

Isle of Wight Safeguarding Adults Board

Annual report

April 2019 to March 2020



Foreword

**Teresa Bell,
Independent Chair**



I am pleased to present the Isle of Wight Safeguarding Adults Board (IOWSAB) Annual Report for 2019/2020. This report summarises what the board achieved throughout the year on behalf of Isle of Wight residents, together as a partnership as well as through the work of individual partner organisations. Since joining the board as independent chair in September 2019, it has been a genuine pleasure to work with such a committed group of organisations, both statutory and voluntary, whose dedication to safeguarding adults at risk is evident – even more so through the recent unprecedented challenges of COVID-19.

Our annual report records achievements alongside valuable information to inform priorities for improvement. As well as annual statistics on safeguarding work, there are details of cases where reviews were carried out to understand what happened and what needs to change. It gives an overview of how partners have worked together during the year to innovate and develop services, including for example, the work with Alcohol Change UK, the progress of the local multi-agency risk management framework and also joint initiatives including the promotion of the family approach to safeguarding with the Isle of Wight Children’s Safeguarding Partnership.

The pandemic has and will continue to have an effect on all of us, impacting on the lives of service users and staff across the partnership. IOWSAB priorities for 2020 to 2021 will therefore reflect our response to the current crisis and will be reviewed throughout the year to ensure that they remain focussed on our changing circumstances so that safeguarding adults at risk remains at the forefront of our work.

I would like to take this opportunity to say how grateful I am to all partners for their support and commitment to the work of the IOWSAB. Thanks also to our talented business team, Emma Coleman and Rachel Cullen, who do so much to ensure the board is well managed, dynamic and responsive.

1

Board membership

Isle of Wight Council – statutory lead

Hampshire Police – statutory lead

Clinical Commissioning Group – statutory lead

Cabinet member for adult
social care and public health

HM Prisons

Healthwatch

The Isle of Wight National
Health Service Trust

The Probation Service

Wessex National Health
Service England

Isle of Wight Council
public health

A residential care home
representative

Southern Housing Association

Fire and Rescue Service

Local Safeguarding
Children's Board

Age UK or an alternative
voluntary sector representative

The Community
Rehabilitation Company

Care UK

Care Quality Commission

Community Safety
Partnership Lead

Isle of Wight Council
housing department

2

Board structure

The Isle of Wight Safeguarding Adults Board has four sub-groups:

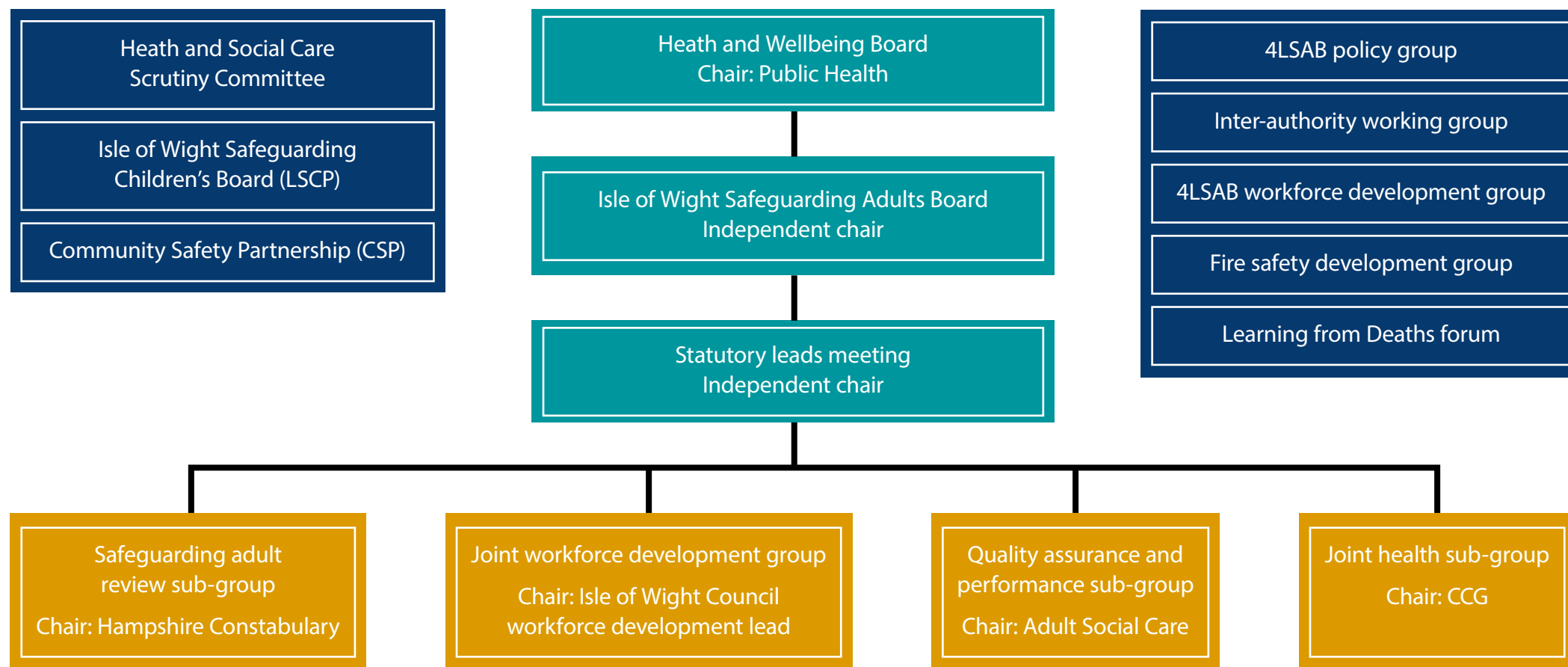
- Safeguarding adults review sub-group.
- Quality assurance and performance sub-group.
- Joint workforce development sub-group with the Safeguarding Children's Partnership.
- Joint health sub-group with the Safeguarding Children's Partnership.

Much of the work of the board is undertaken by members of the four sub-groups in collaboration with the board coordinator and her administrative support. Across its work, the board maintains close links with the Local Safeguarding Children's Partnership and the Community Safety Partnership.

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 Group's 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 coordinator also contribute to regular meetings involving the three safeguarding boards in the Hampshire area – Hampshire County, Southampton and Portsmouth.

Isle of Wight Safeguarding Adults Board hierarchy



2.1 Change of board chair

In 2019/2020, Margaret Geary resigned from her role as Safeguarding Adults Board chair after five years. The board expressed their appreciation for all her hard work and dedication to safeguarding on the Isle of Wight, and wished her all the best for the future. After an extensive recruitment process our new chair, Teresa Bell, was appointed in September 2019.

3

Safeguarding adults reviews and thematic learning

3.1 Cases reviewed, and lessons learned

During 2019/2020, the Safeguarding adults review sub-group on the Isle of Wight considered five cases, none of which met the criteria for a safeguarding adults review. It was felt that although the statutory criteria were not met, there were some important lessons for partners in the services involved with the cases, and so a workshop and a thematic review have been scheduled for the coming year.

Case A

Case A involved an individual with a diagnosis of Parkinson's who had been mainly cared for at home by their spouse with a care package, with some periods in residential care. Concerns are around the management of medications, and the relationship between family carers and professionals. This case will be considered in a joint workshop with Case B in 2019/2020.

Case B

Case B involved an individual with a large grade four pressure ulcer who deteriorated rapidly and passed away. There were concerns about familial neglect due to refusal of care and equipment. This case will be considered in a joint workshop with Case A in 2019/2020.



Case C

Case C involved a homeless individual with substance misuse and mental health issues. There were concerns about lack of communication and information sharing between agencies, and that referrals to the relevant homelessness and substance misuse services for support were not made. This case will be part of a commissioned thematic review with a number of other cases with similar themes of suicide or overdose, homelessness and mental health.

Case D

Case D involved an individual with substance misuse and mental health issues. There were concerns about the substance misuse service provision at the time, and also lack of communication between agencies. This case will be part of a commissioned thematic review with a number of other cases with similar themes of suicide or overdose, homelessness and mental health.

Case E

Case E involved an ex-offender with a history of childhood trauma, mental health issues, substance misuse and self-harm who took their own life. There were concerns at lack of coordination between agencies to support the individual on their release from prison. This case will be part of a commissioned thematic review with a number of other cases with similar themes of suicide or overdose, homelessness and mental health.

Update on progress from safeguarding adults reviews in 2018/2019:

An independently facilitated one day workshop took place in January 2020 on a case referred in the previous financial year with themes of domestic abuse, carer stress, alcohol misuse and co-dependency. This workshop was well attended by a range of agencies including adult social care, NHS Trust, substance misuse, public health and domestic abuse services. A report with recommendations was produced, together with a short briefing for frontline staff to share the learning.



3.2 Work with Alcohol Change UK

In early 2019, Alcohol Change UK published its report **Learning from tragedies**. This highlighted how the role of alcohol is being 'missed or poorly managed' in the care of vulnerable adults, and in some cases contributing to their deaths. This initial report included one of the safeguarding adults reviews undertaken by the Isle of Wight Safeguarding Adults Board, Mrs P. You can view the report at: alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017

Since then they have continued to monitor the role of alcohol in serious case reviews. They have identified another 17 recent safeguarding adult reviews (largely from 2018) which identify the challenges of alcohol misuse in the safeguarding arena, including a multi-agency learning review published by the IOWSAB – Howard. Their daily work rolling out Alcohol Change UK's blue light project highlights that working with vulnerable change-resistant drinkers is a challenge across England and Wales. Indeed, these clients are some of the most challenging and stressful for workers in adult social care, as well as staff across police, housing, homelessness, health and substance misuse services. At present no national guidance exists on the management of this client group in the safeguarding context. This project will fill that gap.

Throughout October 2019 to January 2020, Alcohol Change UK presented to a number of safeguarding adult boards and local authorities across England and Wales proposing a national, multi-partner, project to develop guidance and training on responding to vulnerable adults who are chronic and change resistant dependent drinkers. This will improve local practice as well as challenging and informing national government about needed changes.



The project will be built around seven stages, with the initial scoping workshops due to take place in Spring 2020:

- Scoping the problem.
- Identifying good practice.
- Building a consensus on best practice.
- Developing and publishing national guidance.
- Making recommendations for change
- Developing a training course
- Providing local training and presentations.

Both the Isle of Wight Safeguarding Adults Board and Portsmouth Safeguarding Adults Board have agreed to jointly join this national project and will work together towards a common aim. The main output of this project will be the national consensus guidance; however, each participating area will receive more specific support:

- A development workshop where the local impact of this client group is discussed.
- A local online survey.
- A summary of the feedback from the local workshop and survey.
- Spaces on the regional forums.
- Two training days after the publication of the guidance.
- A presentation to a relevant group about the findings and the guidance.
- The copyrighted training course materials for future local use.

4

Quality assurance and performance

4.1 Adult safeguarding audits

4.1 (i) Making safeguarding personal (MSP) audit

An audit on MSP was carried out in May 2019, and looked at 20 cases. The purpose of the case file audit was to check:

- whether MSP is being applied at the point of contact with the individual at risk (i.e. is the individual asked what action – if any – they would like taken and what outcomes they would want);
- whether MSP principles are adhered to throughout the investigation (i.e. is the individual invited to meetings, are their views and wishes considered at all points and is the individual kept updated with the progress of the enquiry);
- the understanding and application of the MCA;
- the use of advocacy as appropriate;
- areas for improvement.

Findings:

- The audit found that information sharing was poor between agencies, with GDPR often felt to be a barrier, a culture of not sharing information, and a lack of understanding around consent.
- The individuals journey is not reflected in the paperwork.
- Can be confusion between S42 and multi-agency risk management (MARM)
- Repeat referrals are not always being made, meaning a true picture cannot be build up.
- Lack of ownership around having those initial MSP conversations.



Key strengths:

- The victim code for Police is MSP focussed and has been updated.
- MARM well supported by a wide range of agencies in deep dive case.
- Good recognition that MSP falls to all team members in GP surgery – administrators, clinical coders, practice nurses etc.
- Improvement in communication between children’s services and GPs.
- NHS Trust duty of candour letter reflect MSP well.
- Section 42 enquiry reports are now fully supported by a practitioner – more timely return of completed reports.
- Provider report to adult social care from the provider reflected MSP.
- Good examples of partnership working.
- Adult social care has completed significant in-house self-reflective work on their audit responses with their staff.

A repeat of this audit will be scheduled in for the future, so that progress can be determined, and gaps identified.

4.1 (ii) Decision support guidance audit

An audit on the recently launched decision support guidance was undertaken in August 2019. This audit consisted of three parts:

- An anonymous survey of frontline staff.
- Feedback from partner agencies on the use of the guidance and tools to decide when to raise a safeguarding concern to the local authority safeguarding team.
- Feedback from the local authority safeguarding team on using the guidance to make decisions of whether referrals met the criteria for a Section 42 enquiry.

Of the front-line staff surveyed:

- 91 per cent felt they knew where to find support now they had read the guidance;
- 85 per cent found the guidance easy to use and apply;
- 68 per cent said the guidance had given them more confidence to recognise safeguarding issues, however 14 per cent felt it had made it more complicated;
- 91 per cent felt supported by their safeguarding lead or manager.



Feedback from partner agencies indicated that although the document was thorough, this did mean it was a large document for staff to try and digest, and that a series of supportive short guides would be helpful. The accompanying decision-making tool was found to be very useful, with NHS Trust and Isle of Wight Council staff reporting that they used it on a daily basis to inform decision making.

The local authority safeguarding team advised that they had fully adopted the guidance as a decision-making framework to support professional judgement in adult safeguarding work in line with current legislation and 4LSAB multi-agency policy. The guidance has enabled them to have detailed discussions with their partner agencies who are making safeguarding referrals, to highlight the importance of making safeguarding personal and balance this with safety and prevention.

The following recommendations were generated through the audit:

- 1 Quick guide for frontline staff.**
- 2 Decision support guidance for decision makers in any agency – scaled down, and based on new LGA guidance.**
- 3 Decision making tools (tables, flowcharts etc.) to become a toolkit for quick access, rather than being part of a large document.**
- 4 Shorter, simplified referral form for members of the public, smaller voluntary and community groups.**
- 5 Action plan for agencies – embed the revised guidance and toolkit within your staff.**

Both the Isle of Wight SAB Decision Support Guidance and the findings from this audit were presented to the Local Government Association in January 2020 as part of a series of national workshops on Safeguarding Concerns.



4.2 Multi-agency risk management framework

The 4LSAB multi-agency risk management (MARM) framework was introduced in 2016, however two Isle of Wight safeguarding adult reviews have highlighted cases where the MARM framework was not used where it could have potentially reduced risk to the individual and led to a different outcome.

From this, the safeguarding adults board coordinator carried out a multi-agency survey and commissioned three multi-agency workshops to ascertain whether the MARM framework was embedded. These pieces of work highlighted that the MARM framework was not well known, not being applied, and where MARMs were being held, they were of varying quality.

At the April 2019 joint learning event, feedback was that while information sharing between agencies and in particular adults and children's workforces was good, it was unanimously agreed that there are inconsistencies in MARM meetings, and a lack of understanding around the application of the MARM framework. A particular point raised was that no one knew how many MARMs were being called, who was calling them and who should be attending. It was suggested a central point to collate MARM meeting data and promote the MARM framework and toolkit would be an advantage to all agencies.

In response, a MARM task and finish group was set up to identify issues with MARMs, define some quality standards and develop a supporting toolkit for agencies. This group is chaired by the SAB coordinator, with members from adult social care, housing, NHS Trust, primary care, residential and nursing home sector, Southern Housing, Healthwatch, inclusion, ILS, Fire and Rescue and the Police.

The group recommended that the safeguarding adults board consider a MARM coordinator to collate data on who is calling MARMs, how frequently they are being called, which agencies are attending, and which are failing to participate when invited. This information should then be reported back to the board quarterly, with additional recommendations for further work where necessary. Funding was approved for a 12 month, part time post in June 2019, with the new MARM coordinator Sarah Cooke being appointed in November 2019.



A project plan was developed in November 2019 setting out the MARM project goals, aims and objectives. A comprehensive key stakeholder engagement plan was also developed in line with the project plan. The MARM coordinator has met with approximately 40 agencies to promote the MARM framework and toolkit and will continue to do so throughout the lifespan of the project. In addition, the MARM coordinator is shadowing MARM meetings with a view to offering support, help and guidance. This has been well received by agencies.

An audit tool has been developed to determine the efficacy of MARM meetings, and the MARM coordinator will collect data for analysis, the findings of which will be published at a later date. A MARM training record has been developed, with further training requirements being identified and acted upon, either by delivering further specific training in a group setting or on a one to one basis.

The SAB coordinator and MARM coordinator also facilitate training as required, and due to the popularity and high volume of attendees at the 'adult safeguarding and working with risk' training events, further training dates have been arranged in 2020. Some of these will focus on delivering training to senior managers. A directory has been developed which provides the contact details of key agencies on the Isle of Wight. The directory also gives a summary of what each agency provides.

The project is due for completion in November 2020, with a full report going to the SAB to inform any future work.

5

Workforce development

5.1 Working with risk training

Throughout this financial year, the Isle of Wight Safeguarding Adults Board offered a series of full day training courses on 'working with risk'. This multi-agency training course was aimed at frontline staff as well as service managers and strategic leads.

Rather than having one course for each Safeguarding Adult Board policy, one of the aims of this course was to ensure professionals were familiar with a number of board policies, had the confidence to apply them, and were able to utilise the board website as a source of information. This course highlighted the importance of making safeguarding personal and was attended by a wide range of agencies. This course was delivered by Making Connections, with additional sections delivered by the safeguarding adult board coordinator and multi-agency risk management (MARM) coordinator.

Learning outcomes:

- To identify key ingredients and principles around risk and adult safeguarding.
- To identify approaches to working with risk and adult safeguarding.
- To apply the risk and seriousness tool in the Safeguarding Adult Board decision support guidance.
- To identify the criteria for a MARM meeting by using the Safeguarding Adult Board MARM framework.
- How to ensure making safeguarding personal.
- To be familiar with the tools and templates to support MARM meetings.
- To be introduced to the role of the MARM coordinator.

26 November 2019

38 attendees

Organisations attended

- Adult Social Care, Isle of Wight Council
- Citizens Advice Bureau
- Community Action Isle of Wight
- Community CAMHS
- Hampshire Constabulary
- Isle of Wight Council
- NHS Trust
- People Matter IW
- Sevenacres
- Southern Housing Group

4th December 2019

40 attendees

Organisations attended

- Adult Social Care, Isle of Wight Council
- Age Concern
- Age UK Isle of Wight
- Isle of Wight Clinical Commissioning Group
- Isle of Wight Council
- Isle of Wight Fire and Rescue
- Newcross
- NHS Trust
- People Matter IW
- Sevenacres
- Southern Housing Group
- West Wight Sports and Community Centre

23 January 2020

30 attendees

Organisations attended

- Adult Social Care, Isle of Wight Council
- Age UK Isle of Wight
- Brading CE Primary School
- Everycare (IOW & Solent)
- Hampshire Constabulary
- Isle of Wight Council
- Isle of Wight Fire and Rescue
- JHN Healthcare
- Milford Del
- NHS Trust
- Ryde House Group
- Sevenacres
- Southern Housing Group
- St Helens Medical Centre
- Woodlands

18 February 2020

28 attendees

Organisations attended

- Adult Social Care, Isle of Wight Council
- Children Services, Isle of Wight Council
- Hampshire Constabulary
- Inclusion IOW
- Isle of Wight Council
- Local Safeguarding Adults Board
- NHS Primary Mental Health Team
- NHS Trust
- Southern Housing Group



5.2 DASH awareness training

The new commissioned domestic abuse provider, YouTrust IW, delivered six half-day training sessions for Isle of Wight professionals focussing specifically on the domestic abuse, stalking and 'honour'-based violence (DASH) risk assessment form. The YOU Trust is a charity working in Hampshire, Dorset, West Sussex, and the Isle of Wight. For over 30 years they have been providing flexible care, support and advice services centred on the people they support. Last year (2018 to 2019) they provided support to over 24,000 people in such specialist areas as homelessness, learning disabilities, domestic violence and abuse, mental health, young people, and advice services.

These training sessions were open to both the adults and children's workforce, and there was good representation from a number of agencies. The aims and objectives for the sessions are based below:

- 1 Understanding the DASH.
- 2 Why we ask the questions we do.
- 3 How to complete a DASH.
4. How a DASH can help you assess risk

6 September 2019 (morning session)

24 attendees

Organisations attended

- Adult Social Care, Isle of Wight Council
- Barnardos
- Brading CE Primary School
- Children Services, Isle of Wight Council
- Home Start
- Isle of Wight Council
- Isle of Wight Youth Offending Trust
- National Probation Service
- NHS Trust
- Sevenacres
- St Blasius Academy

6 September 2019 (afternoon session)

25 attendees

Organisations attended

- Adult Social Care, Isle of Wight Council
- Barnardos
- Cowes Medical Centre
- Interchange
- Island Learning Centre
- Newport C of E Primary School
- NHS Trust
- The ILC
- The Isle of Wight College
- Southern Housing Group
- Sovereign Housing
- Wroxall Primary School

8 November 2019 (morning session)

22 Attendees

Organisations attended

- Barnardos
- Chantry House
- Greenmount Primary School
- HTP Apprenticeship College
- Isle of Wight Clinical Commissioning Group
- Isle of Wight Youth Offending Team
- Local Safeguarding Children Board
- NHS Health Visiting
- NHS Trust

8 November 2019 (afternoon session)

25 Attendees

Organisations attended

- Adult Social Care, Isle of Wight Council
- Barnardos
- Carisbrooke Primary School
- Community Mental Health
- Isle of Wight Council
- Isle of Wight Youth Offending Team
- Medina College
- NHS Trust
- Sevenacres
- Southern Housing Group
- Sovereign House
- St Blasius Academy
- The Island Free School
- Wootton Community Primary School
- Wroxall Primary School
- You Trust

26 February 2020

24 Attendees

Organisations attended

- Adult Social Care, Isle of Wight Council
- Broadlea Primary School
- Inclusion IOW
- Magnolia House
- Medina Healthcare
- NHS Trust
- St Vincent Care
- You First

27 February 2020

18 Attendees

Organisations attended

- Adult Social Care, Isle of Wight Council
- All Saints CE Primary School
- Carers IW
- Isle of Wight Council
- Hampshire Constabulary
- Little Love Lane Nursery
- NHS Trust
- Southern Advocacy
- Southern Housing Group
- Youth Trust
- WightDASH

5.3 Family approach training

In 2019/2020, a number of workshops were jointly delivered by the Safeguarding Adult Board coordinator and Safeguarding Children's Partnership support manager. The overarching aim of these workshops was to launch the Hampshire, Isle of Wight, Portsmouth and Southampton adults and children's family approach protocol and supporting practitioner toolkit.

The workshops used information from the toolkit to support professionals from both children and adult sectors across the pan Hampshire and Isle of Wight areas to understand how issues including mental health, substance misuse, domestic violence, learning disabilities and neglect affect all family members, including children (as well as unborn babies) and adults at risk as defined in the Care Act 2014.

Delegates were given time to consider how the needs of children and/or adults living with hidden harm impact on the whole family. The importance of early identification of these needs, and effective communication between services, is important in order to support those at risk and their families.



The learning outcomes were:

- Identify how a range of risk factors and vulnerabilities co-exist within families and the cumulative impact and implications for safeguarding children and adults at risk.
- Understand how these cumulative issues impact on children and adults at risk, in relation to immediate risk, their day to day lives, and long-term implications for them and their families.
- Understand the impact of risk and vulnerability on an adult's capacity to parent, care for others and themselves.
- Understand the legislative and statutory frameworks that surround the practice in both the adults and children's sectors.
- Understand the application of the pan Hampshire and Isle of Wight LSCB and LSAB family approach protocol and explore the resources available under the supporting toolkit.
- Understand the important role that professionals play in identifying vulnerability and risk, and the sharing of information in the context of the family approach and child protection/adult safeguarding.
- Be able to signpost to local referral pathways and support services for both children and adults.
- Explore themes including protective factors, restorative practice, strength-based approach, person centred working, mental capacity, professional curiosity and transition.
- Explore learning from serious case review and safeguarding adult review findings and current research to inform evidence-based practice.

The content of the workshops was the same in all locations, and professionals from any agency operating in each of the four local authority areas were able to book onto any event for free.

The training was attended by a wide range of agencies and professionals.



5.4 Training from the National Centre for Domestic Violence (NCDV)

The NCDV delivered two half day sessions to 68 multi-agency professionals from agencies including NHS Trust, Isle of Wight Council adult social care, GP surgeries, Police, schools and the voluntary sector. The sessions included a presentation by Janet Bush, Training Programme Manager for the NCDV, about the service that they provide to the victims of domestic violence, namely the obtaining of emergency injunctions to protect those victims against the violence they are experiencing.

The session covered the criteria for protection, the different kinds of order available, the distinction between legally aided and pro bono victims, how the process works, how to refer to the service – either directly on behalf of the victim, or informing the victim of the service so they may self-refer, and a look at developments in the types of molestation NCDV may be able to assist with.

The National Centre for Domestic Violence was established in 2003 to help survivors of domestic violence and abuse obtain protection against an abuser, as well as offering services to the police, probation service, domestic abuse agency workers, the legal profession and judiciary. They specialise in providing free, fast and effective support to survivors of domestic violence and abuse, usually by helping individuals obtain injunctions from their local county court.

This free service is provided to everybody, regardless of their financial circumstances, sexual orientation, race, gender, age, political, religious belief or otherwise. In brief, their help includes: free injunction service to everybody; injunctions often within 24 hours; a large framework of Legal Aid family solicitors throughout the country; Emergency Prohibited Steps Orders - Emergency Non-Molestation and Occupation Orders; direct links with local authorities, health centres, refuges, Women's Aid centres and other services.



5.5 Joint learning event with the Safeguarding Children's Board and Community Safety Partnership

The Community Safety Partnership, Local Safeguarding Adults Board and Local Safeguarding Children's Board have all individually held learning events following the completion of a DHR, SAR or SCR respectively. However, there has not been an opportunity for the strategic partnerships to work together to examine areas of commonality in learning required and to implement improvements. Common themes were identified in all of these reviews and a half day event was delivered looking at the following:

- Needs of the child – think family.
- Self-neglect and service refusal.
- Domestic abuse.
- Using adult safeguarding processes.
- Information sharing and GDPR.

These sessions were facilitated by an independent consultant – Alison Ridley. Tonia Redvers from The You Trust also delivered a short session on coercive control. The session was also supported by short information sessions on the domestic abuse forum, the You Trust service and the wide range of training offered by both the adults and children's safeguarding boards.

A half-day session was delivered in 2018/19 with a total of 55 attendees (60 places available) at Isle of Wight College.

Agency	Number of attendees
Adult Social Care	13
Clinical Commissioning Group	3
Childrens Social Care	5
Community Safety	2
Education (chools)	4
Inclusion	3
Isle of Wight College	2
NHS Trust	5
Police	1

Agency	Number of attendees
Public Health	2
Residential/nursing homes	2
Housing providers (Isle of Wight Council, Southern Housing, Sovereign Housing etc.)	5
Voluntary sector (Barnardos, Age UK, People Matter IW etc.)	5
Youth Offending Team	1
You Trust	2

Through group work and discussion, a range of intel and feedback was collected. This information has been used to inform the work of the sub-groups, as well as being included in the annual learning needs analysis where gaps in knowledge and training needs are identified.

Feedback highlights:

- Looking at strategic level, communication has improved, especially the conferences held by the safeguarding boards.
- MARM has helped agencies communicate in a much better way which has improved outcomes. Still work to do to get other agencies on board. There is a better sense of ownership and MARM has helped with this.
- Training has improved across the board. There is now a hoarding forum that looks at self-neglect and the risks around them.
- Better understanding that self-neglect isn't necessarily a choice, and professionals understanding that there are multi-aspects involved – substance misuse, ACES, mental health etc.
- Quality assurance network around care homes and how that can also move onto the safeguarding element.
- Good that we undertake reviews and have a desire to learn and improve
- MARMS – Can the process be communicated better? What is the process? Is there an agenda? How many has there been? Who attended? Who instigated them? A central point is needed as it is currently unclear. SAB.
- Need to spend more time with other agencies to understand their processes, what can they input and how can you work together to improve.

- Need more coordinators for areas to better explain and spread information.
- Referral route can be confusing at times for frontline professionals (adults and children). Smart feedback, having someone to triangulate what occurs and feedback what has occurred. DAF, ASC, CSC, You Trust.
- Understanding complex needs is a barrier.
- Dealing with disengagement – how far do you go?
- Challenging poor practice is difficult.
- Understanding service provision of the future.

6

Adult social care safeguarding adult collection data (SAC) return data

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 2019/20, 3709 safeguarding concerns were recorded, which is an increase from 3307 recorded in 2018/19.

Safeguarding concern

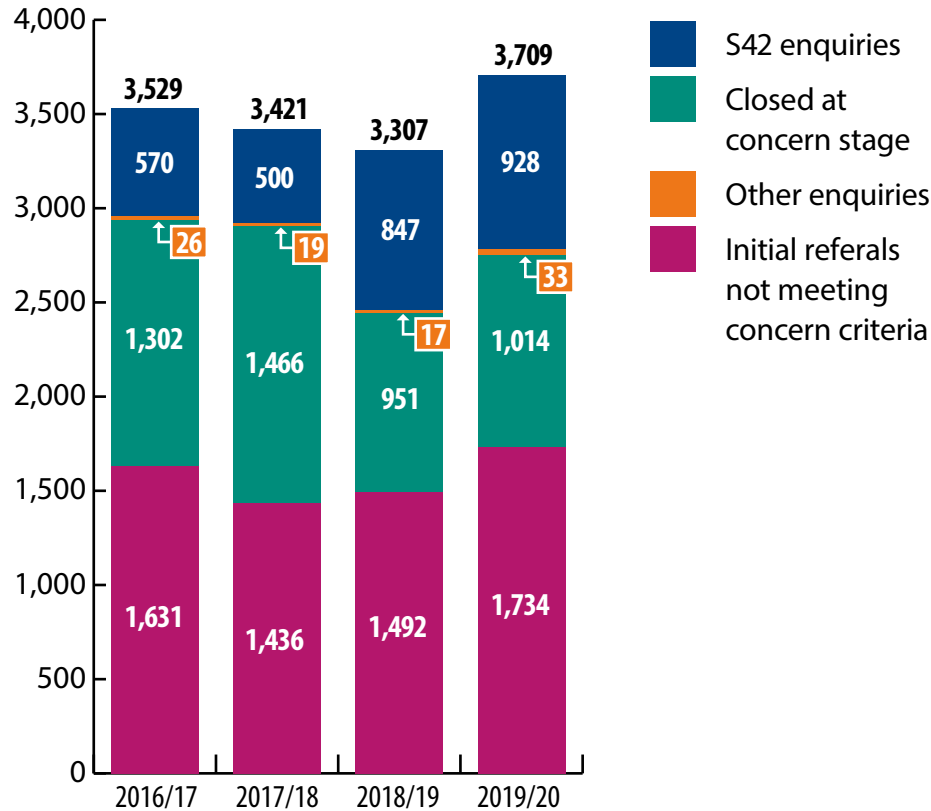
Sign of suspected abuse or neglect that is reported to the council or identified by the local authority.

Safeguarding enquiries

The action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. Can range from a conversation with the adult to a more formal multi-agency plan or action. There are two types:

- **Section 42** – where the adult meets all of the section 42 criteria.
- **Other** – where adult does not meet all of section 42 criteria, but the local authority considers it necessary and proportionate to have a safeguarding enquiry.

Figure 1: Overall referrals analysis



The data in figure 1 indicates a high number of inappropriate referrals, something which has caused increased pressure on the safeguarding team. Although the Isle of Wight Safeguarding Adults Board has been embedding the decision support guidance since 2018, this is currently being revised and updated to suit a 4LSAB audience and will be launched in 2020. The launch of the new guidance will be accompanied by a range of training and resources, and progress with embedding this will be monitored by the quality assurance and performance sub-group.

Figure 2: Reasons for primary support

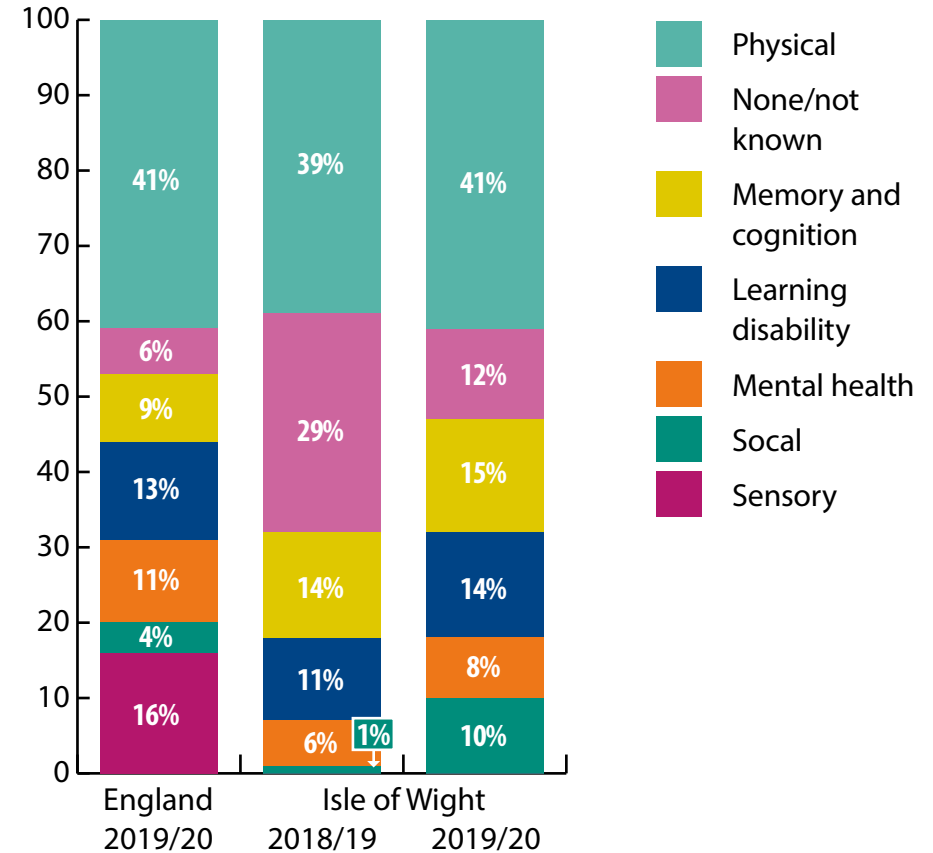


Figure 2 shows the figures for primary support reason for 2018/19, 2019/20 and also the national average for 2018/19 for comparison.

The proportion of recorded primary support reasons are similar to last year, but the percentage of individuals where no support reason is known has been halved.

Figure 3: Types of abuse

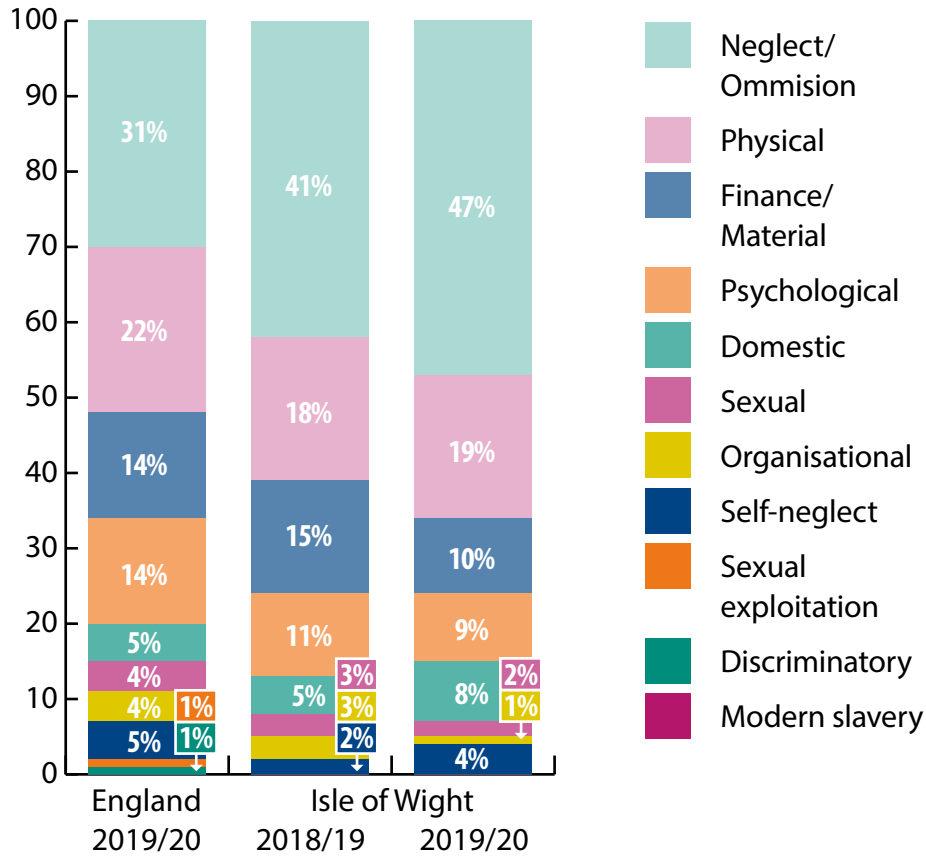
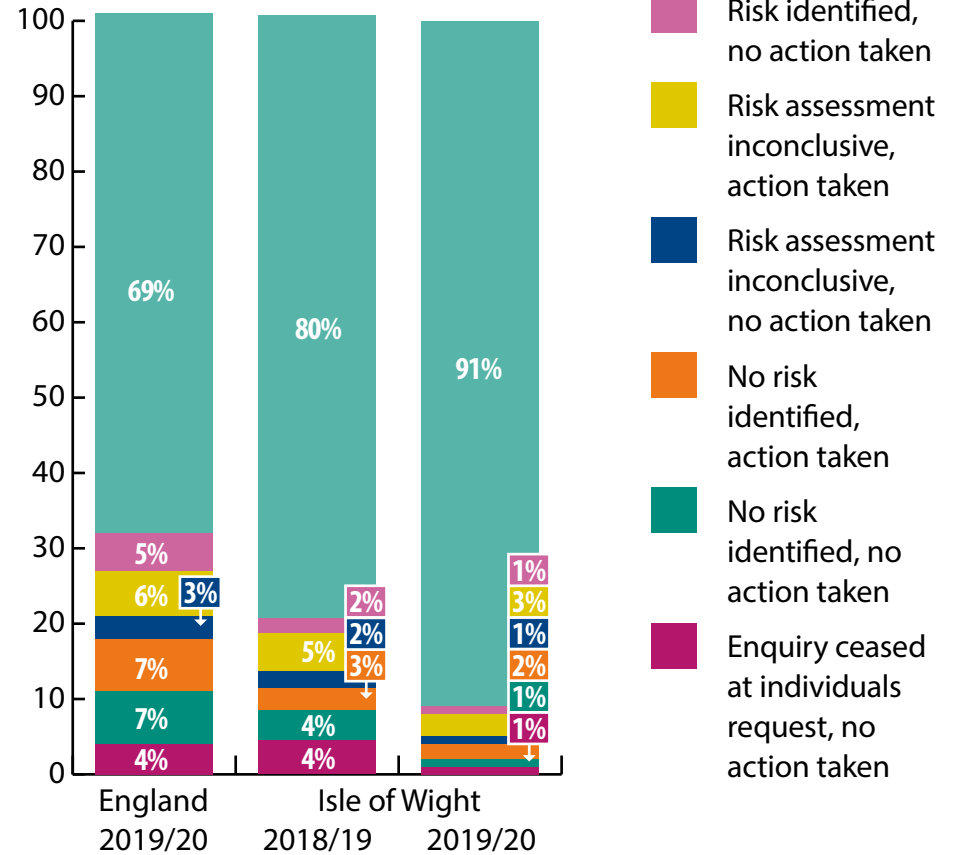


Figure 3 shows the different abuse types, and the Isle of Wight has similar results to last year.

The most common type of risk is neglect and omission which follows the England trend; however, our local figures are higher, particularly this year.

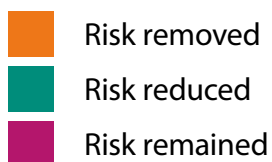
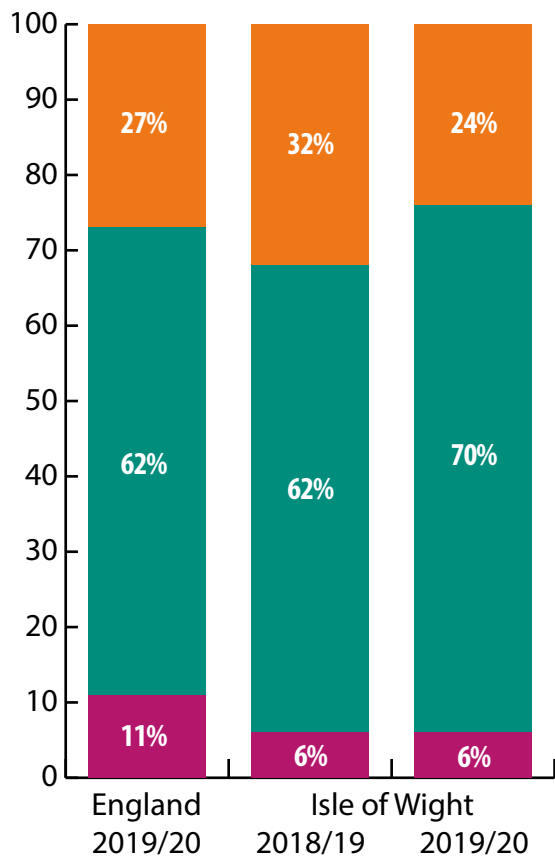
Figure 4: Section 42 Enquiries: Risk Assessment Outcomes – Was a risk identified and was any action taken/planned to be taken?



The Isle of Wight is very high for **risk identified, action taken (91 per cent)** - compared to England at 69 per cent.

Risk identified – Evidence is found of, or potential for, abuse or neglect which could possibly cause harm to the vulnerable adult.

Figure 5: Section-42 Enquiries: Risk Assessment Outcomes – Where risk was identified (in figure 4), what was the outcome when the case was concluded?



Risk assessment inconclusive – No direct evidence is found of, or potential for, abuse or neglect which could possibly cause harm to the vulnerable adult but there is uncertainty as to whether they are susceptible to abuse or neglect.

No risk identified – No evidence is found of, or potential for, abuse or neglect which could possibly cause harm to the vulnerable adult (eg, it may be that immediate action taken when a safeguarding concern is raised has mitigated the risk).

Enquiry ceased at individual’s request – This refers to cases where the individual at risk does not wish for an enquiry to proceed for whatever reason and so preclude a conclusion being reached.

Risk removed – The circumstance causing the risk has been completely removed so that the individual is no longer subject to that specific risk, for example if a care worker in a care home is the perpetrator and they are dismissed as a result of their behaviour. There can always be contention between removal of risk and the desired outcome, as the adult at risk may not wish for the situation where the risk is completely removed, eg, the adult at risk does not wish for the removal of an abusive partner/carer.

Risk remained – The circumstance causing the risk is unchanged and the same degree of risk remains. It is acknowledged that there are valid reasons why a risk remains, for example in the case of an individual wanting to maintain contact with a family member who was the source of the risk, but the safeguarding officer refers the individual at risk for counselling.

Risk reduced – The circumstance causing the risk has been mitigated to some degree. It is acknowledged that there are valid reasons why a risk is reduced rather than removed, for example if an incident occurred in a care home where the perpetrator was not identified but the individual at risk was to be monitored more closely going forwards.

7

Safe Places

The Safe Places scheme on the Island was launched in November 2019 with County Hall, Age UK IW, The Board Café, Medina Leisure Centre, and the Independent Living Centre being the first to receive training and stickers to support the scheme.

Over 60 letters were sent out to businesses across the Island which included supermarkets, ferry ports, leisure services, libraries and town and parish councils to get organisations to sign up to be a safe place for people with disabilities. Those who responded were arranged to be met and if the business was suitable the training in a group or individually was carried out for the venue.

We are continually looking for more places to sign up and Ventnor have taken on board Safe Places with a raft of businesses being trained and supporting people who need them.

At the same time we were promoting Safe Places to people with learning disabilities at day services, residential homes and clubs for people who go out independently or with a support worker to ensure they knew where the Safe Places are, and that they have a card to show if they need support. This work was ongoing then COVID-19 hit and the Safe Places app (which also holds all of the data to take a person to the safe place) were all closed down.



8

Community and voluntary sector project



Healthwatch Isle of Wight and People Matter have been working together with the Isle of Wight Safeguarding Adults Board to promote safeguarding within the community and voluntary sector.

A safeguarding survey was shared with voluntary sector partners at the beginning of 2019 and 42 organisations participated. The survey results were analysed and led to the development of a safeguarding training package specifically for volunteers and staff within community and voluntary sector organisations.

So far, training sessions have been delivered to 6 organisations and 63 people have attended the training, with positive feedback received about the sessions:

"A good session provoking much thought. Thank you."

"Very interesting and informative."



Training was put on hold during the COVID-19 pandemic, but an online version has been developed to enable training to continue online.

Several people expressed an interest in becoming a community 'safeguarding champion'.

Next steps will be to recruit these community champions in each locality area. The champions will be a direct link between voluntary sector organisations and the Isle of Wight safeguarding team and will be available to support their peers within the voluntary sector.



9

Domestic abuse



The purpose of this report is to provide an oversight of the work undertaken by the domestic abuse project officer for the 2019/20 financial year. This report also includes work that forms part of the wider Domestic Abuse Forum's (DAF) priorities and activities.

The role of the domestic abuse project officer is to work alongside the forum to achieve a reduction in domestic abuse and an increase in reporting. To support the forum to develop effective and sustainable links with partner agencies, both statutory and voluntary and with the Community Safety Partnership (CSP) and safeguarding boards, ensuring their participation in the strategy and wider domestic abuse initiatives.

The forum provides effective leadership in the areas of domestic abuse to ensure shared strategic objectives and a joint approach across all sectors, promoting multi agency working, collective decision-making and comprehensive information sharing and data collection.

The domestic abuse project officer post is funded by the Safeguarding Adults Board and hosted by the Isle of Wight Council's community safety team.

The project officer has focused on a number of key work areas within the post. These include:

- Coordination of the Domestic Abuse Forum.
- Domestic violence and abuse conference 2020 – 'missed opportunities'.
- Partnership joint learning event.
- 16 Days of Action campaign.



The coordination of the Domestic Abuse Forum (DAF)

Four DAF meetings were held during the 2019/2020 period with 22 different partner agencies represented. The DAF is currently chaired by the IW Police superintendent. The project officer coordinates the meetings, pulling together the agenda and liaising with partner organisation on their individual actions and future items.

The key priorities outlined in the DAF action plan are:

- Services have formal referral pathways in place for domestic abuse. These should support people who disclose that they have been subjected to it; the perpetrators; and children who have been affected by it.
- Targeted campaigns to raise awareness.
- Staff are trained to an appropriate level.
- To oversee and guide commissioning of services.
- Domestic abuse is prioritised across strategic partnership boards with recognition of the impact on outcomes and need for co-ordinated responses.

The DAF process brings senior professionals together to ensure up to date service information along with any key messages or changes in legislation are circulated within teams.

The DAF action plan has been used as a working document and is currently being reviewed (February 2020) in light of the multiagency review workshop that took place during the missed opportunities conference. For the action plan see appendix one.

Domestic violence and abuse conference – ‘missed opportunities’ – 9 January 2020

110 people attended the missed opportunities conference in January 2020 from a variety of voluntary, statutory and business sector local organisations. The topics covered included:

- Briefing on the local profile and current service provider.
- Coercion and control.
- Voice of the child.
- Stages of homicide.
- Domestic violence and abuse against older people.
- Adult to parent violence.



Further to the above sessions a workshop took place to review the current DAF action plan, enabling the broad range of partners in attendance to feed into its future development and priorities.

Feedback from attendees was very positive and highlighted the content had an impact on individuals working practices. Many commented they would be reviewing their current case load, considering what they had learnt, to ensure there were no 'missed opportunities' for further intervention and support.

The project was nominated and shortlisted for an award at the Isle of Wight Council staff appreciation awards in February 2020 due to the work involved in raising the profile of DVA.

The Community Safety Partnership (CSP), Local Safeguarding Children's Board (LSCB) and Local Safeguarding Adults Board (LSAB) held a joint learning event in April 2019 to explore the recurring theme of information sharing and domestic abuse in recent SARs, DHRs and SCRs (local and national). Exploring the reasons why this theme is reoccurring and what the barriers are to addressing domestic violence. The workshop:

- relaunched the Domestic Abuse Forum now co-ordinated by CSP and its plan;
- introduced the new domestic abuse coordinator on the Isle of Wight and their role, Introduced the new domestic abuse service provider 'You First' and the service to be provided;
- Promoted six half-day workshops to be run by the new provider for adults and children's frontline staff during 2019/20;
- provided four sessions of DASH awareness delivered by YouFirst;
- delivered trauma informed practice workshops;
- promoted information sharing across agencies including adult and children's workforces.



The poster features two photographs: the top one shows an elderly woman being held back by another person while a man in the background looks distressed; the bottom one shows a man in a blue shirt looking thoughtful and a woman in a wheelchair looking out a window. The central text is on a dark teal background with white text.

DOMESTIC ABUSE
Help is closer than you think....

0800 234 6266
iwight.com/domesticabuse

Logos for the Isle of Wight Council and the Isle of Wight Safeguarding Adults Board are at the bottom.

16 days of action against domestic violence

Launched from the missed opportunities conference (January 2020) to raise awareness of the effect that domestic abuse has on employees and how employers can support them. The aim was to raise awareness of the effect it has on people and how we all have a responsibility towards our colleagues in recognising the signs and feeling confident to signpost for support. The CSP along with partners held a series of events and promotional activities which included:

- bus stop and floating bridge advertising;
- campaign material to specifically highlight the effect it has on those impacted by domestic violence and abuse;
- drop-in sessions for businesses organised with Age UK;
- employers packs sent to eight companies;
- email sent to all schools/learning providers, doctors, dentists and housing providers about the campaign and conference;
- meeting with the Isle of Wight Chamber of Commerce and presentation prepared for all members regarding the conference and campaign;
- press coverage in Island Echo, Isle of Wight County Press, Isle of Wight Observer, Vectis Radio (a live one hour interview), and Isle of Wight Radio (prerecorded interview);
- 24,000 reach via Facebook;
- Isle of Wight Council website utilised;
- attending Age UK friendly forum and spoke to local residents about the domestic abuse services and how they access them, the dragonfly project and perpetrator programme.

10

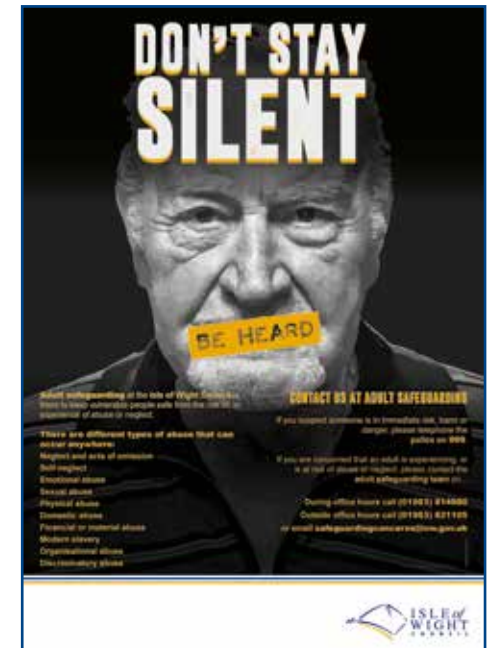
National adult safeguarding awareness week

The Isle of Wight Safeguarding Adults Board attended Tesco in Ryde along with Isle of Wight Council adult social care during the national adult safeguarding week. The board attended for half a day and promoted themselves using displays with posters, information leaflets and handing out free pens/notepads.

The board also organised a half day event at Lord Louis Library, Newport, to promote safeguarding adults and give out help, advice and information to the public. The board invited partner agencies to come along and promote their organisation:

- Healthwatch, Isle of Wight
- Age UK, Isle of Wight
- The Isle of Wight Clinical Commissioning Group

This event was organised alongside a week long media campaign and public engagement events across the Island by Adult Social Care to raise awareness about adult safeguarding, and to launch and promote some new information leaflets for the public. These events were publicised in the County Press, and featured information about adult abuse and neglect, and where to get help.



11

Joint work with the Local Safeguarding Children's Partnership

There is a strong working relationship between the two Local Safeguarding Children's Partnership and Safeguarding Adults board chairs, SAB coordinator and LSCP partnership manager with regular liaison meetings held. Because the Isle of Wight is small, there is some shared membership across the SAB and LSCP boards, and this aids communication and understanding of the adults and children's safeguarding agendas and the commitment to a family approach to services on the Isle of Wight.

The SAB and LSCP run joint workforce development and health subgroups. This has made joint planning for training, including pooled budgets possible and

ensures that both boards are aware of each other's training priorities and can offer a wider range of inputs to front line staff. Areas of commonality are identified and where possible joint training organised, for example, domestic abuse, modern slavery and honour-based violence. The group has developed a common approach to quality assurance of training through observations and a joint annual learning needs analysis process to identify training priorities.

Family approach protocol workshops have been successfully delivered to 189 practitioners by the LSCP partnership manager and the SAB coordinator across the Isle of Wight and this joint approach valued by attendees. It shows the commitment of the boards to integrate a family approach into safeguarding children and adults.



12

4LSAB work

12.1 Animated scribe

In November 2019, we launched the new 4LSAB animated scribe as part of national adult safeguarding awareness week. This short video is aimed at members of the public and helps to explain what safeguarding is, and advises where to go for help and support if you or someone you know is experiencing abuse or neglect. This video was launched on the Safeguarding Adult Board website and twitter, and via Isle of Wight Council social media. It is always available to view on the Safeguarding Adult Board website, as well as the Isle of Wight Council YouTube channel, and has been viewed by several thousand residents across the 4LSAB area.

www.iowsab.org.uk/keeping-adults-at-risk-safe

12.2 Making safeguarding personal (MSP) workshop

The 4LSAB quality assurance sub-group has four workstreams for 2019/2020 – one workstream for each area, with the Isle of Wight leading on making safeguarding personal. This workshop was organised by the Isle of Wight on behalf of the 4LSAB Quality Assurance Sub-group, with support and input from the other three areas. The purpose was to bring together key multi-agency staff to look at existing work on MSP that has already taken place separately within Southampton, Hampshire, Isle of Wight and Portsmouth. The expectation was that attendees would then use this information to develop 4LSAB actions and plan resources to further embed MSP as a 4LSAB piece of work. Further work will then be taken forward by the various 4LSAB sub-groups ensuring a joined-up approach.



A workshop was held on 3 June 2019, at Hampshire Fire and Rescue Headquarters in Eastleigh. There were 29 participants with all four areas well represented. In addition to agencies who are members of the 4LSAB quality group, representatives from local advocacy groups and the voluntary sector were invited.

The workshop itself was structured in three parts:

Part 1: MSP – Where are we now?

This first session was used to set the scene of ‘where we are now’, so that any recommendations for future work were well informed, proportionate and targeted the key issues. A key piece of information was a SHIP-wide staff and manager survey, distributed in April/May 2019 with 455 responses. This anonymous survey provided a current snapshot of understanding and attitudes towards MSP across a number of agencies and areas, and provided staff and managers with a voice.

In general, the staff survey indicated that only a third of those surveyed had received training on MSP, and that less than half felt their practice had changed as a result of guidance or training. However, around two thirds felt that they were supported to implement MSP by their manager, and that their agency promoted MSP.

In the managers survey, over two thirds felt there had been evidence of a change of practice since the Care Act 2014, and responded that supervision was the most popular and effective way of helping their staff put MSP into practice. Both managers and staff were asked: **“What do you think the challengers and barriers are to implementing MSP?”**

There were 324 separate responses, providing a good insight. Some recurring themes were:

- capacity and resources;
- conflict between adults wishes and views of the child when working with a family;
- time pressures;
- lack of understanding of what MSP is in both practitioners and the public;
- seeing MSP as something additional to safeguarding, rather than business as usual;
- culture where people feel safeguarding is something done to you, rather than for you;
- lack of confidence in having initial conversations;
- staff are process driven rather than person focussed.

The full responses to these questions can be found in appendix one and two.



In order to capture the voice of the individual, the workshop next focussed on SARs across the four areas where lack of MSP, lack of person-centred approach, and voice of the adult not being captured were noted as key themes in the review. Each of the four areas were able to give an overview of their SARs, with each area being able to provide at least one example. There was a brief presentation on Mr W, an Isle of Wight SAR, which ensured the individuals voice was heard and considered throughout the workshop.

The first part of the workshop concluded with a look at some of the audits undertaken on MSP in the last couple of years. Both Southampton and the Isle of Wight submitted audit reports, with some general themes coming through:

- Individuals journey not reflected in the paperwork.
- MSP conversation may happen, but they are not recorded.
- Lack of ownership to have the MSP conversations.
- Lack of recording around capacity assessments.
- Perceived lack of consistency of understanding of MSP across organisations.
- Appetite for more concise guides on key points to support front line staff.
- Greater focus on supported decision making more generally appears to be needed.

Part 2: What's been done so far?

In this section, attendees focussed on assessing what had already been done, with a view on taking the 'best bits' from each area to the next stage, which discarding anything that hadn't worked so well.

The four areas assessed were:

- **MSP training**

What worked well; what should be changed and improved; how could delivery be smarter; what has already been done and could be built on.

- **MSP policies**

Do we need local guidance? Do we need to better promote the existing guidance and build on it? Do we need better methods of disseminating the information?

- **Awareness raising campaigns**

how can we use the resources we already have to raise the profile of MSP and Safeguarding with the public? What do we already have – Twitter, website, posters, animated scribe project, one-minute guide to MSP.

- **Data set recently signed off by the quality sub-group**

Part 3 – What now?

In the final section, attendees used all the evidence gathered so far, and used this to determine where the 4LSAB group should focus their efforts in order to further embed MSP across the whole SHIP area. Rather than making general recommendations, attendees were asked to provide specific recommendations and actions for the three main 4LSAB sub-groups to consider.



Appendix one Safeguarding adult collection 2019/2020 return



Section one: Demographic tables

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

Only one entry per row 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

Counts of individuals by age band	Age band						Total ³
	18-64	65-74	75-84	85-94	95+	Not known	
Individuals involved In safeguarding concerns ¹	556	152	277	327	63	0	1,375
Individuals involved in section 42 safeguarding enquiries ²	204	69	142	183	31	0	629
Individuals involved in other safeguarding enquiries ¹	5	1	12	9	2	0	29

Table SG1b

Counts of individuals by gender	Gender			Total ³
	Male	Female	Not known	
Individuals involved In safeguarding concerns ¹	535	839	1	1,375
Individuals involved in section 42 safeguarding enquiries ²	237	392	0	629
Individuals involved in other safeguarding enquiries ¹	9	20	0	29

¹Voluntary data ²Mandatory data ³Automatically calculated totals

Table SG1c

Counts of individuals by ethnicity	Ethnicity							Total ³
	White	Mixed/ Multiple	Asian/ Asian British	Black/African/ Caribbean/ Black British	Other ethnic group	Refused	Undeclared/ Not known	
Individuals involved In safeguarding concerns ¹	1,198	7	4	3	0	0	163	1,375
Individuals involved in section 42 safeguarding enquiries ²	557	2	3	3	0	0	64	629
Individuals involved in other safeguarding enquiries ¹	25	0	0	0	0	0	4	29

Table SG1d

Counts of individuals by primary support reasons	Ethnicity							Total ³	
	Physical support	Sensory support	Support with memory and cognition	Learning disability support	Mental health support	Social support	No support reason		Not known
Individuals involved In safeguarding concerns ¹	560	5	196	202	163	195	242	0	1,563
Individuals involved in section 42 safeguarding enquiries ²	292	2	104	99	60	73	87	0	717
Individuals involved in other safeguarding enquiries ¹	18	0	5	2	1	3	3	0	32

¹Voluntary data ²Mandatory data ³Automatically calculated totals

Section two: Section 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

Counts of enquiries by type and source of risk	Concluded section 42 enquiries ¹			Other concluded enquiries ²			Total section 42 ³	Total other ³
	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)		
Physical abuse	26	141	14	0	0	0	181	0
Sexual abuse	2	20	1	0	0	0	23	0
Psychological abuse	25	58	3	0	1	0	86	1
Financial or material abuse	14	66	12	1	2	0	92	3
Discriminatory abuse	0	1	2	0	0	0	3	0
Organisational abuse	1	2	2	0	0	0	5	0
Neglect and acts of omission	272	142	34	11	5	1	448	17
Domestic abuse	-	77	-	-	2	-	77	2
Sexual exploitation	0	3	0	0	0	0	3	0
Modern slavery	0	2	0	0	0	0	2	0
Self-neglect	-	34	-	-	5	-	34	5

¹Voluntary data ²Mandatory data ³Automatically calculated totals

Table SG2b

Counts of enquiries by location and source of risk	Concluded section 42 enquiries ¹			Other concluded enquiries ²			Total section 42 ³	Total other ³
	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)		
Own home	66	253	6	0	9	0	325	9
In the community (excluding community services)	7	20	6	0	0	0	33	0
In a community service	11	16	2	0	0	0	29	0
Care Home - nursing	58	35	8	4	0	0	101	4
Care Home - residential	180	131	15	8	1	0	326	9
Hospital - acute	8	37	25	0	2	1	70	3
Hospital - mental health	0	9	0	0	0	0	9	0
Hospital - community	1	2	1	0	1	0	4	1
Other	9	43	5	0	2	0	57	2

¹Voluntary data ²Mandatory data ³Automatically calculated totals

Table SG2c

Risk assessment outcomes: Was a risk identified and was any action taken/planned to be taken?	Concluded section 42 enquiries ¹			Other concluded enquiries ²			Total section 42 ³	Total other ³
	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)		
Risk identified and action taken	302	502	62	6	14	1	866	21
Risk identified and no action taken	1	5	1	0	0	0	7	0
Risk assessment inconclusive and action taken	17	11	2	2	0	0	7	0
Risk assessment inconclusive and no action taken	2	7	0	0	0	0	9	0
No risk identified and action taken	10	5	2	3	0	0	17	3
No risk identified and no action taken	8	5	0	1	1	0	13	2
Enquiry ceased at individual's request and no action taken	0	11	1	0	0	0	12	0

¹Voluntary data ²Mandatory data ³Automatically calculated totals

Section three: Mental capacity table

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						Total ¹
	18 to 64	64 to 74	75 to 84	85 to 94	95+	Not known	
For each enquiry, was the adult at risk lacking capacity to make decisions related to the safeguarding enquiry?							
Yes, they lacked capacity	117	36	96	125	37	0	411
No, they did not lack capacity	219	55	90	108	9	0	481
Don't know	18	2	15	20	4	0	59
Not recorded	0	0	0	0	0	0	0
Of the enquiries recorded as 'yes' in row one of this table, in how many of these cases was support provided by an advocate, family or friend?	109	35	91	120	35	0	390

¹Automatically calculated totals

Section four: Making safeguarding personal (MSP) 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 five rows of each table should represent the number of enquiries that concluded during the reporting year.

Table SG4a

MSP table for concluded section 42 safeguarding enquiries	Age group						Total ¹
	18 to 64	64 to 74	75 to 84	85 to 94	95+	Not known	
For each enquiry, was the individual or individual's representative asked what their desired outcomes were?							
Yes, they were asked and outcomes were expressed	246	58	135	147	23	0	609
Yes, they were asked but no outcomes were expressed	83	31	58	89	22	0	283
No	24	4	8	16	5	0	57
Don't know	1	0	0	1	0	0	2
Not recorded	0	0	0	0	0	0	0
Of the enquiries recorded as 'yes' in row one of this table, in how many of these cases were the desired outcomes achieved?							
Fully achieved	143	40	74	96	14	0	367
Partially achieved	97	16	51	38	6	0	208
Not achieved	4	2	8	10	2	0	26

¹Automatically calculated totals

Section five: Safeguarding adult review (SAR) tables

The information in these tables should only include SARs that took place during the reporting year.

Table SG5a

Counts of safeguarding adult reviews	Count
Count of SARs where one or more individual died	0
Count of SARs where no individuals died	0



Isle of Wight Safeguarding Adults

Board business plan 2020 to 2021

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 six 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**

Develop three year IWSAB strategy. Consult with stakeholders on four simple themes:

- **Prevent abuse** – how can we engage with the community so that they recognise abuse; how can we reduce social isolation (so that people and communities are stronger)
- **Protect adults at risk** – staff are trained properly; raise community awareness of what to do; maximise the use of technology in practice (eg, online tools)
- **Learn from experience** – MSP; quality assurance systems; learn from users and carers; review when things go wrong (not just SARs);
- **Improve services** – info sharing and intelligence; consistent policies with rest of Hants; national best practice; performance reporting to SAB.

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

Several 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.

Safeguarding and COVID-19

We respect and acknowledge that services will be prioritising their response to COVID-19, and that some of the timescales for other SAB business may need to change as a result. As a Board, we will be seeking the following assurances during this time period:

- Under Civil Contingency Act business continuity planning processes, what safeguarding impact assessments have been made locally as part of the process, both within single organisations, but also the impact on the multi-agency statutory requirements?
- What assurance is it possible to gain about the local response to safeguarding concerns? For example, what is the extent of s42.1 activity around emerging, societal and safeguarding issues from COVID-19 – particularly the role of volunteers and keeping adults safe who have care and support needs / or who have vulnerabilities are in self-isolating groups?
- What is emerging in your area around Care Act assessments in light of the Emergency Powers Bill?

The areas of focus for 2020/2021 are:

- MAST (Including how the new channel/prevent strategy will work without a MASH).
- Discharge process (including for individuals who are homeless).
- Engagement with Solent and other new providers.
- Links between SIRI's, SARs and coroner's processes.
- Commissioning of new services.
- Meta-analysis of 'safe' CQC findings in care and nursing homes over the last 12 months.
- Liberty protection safeguards (LPS)
- Making safeguarding personal

Other work:

- Health outcomes for people with a learning disability.
- Health outcomes for people who are homeless.
- Transitions (including care leavers).
- 4LSAB thematic review and work with Alcohol Change UK.
- Suicides.
- Locality working.
- MARM coordinator project.
- Voluntary and community sector project.
- Underspend proposal projects.
- 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.
- Any other audit work.
- Continuing the lessons learned workshops for practitioners after safeguarding adult reviews.

These areas of focus will be managed both through the main board, the sub-groups of the board and by the LSAB business unit as detailed below:

Safeguarding Adult Board – main board

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:

- MAST (Including how the new Channel/Prevent Strategy will work without a MASH)
- Discharge processes (including for individuals who are homeless)
- Engagement with Solent and other new providers
- Commissioning new services (IRIS lessons learned)
- Making safeguarding personal
- Suicides
- Locality working

Area of focus	Outcome	Action required	Lead	By when	Evidencing	Red/ Amber/ Green rating
MAST (Including how the new channel/prevent strategy will work without a MASH)	The MAST works effectively as an alternative for a MASH on the Isle of Wight.	<ul style="list-style-type: none"> • Re-establish MAST – sits with Sarah and Dave. 				
Discharge processes (including for individuals who are homeless)	Board are assured people are being discharged from hospital appropriately and safely.	<ul style="list-style-type: none"> • CHIP review. • Report from other forums looking at this. 				
Engagement with Solent and other new providers	The SAB are assured that new partnership arrangements across health organisations (including with mainland partners) deliver the improvements needed as set out by CQC.	<ul style="list-style-type: none"> • Clarity from commissioners on the new service providers • How will Solent and other providers engage with the SAB? 				
Commissioning new services (IRIS lessons learned).	Partner organisations work to a clearly understood protocol about planned changes in service.	<ul style="list-style-type: none"> • T&F group – use IRIS case as an example. • CCG, ASC, public health and Healthwatch. 				
Making safeguarding personal	Staff and managers across the partnership are confident and supported in applying the principles of making safeguarding personal to their day to day practice.	<ul style="list-style-type: none"> • SAB to complete actions at April meeting. 				
Suicides	All partners are aware of the incidence and causes of suicides on the Isle of Wight and have developed appropriate prevention strategies in response to the findings from reviews.					
Locality working	Partners are working effectively together on a locality basis to identify and support people who have chaotic lives.					

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:

- MAST (Including how the new channel/prevent strategy will work without a MASH)
- Discharge processes (including for individuals who are homeless)
- Meta-analysis of 'safe' CQC findings in care and nursing homes over the last 12 months
- Making safeguarding personal
- MARM coordinator project
- Voluntary and community sector project
- Underspend proposal projects
- Any other audit work

Area of focus	Outcome	Action required	Lead	By when	Evidencing	Red/ Amber/ Green rating
MAST (Including how the new channel/prevent strategy will work without a MASH)	The MAST works effectively as an alternative for a MASH on the Isle of Wight.	<ul style="list-style-type: none"> • Assess – monitoring for six months. • Evaluate and next steps – if it works as an alternative it is working re: PREVENT and other partners. 				
Discharge processes (including for individuals who are homeless)						
Meta-analysis of 'safe' CQC findings in care and nursing homes over the last 12 months	Key themes are identified in order to refresh and reframe approach to multi-agency training and development.	<ul style="list-style-type: none"> • Audit. • Building links with isolated groups, eg, nurses in nursing homes, PAs etc. 				

Area of focus	Outcome	Action required	Lead	By when	Evidencing	Red/ Amber/ Green rating
Making safeguarding personal	Staff and managers across the partnership are confident and supported in applying the principles of making safeguarding personal to their day to day practice,	<ul style="list-style-type: none"> Follow up work from MSP audit. 				
MARM coordinator project						
Voluntary and community sector project						
Underspend proposal projects						
Any other Audit work						

Workforce development sub-group (Joint with the LSCP)

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:

- Meta-analysis of 'safe' CQC findings in care and nursing homes over the last 12 months
- Liberty protection safeguarding (LPS)
- Making safeguarding personal
- Transitions (including care leavers)
- 4LSAB thematic review and work with Alcohol Change UK

Area of focus	Outcome	Action required	Lead	By when	Evidencing	Red/ Amber/ Green rating
Meta-analysis of 'safe' CQC findings in care and nursing homes over the last 12 months	Key themes are identified in order to refresh and reframe approach to multi-agency training and development.	<ul style="list-style-type: none"> Themes identified by the QA&P sub-group are fed into the learning needs analysis in order to develop training and learning resources. 				
Liberty protection safeguards (LPS)	Staff and managers across the partnership are confident in applying the new LPS legislation.	<ul style="list-style-type: none"> Board to receive report from Hampshire and Isle of Wight steering group. 				
Making safeguarding personal	Staff and managers across the partnership are confident and supported in applying the principles of making safeguarding personal to their day to day practice.	<ul style="list-style-type: none"> Consider training and resources. 				
Transitions (including care leavers)	Transitions between children's and adults services are effective and safe.	<ul style="list-style-type: none"> SAB needs understanding of how transitions work in practice on the Isle of Wight. Commission tailored training on transitional safeguarding to identify needs 				
4LSAB Thematic Review and work with Alcohol Change UK	Learning from 4LSAB review is applied to improve the response to people who have drug and alcohol dependency who have care and support needs and are at risk					

Sub-group: Safeguarding adults review (SAR)

Core business: supporting the Isle of Wight Safeguarding Adults Board 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.

Areas of focus:

- SARs and other learning reviews.
- Links between SIRI's, SARs and coroners processes.
- Monitoring of SAR and DHR action plans.
- To look at the lessons learned from the joint work with University of Sussex.
- Discharge processes (including for individuals who are homeless).
- 4LSAB thematic review and work with Alcohol Change UK.
- 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.
- Continuing the lessons learned workshops for practitioners after safeguarding adult reviews.

Area of focus	Outcome	Action required	Lead	By when	Evidencing	Red/ Amber/ Green rating
SARs and other learning reviews						
Links between SIRI's, SARs and coroners processes						
Monitoring of SAR and DHR action plans						
To look at the lessons learned from the joint work with University of Sussex						
Discharge processes (including for individuals who are homeless)	There is effective sharing and communication of all safeguarding investigations, reviews and learning across the partnership.	TOR for 4LSAB thematic review on homeless deaths.				

Area of focus	Outcome	Action required	Lead	By when	Evidencing	Red/ Amber/ Green rating
4LSAB thematic review and work with Alcohol Change UK	Learning from 4LSAB review is applied to improve the response to people who have drug and alcohol dependency who have care and support needs and are at risk.					
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						

Health sub-group (Joint with the LSCP)

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, Isle of Wight Prison, and IOWSCB and SAB members to meet together in order to fulfil their responsibilities to keep adults and children safe across the Isle of Wight.

Areas of focus:

- Health outcomes for people with a learning disability.
- Health outcomes for people who are homeless.

Area of focus	Outcome	Action required	Lead	By when	Evidencing	Red/ Amber/ Green rating
Health outcomes for people with a learning disability	Health outcomes are in line with national expectations for people with a learning disability.					

Area of focus	Outcome	Action required	Lead	By when	Evidencing	Red/ Amber/ Green rating
Health outcomes for people who are homeless	People who are homeless receive, and are able to access, health services.					

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.
- Deliver multi-agency training on SAB policies and procedures.

Ongoing projects:

- Safe places
- MARM coordinator
- Safeguarding in the voluntary and community sector

Other sub-groups with SAB involvement

4LSAB groups with Southampton, Hampshire and Portsmouth (SHIP)

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

Inter-authority working group:

- To provide strategic leadership and direction across the area on adult safeguarding issues.
- To promote consistency and collaborative working across the four local safeguarding adult boards and their core statutory member agencies.
- To provide strategic oversight and coordination of the implementation of the local multi-agency safeguarding adults policy and guidance.
- 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 Isle of Wight.

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:

- 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.
- 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.
- 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.
- 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.
- 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.

- 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.
- To develop a think family approach to adult work and identify common themes with the 4LSCB, identifying opportunities for joint working.
- 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.
- 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 four 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 four areas.

Appendix three

Chart data sets



Figure 1: Overall referrals analysis (page 26)

	2016 to 2017	2017 to 2018	2018 to 2019	2019 to 2020
S42 enquiries	570	500	847	928
Closed at concern stage	26	19	17	33
Other enquiries	1,302	1,466	951	1,014
Initial referrals not meeting concern criteria	1,631	1,436	1,492	1,724

Figure 2: Reasons for primary support (page 26)

	England	Isle of Wight	
	2019 to 2020	2018 to 2019	2019 to 2020
Physical	41%	39%	41%
None/not known	6%	29%	12%
Memory and cognition	9%	14%	15%
Learning disability	13%	11%	14%
Mental health	11%	6%	8%
Social	4%	1%	10%
Sensory	16%	0%	0%

Figure 3: Types of abuse (page 27)

	England	Isle of Wight	
	2019 to 2020	2018 to 2019	2019 to 2020
Physical	31%	41%	47%
Finance/Material	22%	18%	19%
Psychological	14%	15%	10%
Domestic	14%	11%	9%
Sexual	5%	5%	8%
Organisational	4%	3%	2%
Self-neglect	4%	3%	1%
Sexual exploitation	5%	2%	4%
Discriminatory	1%	0%	0%
Modern slavery	1%	0%	0%

Figure 4: Section 42 enquiries: Risk assessment outcomes – was a risk identified and was any action taken/planned to be taken? (page 27)

	England	Isle of Wight	
	2019 to 2020	2018 to 2019	2019 to 2020
Risk identified, action taken	69%	80%	91%
Risk identified, no action taken	5%	2%	1%
Risk assessment inconclusive, action taken	6%	5%	3%
Risk assessment inconclusive, no action taken	3%	2%	1%
No risk identified, action taken	7%	3%	2%
No risk identified, no action taken	7%	4%	1%
Enquiry ceased at individuals request, no action taken	4%	4%	1%

Figure 4: Section 42 enquiries: Risk assessment outcomes – where risk was identified (in figure 4), what was the outcome when the case was concluded? (page 28)

	England	Isle of Wight	
	2019 to 2020	2018 to 2019	2019 to 2020
Risk removed	27%	32%	24%
Risk reduced	62%	62%	70%
Risk remained	11%	6%	6%