Annual Report

April 2016 – March 2017

Foreword

Since drafting this annual report the Care Quality Commission (CQC) has published on (12th April 2017nsert date) the report based on its inspection of the Isle of Wight's Health Trust. The Health Trust's Chief Executive has resigned and the Trust has been placed in Special Measures. Within the report a number of concerns are raised which link to weaknesses in the approach to safeguarding. It is in the interests of local people and all those involved in Health and Social Care to support the improvement action which the Health Trust's Board and interim Chief Executive will be implementing. The Safeguarding Adults Board has agreed that it will work closely with the Children's Safeguarding Board to agree an assurance process which seeks to build on existing quality monitoring processes and provides the respective Board members with some confidence that current services provided by the Health Trust are safe and progress is being made on improving the approach to safeguarding. Keeping track of this improvement work will be an ongoing focus over the next year alongside the other priorities identified in this report.

The Safeguarding Adult's Board's work relies on partners' commitment to learning from lessons identified from the case reviews and implementing improvements as a result of those lessons. Partners also support the promotion of information and training about safeguarding so that local people can be better placed to identify and manage risks and ensure vulnerable adults are effectively kept safe. The Annual Report is a reflection of the work of a significant number of the professionals in Health and Social Care who work to try to ensure local people who are vulnerable and need support are safe.

Margaret Geary,
Independent Chair

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Context

These are challenging times; the pressure to do more with less inevitably exposes some gaps in provision, which necessitate a re-shaping of services to ensure that they stay safe. Over the last twelve months, the services on the Isle of Wight have, at times, been stretched beyond the capacity to manage them to the standard that everyone would want to have maintained. Change is never easy, but when resources shrink whilst demand rises, then the present models of care need to be transformed in order to ensure that services remain safe and are manageable.

The partners to the Safeguarding Adults Board recognise this, and are committed to achieving more joined up approaches to service delivery. This may mean re-shaping services, so that some of what was offered before is no longer possible, but it will mean that vital services are retained and are safe and accessible to local people. Any changes will also need to adopt a person-centred approach, that is, will make sure that individuals who need care and support are involved in decisions made about how that care and support will be offered. Transforming care in this way has implications for safeguarding adults. It means that people should have more control over the kind of support they receive when a safeguarding response is required. That increased involvement and control means individuals must take responsibility for identifying what will keep them safe and well for longer, for understanding the risks they might face if they achieve the kind of support they feel they need, and for managing those risks.

The Safeguarding Adults Board is there to support partners and hold them to account for maintaining safe services and responding effectively to risks faced by vulnerable adults, whilst allowing those adults to retain as much control and independence as their circumstances allow.

Over the last twelve months, there have been two completed safeguarding adult reviews, one of which was a joint review with the Children's Safeguarding Board, and one other case review that did not reach the eligibility threshold for a full Safeguarding Adults Review but which generated important lessons for the services involved. A further Safeguarding Adults Review was commenced and is due for completion in 2017/18. Lessons from all of these reviews are shared through learning workshops. Training courses aimed at promoting knowledge of Safeguarding Adults issues have been undertaken. The Board's Quality Assurance and Performance Sub-group continues to try to improve data collection and analysis so that we can have more confidence in the information we have about the type of risks faced by local people and any trends that exist. The data should help target the initial resources available. The minutes of Board meetings are also now being published on the website (www.iwight.com/SAB).

This Annual Report attempts to summarise the Board's activity and partners' activity in 2016/17; it also points to priorities for 2017/18.

Board Membership and Structure

1. Isle of Wight Council – Statutory Lead
2. Hampshire Police – Statutory Lead
3. Clinical Commissioning Group – Statutory Lead
4. H. M. Prisons
5. Healthwatch
6. The Isle of Wight National Health Service Trust
7. The Probation Service
8. Wessex National Health Service England
9. Public Health
10. A residential care home representative
11. A domiciliary care home representative
12. Southern Housing Association
13. Fire and Rescue Service
14. Local Safeguarding Childrens Board
15. Age UK or an alternative Voluntary Sector representative
16. The Community Rehabilitation Company
17. Care UK
18. CQC
19. Community Safety Partnership Lead
20. IWC Housing Department
21. The IWC lead member for Adults Social Care

The Board has three sub-groups:

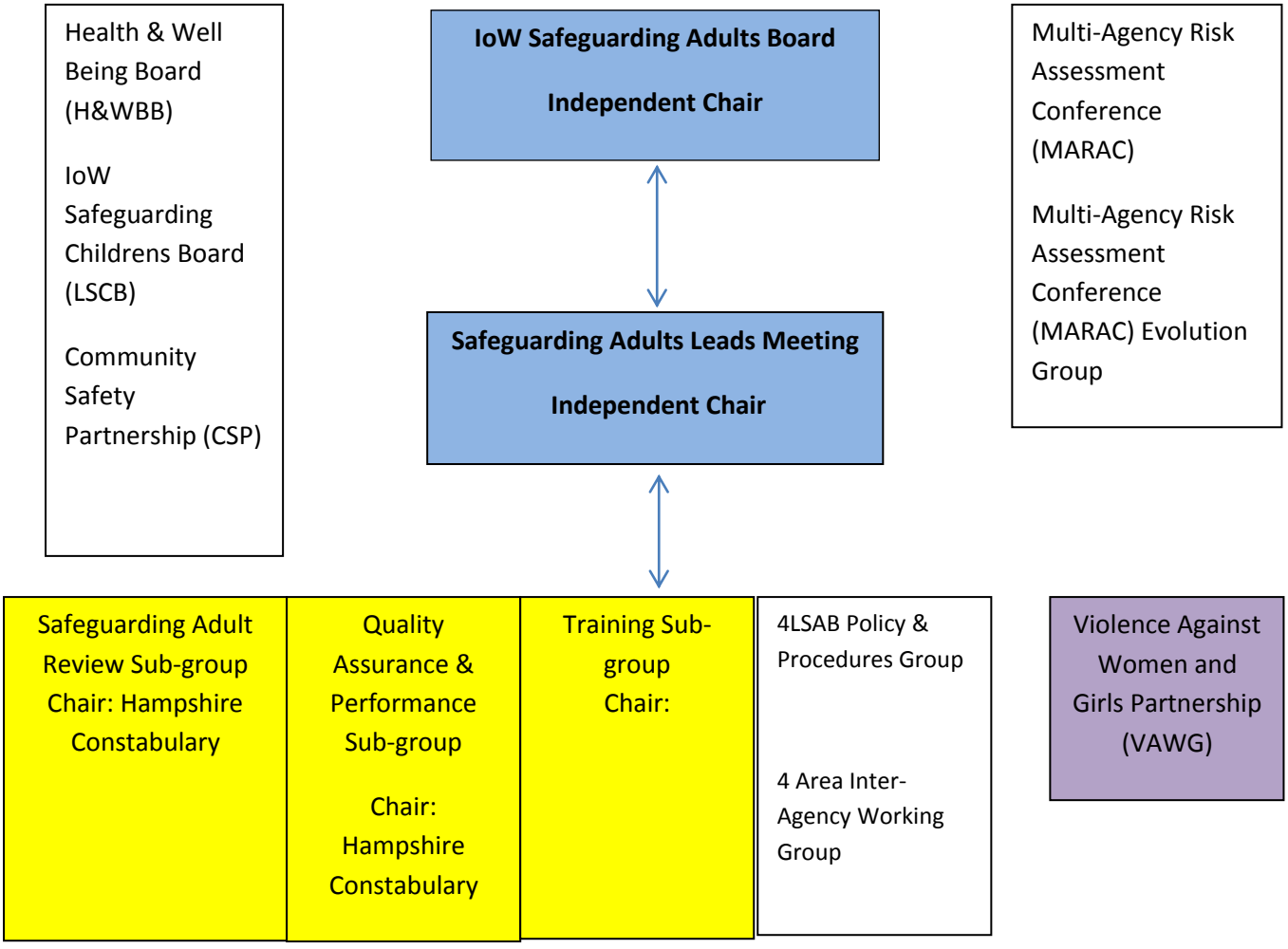
- Safeguarding Adults Review Sub-group
- Quality Assurance and Performance Sub-group
- Training Sub-group

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. The Safeguarding Adults Board also

oversees the work of the Violence Against Women and Girls Co-ordinator. In this, and across its work, the Board maintains close links with the Local Safeguarding Childrens Board and the Community Safety Partnership.

In the last quarter of 2016/17, the Board agreed to establish 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 Lead for Safeguarding, the Director of Adult Social Services and the Chair of the Safeguarding Adults Board.

Isle of Wight Safeguarding Adults Board Hierarchy



Principles Underpinning the Boards Work

The following six principles are included in the Care Act 2014 Statutory Guidance:

- **Empowerment:** presumption of person led decisions and informed consent
- **Prevention:** it is better to take action before harm happens
- **Proportionality:** proportionate and the least intrusive response appropriate to the risk presented
- **Protection:** support and representation of 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 delivery safeguarding

Strategic Priorities in 2016/2017

The Board agreed three strategic priorities. These were to promote:

1. A person centred approach to safeguarding offering effective protection to adults at risk

2. An effective Safeguarding Adults Partnership

3. A resilient community that knows what to do if abuse or neglect happens.

In this report, progress on these priorities is covered under the following headings:

a) Lessons learned from Case Reviews

b) Making Safeguarding Personal

c) Awareness raising and accessibility

d) Partnership links

e) Robust policies and procedures

f) Improved Data Analysis

g) Prevention and Early Intervention

h) Mental Capacity Assessment Work

a) Lessons Learned from Case Reviews

Safeguarding Adults alerts can be raised at any time by anyone. These alerts should be directed to the Local Authority's Safeguarding Adults team based at Enterprise House, St Cross Business Park, Newport (Adults First Response Team: 01983 814980, Out of Hours: 01983 821105). Alerts are then assessed to determine whether they meet the criteria for a Safeguarding Adults case requiring further investigation and multi-agency review leading to a plan to address the presenting risks and keep the individual safe. This process should involve the individual who needs safeguarding from the start. It is outlined in Section 42 of the Care Act 2014 and is often referred to by practitioners as a Section 42 case.

In 2016/17 the Local Authority's Safeguarding Adults team received referrals as outlined in the table below:

Table 1: Referral to the IoW Safeguarding Adults Team 2016/17

Overall Count of Safeguarding Activity	Q1	Q2	Q3	Q4	Grand Totals
Number of Safeguarding Concerns	479	526	478	415	1898
Number Proceeding To Section 42	138	157	128	147	570
Number Proceeding To 'Other' Enquiry	5	3	3	15	26
% to Section 42 Enquiries	29%	30%	27%	35%	30%

Section 44 of the Care Act 2014 required Safeguarding Adults Boards to undertake a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or

suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. If an adult has not died but was subject to serious abuse or neglect which could have resulted in death, and the circumstances outlined above exist then the Safeguarding Adults Board should undertake a Safeguarding Adults Review.

During 2016/17 the Safeguarding Adults Review Sub-group on the Isle of Wight undertook two Safeguarding Adults Reviews. One of these was a joint review with the Childrens Safeguarding Board, and one is still ongoing and will be completed in 2017/18. The Board supported a third review in a case which did not meet the criteria for a full Safeguarding Adult Review, but the circumstances in the years before the person's death 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 2016/17 were:

Case A: Family G

This case review focused on the murder of a 6 year old girl by her father, who subsequently killed himself.

This review was a multi-agency approach between the Safeguarding Children's Board, who led the review, the NHS Trust and the Safeguarding Adult's Board. The purpose of the Review was to:

- Meet the statutory requirements for a Serious Case Review
- Identify appropriate learning for the Safeguarding Adults Board
- Incorporate the learning identified within the two NHS Serious Incident Requiring Investigation Reports (SIRI)

A key recommendation from this case was;

- That the Isle of Wight Safeguarding Adults Board and the Isle of Wight Safeguarding Children Board develop a shared strategic approach to 'Think Family' for the Isle of Wight and agree priority areas for development within their annual planning.

This work has already commenced and a family approach is one of the priority areas identified in the Board's 2017/18 business plan.

Case B: Miss T

This case focused on the death of a young woman following significant multi-agency concerns for her welfare due to her drugs misuse, her emotional and mental health needs and the evidence of sexual exploitation. Miss T died in August 2015 following a cardiac arrest associated with drug taking.

Key recommendations in this case were:

- Better use of independent advocates in situations where individuals have capacity to make decisions for themselves, choose not to engage with professionals but face serious risks.
- The production of guidance for all agencies focussed on escalating decisions and taking action when situations require an urgent response.

- Good practice guidance for practitioners on managing risk in cases where an adult's mental capacity is variable or fluctuating.
- Clearer advice on how and when cases are passed from the Local Authority's Safeguarding Team to longer term caseworkers.
- Regular awareness raising for staff focussed on agencies' roles and responsibilities and the legal options available linked to Adult Safeguarding
- Checks in place to ensure that the protection plan process clearly records the different roles and responsibilities of each of the agencies involved in the case.
- Improving support for staff who are working to try to safeguard individuals in complex circumstances.

Following every case review, workshops are run for practitioners focussing on the lessons learned. The Safeguarding Adult Review Sub-group also produces an action plan listing the recommended actions as a result of lessons learned from case reviews; each action plan is monitored until each agency involved can confirm that the required improvements have been made.

The Safeguarding Adults Board website (www.iwight.com/SAB) contains the reports generated by the Safeguarding Adults Reviews.

b) Making Safeguarding Personal

Both Health and Social Care Services are expected to transform their approach so that the people in need of their care are fully involved in plans to address the risks they face. If individuals are assessed as not having capacity to make decision about how best to ensure that they are safeguarded then an advocate should be recruited to reflect their interests and help to maintain whatever level of involvement is possible for that individual. An individual's involvement is important to ensure that the safeguarding plans that are developed take proper account of their concerns and deliver the best outcomes for them. Individuals should also feel that they retain a level of control over what happens to them as a result of a safeguarding intervention. This approach to safeguarding is in line with the move towards more personalised care planning which is now promoted through legislation, Strategic Transformation Plans and the My Life A Full Life ethos on the Isle of Wight. It links to the evidence that people stay well for longer when they retain some independence and control in their lives.

The HealthWatch report 'Home from Home' on residential care and nursing homes on the Isle of Wight points out that in the best homes individuals are encouraged to be as active as possible and to exercise as much control as possible over routine domestic tasks. This report also highlights the variability of practice within care and nursing homes on the Island. The report has been shared with the Safeguarding Adults Board and has provided a useful evidence base for those partners who are working towards improvement, the residential care home representative on the Board and will inform how the work needed - in whatever the setting – to move from practice which is 'doing unto people' to services which make the most of an individual's ability to be involved and undertake actions on their own behalf or make more informed choices about the kind of care and support they need.

On 16th April 2016, the Safeguarding Adults Board launched the Making Safeguarding Personal approach to Safeguarding work with adults. The presentations made on 16th can be found on the website (www.iwight.com/SAB). The Making Safeguarding Personal approach is embedded within the Care Act 14 and requires all those partners involved in Safeguarding Adults to consider how practitioners need to change practice in order to better involve individuals in shaping any responses aimed at improving their safety and managing the risks they face.

Whilst MSP requires a significant shift in safeguarding culture from 'doing to' to 'doing with', the core principles are not complicated, involving a preventative multi-agency approach with a focus on having & supporting conversations with people - and making those conversations count. Highlights of the April event included Vanessa Goodall who spoke so movingly about her personal experiences as a carer for her husband who was diagnosed aged just 49 with young onset Alzheimer's and the 'Celebrating Safeguarding' presentation by Richard Beardsall, training consultant, whose 'rainbow' analogy struck a chord with so many in the audience. It was followed up with workshops focussed on different aspects of practice by promoting a person-centred approach.

The Board had hoped to invest a relatively small amount of its funds on further promotion of Making Safeguarding Personal within communities so that people better understood what this might mean for them but after discussion, it was felt that this should be part of what the My Life A Full Life programme might cover. This has not proved to be possible and towards the end of the year the Board has been informed that the My Life A Full Life has made available a sum of money for this purpose to Adults Social Care. This will now be a priority in 2017/18.

Person Centred Care and outcomes remain a priority for the IOW NHS Trust. A number of activities have taken place to help achieve this, for example

- A focused Person Centred Care workshop with (Ward Sisters Band 7) in April 17 as part of their Development Day.
- Audit of practice against Regulation 9 (Person Centred care) within the acute hospital
- A further audit tool has been agreed and implemented as part of a Quality Improvement Cycle to retain focus on person centred approaches going forward

Moving towards individuals having more control in shaping the responses to their safeguarding needs has implications about how much information about risks and risk management is provided to those individuals. In making progress towards the change needed to have more person-centred services the Safeguarding Adults Board will be looking for evidence that people are being offered the kind of support that enables them to manage the risks involved in organising their own care.

An audit of Making Safeguarding Personal was undertaken this year by the Quality Assurance and Performance Group. The audit found that the view of the adult concerned was not always expressed and captured in safeguarding processes. It also found that capacity decisions were not always fully recorded and advocacy offered. The audit will be repeated in the next financial year to see if the continued focus on the implementation of Making Safeguarding Personal across agencies improves results.

c) Awareness Raising and Accessibility

A pack has been developed for Board members about their roles and responsibilities.

During this year, the Isle of Wight council's telephone reception system has offered a clear option for people phoning in with concerns about the safety of adults. People with concerns are now instructed to choose an option which will get them directly to the Adult Services First Response Team to report their concerns. Whilst the Adult Services First Response Team is not a dedicated Adult Safeguarding hub, the provision of clear instructions on the phone is a significant improvement in communicating to people where they should report concerns.

In Hampshire a Multi-Agency Safeguarding Hub (MASH) exists which provides a hub for all adult safeguarding alerts to be discussed and responses agreed. This hub covers adults and children's safeguarding concerns raised in Hampshire, Southampton and Portsmouth. It also covers children's concerns raised on the Isle of Wight. It does not cover adult safeguarding concerns raised on the Isle of Wight. Over the last year a mini Multi-Agency Safeguarding Hub has been developed on the Isle of Wight. Unlike the Hampshire hub, this is not a full time hub just for the Island. The mini MASH has, however, meant that once a week agencies have an opportunity to share information about serious risks to vulnerable adults and to agree next steps. This is an important development which will improve communication between agencies about how to improve safety for adults who are at risk and should improve the co-ordination of action taken to reduce the risks they face.

Newsletters

A quarterly newsletter is produced by the small Safeguarding Adults Board team. This informs readers about current activities and some of the issues addressed by Safeguarding Adults work. The newsletters are distributed to Board and Sub-Group members, as well as published on the website.

Festivals

The Safeguarding Adults and Violence Against Women and Girls (VAWG) team have a stall at Island's music festivals to promote both Safeguarding Adults work and information about support for people experience domestic abuse and sexual violence. This year, the team was present at both the Isle of Wight Festival in June and Bestival in September.

Isle of Wight Festival
This was the first year where the LSAB / VAWG Partnership provided support at the Isle of Wight Festival. Supported by volunteers from Southampton Rape Crisis and St Marys Hospital Sexual Health Team, we were able to engage with festival goers and raise awareness for respectful sexual relationships. It is known that only a small number of victims (around 15%) will report rape and serious sexual assault to the police. Our volunteers were available to provide counselling support should a disclosure be made with no formal complaint to police.

Bestival
Following the success of the IWSAB's work in providing a safeguarding presence at the Isle of Wight Festival in 2016, the team returned to Bestival for the 4th year to raise awareness and provide specialist support to victims of sexual assault. Volunteers from Barnardos, Southampton Rape Crisis, and St Marys Hospital Sexual Health Team work with the IWSAB / VAWG team under the banner 'Love Doesn't Hurt' to raise awareness of consent and respectful sexual relationships and provide specialist support to anyone affected. With only around 1:7 victims of sexual assault reporting to the police, access to specialist support and signposting are critical to ensure victims of sexual assault can be offered support, counselling and the opportunity to make an informed decision on what they want to do regarding a formal police complaint.

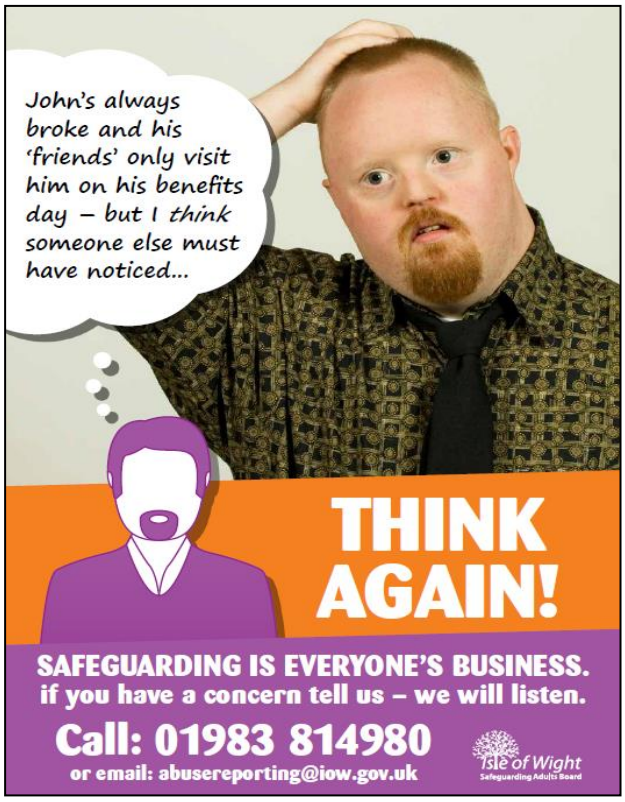
Raising awareness to the risk of rape and serious sexual assault at festivals is a delicate matter which most event organisers shy away from. It is a credit to Isle of Wight Festival and Bestival that they acknowledge the potential risk and are happy for us to be present to raise such awareness. The Island's approach to safeguarding for victims of sexual assaults at festivals is unique in the UK and testimony to the priority both our local festivals give to safeguarding their guests. The national press and BBC Radio 5 Live have all taken a great interest in the work conducted with a view to encouraging festivals on the mainland to have a similar approach. The team gained attention both nationally and internationally for the work, with the Island's Domestic Abuse Coordinator, Dave Huggins, speaking to National Public Radio America about the approach. To listen to his interview go to: http://www.npr.org/2016/08/07/488701857/how-can-we-stop-sexual-assault-at-music-festivals-one-group-says-start-by-educat.

Big Cuppa Event

The Isle of Wight Safeguarding Adults Board were represented at the BBC Radio Solent 'Big Cuppa' Event on the Friday 23rd September. The event, held at Cowes Yacht Haven, attracted a large crowd of Radio Solent fans who came along to learn more about local initiatives for older people. The IWSAB team were joined by the VAWG Strategic Partnership and had a very successful day talking to the visitors about adult safeguarding and domestic abuse. Many people stated that they had little knowledge of the issues and that they found the chance to talk to the team and to find out about how to access support very helpful.

Posters

There have been two poster campaigns in the 2016/2017 financial year. A series of four safeguarding posters were produced to highlight the importance of recognising and reporting of abuse, and to reinforce that 'safeguarding is everybody's business'.



A series of four posters to promote information about support for those experiencing domestic abuse, coercive control and sexual violence have also been produced and distributed.

Training

Over the last twelve months the following training events have been supported by the Safeguarding Adults Board Training Sub-group. The topics covered were identified as required learning via the findings of Safeguarding Reviews locally and nationally and are as follows:

- MCA/DoLS
- Domestic Abuse
- DASH/RIC Completion
- Impact of Rape and Sexual Violence
- Self-Neglect
- Learning Lessons – Miss T
- Learning Lessons – Mr V and Mr W
- Hate/Mate Crime – Train the Trainer

A training calendar was produced and is attached at Appendix A.

LSAB/OPCC Annual Conference

The Annual Conference supported by the Office of the Police and Crime Commissioner and the Isle of Wight's Safeguarding Adults Board attracted up to two hundred attendees from the island, as well as a number of mainland colleagues from the SHIP area. Dr Margaret Flynn, chair of the National Independent Safeguarding Board in Wales, reflected on her findings detailed in the Winterbourne View Hospital Serious Case Review and the Operation Jasmine report. Both of these reports detailed endemic abuse within institutional settings and Dr Flynn, as the author, identified the key learning and stressed the high level of vigilance that is constantly needed to ensure that vulnerable people are safe and protected. Tim Spencer-Lane, of the Law Commission for England and Wales and lead lawyer on the project reviewing the Mental Capacity Act and the Deprivation of Liberty Safeguards, gave a presentation on the review. The review has been submitted and a response is awaited from the government. The Blue Apple Theatre Company gave a performance for conference attendees on 'mate crime'. The company comprises actors with learning disabilities and was founded in 2005 as part of Winchester Mencap. Local people with a learning disability and carers attended the afternoon session to watch both the play and the premiere of a short film by HealthWatch on mate crime featuring students from Haylands Farm and members of John's Club. In 2016/17, the main focus of the conference was on issues faced by those with a learning disability and their carers, and promoted lessons learned about responses, As well as providing important discussions on matters such as the review of the Deprivation of Liberty Safeguards (DoLS). This built on some of the messages throughout the year about hate/mate crime and the vulnerability of people with a learning disability. This will be one of the main themes for the Board in 2017/18.

The area of work that has been least well developed is work to better involve service users. Links have been made with some of the voluntary organisations on the Island and with People Matter. The Chair of the Board has also attended a Learning Disability Forum and a Carers' Forum but there are no systematic links between the Board and any existing service user fora. Attempts to improve this will be made in 2017/18. There have been discussions about having user representation at the Board

but there is an anxiety that this is likely to be tokenistic. Voluntary organisations have been offered a seat on the Board but whilst they have managed to attend some of these meetings, they have not been able to sustain this. Ideally it would be helpful if service users had their own Safeguarding Adults forum which could meet with Board members regularly to raise their own issues and hold the Board to account for some of the progress needed.

d) Partnership Links

Close working links have been formed with HealthWatch on the Isle of Wight. HealthWatch is an important source of evidence of what concerns local people about the health and care services they receive. A DVD produced and launched by HealthWatch at the annual conference will support work in this workstream. In 2016/17 issues about the quality of care in the residential care sector have been reported to the Board and have prompted other work in that sector. HealthWatch's experience of services offered by the Health Trust alongside the recent Care Quality Commission's (CQC) report will support Board members in checking safeguarding aspects of the improvement work that is required.

The Board is accountable to the Health and Well-Being Board and the Health Overview and Scrutiny Board on the Isle of Wight. At present this means reporting to one meeting each year.

The other Boards which members of the Safeguarding Adults Board attend are the children's Safeguarding Board, the VAWG (Violence Against Women and Girls) Strategic Partnership (formerly the Domestic Abuse Forum), the Prevent Board, the Modern Slavery Partnership, and the Community Safety Partnership.

In 2016/17 two meetings have been held between the Chairs and the Board Managers of the Children's Safeguarding Board and the Safeguarding Adults Board. It is hoped that we may do more joint work over the next few years, with a priority being promoting an holistic approach to safeguarding practice that considers the whole family. Safeguarding Adults Board members agreed during 2016/17 to contribute some funding to the Community Safety Partnership to enable it to undertake two DHR's (Domestic Homicide Reviews) which are due for completion in 2017/2018.

The Chair and the Board Manager contribute to meetings of the four Local Safeguarding Adults Boards in Hampshire, i.e. Portsmouth, Southampton, Hampshire and the Isle of Wight. The purpose of these meetings is to continue to develop and improve policies and procedures linked to Safeguarding Adults work.

Domestic Abuse and the Violence Against Women and Girls work on the Isle of Wight is overseen by the Safeguarding Adults Board, but also contributes to the business of the Community Safety Partnership and the Children's Safeguarding Board. The Domestic Abuse Co-ordinator is line managed by the Safeguarding Adults Board Manager. This role involves co-ordinating and managing the VAWG Strategic Partnership, delivering training, co-ordinating events, producing a VAWG Strategy for the island and formulating an annual action plan. In 2016/17 the Domestic Abuse Co-ordinator organised the first annual VAWG conference held at the Riverside centre, which was attended by around 120 professionals. A two-week exhibition by a local artist at Quay Arts on Domestic Homicide was commissioned as part of the conference. A four year Domestic Abuse strategy for the island was also developed during this year. A full account of work achieved can be found in the separate Domestic Abuse annual report.

e) Robust Policies and Procedures

The policy framework for Adult Safeguarding was developed and agreed by the four Local Safeguarding Adults Board in Hampshire in 2014. It is reviewed and updated regularly. Over the last year the following policies and procedures have been updated:

- The Local Safeguarding Adults Board's Constitution (https://www.iwight.com/Council/OtherServices/Safeguarding-Adults-Board/Introduction2)
- Self-neglect guidance (https://www.iwight.com/Council/OtherServices/Safeguarding-Adults-Board/Guidance-Policy-and-Procedure)
- Escalation process (https://www.iwight.com/Council/OtherServices/Safeguarding-Adults-Board/Guidance-Policy-and-Procedure)
- SHIP Risk Framework Dec 2016 (https://www.iwight.com/Council/OtherServices/Safeguarding-Adults-Board/Guidance-Policy-and-Procedure)

At the Isle of Wight Safeguarding Adults Board, Southern Housing Group has shared its Safeguarding Adults approach and highlighted improvement action it is taking this year. Adult Social Care Safeguarding Team has updated its guidance and shared with Board members. There has been a presentation from the Isle of Wight's Health Trust summarising the early actions required from the CQC after its inspection in November 2016. The Health Trust will update the Board on the action required with the CQC's full report is available. It is expected in March 2017.

The Clinical Commissioning Group has updated the Board on the Mental Health Crisis Care Concordat and has put forward a number of proposals for work in 2017/18 which focus on improving medicines management in care homes and developing a more co-ordinated multi-agency approach to discharge from hospital.

The Prison's Service send representatives to the Safeguarding Adults Board meetings. The Prison's Service is developing its approach to adult social care with the help of Care UK and the Isle of Wight Council's Adult Social Care Service and the Clinical Commissioning Group and Health services on the Island.

f) Data Collection and Analysis

The Safeguarding Adults Board relies heavily on the Adult Social Care Outcomes Framework data. The most recent data from this source and explanation of it is attached at Appendix B.

Other data from Police and the Health Trust is available but there is limited capacity to analyse this data so it is of limited value in identifying trends or fully understanding emerging issues. In order to overcome this weakness in the analysis in 2016/17 the Health Trust offered to let their analyst work on the Safeguarding Adults Board information in return for a relatively small amount of funding. This was agreed but the analyst was simply not available to undertake the work. The offer from the Health Trust to help with analysis has been made again and the Quality Assurance and Performance Sub-group of the Safeguarding Adults Board has agreed to take up this offer in 2017/18.

A new data tool is being used to collect the Safeguarding Adults information. This tool has been revised following feedback and input from partners agencies to ensure data is a) available and b) relevant.

g) Prevention and Early Intervention

Discussions have taken place with the My Life A Full Life team to try to understand how best to link to their community based work. As a result of these discussions and representation made by the Director of Adult Social Care, a reference has been made to Adult Safeguarding in the strategic plans and latterly some funding has been identified which will be used in 2017/18 to promote Making Safeguarding Personal in localities in ways which help to transform practice so that individuals have more ownership of the work aimed at keeping them safe and there is a broader understanding amongst health and care practitioners and within communities about the importance of working with rather than simply for people in order to help them manage the risks they face.

Vulnerable Adults Panel (VAP)

A Vulnerable Adults Panel is now operating on a regular basis. It is convened by Adult Social Care and involves a range of agencies to agree how best to manage cases where individuals are at risk but where the risks can be managed in their communities; they may never need to be reported to the Safeguarding Team or require a Section 42 Safeguarding investigation. This is a positive development which should improve outcomes for local people. The TOR and referral form can both be found on our website: www.iwight.com/SAB.

h) Mental Capacity Assessment and Deprivation of Liberties

This was a main focus of the Board in 2015/16. It has continued as a focus for training and awareness raising in 2016/17 with regular monthly workshops where the MCA & DoLS Safeguarding Lead for the work goes through specific cases and generates important lessons for those who attend. These workshops are very popular with practitioners and have proved to be an effective way of raising confidence amongst professionals about mental capacity assessment work and the importance of identifying when Deprivation of Liberties Safeguards (DoLS) need to be recorded and reported.

At the Health Overview and Scrutiny Committee on 12 December 2016 members of the Committee expressed a wish to participate in some training on mental capacity and DoLS. A commitment was made to organise this training which will take place after the elections in May 2017.

Summary of DoLS 2016/2017

The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.

Care homes or hospitals must ask a local authority if they can deprive a person of their liberty. This is called requesting a standard authorisation. There are six assessments which have to take place before a standard authorisation can be given. If a standard authorisation is given, one key safeguard

is that the person has someone appointed with legal powers to represent them. This is called the relevant person's representative and will usually be a family member or friend.

Other safeguards include rights to challenge authorisations in the Court of Protection, and access to Independent Mental Capacity Advocates (IMCAs).

A Supreme Court judgement in March 2014 made reference to the 'acid test' to see whether a person is being deprived of their liberty, which consisted of two questions:

- Is the person subject to continuous supervision and control? *and*
- Is the person free to leave? – with the focus, being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

If someone is subject to that level of supervision, and is not free to leave, then it is likely that they are being deprived of their liberty. Many, many more people are considered to be deprived of their liberty following the 2014 ruling, which has had an impact on the Local Authority's ability to respond to DoLS requests. The table below details the activity over 2016/17.

Month	New Requests	Assessments completed		Requests withdrawn	Total Outstanding
		Granted	Refused		
April	31	23	3	**23**	711
May	67	**22**	0	18	722
June	**55**	25	2	35	703
July	46	**25**	1	29	678
August	54	12	1	**24**	695
September	53	**12**	3	26	716
October	61	**8**	2	29	746
November	82	6	3	30	769
December	41	13	3	24	785
January	43	15	3	**42**	738
February	46	13	3	33	721
March	56	13	1	20	**712**
Year Totals	**635**	**187**	**25**	**333**	

Current DoLS Priority at end March 2017:

Priority	Count @ 31/03/17	Updated Count @ 19/04/17
1	2	2
2	46	46
3	614	607
Renewal	59	57
Total	**732**	**712**
Reviews Completed		**4**

Brief summary of criteria:

Priority 1 (High): Continuous 1:1 care, sedating medication, covert medication, use of physical restraints, restrictions on family contacts, attempts to leave, objections to placement by individual or others;

Priority 2 (Medium): occasional requests to leave, some periods of unsettled behaviour or mood, infrequent use of restraint or sedation;

Priority 3 (Low): minimal control or restraints, settled placement, end of life care.

Board Priorities for 2017/2018

This is a brief summary of the priorities for 2016/17 that were identified at Safeguarding Adults Board meetings and at the Development Day held for Board members on 6 January 2017.

The priorities are as follows:

- Improving medicines management within Care Homes led by the CCG
- Developing a more co-ordinated multi-agency approach to discharge from hospital led by the CCG
- Improving safeguarding for people with Learning Disabilities with a specific initial focus on preventing mate/hate crime
- Improving understanding and management risks amongst people with individual budgets who commission services themselves
- Improving service user links to the Safeguarding Adults Board
- Further promotion of Making Safeguarding Personal practice amongst practitioners and more widely
- Improving data analysis

Appendix A – 2016/2017 Training Calendar

Course	Trainer	Dates	Audience
DA Training (3 full days)	Bruce Marr	Thursday 15th September 2016 Tuesday 13th December 2016 Tuesday 14th February 2017	Multi-agency
DASH/RIC Awareness Training (3 x half day sessions)	Fiona Gwinnett and Dave Huggins	3 x half day sessions 6th July 2016 18th October 2016 18th January 2017	2 x multi-agency sessions Plus 1 hour sessions in target agencies (Southern Housing Group)
DoLS Case Sessions	Stephen Ward	Monthly 2.5 hour sessions at County Hall	Multi-agency 2 hour drop in sessions for professionals with basic knowledge of MCA
Impact of Sexual Violence/Rape (2 day course)	CIS'ters	Wednesday 18th January 2017 PLUS Wednesday 15th February 2017	Multi-agency
Learning Lessons Mr V & Mr W (5 x half day sessions)	David Thornicroft	Friday 30th September 2016, 10:00 – 13:00 Monday 31st October 2016, 10:00 – 13:00 Monday 31st October, 14:00 – 17:00 Tuesday 10th January, 10:00 – 13:00 Tuesday 10th January, 14:00 – 17:00	Multi-agency
Learning Lessons Miss T (4 x half day sessions)	Alison Ridley	Friday 24th February 2017 (2 sessions) Friday 10th March 2017 (2 sessions)	Multi-agency

Mate Crime Workshop x 1 (1 x full day)	Rod Landman	Wednesday 13th July 2016	1 x 'Train the Trainer' workshop for professionals and family carers who engage directly with service users with LD and autism
Self-neglect Workshop x 4 (4 x full days)	Suzy Braye	Wednesday 6th April 2016 Thursday 28th April 2016 Wednesday 9th November 2016 Wednesday 7th December 2016	Multi-agency

Statistical Neighbours

The Statistical Neighbours used as a comparator in this presentation are those selected by the Department of Health, in their Adult Social Care Spending Efficiency Tool.

It comprises of the following Local Authorities:

Isle of Wight	**Somerset**
Devon	**North Yorkshire**
East Sussex	**Dorset**
Cornwall	**Shropshire**
East Riding of Yorkshire	**Cumbria**
North Somerset	**Poole**
Norfolk	**Herefordshire**
Torbay	**Lincolnshire**

Section 1 - Summary

Safeguarding Concerns that commenced during period

	2015/16		2016/17	
	Individuals	*Cases*	*Individuals*	*Cases*
Concerns	1527	2631	**1306**	**1898**
Section-42 Enquiries	576	676	**495**	**570**
S42 Per 100,000 adults	505	592	**432**	**497**
England Enquiries per 100k adults	*239*	*232*	~	~
Statistical Neighbours Enquiries per 100k adults	*170*	*167*	~	~

SAC return – Section 1

Individuals by Age-group and Gender

Age-group	2015/16	2016/17	England 2015/16
18-64	34% 198	**36%** 178	36%
65-74	10% 60	**10%** 50	12%
75-84	26% 149	**22%** 109	22%
85-94	26% 150	**23%** 116	29%
95+	4% 22	**8%** 42	
Gender			
Male	42% 245	**39%** 194	40%
Female	58% 334	**61%** 301	60%

SAC return – Section 1

Individuals by Ethnicity

	2015/16	2016/17	England 2015/16
White	94% 545	**93%** 462	84%
Mixed/ Multiple	2	1	1%
Asian / Asian British	5	2	3%
Black / African / Carib / Black British	2	2	3%
Other Ethnic group	0	0	1%
Refused	0	0	8%
Undeclared / Unknown	4% 25	**6%** 28	

SAC return – Section 1

Concerns: Count by Primary Support Reason, and, Health Conditions (Autistic Spectrum only)

PSR	2015/16	2016/17	England 2015/16
Physical Support	26% 151	**31%** 181	42%
Sensory Support	1% 5	**1%** 8	1%
Memory & Cognition	13% 76	**17%** 100	9%
Learning Disability	15% 85	**15%** 89	14%
Mental Health	6% 35	**8%** 45	12%
Social Support	1% 4	**5%** 28	4%
None/ Not Known	38% 223	**24%** 140	18%
Health condition			
Autism	8	**20**	
Asperger's Syndrome/ High Functioning Autism	1	**2**	

Section 2

Section-42 Enquiries concluded during period

Length of time open (referral date to Enquiry completion date)

Duration	2014/15	2015/16	2016/17
Up to a month		31% 265	**31%** 128
1 to 2 months		17% 144	**20%** 84
2 to 3 months		13% 108	**14%** 60
3 to 6 months		18% 153	**20%** 84
6 to 12 months		7% 60	**11%** 46
1 to 2 years		13% 109	**3%** 11
Over 2 years		1% 8	**1%** 4
Total Concluded Cases	552	847	**417**

SAC return – Section 2

Type of risk

	IOW 2015/16	IOW 2016/17	*England 2015/16*	*S. Neighbours 2015/16*
Neglect & Omission	51% 414	**50%** 210	32%	26%
Financial / Material	17% 137	**19%** 81	16%	15%
Physical	14% 112	**13%** 56	24%	23%
Psychological	10% 81	**10%** 44	14%	15%
Sexual	5% 41	**4%** 16	5%	5%
Organisational	4% 29	**3%** 12	4%	4%
Self-Neglect	4% 29	**3%** 12	2%	3%
Domestic Abuse	2% 20	**3%** 11	2%	3%
Discriminatory	<1% 1	**1%** 3	1%	2%

SAC return – Section 2

Source of risk

	2015/16	2016/17	*England 2015/16*	*S. Neighbours 2015/16*
Service Provider	49% 418	**53%** 231	34%	28%
Other: Known to individual	40% 338	**38%** 166	51%	57%
Other: Not known	11% 91	**9%** 38	15%	15%

SAC return – Section 2

Type and source of risk

	Service Provider		Other: Known		*Other: Unknown*	
	IOW	England	**IOW**	England	**IOW**	England
Physical	**52%**	24%	**38%**	62%	**11%**	14%
Sexual	**25%**	13%	**69%**	64%	**6%**	23%
Psychological	**32%**	21%	**64%**	66%	**5%**	13%
Financial / Material	**30%**	15%	**65%**	64%	**5%**	21%
Organisational	**92%**	71%	**8%**	18%	**0%**	11%
Neglect & Omission	**71%**	57%	**19%**	29%	**10%**	14%

SAC return – Section 2

As of 2016/17 table SG2b has changed to give more detail within some of the categories. Shown here is the old version of the table with this year's data merged in, to enable comparisons.

Location of risk

	IOW 2015/16	IOW 2016/17	*England 2015/16*	*S. Neighbours 2015/16*
Own Home	305 (36%)	**132 (30%)**	43%	40%
Service within Community	10 (1%)	**14 (3%)**	3%	4%
Care Home	370 (44%)	**197 (45%)**	36%	37%
Hospital	55 (6%)	**36 (8%)**	6%	9%
Other	110 (13%)	**59 (13%)**	11%	9%

SAC return – Section 2

Location and Source of risk

	Service Provider		Other: Known to individual		*Other: Unknown* to individual	
	IOW	England	**IOW**	England	**IOW**	England
Own Home	**37%**	23%	**61%**	63%	**2%**	14%
Service within Community	**50%**	34%	**43%**	50%	**7%**	16%
Care Home	**75%**	55%	**21%**	33%	**4%**	12%
Hospital	**31%**	18%	**14%**	58%	**56%**	24%
Other	**29%**	16%	**61%**	57%	**10%**	27%

IOW – 2016/17, England 2015/16

SAC return – Section 2

(old table SG2c, now replaced by new SG2c & SG2e. The content of these new tables is shown here. National comparisons available next year)

(new) SG2c & 2e - Risk Assessment Outcomes:

Was a risk identified and was any action taken / planned to be taken?

2016/17	Service Provider	Other: Known	Other: Unknown
Risk identified and action taken	196	123	27
Risk identified and no action taken	6	8	1
Risk - Assessment inconclusive and action taken	10	16	4
Risk - Assessment inconclusive and no action taken	1	7	3
No risk identified and action taken	9	6	0
No risk identified and no action taken	9	9	3
Enquiry ceased at individual's request and no action taken	0	0	0
Where risk was identified (top two rows, above), what was the outcome when the case was concluded?			
Risk Remained	28	36	7
Risk Reduced	115	66	14
Risk Removed	59	29	7

SAC return – Section 3

Counts of concluded safeguarding enquiries by mental capacity of adult at risk.

	IOW 2015/16	IOW 2016/17	*England 2015/16*	*S. Neighbours 2015/16*
Yes – Lacked Capacity	331 (39%)	174 (42%)	27%	22%
No (i.e. has mental capacity)	514 (61%)	142 (34%)	48%	39%
Don't know	2 (<1%)	78 (19%)	12%	25%
Not Recorded	0	23 (6%)	14%	14%
Were those lacking capacity (row-1 above), supported by advocate, family or friend?	-	60 (34%)	*62%*	*55%*

SAC return – Section 4

Making Safeguarding Personal (MSP)

Were they asked their desired outcome, and did they express one?	2015/16	2016/17	*England 2015/16*	*S. Neighbours 2015/16*
They were asked, and outcome was expressed	-	25% 103	47%	28%
They were asked, but no outcome was expressed	-	8% 34	11%	6%
Not asked	-	11% 45	16%	16%
Don't know	-	23% 95	4%	13%
Not recorded	-	34% 140	22%	38%
Outcome success? (where outcome was expressed – row 1, above)				
Fully achieved	-	*60%* 55	*67%*	*55%*
Partially achieved	-	*31%* 28	*22%*	*18%*
Not achieved	-	*9%* 8	*11%*	*27%*

SAC return – Section 5

Counts of individuals involved in Safeguarding Adult reviews (SARs)

	2015/16	2016/17
Count where one or more individual died	1	0
Count where no individuals died	0	0

Isle of Wight Safeguarding Adults Board

Appendix C – Acronyms

Acronym	Meaning	Context for clarification if required
4LSAB	Four Local Safeguarding Adults Boards	
ARC UK	Association for Real Change UK	
ASB	Anti-Social Behaviour	
ASC	Adult Social Care	
ASCD	Adult Social Care Director	
CA12	Vulnerable adult form	Used by Hampshire Constabulary
CCG	Clinical Commissioning Group	
CPD	Continuous Professional Development	
CQC	Care Quality Commission	
CRC	Community Rehabilitation Company	
CSA	Child Sexual Abuse	
CSE	Child Sexual Exploitation	
CSP	Community Safety Partnership	
DA	Domestic Abuse	
DAF	Domestic Abuse Forum	
DASH	Domestic Abuse, Stalking and Honour Based Violence	
DASM	Designated Adult Safeguarding Manager	
DHR	Domestic Homicide Review	
DoLS	Deprivation of Liberties Safeguards	
DVA	Driver and Vehicle Agency	
DVD	Digital Video Disc	
E Learning	Electronic learning	
E Staff	Emergency staff	
FGM	Female Genital Mutilation	
GP	General Practitioner	

HM Prisons	Her Majesty's Prisons	
HSCIC	Health and Social Care Information Centre	
IAWG	Inter-Authority Working Group	
IOWNHST	Isle of Wight National Health Service Trust	
IoWSAB	Isle of Wight Safeguarding Adults Board	
IW/IoW/IOW	Isle of Wight	
IWASP	Isle of Wight Against Scams Partnership	
IWC	Isle of Wight Council	
IWSAB	Isle of Wight Safeguarding Adults Board	
KPI	Key Performance Indicator	
LA	Local Authority	
LAC	Looked After Children	Children's Services
LAC	Local Area Co-ordinators	Public Health
LMC	Local Medical Committee	
LSAB	Local Safeguarding Adults Board	
LSCB	Local Safeguarding Childrens Board	
MARAC	Multi-Agency Risk Assessment Conference	
MASH	Multi-Agency Safeguarding Hub	
MCA	Mental Capacity Act	
MECC	Making Every Contact Count	Foundation training
MLAFL	My Life A Full Life	
MP4	Digital multimedia container format	Used to store video, audio & other data
MSP	Making Safeguarding Personal	
MSP	Modern Slavery Partnership	
NHS/NHST	National Health Service/National Health Service Trust	
OPCC	Office of the Police and Crime Commissioner	
PARIS	Software system for community care services	
PREVENT	Safeguarding people & communities from the threat of terrorism	Hampshire Constabulary
RIC	Risk Indicator Checklist	
S42	Section 42	Care Act 2014
SAB	Safeguarding Adults Board	
SAC	Safeguarding Adults Collection	
SAR	Safeguarding Adult Review	
SCIE	Social Care Institute for Excellence	
SEND	Special Education Needs and Disability	
SHG	Southern Housing Group	
SHIP	Southampton, Hampshire, Isle of Wight, Portsmouth	
TOR/ToR	Terms of Reference	
TTG	Through The Gate	Hampshire &I W CRC Women's Group
UK	United Kingdom	
VAWG	Violence Against Women and Girls	
VSO	Voluntary Service Organisation	