4LSCB, identifying opportunities for joint working.
8. To enable a single, common data set to identify trends that can be reported back to Boards. The formation of a task and finish group is required to complete this task.
9. Identify themes and trends and provide a strategic response to them. Operational responses to issues are the responsibility of individual agency partners. This work will form part of the plan of work and outcomes will be escalated to the relevant boards and added to Risk Registers as necessary

4LSAB Workforce Development Group

The 4 Local Safeguarding Adults Boards cover the local authority areas of Hampshire, Southampton, Portsmouth and the Isle of Wight. The 4LSAB's have a duty to ensure the effectiveness of what organisations and agencies do in order to safeguard and promote the safety and wellbeing of adults at risk of harm, this includes development of the workforce. This sub group aims to bring together agencies across the area to;

- Coordinate approaches and collaborate where possible in delivering safeguarding adults workforce development activities
- Develop the strategic direction for safeguarding adults focussed workforce development across the 4 areas.

Sub Group: Safeguarding Adults Review (SAR)
Core Business: supporting the IOW SAB 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. • **SARs and other learning reviews** • **Joint work with Health services around boundaries between SIRI's and SARs** • **Monitoring of SAR and DHR action plans** • **To look at the lessons learned from the joint work with University of Sussex**

Other Sub-Groups with SAB Involvement

Health Sub-Group
Core business: The overarching purpose of the group is to safeguard and promote the welfare of children and adults across the Isle of Wight health economy in line with the statutory duty under the Adult Care Act (2014) and Section 11 of the Children Act (2004). The Health Subgroup has been established to enable health representatives, including NHSE Wessex, Clinical Commissioning Group (CCG), Public Health and the NHS Trust, Primary Care, CAMHS, Health Watch, IOW Prison, and IOWSCB and SAB members to meet together in order to fulfil their responsibilities to keep adults and children safe across the IOW. The following adult related areas will be looked at by the sub-group: • Embed family approach across health • Oversight of refreshing of mental health services on the island • Mental Capacity Act – 6 step plan for health • Responding to new issues in health The following workstreams being managed by other sub-groups will also feed in to the health sub-group with actions and recommendations: • LeDer • Maintaining a watching brief on Discharge practices across Health and Social care • Joint work with Health services around boundaries between SIRI's and SARs • Protocol around change in service • Lessons from case reviews