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Annual Report

April 2017 – March 2018

Foreword

"2017/18 has been a very busy year for Safeguarding Adult Board partners. This Annual report summarises some of the main aspects of the progress made over the year.

Adult Services commissioned an important independent review of the work linked to Adult Social Care's Safeguarding Adults Team and its role in investigating and co- coordinating responses to individuals who are referred to them as a result of concerns about their safety . This review has resulted in some key improvement action. The progress made will be reviewed by the Safeguarding Adults Board in September 2018 - a year after the production of the independent report. A number of the improvements recommended are already clearly in place and all are being worked on.

Regular meetings involving Police and Adult Social Care staff about Safeguarding Adults cases have been introduced. These triage meetings have already resulted in a better understanding between the agencies about each other's roles and responsibilities. These will continue in 2018/19 and hopefully involve Health colleagues. They are now known as Multi-Agency Safeguarding Triage meetings (MAST).

At the start of 17/18 the Health Trust was placed in Special Measures as a result of a CQC inspection. A new leadership is now in place. The CQC revisited the Trust services less than a year after the new leadership was in place. Unsurprisingly but disappointingly for local people, the short timescale meant that the culture change needed to achieve significant improvements had not taken place. This has to be a concern for all partners, but the CQC's comments about the new leadership were relatively positive. In the Safeguarding Adults Board it is in all partners' interests and, more importantly in the interests of local people, that we support these leaders to make the progress needed and ensure that the safety concerns identified by CQC are addressed.

One of several aspects of the work which need to be further developed is concerned with raising awareness in local communities about how best to support adults who have care and support needs. It is hoped that in 2018/19 it will be possible to build on the close working relationship with HealthWatch and links with People Matter, to identify the kind of support that exists for people in their localities and how to better involve local communities in intervening with individuals who have care and support needs, in ways that help them to manage the risks they face. "

Margaret Geary,
Independent Chair

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1. Introduction

The Safeguarding Adults Board relies on the commitment and energy of its partner members. This report will summarise the key activity undertaken and the assurance achieved.
The main areas covered will include:

- Safeguarding Adults reviews work and lessons learned
- Quality Assurance and Performance issues
- Training and Awareness Raising
- Task and finish group work focused on the experience of people with a learning disability
- Joint work with Healthwatch
- Violence Against Women and Girls

The work of the Safeguarding Adults Board (SAB) is only possible when partners are ready to prioritise it and deliver the outcomes needed. In 17/18 the priority Adult Social Care (ASC) has given to improving the approach to Safeguarding has been a significant factor in driving the progress achieved.

The CCG's leadership in developing a better understanding of hospital discharge from a multi-agency perspective has, together with HealthWatch's work on this topic, given Board members a clearer view of what safer discharge practices should be developed.

The Safeguarding Adults Board has also supported the Clinical Commissioning Group's (CCG) work to improve medicines management in care and nursing homes. This is a part of the quality improvement work needed across health and social care services. Partners recognise the need to raise standards.

The CCG and ASC have worked together to produce an important quality framework which is to be used for assessing and supporting care homes, nursing homes and domiciliary care providers to ensure that services are delivered to as high a standard as possible. Work to improve quality using this framework will start by prioritising those services judged to most need this approach.

The Health Trust has been the subject of several CQC investigations in 17/18 and were placed in Special Measures in 2017. This has resulted in new leaders being installed at the Trust. Several meetings have taken place with the new Director of Nursing and communities and the new chief Executive during 17/18 the trusts improvement priorities have meant that they have not managed to attend the SAB meetings. The joint CCG/Trust lead for Safeguarding has attended on their behalf but the intention is to ensure that in 18/19 a senior director from the Trust is freed up to attend the SAB.

Police chairing of the Safeguarding Adults Review Sub-group has been much appreciated as has the regular attendance of the local Police Commander at the SAB meetings and the Statutory Leads Meeting which meets a few weeks before the Board meeting.

The ongoing pressure on public sector funding continues to impact on partners and their capacity. Partners in the voluntary/community sector and other statutory services such as the Fire Service, Trading Standards, Probation Service and Housing services are represented at the Board and make important contributions. In 18/19 we hope to pay more attention to the importance of their roles in safeguarding adults and to better understand the impact that these services have on ensuring local people are safeguarded.

2. Board Membership

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

3. Board Structure

The Board has three sub-groups:

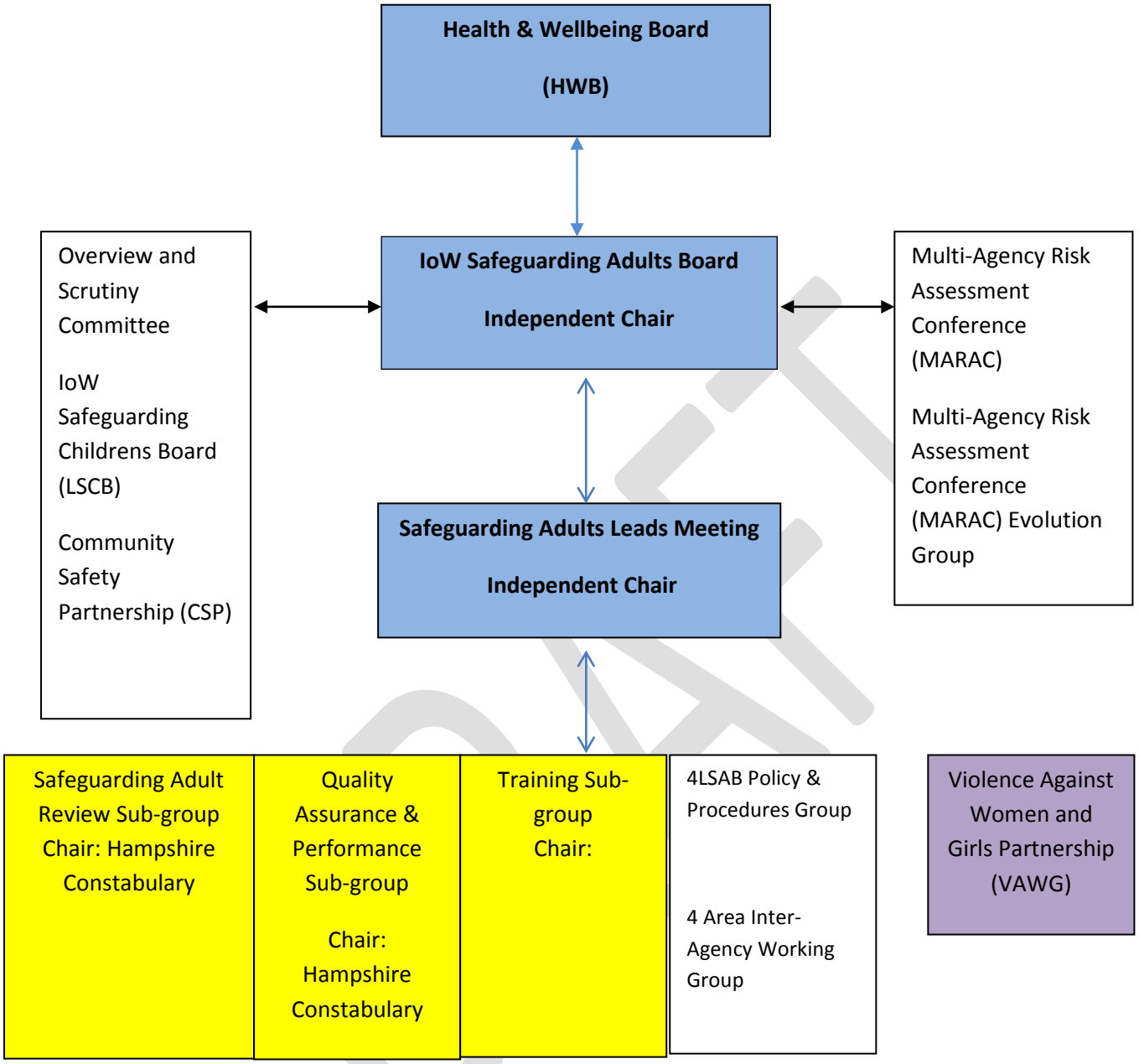
- **Safeguarding Adults Review Sub-Group**
- **Quality Assurance and Performance Sub-Group**
- **Training Sub-Group**

Much of the work of the Board is undertaken by members of the three sub-groups in collaboration with the Board Manager and her Administrative Support. 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. It is proposed that the Violence Against Women and Girls work will transfer to the Community Safety Partnership in 2018/2019.

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

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

Isle of Wight Safeguarding Adults Board Hierarchy



4. Safeguarding Adults Reviews

4.1 Cases investigated and lessons learned

During 2017/18 the Safeguarding Adults Review Sub-group on the Isle of Wight undertook 1 statutory Safeguarding Adult Review. The Board completed 1 discretionary review in a case which did not meet the criteria for a full Safeguarding Adult Review, but took place in circumstances which led the Sub-group members to agree that a review would generate important lessons for partners in the services involved with the case. The main findings in the cases reviewed in 2017/18 were:

Case A: Mr R

This statutory case review focused on the death of an 87 year old man who died in 2015. The circumstances of his death raised safeguarding concerns which were initially investigated by ASC's Safeguarding Team. The initial investigation took an unusually long time and was finally concluded in April 2016 and referred to the SAR Sub-Group for a statutory review. When it was finally concluded in April 2016 the decision to undertake a full statutory review was then confirmed by the SAR Sub-group. The review was completed in 2017 but the Board has not been able to publish it as a Coroner's Court hearing by Jury has been ordered and is still to take place. Every effort has been made by ASC to keep relatives informed in this case but understandably these relatives have been distressed both by the circumstances of their loved one's death and by the delays in publication. Lessons have been learned and improvements to practice have been introduced which should mean that the circumstances in this case cannot be repeated. It should be possible to report in more detail on the lessons learned in the 2018/2019 report.

Case B: Mrs P

This non-statutory case review focused on the death of a woman following significant multi-agency concerns for her welfare due to her alcohol misuse, her physical and mental health needs and the allegations of domestic and sexual abuse. Mrs P died in January 2017.

Key recommendations in this case were:

- The SAB should oversee refreshed training and guidance for all agencies based on the SHIP Safeguarding Adults policy, so that all agencies are clear about the need for action based on Section 42 of the Care Act 2014 when abuse or neglect of an adult with care and support needs is suspected, and that the lead agency for safeguarding under Section 42 is the local authority.

- The SAB should ensure that all agencies have robust systems to challenge each other respectfully, and escalate concerns in a timely way when appropriate.

- All agencies should consider whether their out of hours services are sufficiently robust to meet the needs of adults in need of care and support and their families, and how services work together out of hours.

- The SAB should commission research into what works best with hard to engage service users and those with fluctuating capacity and develop a programme of work to implement best practice on the island.

- The SAB should closely monitor the development of the IoW M.A.S.T. (Multi-Agency Safeguarding Triage) to ensure that joint policies are clearly understood within the context of a whole system approach and a shared value base.

Case C: HD

A non-statutory case review was started in 2017 focussing on the death of a 53 year old man in a bus shelter who was of no fixed abode at the time of his death in March 2017. The scoping chronologies identified significant multi-

agency involvement and raised concerns regarding how agencies had worked individually and together to safeguard HD, although it was not unanimously agreed whether his death was intrinsically linked to abuse or neglect. The review was completed in 2018, but has yet to be agreed at a Board meeting and will not be published until 2018/2019.

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.

4.2 Making Safeguarding Personal

All Safeguarding Adults work should be carried out in ways that involve the individual who needs to be safeguarded and/or their advocate, as much as possible in developing responses to the risks they face. Across the country Safeguarding Adults practice has not always fully involved individuals and/or their advocate in making decisions about how to keep them safe. The Care Act 2014 recognised the need to change this so that individuals retain as much control as possible over how to better manage the risks they face and responses take better account of their interests and circumstances. In 17/18 work was commissioned on the Isle of Wight to promote the Making Safeguarding Personal approach and identify what further work might be required to ensure practitioners more routinely ensure individuals are involved in developing action to keep them safe.

4.3 Multi-Agency Safeguarding Hub or Triage (M.A.S.H. or M.A.S.T.)

A multi-agency Safeguarding Hub (M.A.S.H.) exists in Hampshire. It brings together statutory partners involved in Children's and Adults Safeguarding. These hubs exist in a number of areas throughout the country.

By bringing partners together the hubs:-

- improve professionals understanding of each other's role
- facilitate daily multi-agency planning and decision-making about how best to keep individuals safe
- provide a clear point of access for all agencies that may need to refer cases when they have concerns about the safety of adults in need of care and support.

The Hampshire M.A.S.H. serves Hampshire County, Southampton and Portsmouth. The Isle of Wight Children's Services which are managed by Hampshire County Council also participate in the Hampshire M.A.S.H. mainly through the Hampshire management arrangements, but adult services on the Isle of Wight are not partners in the M.A.S.H. There simply isn't enough management capacity in all the services involved in Adult safeguarding on the island to contribute the staff required to be effectively engaged in the mainland M.A.S.H.

Yet, for some years it has been recognised that there needs to be better coordination between partners on the Isle of Wight in sharing information about cases and planning responses. Safeguarding Adults Reviews have highlighted concerns about communication between services; weaknesses in the practices different agencies; understanding of each other's roles and the legislative limitations; and confusion about where and when to refer concerns about the safety of adults in need of care and support. A M.A.S.H. is not the only way of dealing with the issues. Other action is needed, but if a multi-agency hub/triage could be established on the Isle of Wight it would contribute to addressing all the issues listed above.

In 17/18 Adult Services initiated work with Hampshire Police to develop a Multi-agency Safeguarding Hub on the Isle of Wight. There was some controversy over the name because it simply wasn't possible for Hampshire Police to commit to replicating their investment on the mainland M.A.S.H. As a result of this it was agreed to name the Isle of Wight joint meetings a Multi-Agency Safeguarding Triage (M.A.S.T.). This team meets 3 times a week rather than every day. At present it regularly involves the police and adult services managers. It is hoped that in 2018/2019 a business case for involving Health Services in the multi-agency team will result in a Health services manager regularly contributing to this meeting.

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

A regular multi-agency risk management meeting (MARM) convened by Adult Social care is focussed on planning intervention if necessary, with adults in need of care and support who have been identified as facing circumstances in which they are struggling to keep themselves safe. The MARMs were started in 17/18 and have proved to be very useful in planning the kind of earlier interventions with people which should avoid the need for safeguarding referrals at a later stage and more importantly will offer the support the individual needs.
It is hoped that the MARM will continue to meet in 18/19 and become an effective source of better co-ordinated support for individuals.

4.5 Thanks to Kevin Walton

In 17/18 Kevin Walton retired. He had chaired the Safeguarding Adults Review sub-group on the Isle of Wight. He worked in Hampshire Constabulary's Series Case Review Team. His knowledge about Safeguarding Adults Reviews and his experience in Chairing this sub-group over the last 4 years has been much appreciated.
Ruth Attfield will now chair this sub-group. She also works in Hampshire Constabulary's serious case review team and is experienced in Chairing Safeguarding Adult Review meetings.

5. Quality Assurance and Performance Sub-Group

5.1 Data Collection and Analysis

This is important as it provides some of the evidence that should underpin improvement action. In 17/18 there have been a number of positive developments in the provision of this data. Adult Services now produce monthly reports on the number and type of referrals received by the Safeguarding Adults Team. The data includes information about timescales for the action taken, and the nature of that action and the outcomes. The attached appendix 1 shows the data for 2017/2018.

The joint lead for the Clinical Commissioning Group and the Health Trust has produced an initial proposal for a Universal data report which includes information about Children & Adults Services Incident Reports and other information linked to Safeguarding Concerns. In 17/18 the Safeguarding Adults Board was provided with a first draft of this universal data report for Health Services. It may be refined in light of partners experience in using it, but the concept was welcomed.

Data is currently received from ASC, Health, Police and Healthwatch. This data is received and discussed with the Chair of the Quality Assurance and Performance Group, the Board Manager, ASC Data Team representative and the NHS data analyst at a small pre-meet a fortnight before the main meeting. The parameters for the analyst's report are then set and questions are formulated and sent to each agency on their own data. The analyst's report and the answers to questions are then brought to the main Quality Assurance and Performance Sub-Group meeting for discussion. This data analysis was newly established in 17/18 and will be part of the quarterly report to the Board in 2018/2019.

5.2 Review of Adult Social Care's safeguarding Team

In September 2017 the Safeguarding Adult Board had a presentation from the Independent Expert commissioned by Adult Social Care to review the work of the Adults Safeguarding Team on the Isle of Wight. This team is of central importance to all the partners. It is the team to whom all concerns about the safety of adults in need of care and support should be referred. They must assess all the referrals to determine if they meet the criteria laid down for instigating a Section 42 (Care Act 2014) Safeguarding Investigation.

The Independent review of this teams work generated 12 recommendations for improvement. These are being addressed. The Safeguarding Adults Board will review progress against the recommendations in September 2018.

5.3 Adult Safeguarding Thresholds

The data from Adult Social Care and the information from the Safeguarding Adults Review Sub-Group has consistently pointed to a lack of shared understanding between services about when concerns about adults in need of care and support reach a level at which they should be referred to the Safeguarding Adults Team for investigation. The Adult Social Care data reported annually and on a monthly basis show that only about 30% of the safeguarding referrals in the Adult Safeguarding team are converted to Section 42 Investigations. This means that a lot of the limited capacity within the team is used up in assessing referrals, about 70% of which result in no further safeguarding action. The Isle of Wight is not alone in experiencing this. The 3 other Safeguarding Adults Boards in Hampshire have similar experiences.

When the M.A.S.T. and M.A.R.M. are established and working effectively participants from a range of agencies should develop more of a shared understanding of the criteria for safeguarding referrals. The Safeguarding Adults

Board members have however recognised a need to develop a decision tool and guidance to support practitioners in a wide range of services to understand more about when a referral to the Safeguarding Adult Team is necessary.

This decision tool and guidance has now been produced and will be the subject of consultation with providers and then hopefully refined for use in 2018/2019. It has been shared with the other Safeguarding Adults Boards in Hampshire and it is likely to be adapted and adopted across the 4 Boards area.

5.4 Medicines Management

In 17/18, the Safeguarding Adults Board supported the Clinical Commissioning Group in its efforts to improve the medicines management work within Care homes and Nursing homes. Poor practice in medicines management can lead to safeguarding issues so it was important to try to improve standards.

It is however the case that not all medicines management errors give rise to safeguarding concerns, yet, at present it is clear from the data that Care and Nursing feel they have to refer even minor incidents to the Safeguarding Adults Team. The independent review of this Safeguarding Adults Team pointed to the need for a process that distinguishes between poor medicines management practice which does not lead to a safeguarding and that which should be referred to the Safeguarding Adults Team. Such a process has yet to be agreed.

5.5 Hospital Discharge

In early 17/18 the Clinical Commissioning Group reported to the Safeguarding Adults Board on a multi-agency review of the experience of hospital discharge. Healthwatch also carried out a consultation focussed on people's experience of discharge.

Both the multi-agency review and the Healthwatch consultation exposed concerns about the timing of discharges, the lack of information communicated to care homes, carers etc. (including to prison staff where prisoners had been patients), poor communication to patients particularly in mental health services and a range of other concerns about the circumstances in which people had experienced hospital discharge.
Since new leadership has started in the Health trust, new, more comprehensive policies have been introduced about discharge and there has been some evidence of improvement in mental health services. The hospital managers themselves admit it is taking longer to achieve the positive cultural change they would wish to see across the Health trust.

During 16/17 and 17/18, the Adult Social Care director oversaw the introduction of a much more effective approach to ensuring that Adult Social care is managing transfers of care from hospital to home or to Care/Nursing homes when social care intervention is required.

As a result delays in transfers of care attributable to Adult Social Care have been significantly reduced. The table below shows the result of this targeted management intervention over the last 12 months:

ADULT SOCIAL CARE

TARGET: Local Daily Rate per 100k	4.58

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
No. of DTOC bed days in month	140	96	52	122	84	125	73	84	99	61	106	109	97
Monthly Rate per 100k population	122.2	83.8	45.4	106.5	73.3	109.1	63.7	73.3	86.4	53.2	92.5	95.1	84.6
ASC Daily Rate per 100k population	3.9	2.8	1.5	3.4	2.4	3.5	2.1	2.4	2.8	1.9	3.0	3.2	2.7

NHS

TARGET: Local Daily Rate per 100k	2.29

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
No. of DTOC bed days in month	123	124	327	209	74	88	189	110	31	50	106	140	74
Monthly Rate per 100k population	107.3	108.2	285.3	182.4	64.6	76.8	164.9	96.0	27.1	43.6	92.5	122.2	64.6
NHS Daily Rate per 100k population	3.5	3.6	9.2	5.9	2.2	2.5	5.5	3.1	0.9	1.6	3.0	4.1	2.1

Combined

TARGET: Local Daily Rate per 100k	6.87

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
No. of DTOC bed days in month	263	250	379	331	158	213	262	194	130	111	212	249	171
Monthly Rate per 100k population	229.5	218.2	330.7	288.8	137.9	185.9	228.6	169.3	113.4	96.9	185.0	217.3	149.2
COMBINED Daily Rate per 100k population	7.4	7.3	10.7	9.3	4.6	6.0	7.6	5.5	3.7	3.5	6.0	7.2	4.8

Not all delayed transfers of care generate safeguarding concerns, but clearly getting people moved from hospital promptly at a time that is right for them is important to maintaining their wellbeing.

6. Training Sub-Group and raising awareness

6.1 Mental Capacity Workshops

Free monthly 2.5 hour sessions presented by Stephen Ward (MCA and MHA Lead, IOW Council and IOW NHS Trust) existed throughout 2017/2018 for professionals who already have a basic knowledge of the Mental Capacity Act, but who would like further information. We were able to deliver 9 sessions this year, providing training to 129 individuals across various agencies.

Participants will develop

- understanding of the main provisions of the Mental Capacity Act
- confidence in applying the principles of the MCA in practice
- confidence in assessing the capacity of service users
- competence in making best interests decisions
- skills in recording evidence of capacity and best interests

Overall competence and confidence in using the MCA to protect vulnerable service users.

6.2 Lessons Learned Workshops

The following is one example of the lessons learned workshops held after safeguarding adults reviews have been completed and action plans agreed.

This review 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, and was completed and published in the previous financial year. Miss T died in August 2015 following a cardiac arrest associated with drug taking. From this case, there were 8 half-day sessions of multi-agency training, focusing on the issues raised in the case which included the need for more of a think family approach to sexual exploitation, promoting a better understanding within the Police service and Mental Health services about their respective roles and the need for early multi-agency care planning. Four of those workshops were delivered in 2017/2018 and attended by 68 professionals from various agencies including ASC, Childrens Services, Probation, Community Rehabilitation Company (CRC), Police, IRIS, Wight-DASH, GP Surgeries, Southern Housing Group, NHS Trust, Youth Offending Team (YOT), Public Health and several voluntary sector groups.

6.3 LSAB Annual Conference

The annual Isle of Wight Safeguarding Adults Board conference was held on Wednesday 7 March 2018 at Gurnard Pines, Cowes, Isle of Wight; the focus for this year's conference was on Safeguarding and Dementia. The conference was attended by around 140 delegates from a varied range of sectors.

Jill Manthorpe, Professor of Social Work and Director of the social Care Workforce Research Unit at King's College London led the programme with her presentation **Dementia and Safeguarding.** The presentation addressed practice responses to the complexities of dementia.

Inclusion Outright presented next with **'Vanessa's Story'.** Jane Hughes and Maggie Bennett spoke about the importance of prevention by promoting safer communities and safer organisations and building resilience in communities with agencies working together to provide resources and activities to enable dementia sufferers to live

the best lives possible. A piece of forum theatre followed telling Vanessa's story powerfully demonstrating the impact of dementia on relationships.

Nourishing Minds through Nature was the presentation brought by **Dr Kim Brown**. She spoke about the positive different that nature therapy makes to the lives of dementia sufferers.

After lunch **Sam Clark &, the chief Executive of the Local Area Coordination Network and Heather Rowell, IoW LAC Programme Manager** gave some background to the network and described its origins and how it works nationally in the UK.

Professor Keith Brown, Director of the National Centre for Post Qualifying social Work and Professional Practice at Bournemouth University gave a detailed presentation on **Safeguarding, Scams and Mental Capacity.**

Julie Woodhouse and Sally Ash of the IoW Trading Standards followed with a presentation detailing the IWASP – Isle of Wight Against Scams Partnership.

Before attending I wondered how much I would be able to use in my role, however I gained something useful from each input.

A great deal of content to take away, consider and share with colleagues. Thought provoking, powerful messages to take away.

Very inspiring day – have learnt so much. Have come away from conference with increased enthusiasm for ensuring all aspects of patients care needs are addressed.

We were very pleased to have a wide range of agencies displaying information about the resources and services they offer.

7. Task and Finish group focussed on Safeguarding and people with Learning Disabilities

The term '**Mate Crime'** is being used by some disability organisations to raise awareness. People with learning disabilities are often befriended by people who then exploit them. These are groups and individuals who pretend to be friends but who are really taking advantage of people.

Helping people with learning disabilities to understand what constitutes Hate Crime is vital.
People with learning disabilities often do not recognise that they have been the subject of hate or mate crime

Common Trends in Hate or Mate Crime:

- There have usually been previous incidents, which may have only been seen as 'low level' incidents
- Crimes often become regular and target the individual victim or their family/ friends
- Perpetrators are often predatory 'friends', support workers, acquaintances, neighbours, local residents, school children, groups of young adults or family
- Incidents are likely to escalate in severity and frequency
- Multiple perpetrators can be involved in incidents condoning and encouraging the main offender, often filming on mobile phones and sending pictures to friends or social networking sites like Facebook, Twitter or YouTube
- False accusations may occur calling the victim a paedophile or 'grass'
- There may be repeated attacks with excessive violence
- Cruelty, humiliation, degrading treatment (may be related to the nature of the disability e.g. blindfolding someone with a hearing impairment, destroying mobility aids etc).

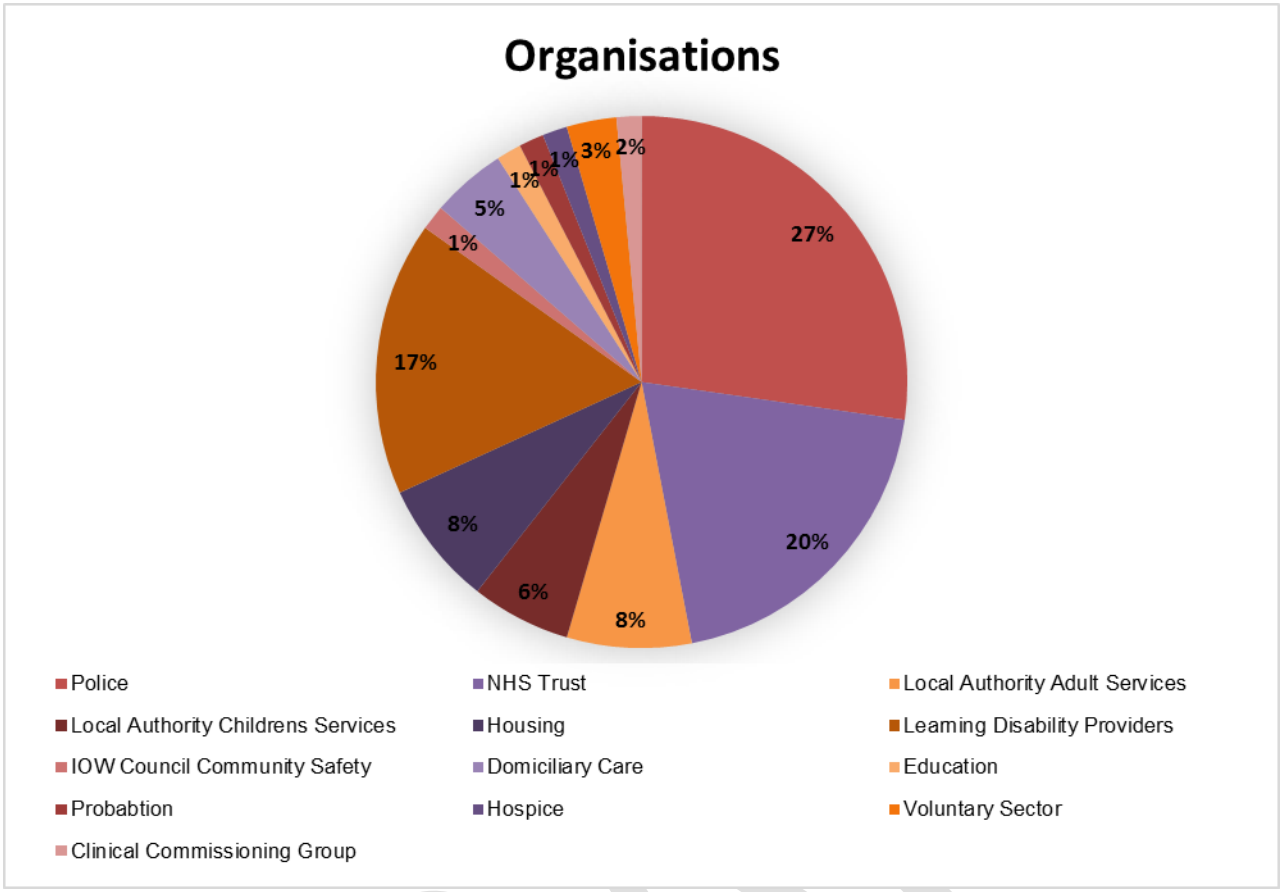
Police report a 30% increase in overall reported hate incidents locally since 2014, but there is very little hard local information available on scale and who is affected, but there is strong local belief among affected groups that the above baseline, together with anecdote, justifies action; particularly on reporting, which currently, hinders understanding and local response.

The Isle of Wight Safeguarding Adults Board member organisations report growing concern on hate crime and in particular people with learning disabilities describe incidents involving 'friends' that can be described a 'mate crime'. Our demographic is of a high number of people with disabilities of all ages, with small often isolated cohorts of people from BME groups. In addition, the LGBT community speaks of unreported crime. In a rural area that may not always recognise hate crime, there is added concern that small at-risk communities may not report through fear of unintended consequences or inaction.

The Isle of Wight Safeguarding Adults Board recognises the potential role of local councils in responding to hate crime, along with a need for improved reporting and better understanding of local scale and drivers.

Learning indicates that more intensive project development and preparation of those involved was needed, as well as integration with reporting networks, the police and sources of support.

The SAB supported a number of multi-agency workshops, attended by **66** professionals across the Island.



Key Messages

- Most participants had heard of the term hate crime but had less understanding of the term disability hate crime and the majority had not heard of the term mate crime.
- The need for improved recognition and reporting from all partner agencies.
- Safeguarding responses can sometimes blur the need for Police responses to disability hate crimes.
- There is a tolerance of 'low level' concerns.
- Minor incidents of mimicry or name calling on the street or at home may not seem important but the impact on the person can be significant
- The focus of enabling safety, needs to be on encouraging an understanding for the individual of their rights to freedom and justice, rather than reinforcing the already negative public image of learning disabled people being inherently 'weak', 'easy targets' and 'dependent'.
- Learning disability services need to take more responsibility to provide information, advise and support to people with learning disabilities about hate and mate crime.
- A number of 'hot spots' for hate and mate crime on the Island, i.e. Newport Bus Station.
- Community safety strategy to tackle the 'hot spots' in partnership with local services.

It's easy to make assumptions about **Hate and Mate Crime**. Offenders do not usually pick difficult targets. They tend not to pick the hardest property to burgle or the toughest person to assault. Being caught or injured is a risk and so they will select the people who pose the least risk to themselves.

Some common assumptions:

'It can't be a disability **Hate Crime** because':

- The perpetrator is the victim's carer
- The perpetrator has a disability as well
- The perpetrator has assaulted other people and they weren't disabled
- The victim was just in the wrong place at the wrong time
- The perpetrator was motivated by drink or anger
- And the most common assumption of all is that nothing will be done about it...

The SAB is currently supporting a PCC partnership bid, led by People Matter to develop a Safe Space model that will provide a safe space for people to report concerns, gain information and advice about hate and mate crime, as well as improving recognition and reporting. The aim would be to:

- Prevent the escalation of severity and frequency
- Raise awareness of the scale of hate and mate crime
- Improve the confidence of the learning-disabled community
- Recognise the behaviour for what it is
- Respond to and report all incidents.

8. Joint work with Healthwatch

8.1 Ryde House Visits

In 17/18 Board members also took part in visits to better understand the safeguarding approach in the different houses that form the services offered to people with learning disabilities at Ryde House. It was clear from a series of joint visits that staff at Ryde House not only understood Safeguarding processes, but had actively updated their practice so that their residents were given as much responsibility as they could manage in keeping themselves safe and in acting in ways that did not place others at risk. There was a positive approach to limiting any need for restraint and a clear view amongst the staff that were interviewed that their training was regularly refreshed and relevant to the work. Ryde Houses services range from providing homes for individuals whose care needs require a ratio of 5:1. It appeared that the training offered adequately covered this range of need.

8.2 Healthwatch Report

The Healthwatch report on Care & Nursing Homes along with evidence from CQC lists and a range of other sources was one of the prompts for the CCG and Adult Social Care jointly producing a quality framework which could be used by the Homes themselves, but also by commissioners to support quality improvements. Initially, there was some resistance to implementation of this framework as care and nursing homes are faced with a great deal of form filling and the addition of another set of questions seemed to stretch their capacity too far. However, everyone agreed that a Quality Framework of this kind should be welcomed so once the matrix has been refined, it will start to be implemented in 2018/2019. It will provide a mechanism through which effective support for continuous improvement in the care and nursing homes across the island can be established. An outline of what the Quality Matrix involves is provided below:-

In January 2018 the Isle of Wight Council Adult Social Care Department took the decision to second its limited resource of 1.6WTE to the Clinical Commissioning Group to support the creation of an Integrated Quality Team for the Independent Sector. The Integrated Quality Team have been working across both organisations to develop a new Quality Assurance Framework which is intended to provide improved market oversight for commissioners and other colleagues and which will support the work which has commenced to raise standards of care and support across the Isle of Wight.

The Integrated Quality Team (CCG/Council) have been working with Healthwatch Isle of Wight to develop a Quality Framework for use with all nursing, residential and homecare providers, with the aim of enhancing the Quality of care across these services.

The framework will collate information into a Quality Matrix which will be used by the integrated team and commissioning team. This will be refreshed quarterly with incoming Data; in addition when the quality visits take place; or if any particular concerns are escalated through the respective teams. The ratings will not at this stage be on public view, however if homes or home care agencies choose to publicise their own rating this will be up to individual providers.

The Quality Team have developed a risk criteria with individual expert teams and this enables assessment of each domain provides a 'Risk Rating' score for every provider. This will be used to inform where to target quality improvement and support activities appropriately, in the specific areas needed it will also assist in identifying trends and themes throughout the health and social care system.

The Quality rating will be discussed with the provider during the quality visit. The ratings are monitored on a quarterly basis and if there is a significant percentage increase or drop which changes the Quality rating, this will be escalated to the commissioning team. If this has changed the overall risk rating of the service in a negative way and the escalation will be followed accordingly, positive changes in ratings will be discussed on the visit from the commissioning relationship manager. Any appeals to the rating can be made in the first instance to the Integrated Quality team, if the provider is not satisfied with the outcome, they can escalate to the commissioning team. If they are still not satisfied with the response, this will be escalated to the Local Quality Care Network (LQCN) formerly the Isle of Wight Quality Surveillance Group (QSG), where meetings are held Bi-monthly.

9. Violence Against Women and Girls

9.1 Isle of Wight Festival

The Island's Safeguarding Adults Board was at the Isle of Wight Festival once again this year to raise awareness of consent and domestic abuse.

Volunteers from 'Yellow Door' Counselling Service (formerly Southampton Rape crisis), the Hampton Trust and the NHS Sexual Health team were on hand to provide specialist support and a 'safe space' to anyone affected by the issues. Based in Strawberry Fields, under the banner 'Love Doesn't Hurt', the team met hundreds of festival goers over the course of the weekend; who came to the make jewellery, paint stones and discuss any issues or concerns they had.

The Isle of Wight Council Cabinet member for adult social care and public health, Councillor Clare Mosdell, said: "The Isle of Wight Festival has completely taken on board the message of respectful sexual relationships and our annual presence here, for the second year, shows that the organisers take safeguarding seriously. It's essential that the public know that domestic and sexual abuse is unacceptable and it is important that the safeguarding team attends events such as this to provide information and advice in an informal way."

The Isle of Wight Council's Safeguarding Adults Board manager, Fleur Gardiner, said: "It was great to return to the festival this year to continue our awareness raising work. We spoke to so many different people over the weekend, many of whom have been affected by these issues in their lives. Feedback from the public was overwhelmingly positive about our work and about the priority the festival gives to safeguarding. Everyone we spoke to felt the event was very well managed and, most importantly, that they felt safe".

9.2 Proposed Changes to VAWG

The Domestic abuse co-ordinator (DAC) role and coordination of VAWG work is an operational function which historically sat within the Community Safety Service of the Isle of Wight Council with governance from the Domestic Abuse Forum. After a period whereby the Safeguarding Adults Board delivered the domestic abuse and VAWG co-ordination functions on behalf of the wider partnership, the SAB's statutory leads approved the management and administration of VAWG work transferring to the Isle of Wight Council, under the Community Safety Team and with governance returning to the CSP as of April 1st 2018. A domestic abuse co-ordinator post will support this function.

Gilles Bergeron who is currently seconded by Public Health to support the Domestic Abuse commissioning process for 2.5 days per week will continue in this role until October 2018. This will support a smooth transition to the new contract. The contract management responsibility will sit with the integrated commissioning unit after this date.

After two years as Chair of the VAWG group Kathy Marriott, Area Director for Children's Services has stepped down from the role and Superintendent Sarah Jackson has been elected chair of the group.

A VAWG workshop is due to take place on 23 July 2018. This will provide an opportunity to review the terms of reference for the group, review the work of the group over the last 12 months and develop an action plan for the next two years. The workshop will also review the role of domestic abuse co-ordinator, which will come under the Local Authority's Community Safety Team in the future.

9.3 Integrated Commissioning of Domestic Abuse Services

Funding for Domestic Abuse services on the Isle of Wight has traditionally been delivered through annual grant arrangements and monitored separately by respective funding agencies. In 2017 the IOW Local Authority and OPCC agreed to develop a specification for an integrated Domestic Abuse service which would bring together all existing interventions whilst adding a perpetrator programme. A Project Manager was recruited in April 2017 on a part time basis to lead on the development of this integrated commissioning framework of VAWG services on the Island.

The overarching aims are to:

- secure funding streams, formalise long term partnership agreements and deliver long term financial stability for DA provision on the Island; and
- develop and procure an integrated contract bringing together all existing Domestic Abuse components by April 2018 in line with OPCC requirements.

The principle aims of the Service are to:

- Improve safety and reduce risk to those affected by domestic abuse
- Support victims and survivors of sexual crime
- Offer community based perpetrator interventions for adult perpetrators of domestic abuse which helps stop abusive behaviours and promotes healthy relationships.
- Improve access, interventions, referral pathways and outcomes for adult victims, their children and their families affected by domestic abuse

A pooled budget of £313,112 per year for 2.5 years (+2) has been agreed. Budget contributors are ASC, Public Health, Housing (S.P), Children Services and the OPCC. A service specification has been developed and is currently out to tender. Service is due to begin on 01 October 2018.

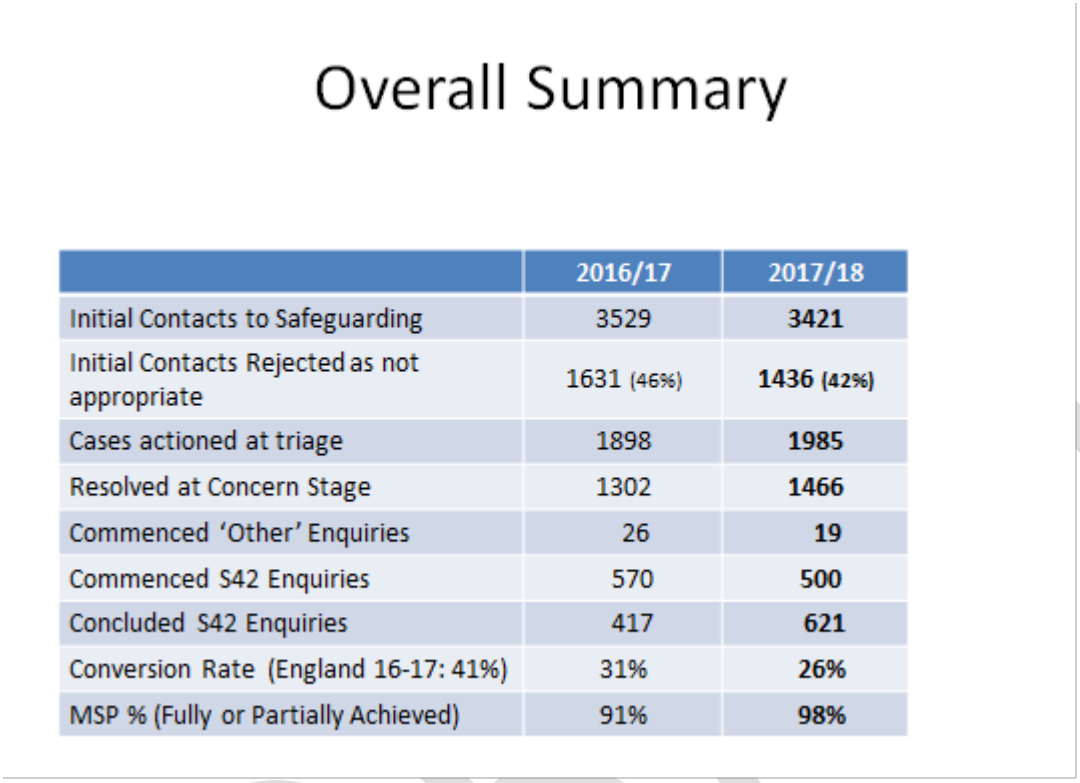
9.4 VAWG (Violence Against Women and Girls) Conference

The annual VAWG conference was held on 22nd November 2017 at the Riverside Centre in Newport and was attended by around 100 professionals from across the Island. The theme this year was 'Coercive Control', and featured speakers from Wight-DASH, Aurora New Dawn, Hampshire Constabulary and the Crown Prosecution Service. In the afternoon, the Certain Curtain Theatre Company performed their play 'Lady in Red'. This award-winning play looks at one woman's attempts to leave an abusive relationship and the barriers she faces. It helps the audience to finally answer the age old question 'Why doesn't she just leave?' which remains the main obstacle to many people fully understanding the true nature of domestic violence. It explores the whole relationship from the warning signs, through pregnancy, the barriers to seeking help and covers all aspects of domestic violence with a particular focus on the emotional and psychological abuse, coercive control and its effects.

10. Adult Social Care – Safeguarding Adults Collection Data 2017/2018

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 2017/18, 3421 safeguarding concerns were recorded, which is an increase from 3,204 recorded in 2016/17 (*see Appendix 1*).



Overall Summary

	2016/17	2017/18
Initial Contacts to Safeguarding	3529	**3421**
Initial Contacts Rejected as not appropriate	1631 (46%)	**1436 (42%)**
Cases actioned at triage	1898	**1985**
Resolved at Concern Stage	1302	**1466**
Commenced 'Other' Enquiries	26	**19**
Commenced S42 Enquiries	570	**500**
Concluded S42 Enquiries	417	**621**
Conversion Rate (England 16-17: 41%)	31%	**26%**
MSP % (Fully or Partially Achieved)	91%	**98%**

A Section 42 Enquiry (Care Act 2014) is a decision made by Adult Social Care that the information received and gathered would give reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)

- **has needs for care and support (whether or not the authority is meeting any of those needs),**
- **is experiencing, or is at risk of, abuse or neglect, and**
- **as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.**

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

This is often referred to as the 3-part test. In deciding what the LA thinks is necessary the LA must consider and reflect in their decision making the 6 statutory safeguarding principles.

The 6 principles are:

- Empowerment
- Preventing
- Proportionality

- Protection
- Partnership
- Accountability

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

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

In 2017/18 42% of reported safeguarding concerns were assessed by the adult safeguarding team as not meeting the S42 enquiry duty, (this is a small decrease of 4% from the 2016/17 data).
The number referrals of that are not safeguarding concerns are still significant, however the LA adult social care and SAB work on thresholds for reporting safeguarding concerns will help to ensure that incidents and accidents that are not safeguarding are referred on more appropriately, leaving the Safeguarding Team to respond more effectively and proportionately to concerns that are safeguarding.

In 2017/18 500 individuals were supported by the adult safeguarding team, following a S42 decision, 65% of those adults were asked about their desired outcomes and subsequently supported to achieve their outcomes in relation to their rights to be safe from abuse and neglect, to be kept safe and helped to protect themselves from abuse and neglect. 64% of those were individuals aged 65 or over. 53% of enquiries were concerning allegations of neglect or acts of omission.

The current conversion rate 2017/18 from safeguarding concern to S42 enquiry is 26/% - this is lower than the national average, however the current work to increase understanding of safeguarding concerns and enquiries should see an increase in this statistic.

Appendices

Appendix 1 - ASC SAC Return 2017/2018

Overall Summary

	2016/17	2017/18
Initial Contacts to Safeguarding	3529	**3421**
Initial Contacts Rejected as not appropriate	1631 (46%)	**1436 (42%)**
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Conversion Rate (England 16-17: 41%)	31%	**26%**
MSP % (Fully or Partially Achieved)	91%	**98%**

Section 1 - Summary

Safeguarding Concerns that commenced during period

	2016/17		2017/18	
	Individuals	*Cases*	*Individuals*	*Cases*
IOW Concerns	1306	1898	**1529**	**1985**
IOW S42 Enquiries	495	570	**426**	**500**
S42 Per 100k adults	432	497	**372**	**436**
England S42 per 100k adults	251	306	~	~
SE England S42 per 100k adults	272	319	~	~

SAC return – Section 1

Individuals involved in S42 Enquiries - by Age-group and Gender

Age-group	2016/17	2017/18	England 2016/17
18-64	**36%** 178	**30%** 127	36%
65-74	**10%** 50	**12%** 53	12%
75-84	**22%** 109	**21%** 88	22%
85-94	**23%** 116	**29%** 125	24%
95+	**8%** 42	**8%** 33	5%
Gender			
Male	**39%** 194	**41%** 176	40%
Female	**61%** 301	**59%** 250	60%

SAC return – Section 1

Individuals involved in S42 Enquiries - Individuals by Ethnicity

	2016/17	2017/18	England 2016/17
White	**93%** 462	**94%** 401	84%
Mixed/ Multiple	1	0	1%
Asian / Asian British	2	2	3%
Black / African / Carib / Black British	2	2	3%
Other Ethnic group	0	0	1%
Refused	0	0	<1%
Undeclared / Unknown	**6%** 28	**5%** 21	8%

SAC return – Section 1

Individuals involved in S42 Enquiries - by Primary Support Reason, and, Health Conditions (Autistic Spectrum only)

PSR	2016/17	2017/18	England 2016/17
Physical Support	**31%** 181	**37%** 198	42%
Sensory Support	**1%** 8	**2%** 8	1%
Memory & Cognition	**17%** 100	**19%** 98	10%
Learning Disability	**15%** 89	**11%** 59	13%
Mental Health	**8%** 45	**8%** 43	12%
Social Support	**5%** 28	**7%** 37	4%
None/ Not Known	**24%** 140	**16%** 86	18%
Health condition			
Autism	**20**	**19**	
Asperger's Syndrome/ High Functioning Autism	**2**	**1**	

Section 2

Section-42 Enquiries <u>concluded</u> during period

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

Duration	2015/16	2016/17	2017/18
Up to a month	31% 265	31% 128	**38%** 233
1 to 2 months	17% 144	20% 84	**17%** 108
2 to 3 months	13% 108	14% 60	**10%** 65
3 to 6 months	18% 153	20% 84	**18%** 112
6 to 12 months	7% 60	11% 46	**13%** 83
1 to 2 years	13% 109	3% 11	**3%** 20
Over 2 years	1% 8	1% 4	0
Total Concluded Cases	847	417	**621**

SAC return – Section 2

Section-42 Enquiries: Source of risk

	2016/17	2017/18	*England 2016/17*	*SE England 2016/17*
Service Provider	**53%** 231	**47%** 297	33%	32%
Other: Known to individual	**38%** 169	**43%** 276	51%	46%
Other: Not known	**9%** 38	**10%** 62	16%	21%

SAC return – Section 2

Section-42 Enquiries: Type and source of risk

	Service Provider		Other: Known		*Other: Unknown*	
	IOW	England	**IOW**	England	**IOW**	England
Physical	**40%**	25%	**57%**	59%	**3%**	16%
Sexual	**0%**	13%	**89%**	64%	**11%**	23%
Psychological	**27%**	21%	**71%**	66%	**2%**	14%
Financial / Material	**24%**	14%	**66%**	64%	**10%**	21%
Organisational	**33%**	70%	**33%**	16%	**33%**	14%
Neglect & Omission	**67%**	57%	**19%**	29%	**13%**	14%

SAC return – Section 2

Section-42 Enquiries: Location of risk

	IOW 2016/17		IOW 2017/18		*England 2016/17*	*SE England 2016/17*
Own Home	30%	132	**33%**	211	44%	42%
Community	4%	18	**4%**	28	3%	4%
Service within Community	3%	14	**3%**	22	3%	2%
Nursing Home	8%	35	**8%**	50	12%	13%
Residential Home	37%	162	**35%**	223	24%	22%
Hospital – Acute	6%	28	**7%**	45	3%	3%
Hospital – MH	< 1%	1	**1%**	4	2%	2%
Hospital - Community	2%	7	**1%**	4	1%	1%
Other	9%	41	**8%**	48	8%	11%

SAC return – Section 2

Section-42 Enquiries: Location and Source of risk

	Service Provider		Other: Known to individual		*Other: Unknown* to individual	
	IOW	England	IOW	England	IOW	England
Own Home	**27%**	23%	**67%**	63%	**6%**	14%
Community	**0%**	13%	**96%**	65%	**4%**	23%
Service within Community	**50%**	36%	**41%**	49%	**9%**	15%
Nursing Home	**70%**	56%	**20%**	31%	**10%**	13%
Residential Home	**78%**	52%	**16%**	33%	**6%**	15%
Hospital – Acute	**24%**	23%	**20%**	48%	**56%**	29%
Hospital – M Health	**0%**	18%	**100%**	59%	**0%**	23%
Hospital - Community	**0%**	19%	**50%**	56%	**50%**	25%
Other	**21%**	15%	**77%**	58%	**2%**	27%

SAC return – Section 2

Section-42 Enquiries: Risk Assessment Outcomes

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

	IOW 2017/18	*England 2016/17*	*SE England 2016/17*
Risk identified and action taken	**90%**	65%	69%
Risk identified and no action taken	**2%**	6%	2%
Risk - Assessment inconclusive and action taken	**3%**	6%	6%
Risk - Assessment inconclusive and no action taken	**< 1%**	3%	4%
No risk identified and action taken	**2%**	6%	10%
No risk identified and no action taken	**3%**	9%	6%
Enquiry ceased at individual's request and no action taken	**< 1%**	4%	4%
Where risk was identified (top two rows, above), what was the outcome when the case was concluded?			
Risk Remained	**15%**	13%	18%
Risk Reduced	**58%**	61%	62%
Risk Removed	**27%**	26%	20%

SAC return – Section 3

Section-42 Enquiries: By mental capacity of adult at risk.

	IOW 2016/17	IOW 2017/18	*England 2016/17*	*SE England 2016/17*
Lacks Capacity	42% 174	**47%** 290	29%	26%
Does not lack capacity	34% 142	**44%** 275	52%	64%
Don't know	19% 78	**9%** 56	12%	6%
Not Recorded	6% 23	**0**	6%	4%
Were those lacking capacity (row-1 above), supported by advocate, family or friend?	34%	**86%**	73%	79%

SAC return – Section 4

Section-42 Enquiries: Making Safeguarding Personal (MSP)

Were they asked their desired outcome, and did they express one?	IOW 2016/17	IOW 2017/18	*England 2016/17*	*SE England 2016/17*
They were asked, and outcome was expressed	25% 103	**43%** 264	55%	59%
They were asked, but no outcome was expressed	8% 34	**22%** 139	12%	12%
Not asked	11% 45	**23%** 144	16%	13%
Don't know	23% 95	**12%** 74	7%	6%
Not recorded	34% 140	**0**	11%	9%
Outcome success? (where outcome was expressed – row 1, above)				
Fully achieved	60% 55	**63%** 165	68%	61%
Partially achieved	31% 28	**36%** 94	26%	35%
Not achieved	9% 8	**2%** 5	6%	5%

SAC return – Section 5

Counts of individuals involved in Safeguarding Adult reviews (SARs)

	2016/17	2017/18
Count where one or more individual died	0	1
Count where no individuals died	0	0

Information provided by Emma Coleman
Individual was in age band 85-94

Isle of Wight
Safeguarding Adults Board

Business Plan
2018 -2019

Our purpose

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

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

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

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

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

Everything we do is underpinned by the 6 safeguarding principles:

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

Implementation and Monitoring

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

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

8 areas of focus were agreed at the LSAB Annual Development Day with Board members in January 2018. These areas of focus are also informed by feedback from HealthWatch and from service user and carer groups. In addition to the 8 areas of focus the Board's 'business as usual' includes undertaking Safeguarding Adults Reviews, monitoring the quality and performance of safeguarding on the Island, commissioning training and promoting awareness of the Board's work via conferences, events and publicity.

The 8 areas of focus for 18/19 are:

1. **Seeking assurance on the status of 'Making Safeguarding Personal' across all agencies on the Island**
2. **Building on the work in 17/18 with adults with a learning disability to seek to support safe spaces initiatives and work aimed at safeguarding these individuals.**
3. **Generating recommendations with partners about how best to improve safeguarding advice / support for people with individual budgets who commission personal services themselves**
4. **Seeking assurance that hospital discharge is safe (including A & E) for all adults at risk**
5. **Seeking assurance that the Medicines Management project has improved safety in care and nursing homes**
6. **Developing a joined up Family Approach to safeguarding with the LSCB.**
7. **Raising the profile of the Board, through a marketing campaign and better engagement with the community**
8. **Seeking assurance that the Thresholds for safeguarding adults are understood & applied by all partners.**

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

Sub Group: Quality Assurance and Performance

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

Areas of Focus:

- Seeking assurance on the status of 'Making Safeguarding Personal' (MSP) across all agencies on the Island (1)
- Seeking assurance that hospital discharge is safe (including A & E) for all adults at risk (4)
- Seeking assurance that the Medicines Management project has improved safety in care and nursing homes (5)
- Seeking assurance that the Thresholds for safeguarding adults are disseminated to and understood by all partners (8)

Outcome	Action required	Lead	By when	Evidencing the outcome	Red/Amber/Green rating
Staff across the partnership understand and implement MSP principles in their safeguarding duties. Adults' wishes and feelings are central to safeguarding.	1.1 multi-agency self-audit of all partner agencies	QA&P Group Chair	June 2018	1.1 audit reports and resulting action plans to be shared with the Board	
	1.2 multi-agency audit of 10 safeguarding cases	QA&P Group Chair	September 2018		
	1.3 Feedback from Healthwatch	QA&P Group Chair	Quarterly		

Hospital discharge is safe for all adults at risk	1.1 Quarterly progress report on Hospital to Home and Red Bag Scheme from NHS Project Lead to QA&P Group Members 1.2 Assurance that plans are in place for vulnerable groups currently excluded from Hospital to Home to be included in work on safe discharge 1.3 Feedback from Healthwatch	QA&P Group Chair QA&P Group Chair QA&P Group Chair	March 2019	1.1 CCG/NHS to carry out audit after 3 months and share results with the QA&P Group	
There is safe management of medicines in care and nursing homes	1.1 Quarterly report on the Medicines Management Programme from the CCG	CCG	June 2018	1.1 CCG Report to be presented to the SAB	

Thresholds are clear and applied consistently	1.1 Share information regarding the new Thresholds Documents with Partner Agencies and display on LSAB Website	LSAB Business Unit	My 2018	1.1 Improvement in conversion rate from concern to S42	
	1.2 Jointly commission Thresholds Workshops with Adult Social Care	LSAB Business Unit	April 2018	1.2 Feedback report from Thresholds Workshops Facilitator	
	1.3 Analyse quarterly data on Concern / S42 conversions rate	QA&P Group Chair	Quarterly	1.3 Report from Adult Social Care to go to the Board	
	1.4 Feedback from both Adult Social Care and Partner Agencies on referrals	QA&P Group Chair	Quarterly	1.4 Reports to QA&P group	

Training Sub-Group					
Core Business: ensuring that the training and development of the local workforce in relation to safeguarding adults meets high quality standards and reflects the issues and themes identified by the Board and required by statutory guidance. **Areas of Focus:** • Generate recommendations with partners about how best to improve safeguarding advice / support for people with individual budgets who commission personal services themselves (3) • Developing a joined up 'Family Approach' to safeguarding with the LSCB • Raising the profile of the Board, through a marketing campaign and better engagement with the community (7) • Assurance that the Thresholds for safeguarding adults are disseminated to and understood by all partners (8) • Building on the work in 17/18 with adults with a learning disability to seek to support safe spaces initiatives and other work aimed at safeguarding these individuals.					
Outcome	**Action required**	**Lead**	**By when**	**Evidencing the outcome**	**Red/Amber/Green rating**
People who commission personal services via individual budgets have access to information on safeguarding	1.1 Production of posters and leaflets & information on the LSAB and on partners' websites	Training Group Chair with the LSAB Business Unit	December 2018	Information widely available	
A Family Approach to Safeguarding is adopted across the adult's and children's workforces	1.1 Adults and Childrens Safeguarding Training to include information on a 'Family Approach'	Training Group Chair LSAB / LSCB Business Units	March 2019 March 2019	1.1 Safeguarding Training packages have been updated 1.2 Report on numbers of staff trained to go to Training Sub-	

	1.2 Specific training to be jointly commissioned where required			Group	
There is improved awareness of the LSAB amongst professionals and the general public	1.1 Commission an independent website for the LSAB with both a public and professional section 1.2 Hold an Annual Conference for Multi-agency Professionals	LSAB Business Unit LSAB Business Unit	October 2018 March 2019	1.1 Annual report for the Board on numbers of people accessing the website and downloading information 1.2 Feedback from Conference to go into a report for the Board	
The thresholds for safeguarding adults are understood and applied consistently across the partnership	1.1 Three multi-agency training sessions to be delivered to partner agencies	Training Group Chair / Business Unit	July 2018	Report on numbers of staff accessing training to go to the Training sub group QA data will show an improved conversion rate between contacts and S42s	
	1.2 Training commissioned on working with adults with complex needs	Business Unit / ASC WFD Unit	June 2018	Report on numbers of staff accessing training to go to the Training sub group	

	& fluctuating capacity			Audit will show improvement on multi-agency responses to adults with complex needs.	
Training support is available for those developing Safe Spaces initiatives on the Island	1.1 Training commissioned where need is identified - e.g. further mate /hate crime training	Training Group Chair / Business Unit	November 2018	Colleagues developing Safe Spaces initiatives receive training on hate / mate crime	

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.
- Develop 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.

Area of Focus:

- Raising the profile of the Board, through a marketing campaign and better engagement with the community (8)
- Developing a joined up 'Family Approach' to safeguarding with the LSCB (6)

Outcome	Action Required	By Whom	By When	Evidencing the Outcome	Red/Amber/Green rating
Improved awareness of the LSAB amongst professionals and the general public	1.1 Commission an independent website for the LSAB	SAB Business Unit	June 2018	Website up and running and accessible to all Annual report for the Board on numbers of people accessing the website and downloading information	
	1.2 Independent Chair to continue to	SAB Independent Chair	March 2019	Meetings held and information gathered	

	visit service user groups			to inform LSAB plan.	
	1.3 Produce a series of posters and leaflets on LSAB work for the public and professionals	SAB Business Unit	November 2018	Leaflets and posters visible in partner agencies and public spaces	
	1.4 LSAB attendance at selected public events to raise awareness of adult safeguarding on the Island	SAB Business Unit	March 2019	Reports on public awareness events to go the Board. Numbers of people contacting the Board for information increases	
The LSAB and LSCB develop a joined up 'Family Approach' to safeguarding	1.5 LSAB / LSCB Managers to develop and agree the framework for this priority work	LSAB / LSCB managers	April 2018	A framework detailing the scope of the project and desired outcomes is produced	

Sub Group: Safeguarding Adults Review (SAR)
Core Business: supporting the IOW SAB Independent Chair in commissioning and overseeing Safeguarding Adult Reviews (SARs) and other reviews of practice and recommending ways in which the learning and improvement from such reviews can be embedded into practice. **This sub group focuses solely on the business of commissioning and managing SARs and other learning reviews under S44 of the Care Act 2014. Recommendations from SAR action plans will inform the commissioning of training and areas of practice that might benefit from audit via the QA&P subgroup.**

Outcome	Action Required	By Whom	By When	Evidencing the Outcome	Red/Amber/Green rating
SARs are completed in a timely manner	1.1 Board members ensure their organisations respond in a timely manner to requests for information for the purposes of reviews.	SAR SG Chair	March 2019	Reviews are completed within timescales	
SAR action plans are progressed in a timely manner	1.1 Board members ensure their organisations provide prompt updates for SAR action plans	SAR SG Chair	March 2019	Action plans are completed within timescales	
Learning from reviews is embedded in practice and across	1.1 Engagement in the University of Sussex project on	LSAB Manager	March 2019	Reduction in the recurring themes from SARS -	

agencies	embedding learning from SARs across systems			improvements in practice	