
# Annual Report

## April 2020 – March 2021

## Foreword

Welcome to the Annual Report for the Isle of Wight Safeguarding Adults Board (IOWSAB) 2020/21. It feels only right, as we reflect back over this extraordinary year, that I take the opportunity on behalf of the IOWSAB, to mourn the deaths of residents who have died as a result of Covid and to acknowledge the grief of their families and friends. I would also like to commend the hard work, dedication, and commitment of health, social care staff and all the key workers who kept everything going during the pandemic. As Independent Chair I have felt privileged to be involved with such a hardworking and creative partnership during this challenging time. It was evident from the start of the outbreak that there have been massive efforts and close working across agencies to meet the demands of the pandemic and lockdowns, to provide assurance that safeguarding responsibilities remained the highest priority, despite the additional and extreme pressures on services.

This annual report describes what the Board aimed to achieve during 2020/21 and what we have been able to achieve. The annual report provides a summary of who is safeguarded in the Isle of Wight, in what circumstances and why. This helps us to know what we should be focussing on for the future, in terms of who might be most at risk of abuse and neglect and how we might work together to support people who are most vulnerable to those risks.

Safeguarding Adults Reviews (SARs) are a statutory duty for SABs and during the past year 8 cases were considered for such a review, 2 of which met the legal criteria. For the other cases, it was agreed that although the criteria were not met, there were some important lessons for partners in the services involved and so 2 thematic reviews have been commissioned, the scope of which are detailed in this report. The SARs and thematic reviews provide important insights and learning, resulting in improvement actions across our partnership and more widely.

The length of this report reflects the extent and depth of the valuable and influential work which is carried out by the IOWSAB throughout the year. My thanks, as ever, go to the small but excellent IOWSAB team, as well as to the Chairs of the IOWSAB Subgroups who do so much to ensure that our ambitions for safeguarding on the Island can be achieved**.**

**Teresa Bell,** Independent Chair

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## 1. 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. Southern Housing Group Ltd.

13. Fire and Rescue Service

14. Local Safeguarding Children's 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

## 2. Board Structure

The Board has four sub-groups:

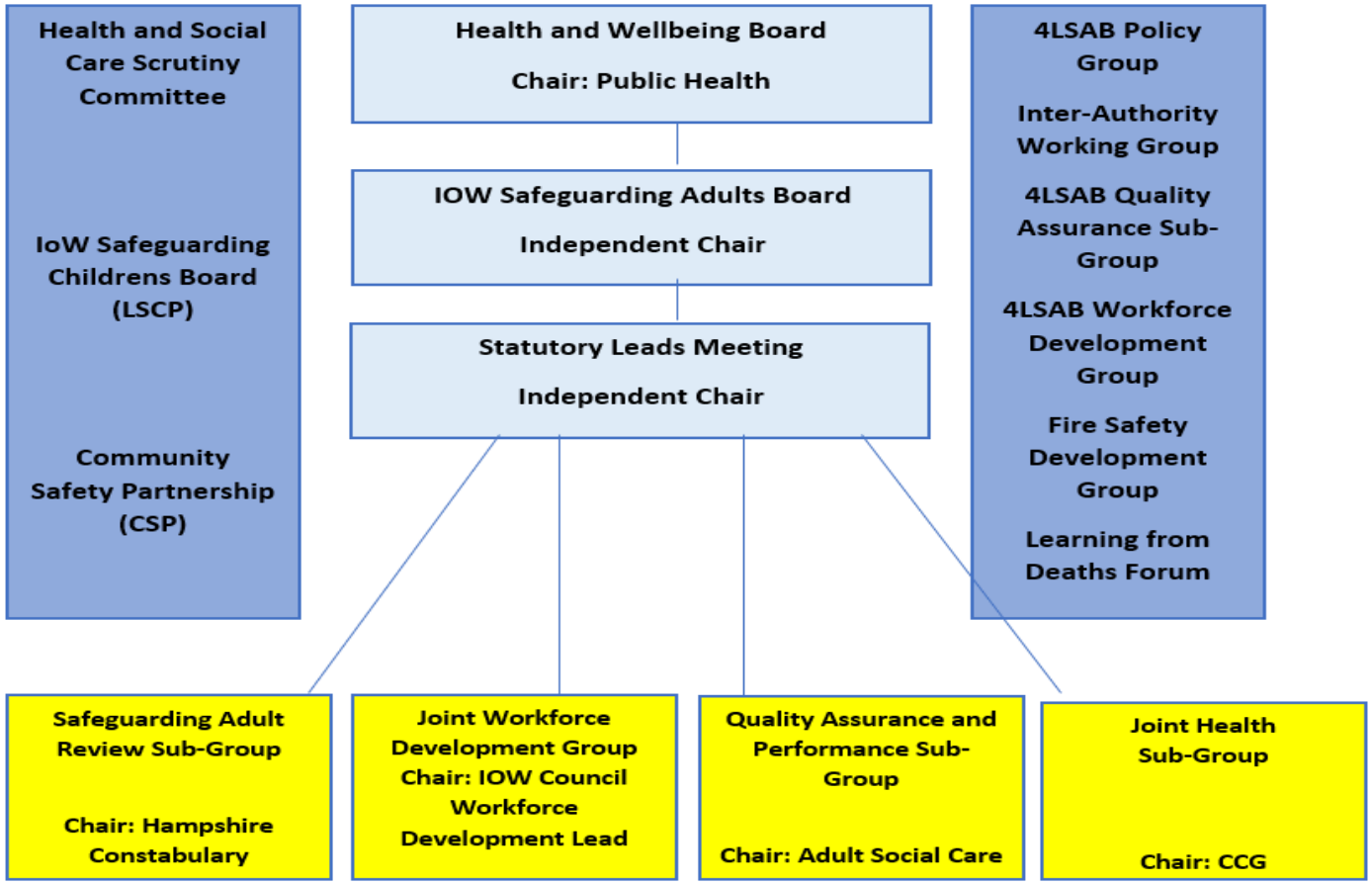
- **Safeguarding Adults Review Sub-Group**
- **Quality Assurance and Performance Sub-Group**
- **Joint Workforce Development Sub-Group with the Safeguarding Children's Partnership**
- **Joint Health Sub-group with the Safeguarding Children's Partnership**

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

The Board also has a Statutory Leads group, which meets a few weeks before Board meetings to check on progress against some key actions, raise and discuss any concerns, and agree how best to put forward proposals to the Board to address those concerns. This group involves the Isle of Wight's Police District Commander, the Clinical Commissioning Groups Deputy Director of Quality, the Assistant 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 3 Safeguarding Boards in the neighbouring Hampshire County area i.e., Hampshire, Southampton, and Portsmouth.

**Isle of Wight Safeguarding Adults Board Hierarchy**



## 3. Covid-19 Response

### 3.1 Safeguarding Adults Board Functioning

During the pandemic, the Board assessed how it could manage its duties appropriately given the shift in focus and partner agency availability. Safeguarding remained a statutory duty under The Coronavirus Act 2020, and so the main Board continued to meet virtually in the form of a monthly one-hour 'mini-SAB' focussed solely on the response to Covid and Safeguarding, and to seek assurance from partners that safeguarding was being prioritised. The three Statutory Leads met with the SAB Chair and SAB Manager weekly, and the SAB Manager attended a weekly multi-agency operational group looking at safeguarding responses across the Island, as well as a weekly National SAB Managers Meeting, to ensure the Board was fully informed and involved.

With the response to the pandemic dominating the work of the Board, it's partners and sub-groups, the 2020/2021 Business Plan was reviewed to reflect Covid-19 and Safeguarding as a central priority. The business plan was kept fluid to enable the Board to react to the pandemic as events unfolded.

One key area for assurance was around the interpretation of Care Act easements. Adult Social Care provided their workforce with a 10-page briefing note from the Assistant Director and Principle Social Worker explaining the implications of the Easements Guidance, the conditions which must be met before Easements are considered by IOW Council, and asked all managers to Red/Amber/Green rate their service in terms of those conditions. There was an 18-step process to complete before IOW Council would consider the use of any Easement which needed to then be signed off by the Director. The 18 steps included a risk assessment, impact evaluation, use of the Ethical Framework, informing the Lead Member, Department of Health and Social Care, voluntary sector and advocacy groups before any Easement would be approved. Easements have not yet been used and it is highly unlikely this will change.

The Board was also involved in re-establishing of the IOW Multi-agency Safeguarding Triage (MAST). A weekly multi-agency operational meeting took place throughout the Covid-19 pandemic, with the Board Manager attending to discuss the safeguarding responses during the Covid-19 pandemic, as well as looking at future possible surge in safeguarding referrals. The existing MAST framework was updated to reflect new virtual working, capacity of teams and process and was completed in July 2020.

### 3.2 Sub-groups

All Sub-groups carried out regular Covid-19 related work focussed on assurance and support in the short-term, followed by more long-term evaluation of the safeguarding response. The Quality Assurance and Performance Sub-group focussed on quantitative and qualitative intelligence from partners, including discussion of community feedback from Healthwatch. The health sub-group focussed on collating key risks, challenges and opportunities that had arisen during Covid-19, as well receiving/assessing an adult, child, and LAC (Looked After Child) Surge Plan from health colleagues, which aimed to assist agencies to recognise, plan and respond to surges.

The Board continued to receive referrals for Safeguarding Adult Reviews with the SAR Sub-group meeting every 6 weeks, however scoping was limited due to partner capacity. Action plan updates were received from those who could work on them. The group agreed that for any cases where SAR criteria was met, SARs would be commissioned with the process tailored to work around partner capacity, with deadlines extended and flexibility in panel meetings. Learning from SARs continued to be included in any e-learning being developed, including podcasts and webinars.

### 3.3 Training

Throughout the pandemic, it was not possible to deliver face-to-face training, and so the focus was moved to delivering learning virtually. The Board worked with several training providers to develop webinars which were delivered throughout the year, e-learning which could be undertaken at any time, and additional resources such as podcasts on Multi-agency Risk Management and Safe Places.

### 3.4 Awareness Raising

When the pandemic began, the Board were involved in the distribution of Covid-19 related resources for volunteers, professionals, and the public. This included promotion of the 4LSAB Animated Scribe safeguarding video by IOW Council, IOWSAB and some Town & Parish Councils. In addition, the following work was undertaken:

- Utilise website, twitter, and email networks to promote safeguarding resources.
- Work with the Domestic Abuse Coordinator and Safeguarding Children Partnership on radio broadcast around domestic abuse.

- Share resources with IOW Council to promote on their social media and website
- Repost/retweet safeguarding related posts from Police and IWASP (Isle of Wight Against Scams Partnership)

IOWSAB provided additional documents to the comprehensive training package for redeployed staff and volunteers offered by IOW Council including:

- link to animated scribe safeguarding video
- One Minute Guide to Adult Safeguarding for Coronavirus Volunteers
- Leaflet: Safeguarding Adult for People who are Self-isolating
- Leaflet: Safeguarding Adult for Mutual-Aid Groups
- Guide: Covid-19:Social isolation and safeguarding adults – Advice for professionals

## 4. Safeguarding Adults Reviews and Thematic Learning

### 4.1 Cases reviewed, and lessons learned

During 2021/2021, the Safeguarding Adults Review (SAR) sub-group on the Isle of Wight considered 8 cases, 2 of which met the criteria for a statutory Safeguarding Adults Review (SAR). For the other 6 cases, it was felt that although the statutory criteria were not met, there were some important lessons for partners in the services involved in some of the cases, and so 2 thematic reviews have been commissioned.

**Case A**

Case A involved an individual who died in a care home, and there were concerns about the use of bed rails and communication between agencies. The cause of death was deemed to be natural causes, and so the SAR criteria was not met, and no further action was required. Any concerns raised by the group were passed to CQC to include in their investigation.

**Case B**

Case B involved an individual who was referred into the SAR sub-group following their death by suspected suicide. The individual had a long history of substance misuse and mental health concerns, and had extensive contact with agencies throughout the year prior to their death. Although the SAR criteria was not met, this case will be considered as part of a wider thematic review on homelessness, mental health, and suicide/overdose with 4 other cases.

**Case C**

Case C involved an individual with a history of alcohol dependency, self-harm, and homelessness prior to their death. They were well known to a number of services, however had a history of disengagement. The case did not meet SAR criteria as their cause of death was deemed to be natural causes, however there were concerns about a lack of holistic approach from agencies and so the case will be considered through a wider thematic review on homelessness, mental health, and suicide/overdose with 4 other cases.

**Case D**

Case D involved an individual with mild learning disabilities who had a history of non-engagement with services and may have had periods of self-neglect. The individual was taken to hospital following a house fire which was started by carelessly discarded smoking materials, where they later died from their injuries. The SAR criteria was not met, and the learning from this case is being taken forward by the 4LSAB Fire Safety Development Group.

**Case E**

Case E involves an elderly individual found in a very neglected state within their home where they had been under the care of family. The individual was removed and placed in a residential home, where their condition has vastly improved, and they have confirmed they do not wish to return home to the care of their family. The group felt that this case did meet SAR criteria, and the review will be undertaken by an independent reviewer as part of a wider thematic review on neglect.

**Case F**

Case F involved an elderly individual being cared for by their partner who was struggling to cope. The individual was taken to hospital with ulcerated legs, a pressure ulcer to their right elbow and an ulcerated sacrum, where they later died. Prior to their hospital admission, the individual was found to have not been moved for seven days. A criminal investigation was launched however no charges were brought. The case did not meet the statutory SAR criteria, and the case will be looked at via a thematic review with 3 other cases.

**Case G**

Case G involved an individual with chronic skin changes to their legs, and two active and open ulcerations on the right lower leg. One of the ulcers was through the muscle to bone. At the time of the referral, their cause of death was suspected to be sepsis relating to the ulcers, and there were concerns about the care they received prior to their death. This case did not meet the SAR criteria, but will be looked at via a thematic review with 3 other cases.

**Case H**

Case H involved an elderly individual with advanced dementia, whose partner reported they was struggling providing care to them at home. They advised they did not know what to do when they developed pressure sores, as they were adamant they did not want to go to hospital. The case was referred due to concerns around neglect, and multiple concerns across several key agencies around whether there was adequate follow up an individual with an identified chronic and deteriorating condition, and whether there had been robust reassessment of health and care needs in a timely way. This case does meet the SAR criteria, and will be considered within a thematic review on Neglect with 3 other cases with similar themes and learning.

**Thematic Review – Homelessness, suicide/overdose, mental health, and alcohol/substance misuse**

The Isle of Wight Safeguarding Adults Board identified 5 cases which, although do not meet statutory criteria for Safeguarding Adult Reviews individually, when aggregated may offer valuable thematic insights into safeguarding practice on the Island. This thematic review includes cases B and C above, as well as 3 cases considered in 2019/2020. In order to better understanding the multi-agency health and social care system on the Island, an independent reviewer has been commissioned. The thematic review will focus on a range of points, including building an Island profile in relation to multiple needs including homelessness, mental health, and substance misuse, as well as looking at the effectiveness of partnership collaboration to support people with multiple needs and whether there is evidence of a combined approach negating further risk of harm. The review report will generate system-applicable learning from each case and highlight themes in practice, and is expected to complete in late 2021.

**Thematic Review – Neglect**

From the cases considered in this financial year, the Isle of Wight Safeguarding Adults Board identified 4 cases with similar themes and feel the most pertinent way to address the learning is through a thematic review. This review comprises cases E, F, G and H above, 2 of which meet the criteria for a SAR and 2 of which don't. The main themes for consideration are personal budgets/individuals funding their own care, impact of Covid, family resistance, and Care Assessment quality. An independent reviewer has been commissioned, and is currently in the process of gathering more detailed information from a number of agencies. This review is expected to be completed within the 2021/2022 financial year.

**Update on Progress from Safeguarding Adult Reviews in 2019/2020**

In 2019/2020, the Safeguarding Adults Review sub-group considered 5 cases, none of which met SAR criteria; however, they were part of two key pieces of work:

- Two cases considered in 2019/2020 featured a number of similar themes including relationship breakdown between professionals and family carers, management of health conditions, safeguarding individuals who fund their own care, and professional curiosity. It was felt that the best approach would be to combine the themes from the two cases and hold a professional's workshop to work through some of the themes. In a reciprocal arrangement, this workshop was facilitated by Portsmouth Adult Social Care which provided an independent view but also ensured the facilitator had some knowledge about local services. The recommendations from this workshop will be taken forward in 2021/2022.
- Three further cases were considered in 2019/2020, and again there were themes common to all three cases, including suicide/overdose, homelessness, mental health issues and lack of communication between agencies. All three cases are being considered as part of the Thematic Review discussed above, together with 2 cases considered in 2020/2021.

**4.2 Work with Alcohol Change UK**

In 2019/2020, the Isle of Wight and Portsmouth Safeguarding Adult Boards started collaborating with Alcohol Change UK on a national piece of work on Safeguarding Dependent Drinkers. This national workstream developed from a publication 'Learning from Tragedies', which focussed on a number of SARs across England and Wales.

Both Boards have continued this work into 2020/2021, however due to Covid, the project has had to continue virtually. There has been a national survey to gain feedback from professionals working directly with this client group instead of holding face to face workshops. There was an excellent response rate from the island, and our local responses were in line with the following national picture:

- **63% of practitioners surveyed felt that problem drinkers who are unwilling or unable to change are a challenge to their services**

- **82% felt that the local response to this client group is either poor or in need of improvement**
- **73% felt that tackling this client group should be a high priority**
- **53% felt that their skills at working with this client group needed improvement**
- **91% believed that a multi-agency group focusing on the needs of this client group would be a local asset.**

In order to support practitioners, Alcohol Change UK delivered a series of free webinars on the following topics:

- **Foetal Alcohol Spectrum Disorders and Mental Capacity - Dr Raja Mukherjee**
- **Alcohol dependency - Lessons from Safeguarding Adult Reviews - Professor Michael Preston-Shoot**
- **Alcohol, Neurobiology & Mental Capacity - Dr Stefania Bonaccorso**
- **Alcohol Related Brain Damage and Mental Capacity - Professor Ken Wilson**

These national webinars were well attended by Island professionals, and were accompanied by a number of training sessions for Isle of Wight and Portsmouth delivered in 2020/2021. The webinar recordings are also available via the IOWSAB website. Although the client group is adult, it was recognised that the children's workforce undertakes vital work with parents and families, and so child-centred services were able to provide key input to the national survey as well as attend the webinars and training.

The project is due to conclude in 2021, with Alcohol Change UK due to present their project report, findings, and recommendations for next steps to the Safeguarding Adult Board and various Commissioners in the Autumn. From this, a local plan will be developed and monitored by the Board.

## 5. Quality Assurance and Performance

### 5.1 MARM Coordinator

MARM (Multi-agency Risk Management) is a multi-agency approach to managing cases relating to adults where there is a high level of risk, but the circumstances may sit outside of the statutory Adult Safeguarding framework. This multi-agency approach is key in prevention and early intervention when working with complex individuals. A MARM Coordinator 18-month project role was created in November 2019 in response to a highly critical IOW SAR, IOW SAB audit and feedback from a multi-agency forum created by the SAB which all raised the issue of the 2016 4LSAB MARM Framework still not being embedded with Island professionals three years after being published. This was having a negative impact on the outcomes of adults at risk experiencing unmanageable levels of high risk. Understanding of MARM was 'patchy', not all agencies were using MARM correctly, and the person at risk was not always invited to the MARM meeting so that their thoughts and wishes could be heard and taken on board with the help of a key representative.

The aim of the MARM Coordinator project role was to:

- Support agencies/organisations to adopt and apply the MARM Framework to embed it within their own agencies/organisations
- Provide a central point of contact for support and advice for agencies/organisations
- Promote the MARM Framework and toolkit
- Assess the quality standards of MARM meetings via an audit e.g., when they are called, which agencies/organisations lead, frequency of MARM meetings, who is/who is not attending, etc.
- Provide a training resource for agencies/organisations, either as set training events or on a 1-1 ad hoc basis, both with a trainer
- Meet on a regular basis with the MARM Task and Finish Group
- Provide regular reports to the Safeguarding Adult Board on progress

**MARM Toolkit**

In addition to the 4 Local Safeguarding Adult Board (4LSAB) MARM Framework, a number of useful MARM tools, guides and templates were developed and added to the Safeguarding website under MARM. These are available to all agencies and organisations and is widely shared. Examples of the available MARM resources are listed below:

- Chairing meetings guidance
- Planning meeting agenda
- Planning meeting minutes
- Meeting invitation generic
- Meeting invitation detailed
- FAQs
- MARM Flowchart
- Attendance and confidentiality statement
- One-minute guide on managing difficult conversations
- Quick guide advocacy
- Quick guide consent and general data protection regulation (GDPR)
- Quick guide flowchart for advocacy support

- Quick guide happiness safety plan matrix
- Quick guide how to get the best out of virtual meetings
- Quick guide Information sharing – lawful basis and general data protection regulation (GDPR)
- Quick guide to making sure your MARM action plans are smarter
- Quick guide making a difference
- Quick guide making safeguarding personal
- Quick guide managing conflict during MARM meetings
- Quick guide FAQs
- Quick guide MARM flowchart
- Quick guide Mental Capacity Act (MCA) – five statutory principles
- Quick guide MARM checklist
- Quick guide MARM prompts
- Quick guide on the day of the meeting
- Quick guide questions to support making safeguarding personal
- Quick guide the 7 Caldicott principles

- Quick guide questions to support making safeguarding personal
- Quick guide tips for effective MARM
- Quick guide when a safeguarding concern does not lead to a Section 42 Enquiry
- One-minute guide to meetings
- One-minute guide on the 4 local Safeguarding Adults Board framework
- How to organise a MARM meeting
- Template request for information letter with the adult's consent
- MARM report template for agencies who cannot attend a MARM meeting
- MARM meeting letter to the person at risk key representative

In addition to the above, a MARM podcast has been developed and is also available on the website. The tools, guides and templates are reviewed on a regular basis. New tools, guides, and templates, etc., were developed as new ideas were brought to the attention of the SAB Manager and MARM Co-ordinator.

The introduction of the MARM toolkit available to all agencies and organisations has served to underpin the MARM Framework, and to provide agencies and organisations with the tools, tips, guides, and templates needed for all MARM related issues and activities. However, it has also been highlighted that some agencies were still finding it difficult to engage with the MARM Coordinator and other agencies. This in turn left gaps in the management and the co-ordination of the MARM risk management plan for individuals at risk. To address this, mitigating actions were taken by the SAB Co-ordinator and MARM Co-ordinator by meeting with the identified agencies to offer help, support, and encouragement.

**5.2 MARM Audit undertaken**

In order to assess how well embedded the MARM Framework is, an audit was undertaken by the IOW SAB MARM Coordinator and IOW SAB Manager in March 2021. The audit looked at agencies use of the 4LSAB MARM Framework over a 12-month period from January 2020 - January 2021.

The audit had the following Aims/Objectives:

a. To determine the quantity, frequency, and quality of MARM meetings through quantitative and qualitative data

b. To gather feedback from professionals around their MARM knowledge and skills, and to compare this with feedback from 2 years ago

c. To gather feedback from individuals about their experiences of the MARM process

d. To improve the application of the MARM framework

e. To ensure agencies and organisations understand the MARM process

f. To improve the MARM experience for the adult at risk

The audit sample consisted of 19 audit returns submitted to the MARM Coordinator by a range of agencies, together with an anonymous island wide staff survey.

**Key Strengths**

- Agencies have adapted to Covid restrictions and MARMs have been held virtually with additional support being provided to the individual at risk. 'Hybrid' MARMs led by IOW Council Housing have also been a good model to follow.
- 100% of professionals responding to an island wide staff survey knew what MARM was. In the same survey in 2018, 88% of respondents knew what MARM was.

- 100% of respondents said that clear actions were given. In 2018, only 69% of respondents said there were clear actions given, so this indicates there has been an improvement.
- The vast majority of respondents (74%) feel MARMs are 'somewhat embedded'. In 2018, 15% of respondents felt MARMs were 'not at all embedded', and so it is encouraging to see that this is down to 0% in 2020.
- 86% of actions given led to a reduction in risk for the individual, which is a good result. It is also an increase from 76% in 2018.
- There is clear evidence in the data collection that in the majority of cases, the individual at risk was given the option to attend the MARM meeting and briefed prior to the meeting. The qualitative data shows that in the majority of cases, there was a good outcome for the individual at risk as a result of a MARM meeting. Examples include clear risk management plans in place resulting in accommodation being offered, support with pain relief, agreement from the individual to work with agencies, follow up MARM review meetings offered, and good engagement between agencies with a sharing of risk management plans.
- With the toolkit being in place, meetings now have structure and more outcomes.
- Teams with admin support have a better organised, more well attended MARMs, are able to provide some data and are able to follow up on actions ensuring better outcomes for the individual.

**Risks and Issues**

- Some MARMs may have been more suited to the safeguarding route, and others could have been held more appropriately as a departmental meeting, e.g., a professionals meeting, or as a direct referral to one other service.

- Meeting support and organisation: There is no dedicated administrative support for many agencies, which can mean a lack of organised set up, meeting invitations may not go out/go to the right people, minutes may not be taken or may be taken by someone with lack of minute taking experience and meeting minutes may not be well recorded, accurate, or circulated appropriately

- Just over half (52%) of people surveyed advised that their MARM meetings had the relevant people attending. There was a similar result in 2018, with 58% of respondents advising the relevant people attended. This suggests that there is still significant work to be done with agencies

- It can be difficult to get agencies to be involved in the MARM process if the individual is not known to them, however from the audit returns it has been shown that this can be a successful route to engagement with the individual where they may have previously refused

- Getting the person at risk to attend has been difficult at times - virtual meetings might be difficult for the person at risk and challenging for members of staff

- There is a reliance on agencies/organisations to complete their MARM actions, but no overarching governance structure in place to monitor agencies/organisations once they have held their MARM meeting

- There is currently nowhere to escalate MARMs to when the issues have not been resolved, the risks have not been reduced or there is disagreement between agencies. A higher multi-agency panel would be beneficial

- Learning at training sessions is not always taken back to the team and incorporated into practice

- Decision making in practice can be difficult as individuals can be complex

The findings from the audit will assist the IOWSAB to identify where practice should be improved (through, for example, access to additional specialist training, contemporary research and best practice, and enhanced single agency operating procedures), identify areas which require a multi-agency solution and response, and to challenge individual agencies where there is evidence to show current practice, including supervision and management oversight, requires improvement

## 6. Workforce Development

### 6.1 Isle of Wight Learning and Development Strategy

The local Isle of Wight Safeguarding Adults Board Workforce Development strategy was refreshed in line with the overarching 4LSAB Workforce Strategy. The purpose of the strategy is to outline:

- The roles and responsibilities of the LSAB, partner agencies and all other organisations working with adults at risk in ensuring all those working with adults at risk receive appropriate safeguarding training.
- A common understanding of single and multi-agency training.
- The standards for the provision and delivery of training.
- How the training provided by LSAB will be evaluated

This will ensure that commissioned training meets the outcomes outlined, can be clearly advertised at the appropriate level, and evaluated for impact.

### 6.2 Training Programme

As part of the MARM Coordinator Project, it identified that there was a general disparity of skills, knowledge, and awareness of MARM between the various agencies and organisations. Some agencies and organisations had heard of MARM or had a fairly good understanding of MARM, whilst others had very little knowledge. A few agencies and organisations were using MARM, some appropriately and others inappropriately, for example calling a MARM as an urgent meeting, not including the individual at risk, and there were varying degrees of risk management planning.

To mitigate this, a MARM training programme was therefore identified. MARM training events were offered, delivered, and made accessible to all agencies and organisations across the Island. A series of training events included:

· An Introduction to MARM

· MARM Training for Managers

· MARM and Working with Risk

· One to one and team MARM training on request

Latterly, virtual MARM training events were offered to overcome the inability to offer face to face training due to Covid. The SAB Manager and MARM Co-ordinator were proactive in delivering MARM training on a face to face and virtual basis. A training log was kept on all training events whereby participant feedback received was captured, taken on board, and acted upon accordingly. This included positive comments, challenges identified by participants, gaps in knowledge, and areas for further staff development needs. Examples of participant feedback included ideas for new MARM tools, requests for specific training such as the difference between Section 42 and MARM, and when to call a MARM meeting. Any emerging themes were then incorporated into future training events.

**6.3 Learning Needs Analysis**

The annual Learning Needs Analysis took place virtually in November 2020. The group followed a new format, with a presentation of a range of evidence to builds a picture of learning needs arising from various audits, learning from SARs, national and local strategy changes, the Missed Opportunities Domestic Abuse Conference, outcomes from the Covid-19 Assurance Framework plus the learning needs analysis questionnaires which were submitted by partners. This enabled evidence-based planning to take place, and as soon as budget is agreed the 2021 training plan will be commissioned based on the agreed learning needs below:

| **Identified Learning Needs for 2021/2022** |
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| **Introduction to MARM** |
| **S42** |

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| **Barriers to Making Safeguarding Personal** |
| **Self-Neglect** |
| **Safeguarding Concerns Framework** |
| **Thematic review on homelessness, suicide, mental health, and substance/alcohol misuse** |
| **Fire Safety and Safe & Well visits** |
| **Domestic Abuse: Needs of Elderly and Vulnerable communities with complex support needs/disabilities** |
| **Hoarding** |
| **Family Approach Protocol and Toolkit** |
| **A Family Approach to Safeguarding and LGBT+** |
| **Transitions** |

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| **Mental Capacity** |
| **Alcohol Change UK resources** |

### 6.4 Online Learning Management System – The Learning Hub

Following the procurement of a new digital learning environment by Isle of Wight Council which can host external content as well as content specific to safeguarding adults e.g., hoarding, both the SAB and the SCP have been given an opportunity to join this online system for an annual fee. Specific targeted SAB/SCP pages have been designed and will have free access for all professionals on the Island, including residential and nursing homes, domiciliary care and PAs, and the voluntary and community sector. These pages will feature a range of e-learning, webinars, and podcasts, and will also offer online booking for all future training courses. It will also provide a central record for attendance and evaluations, meaning regular reports can be shared with the Workforce Development Group.

The Learning Hub is due to go live on 1st April 2021.

## 7. Policies and Procedures

### 7.1 Safeguarding Concerns Guidance

Throughout 2020, the Board worked collaboratively with key stakeholders and safeguarding partners across Hampshire, Southampton, and Portsmouth to develop new 4LSAB Safeguarding Concerns Guidance. Launched in October 2020, the Guidance is designed to support decision making and reporting of adult safeguarding concerns in order to impact positively on outcomes for people with a need for care and support who are at risk of, or experiencing, abuse or neglect. The new Safeguarding Concerns Guidance and accompanying protocols are not replacing professional judgement; they act more as a benchmark to assess concerns and help determine which concerns meet the criteria required for a safeguarding concern. The Guidance replaced the Isle of Wight only 'Decision Support Guidance and Toolkit' launched in 2018, although much of the toolkit was carried over to the new document.

This framework sits alongside the 4LSAB Multi-Agency Adult Safeguarding Policy, Process and Guidance 2020, draws on the Care Act 2014 and accompanying statutory guidance, and connects to the LGA Local Government Association) and ADASS (Association of Directors of Adult Social Services) framework 'Making decisions on the duty to carry out safeguarding enquiries. This multi-agency framework promotes:

- Personalised approaches which balance well-being with safety and prevention
- Engagement with the adult about how best to respond to their safeguarding situations in a way that enhances their involvement, choice, and control
- An adult's rights, ensuring that those who lack mental capacity (as well as those who have capacity) are empowered and included within safeguarding support
- Empowering people so that they are partners in understanding and managing risk in their own lives
- An emphasis on the need for transparency and openness in managing conflicting outcomes (both of the adult and between the adult and professional organisations)
- The role of advocacy in all of the above.

In addition to the main Guidance are three additional protocols:

- 4LSAB Multi-agency Protocol for Pressure Ulcers and Adult Safeguarding
- 4LSAB Multi-agency Protocol for Falls and Adult Safeguarding
- IOWSAB Multi-agency Protocol for Medicines Incidents and Adult Safeguarding

The Guidance was also launched with a number of case studies to support practitioner learning, including a case where a woman acting as a carer for her husband with dementia is at risk of abuse when his behaviour deteriorates due to his condition, a homeless individual with a history of alcohol abuse who is the victim of financial and physical abuse, as well as showing signs of self-neglect, and a man with dementia in a residential setting who is being financially abused by his son. These case studies can be used by practitioners on their own, in a group setting, or within supervision as a learning tool.

To support agencies to embed the Guidance with their workforce, a series of multi-agency virtual webinars are scheduled for summer/autumn 2021. These webinars will be the same across the Southampton, Hampshire, Isle of Wight, and Portsmouth areas to ensure a consistent message and will be complemented by an e-learning package which will be available towards the end of 2021.

## 8. Adult Social Care Safeguarding Adult Collection Data (S.A.C.) Return Data

A ***safeguarding concern*** is where there is reasonable cause to suspect that an adult with care and support needs is at risk of or is experiencing abuse or neglect, and due to their care and support needs, is unable to protect themselves from the abuse or neglect.

A safeguarding concern can be raised by anyone. In 2020/21, 3660 safeguarding referrals were received, which is an small decrease from 3709 recorded in 2019/20.

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

**Safeguarding enquiries**
The action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. Can range from a conversation with the adult to a more formal multi-agency plan or action. There are two types:
• Section 42 – where the adult meets all of the section 42 criteria.
• Other – where adult does not meet all of section 42 criteria, but the local authority considers it necessary and proportionate to have a safeguarding enquiry.

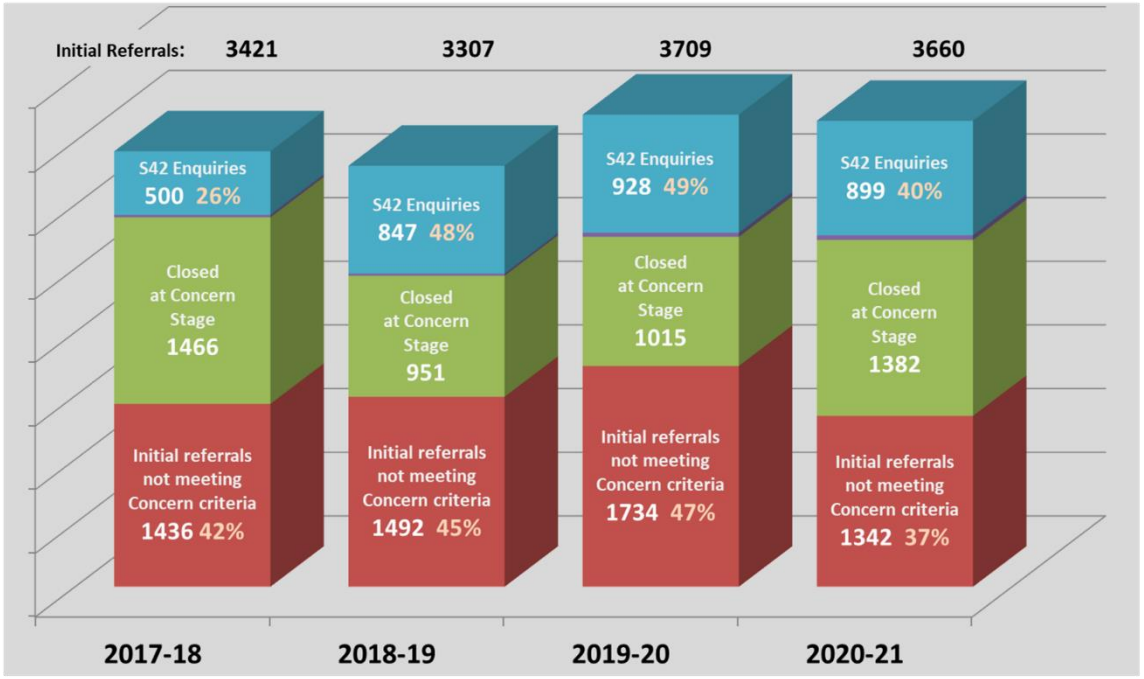


***Figure 1 – Overall Referrals Analysis***

The data in figure indicates that the number of inappropriate referrals ('initial referrals not meeting concern criteria') has reduced from 47% to 37%.

In 2020/2021, the Safeguarding Adults Board launched new 4LSAB Safeguarding Concerns Guidance with the aim of reducing inappropriate referrals. The guidance has been launched alongside multi-agency training sessions, which will continue into 2021/2022.

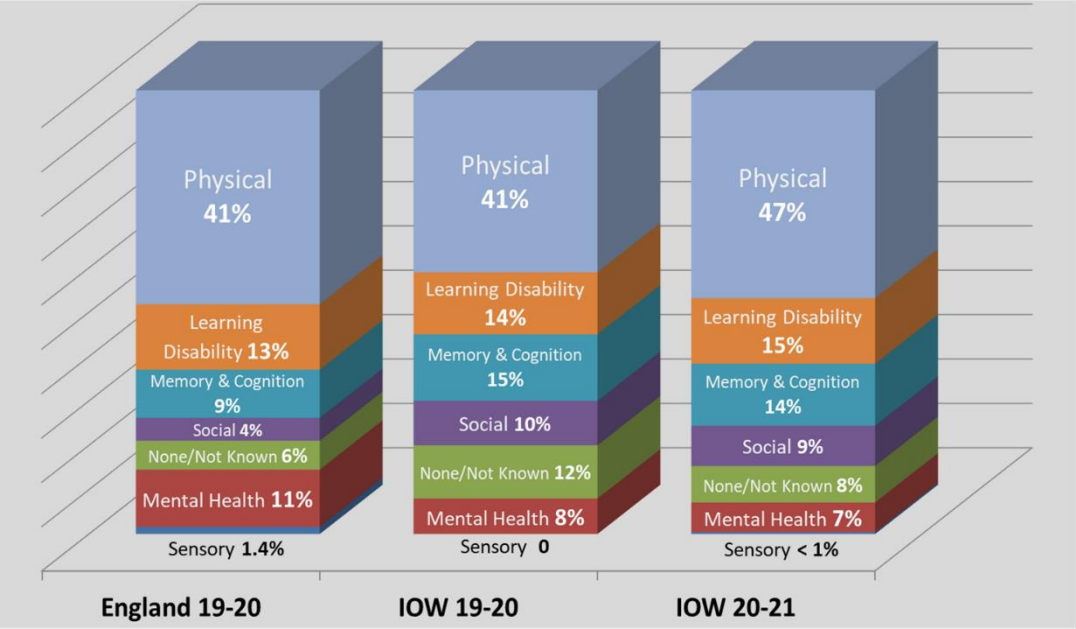


***Figure 2 – Reasons for primary support***

Figure 2 shows the figures for primary support reason for 2019/2020, 2020/2021, and also the national average for 2019/2020 for comparison.

The proportion of recorded primary support reason of Physical Support is similar to last year, but the percentage of individuals where the support reason is Not Known has reduced from 12% to 8%. This is a further reduction from the 2018/2019 figure of 29%.

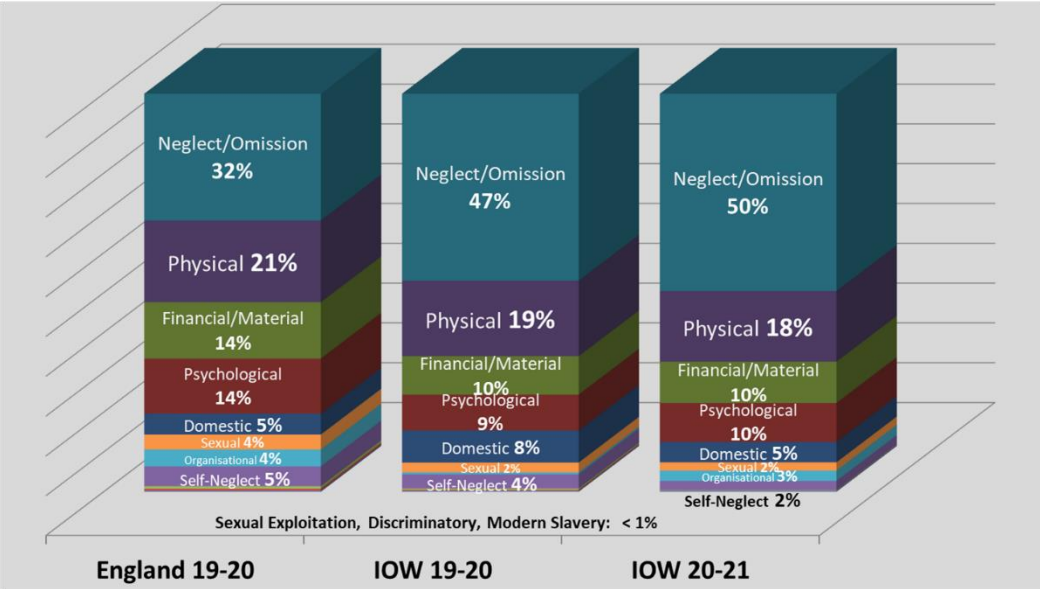


***Figure 3 – Type of Risk***

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

The most common type of risk is Neglect and Omission which follows the England trend – however, the Island figures are significantly higher, a trend which has emerged over the last few years.

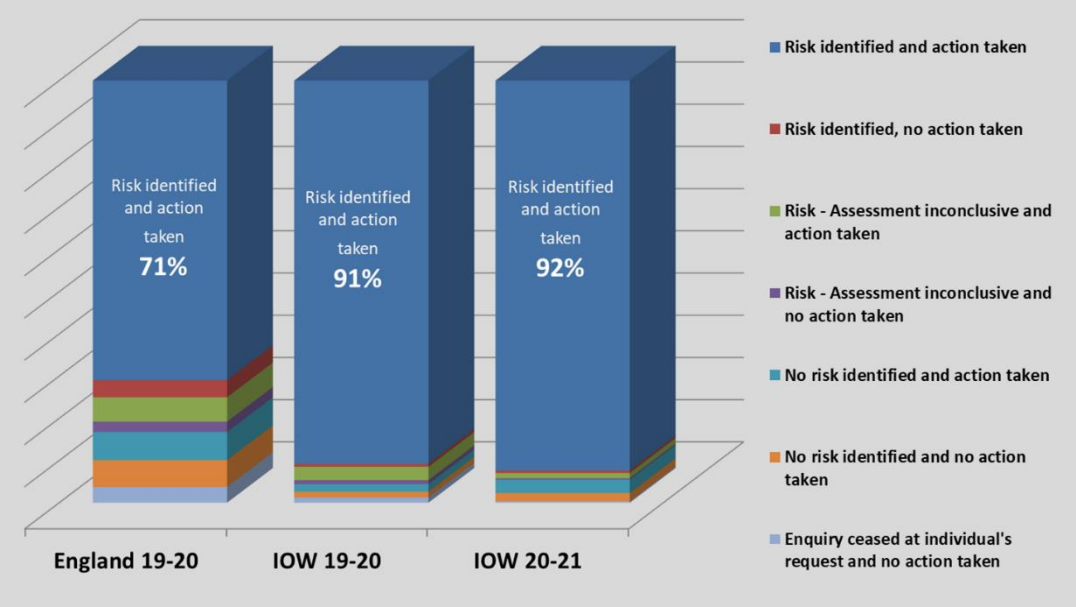


***Figure 4a – Risk Assessment Outcomes***

Figure 4a shows that the Isle of Wight has a very high figure for "Risk Identified/Action Taken" at 92%. This is significantly higher than the England average of 71%.

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

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

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

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

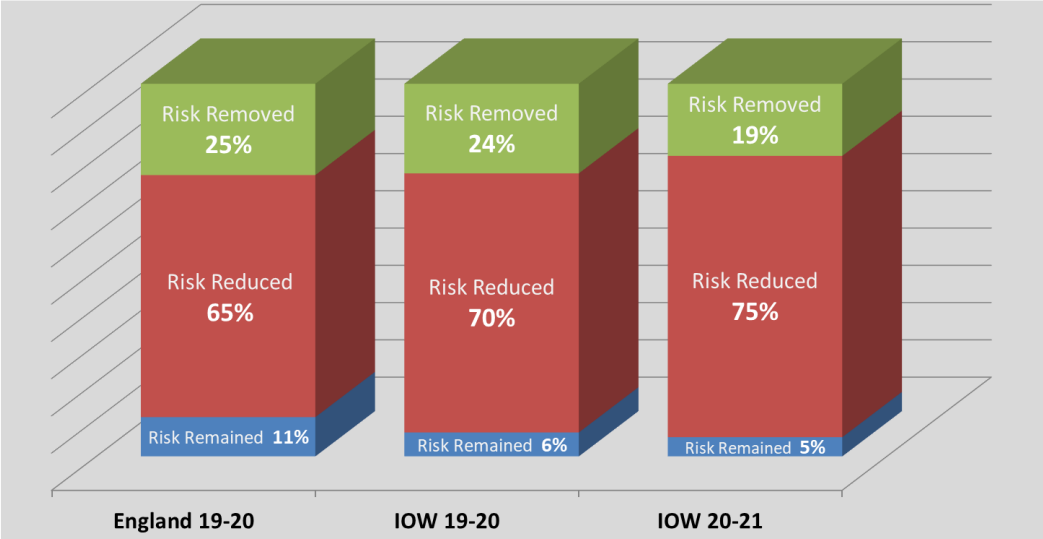


Figure 4b shows what happened in cases where risk was identified.

The 'Risk Remained' is at 5% and is not expected to ever be zero, as there can always be contention between removal of risk and the desired outcome. The adult at risk may not wish for the situation where the risk is completely removed – e.g. the adult at risk does not wish for the removal of an abusive partner/carer.

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

**Figure 4b – *Risk Assessment Outcomes continued***

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

**Risk removed** - The circumstance causing the risk has been completely removed so that the individual is no longer subject to that specific risk, for example if a care worker in a care home is the perpetrator and they are dismissed as a result of their behaviour.

## 9. Domestic Abuse

The Safeguarding Adults Board fund a Domestic Abuse Project Officer whose role is hosted by the IOW Council's Community Safety Team. Their role is to work alongside the multi-agency Domestic Abuse Forum to achieve a reduction in domestic abuse and an increase in reporting, to support the forum to develop effective and sustainable links with partner agencies, both statutory and voluntary and with the Community Safety Partnership (CSP) and safeguarding boards, ensuring their participation in the strategy and wider domestic abuse initiatives.

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

One of the key actions identified by the agencies within the Forum was the need to have a clear referral pathway highlighting the support available for those experiencing domestic abuse. The Hampshire pathway was adapted, and an IOW version created to ensure agencies have a better understanding of the referral process and are confident at signposting for support. The IOW referral pathway was shared with the Forum and circulated via partners. It has been added to the webpages and is regularly shared within Newsletters and updates. It was shared with schools on their return in September 2020.

The forum has also been working on the following key priorities:

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

## 9.1 Covid-19 related impact on Domestic Abuse Services

There have been 3 National Lockdowns during 2020/2021 due to the COVID-19 pandemic which has increased the impact on survivors. The IOW Council domestic abuse webpages were updated to reflect the change in delivery from services due to Covid-19. It was also regularly updated with the latest information to ensure anyone accessing those pages received the correct information. In addition, social media was regularly used to promote the support available.

There were two press releases through the local press - “Services still available for victims of domestic abuse during the Coronavirus pandemic” and “Surge in calls to Island Domestic abuse services during Coronavirus lockdown”. The aim was to raise awareness of the impact of Covid-19 on the domestic abuse services, and to inform the community that support was still available to anyone that needed it. The press releases highlighted the impact on victims in lockdown and how perpetrators were using this as a means of control. As a result of these press releases, there was an opportunity to speak on Isle of Wight radio in April to discuss the support for victims of domestic abuse. This was a live interview in which some of the issues for victims in lockdown were discussed, as was the support that was available locally.

## 9.2 Key Campaigns

**Elder Abuse Day – 15th June 2020**

To increase awareness in the elderly and vulnerable community and increase referrals for support. This was a month-long campaign with a press release, radio interview, weekly social media messages and bus stop posters.

**Impact on Children Campaign - October 2020**

To increase awareness of the impact on children experiencing domestic abuse at home and the support services available. Posters and information were circulated to all schools and early years providers with the DA Referral pathway and access to free e-learning.

**16 Days of Action Against Domestic Violence – November/December 2020**

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

- Increased awareness of Dragonfly Project and promoted free daily training sessions run by You First
- Free Zoom taster session on Freedom programme facilitated by WightDASH which was well attended and resulted in new referrals
- Promoted information sharing across agencies including adult and children's workforces
- Bus stop advertising of 3 sites using consistent branding and images to promote a fully inclusive service, including perpetrator programme details
- Developed campaign material to specifically highlight the effect it has on those impacted by DVA
- Employers' packs and promotional material posted to all main supermarkets - 25 in total across the Island
- Email pack with posters and local support sent to all schools alongside a competition to raise awareness
- Posters sent to Health Care providers to display
- Press release to introduce the campaign
- Facebook and Instagram posts with daily stories covering a wide range of DA issues. 16 individual graphics were created to introduce a different topic each day throughout the campaign. The 16 stories introduced a different topic through a question or fact encouraging the reader to find out more. The Facebook reach for this was 10,851 with 14,790 people viewing the stories. There was an Instagram reach of 297 with 625 people who viewed the story. This was a new type of campaign for the IOW Council and was not something that they had previously attempted. In a previous campaign 16 feed posts had been created but data suggests these stories worked really well to keep interest and give interactive ways for people learning about the different topics and support.
- IOW Council website utilised and signposted too

## 10. National Adult Safeguarding Awareness Week

In November 2020, there was a week-long campaign coordinated across the Isle of Wight, Hampshire, Southampton, and Portsmouth area to raise awareness of adult safeguarding through a set of locally relevant themes. On the Island, the awareness raising and sharing of resources for professionals was led by the Safeguarding Adults Board, and the accompanying messages for the public were shared by Isle of Wight Council starting with a radio interview with the ASC Assistant Director Laura Gaudion to introduce the week to the public and publicise the support available and where to get help. The themes for the week were:

**Day 1 - Prevention and safeguarding in local communities**

Living a life that is free from harm and abuse is a fundamental right of every person. All agencies and organisations across Southampton, Hampshire, Isle of Wight, and Portsmouth must be committed to preventing abuse and neglect, raising safeguarding concerns and putting adults at the centre of our work. Messages under this theme included:

- What is Adult Safeguarding?
- What do we Mean by Care & Support needs?
- Promotion of the Animated Scribe Video
- Preventing Abuse and Neglect
- Impact of vulnerability on an adult's ability to protect themselves from abuse or neglect

**Day 2 – Loneliness and Social Isolation**

Over 9 million people in the UK across all adult ages – more than the population of London – are either always or often lonely. Half a million older people go at least five or six days a week without seeing or speaking to anyone at all. Individuals who are lonely or socially isolated may be vulnerable and open to forms of abuse such as scams and financial abuse.

**Day 3 - Mental health**

It has never been more important for all of us to look after our mental health – as professionals working with people with mental health needs and as individuals to check in on our own mental health. Day 3 focussed on Mental Health as part of National Safeguarding Week and distributed a range of local and national resources to promote awareness of good practice as individuals and when working with people with mental health issues.

**Day 4 - Fraud, Scams and Cybercrime**

For this day, the messages and resources were provided by IWASP – the Isle of Wight Against Scams Partnership, whose webpage includes links to professionals training and resources, as well as scams awareness information for the public to help keep themselves safe and let them know where to report scams and financial abuse.

**Day 5 - Domestic abuse**

A key part of day 5 was to publicise and promote the Domestic Abuse Referral Pathway which is there to help professionals make referrals to services for domestic abuse. Other resources from Safe Lives were shared, including a report on domestic abuse and mental health, highlighting the additional barriers people experiencing mental health problems will face with making a disclosure, being believed, and accessing services.

A support guide for practitioners and managers produced by the Local Government Association was also widely shared. The purpose of this guide is to help staff to give better informed and more effective support to people who need an adult safeguarding service because of domestic abuse. It addresses situations where an adult who has care and support needs is being harmed or abused by an intimate partner or close family member in a way which could also be defined as domestic abuse.

**Day 6 - Homelessness**

This day focussed on some key resources and briefings for professionals around supporting people who are homeless and experiencing abuse and neglect, including:

**Adult safeguarding and homelessness: A briefing on positive practice**

The purpose of this briefing from the Local Government Association is to assist senior leaders, such as members of Safeguarding Adults Boards (SABs), as well as commissioners, practitioners and operational managers who are working across relevant sectors and agencies in this field, to support people who are homeless and at risk of or experiencing abuse or neglect. This briefing includes learning from SARs.

**Rethinking Rough Sleeping in the Pandemic**

This open access article from RiP (Research in Practice) talks about homelessness in the light of the pandemic, and lists 4 key recommendations and examples of new challenges relating to Covid:

- Working together locally towards systems and culture change to support joined-up working across teams
- Ensuring people with care and support needs are at the centre of decision making
- Ensuring practitioners are informed and supported
- Raising public awareness of the issue of rough sleeping and challenging bias

**Shelter's National Homeless Advice Service**

Shelter's National Homelessness Advice provide FREE expert advice, training and support to professionals working in local authorities, voluntary advice agencies and public authorities in England. Funded by the Ministry for Housing, Communities and Local Government (MHCLG) and delivered by Shelter, their team is available to help professionals and voluntary sector agencies deal with a wide range of issues that can impact on an individual's housing situation, delivered in a way that is tailored to your level of knowledge and that can be practically applied in your role.

They offer a series of free 90-minute webinars via Zoom on subjects such as Casework skills: Good practice, Introduction to Welfare Benefits, Dealing with Landlord Harassment and Unlawful Eviction, suspending a warrant, and Recognising Coercive Control.

**Day 7 - Family approach**

The final day of the campaign centred around the 4LSAB/4LSCP Family Approach Protocol and Toolkit. Safeguarding people across our island means that professionals need to take a Family Approach when supporting people at risk of harm. A Family Approach is one that secures better outcomes for children (including unborn babies), adults with care and support needs, children, and their families by co-ordinating the support they receive from Adult and Children and Family Services. The support provided by these services should be focused on problems affecting the family as this is the only effective way of working with families experiencing the most significant problems.

## 11. Joint Work with the LSCP

There is a strong working relationship between the two LSCP and SAB Board Chairs, SAB Coordinator and LSCP Partnership Manager with regular liaison meetings held. Because the IOW is small, there is some shared membership across the SAB and LSCP Boards, and this aids communication and understanding of the adults and children's safeguarding agendas and the commitment to a Family Approach to services on the IOW.

The SAB and LSCP run joint Workforce Development and Health subgroups. This has made joint planning for training, including pooled budgets possible and ensures that both Boards are aware of each other's training priorities and can offer a wider range of inputs to front line staff. Areas of commonality are identified and where possible joint training organised.

### 11.1 Joint Health Sub-group

Although the primary focus of the sub-group in this financial year was to look at the risks, challenges and opportunities arising during the Covid-19 pandemic, the group also received a key report on the National LeDeR (Learning Disability Mortality (death) Review) Programme. Of the 9 Isle of Wight cases which had been reviewed and closed, it was found that 1 received excellent care, 4 received good care, and 3 received satisfactory care. In the 1 remaining case, it was identified that the care the individual received fell short of expected good practice and although this impacted on their wellbeing, it did not contribute to their death. The recommendations, themes and learning from these reviews go to the Learning Disability Strategy Group.

### 11.2 Learning Needs Analysis

In November 2020, a joint Learning Needs Analysis was undertaken with partner agencies to:

- Evaluate the current training programme
- Identify gaps

- Consider learning needs from both business plans as well as the SAB Covid Assurance Framework
- Learning outcomes from audits
- Learning outcomes from reviews
- Learning needs identified in other sub-groups
- Learning needs relating to any new policies and procedures
- Learning needs identified from the Missed Opportunities Conference on Domestic Abuse

The Learning Needs Analysis took the form of a workshop, with agencies also able to share learning needs identified within their own service. From this multi-agency workshop, the following themes for training were identified and will frame the 2021/2022 training calendar for both the SAB and the SCP:

- MARM (Multi-agency Risk Management)
- MSP (Making Safeguarding Personal)
- Self-neglect
- Training on the new Safeguarding Concerns Guidance
- Fire Safety Framework and Safe & Well Visits
- Domestic abuse: Needs of Elderly and Vulnerable communities with complex needs/disabilities
- Hoarding
- The Family Approach
- Safeguarding and LGBT+
- Safeguarding in Transitions
- Mental Capacity (16+)

Courses will be offered as joint adults/children where appropriate to ensure both workforces receive a consistent message and are aware of their responsibilities to safeguarding both children and adults at risk.

**11.3 Safeguarding in Transition**

Transition to adulthood can be a particularly challenging and vulnerable time, and it is possible to need care and support without having 'Care and Support' needs which form part of the Care Act statutory safeguarding criteria. Harm, and its effects, do not stop at the age of 18 but in reality, support does stop at 18 for many young adults. Child and adult safeguarding systems are conceptually and procedurally different, governed by different statutory frameworks. Experience shows that young people entering adulthood can experience a 'cliff-edge' in terms of support, exacerbated by the notable differences between thresholds/eligibility criteria of children's and adults' safeguarding. This makes the transition to adulthood harder for young people facing ongoing risk and possibly harder for professionals trying to navigate an effective approach to help them.

It has been recognised that a clear and consistent overarching multi-agency policy and guidance on managing safeguarding concerns during transition is needed. Underneath this, there is scope for each local authority area to 'localise' and develop its own business process. The production of this policy and guidance will be a joint piece of work across the whole SHIP area – Southampton, Hampshire, IOW, and Portsmouth – and will have input from both the adults and children's leads. Initial scoping has taken place, with work scheduled for 2021/2022.

**11.4 LADO support to SAMA Network**

The 4LSAB SAMA (Safeguarding Allegations Management Advisor) network meets every 2 months, with representatives from a range of agencies across the SHIP area who manage allegations against people in positions of trust. This strategic group looks at policies and guidance, discusses training and also looks at anonymised historic cases as a learning exercise. Although a sub-group of the SABs, this group has regular attendance from one or more of the LADOs across the SHIP area. Their input has been invaluable to understand the similarities and differences between adult and child processes, but also where procedures can be linked up between the LADOs and SAMAs to ensure referrals are made and information is shared in operational practice where necessary.

## 12. 4LSAB Work

### 12.1 Self-neglect resources

One of the priority areas for the 4LSAB in 2020/2021 was self-neglect, and in Autumn 2020 September SAB led on the development of two new resources for professionals – a One Minute Guide to Self-Neglect, and a Self-Neglect Learning Briefing. Both of these documents were launched across the 4LSAB area in September 2020, and have proved to be useful documents for both statutory agencies and the voluntary and community sector. The One Minute Guide sets out how to spot signs of self-neglect, with examples such as poor diet and nutrition, refusing necessary help from health and social care, rodent infestation, and potential fire hazards due to lack of household maintenance. The guide also includes local referral numbers, and has links to local and national policies.

The learning briefing contains links to local Safeguarding Adults Reviews where self-neglect was a factor, and highlights the key learning from these reviews and how they should be incorporated into professional practice. The briefing covers the relevant legal literacy and legislation, as well as best practice guidance for working with individual who may showing signs of self-neglect.

### 12. 2 Learning and Development Strategy

Throughout 2020, the 4LSAB Workforce Development Group worked collaboratively on refreshing the 4LSAB Multi-agency learning and Development Guidance. The guidance was published in November 2020, and is designed to support the development of best practice in relation to safeguarding adults across Southampton, Hampshire, Isle of Wight, and Portsmouth.

The guidance has been informed by the requirements outlined in the following relevant legislation and guidance, and has been designed to help inform both single-agency and multi-agency safeguarding learning and development plans:

- The Care Act (2014) (England) Statutory Guidance.
- The Care Act (2014) introduced the first statutory framework for adult safeguarding which enacted the principle that safeguarding the responsibility of all agencies and requires them to adopt a proportionate, transparent outcome focused approach. The Act also establishes 'Making Safeguarding Personal', as core practice. This demands a move away from procedurally driven safeguarding to an approach in which the adult and their wishes shape and drive safeguarding activity in order to achieve the outcomes they want.
- Hampshire, IOW, Portsmouth, and Southampton 4LSAB Multi-Agency Safeguarding Adults Policy and Guidance and toolkit (Hampshiresab.org.uk, 2016).
- Adult Safeguarding: Statement of Government Policy (GOV.UK, 2011).
- Roles and Responsibilities in Adult Safeguarding in Health and Care Services (CQC, 2014).
- Safeguarding Adults, a National Framework of Standards for Good Practice and Outcomes in Adult Protection Work (ADASS, 2005).
- The National Competency Framework for Safeguarding Adults (NCPQSW, 2015)  The Bournemouth Document
- Adult Safeguarding: Roles and Competencies for Health Care Staff: Intercollegiate Document (RCN, 2018).

The guidance seeks to establish a consistent approach across agencies and can be used as a reference tool to benchmark training provision. It also references the requirement to revise implementation methods and prioritisation of training topics to deliver adult safeguarding training during a pandemic such as Covid-19.

**12.3 SAMA (Safeguarding Allegations Management Advisor) Network**

The 4LSAB SAMA Network has continued to strengthen in 2020/2021, with a meeting every 2 months chaired by the IOWSAB Board Manager. SAMAs are key individuals within each agency who deal with cases of allegations against people in positions of trust. Although not a statutory requirement, the Board strongly advise that each agency should have a SAMA.

With key representatives from across the 4 areas, the network has worked on a range of projects in 2020/2021:

- Reviewed and updated the SAMA webpage
- Discussion and presentation on single-agency SAMA polices to identify gaps and challenges in the process, and to provide guidance for those agencies that don't yet have a single-agency policy
- Devised a referral form for historic cases to be referred to the group for learning
- Guest presentation on Professional Boundaries and Violations
- Presentation and Q&A session with DBS (Disclosure & Barring Service)

**Appendix A – Safeguarding Adult Collection 2020/2021 Data Return**

| Table SG1a | Age Band | | | | | | |
|---|---|---|---|---|---|---|---|
| **Counts of Individuals by Age Band** | **18-64** | **65-74** | **75-84** | **85-94** | **95+** | **Not Known** | **Total** |
| Individuals Involved in Safeguarding Concerns | 773 | 237 | 381 | 370 | 79 | 0 | **1840** |
| Individuals Involved in Section 42 Safeguarding Enquiries | 224 | 90 | 167 | 199 | 37 | 0 | **717** |
| Individuals Involved in Other Safeguarding Enquiries | 7 | 4 | 11 | 11 | 4 | 0 | **37** |

| Table SG1b | Gender | | | |
|---|---|---|---|---|
| **Counts of Individuals by Gender** | **Male** | **Female** | **Not Known** | **Total** |
| Individuals Involved in Safeguarding Concerns | 757 | 1083 | 0 | **1840** |
| Individuals Involved in Section 42 Safeguarding Enquiries | 304 | 413 | 0 | **717** |
| Individuals Involved in Other Safeguarding Enquiries | 20 | 17 | 0 | **37** |

| Table SG1c | Ethnicity | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Counts of Individuals by Ethnicity** | **White** | **Mixed / Multiple** | **Asian / Asian British** | **Black / African / Caribbean / Black British** | **Other Ethnic Group** | **Refused** | **Undeclared / Not Known** | **Total** |
| Individuals Involved in Safeguarding Concerns | 1556 | 6 | 8 | 5 | 3 | 0 | 262 | **1840** |
| Individuals Involved in Section 42 Safeguarding Enquiries | 632 | 1 | 6 | 1 | 1 | 0 | 76 | **717** |
| Individuals Involved in Other Safeguarding Enquiries | 35 | 0 | 0 | 0 | 0 | 0 | 2 | **37** |

| Table SG1d | Primary Support Reason | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Counts of Individuals by Primary Support Reasons** | **Physical Support** | **Sensory Support** | **Support with Memory & Cognition** | **Learning Disability Support** | **Mental Health Support** | **Social Support** | **No Support Reason** | **Not Known** | **Total** |
| Individuals Involved in Safeguarding Concerns | 704 | 7 | 183 | 200 | 201 | 315 | 230 | 0 | **1840** |
| Individuals Involved in Section 42 Safeguarding Enquiries | 336 | 3 | 100 | 106 | 48 | 65 | 59 | 0 | **717** |
| Individuals Involved in Other Safeguarding Enquiries | 17 | 0 | 5 | 0 | 2 | 2 | 11 | 0 | **37** |

| Table SG1e | | | | | |
|---|---|---|---|---|---|
| **Counts of Individuals by Reported Health Conditions** | **Sub-class** | **Individuals Involved in Safeguarding Concerns** | **Individuals Involved in Section 42 Safeguarding Enquiries** | **Individuals Involved in Other Safeguarding Enquiries** | **Total Enquiries** |
| Long Term Health condition - Physical | Chronic Obstructive Pulmonary Disease | 0 | 0 | 0 | **0** |
| Long Term Health condition - Physical | Cancer | 0 | 0 | 0 | **0** |
| Long Term Health condition - Physical | Acquired Physical Injury | 0 | 0 | 0 | **0** |
| Long Term Health condition - Physical | HIV / AIDS | 0 | 0 | 0 | **0** |
| Long Term Health condition - Physical | Other | 0 | 0 | 0 | **0** |
| Long Term Health condition - Neurological | Stroke | 0 | 0 | 0 | **0** |
| Long Term Health condition - Neurological | Parkinson's | 0 | 0 | 0 | **0** |
| Long Term Health condition - Neurological | Motor Neurone Disease | 0 | 0 | 0 | **0** |

| | | | | | |
|---|---|---|---|---|---|
| Long Term Health condition - Neurological | Acquired Brain Injury | 0 | 0 | 0 | **0** |
| Long Term Health condition - Neurological | Other | 0 | 0 | 0 | **0** |
| Sensory Impairment | Visually impaired | 0 | 0 | 0 | **0** |
| Sensory Impairment | Hearing impaired | 0 | 0 | 0 | **0** |
| Sensory Impairment | Other | 0 | 0 | 0 | **0** |
| Learning, Developmental or Intellectual Disability | Learning Disability | 0 | 0 | 0 | **0** |
| Learning, Developmental or Intellectual Disability | Autism (excluding Asperger's Syndrome / High Functioning Autism) | 64 | 30 | 0 | **30** |
| Learning, Developmental or Intellectual Disability | Asperger's Syndrome/ High Functioning Autism | 2 | 1 | 0 | **1** |
| Learning, Developmental or Intellectual Disability | Other | 0 | 0 | 0 | **0** |
| Mental Health Condition | Dementia | 0 | 0 | 0 | **0** |

| | | | | | |
|---|---|---|---|---|---|
| Mental Health Condition | Other | 0 | 0 | 0 | **0** |
| No Relevant Long-Term Reported Health Conditions | None | 0 | 0 | 0 | **0** |
| | | **66** | **31** | **0** | |

**Please note Table SG1f collects counts of cases not counts of individuals**

| **Table SG1f** | |
|---|---|
| **Counts of Safeguarding Activity** | **Count** |
| Total Number of Safeguarding Concerns | 2319 |
| Total Number of Section 42 Safeguarding Enquiries | 899 |
| Total Number of Other Safeguarding Enquiries | 37 |

| Table SG2a | Concluded Section 42 Enquiries | | | Other Concluded Enquiries | | | | |
|---|---|---|---|---|---|---|---|---|
| Counts of Enquiries by Type and Source of Risk | Source of Risk | | | Source of Risk | | | | |
| | Service Provider | Other - Known to Individual | Other - Unknown to Individual | Service Provider | Other - Known to Individual | Other - Unknown to Individual | Total Section 42 | Total Other |
| Physical Abuse | 27 | 112 | 17 | 0 | 0 | 1 | **156** | **1** |
| Sexual Abuse | 1 | 14 | 3 | 0 | 0 | 0 | **18** | **0** |
| Psychological Abuse | 27 | 51 | 8 | 0 | 0 | 0 | **86** | **0** |
| Financial or Material Abuse | 10 | 76 | 5 | 0 | 1 | 0 | **91** | **1** |
| Discriminatory Abuse | 0 | 0 | 1 | 0 | 0 | 0 | **1** | **0** |
| Organisational Abuse | 20 | 1 | 2 | 1 | 0 | 0 | **23** | **1** |
| Neglect and Acts of Omission | 249 | 131 | 55 | 9 | 11 | 3 | **435** | **23** |
| Domestic Abuse | | 45 | | | 2 | | **45** | **2** |
| Sexual Exploitation | 0 | 1 | 0 | 0 | 0 | 0 | **1** | **0** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Modern Slavery | 0 | 2 | 0 | 0 | 0 | 0 | **2** | **0** |
| Self-Neglect | | 20 | | | 1 | | **20** | **1** |

| **Table SG2b** | **Concluded Section 42 Enquiries** | | | **Other Concluded Enquiries** | | | | |
|---|---|---|---|---|---|---|---|---|
| **Counts of Enquiries by Location and Source of Risk** | **Source of Risk** | | | **Source of Risk** | | | | |
| | **Service Provider** | **Other - Known to Individual** | **Other - Unknown to Individual** | **Service Provider** | **Other - Known to Individual** | **Other - Unknown to Individual** | **Total Section 42** | **Total Other** |
| Own Home | 82 | 210 | 10 | 1 | 6 | 0 | **302** | **7** |
| In the community (excluding community services) | 3 | 19 | 3 | 0 | 0 | 0 | **25** | **0** |
| In a community service | 17 | 8 | 2 | 0 | 1 | 0 | **27** | **1** |
| Care Home - Nursing | 60 | 36 | 9 | 5 | 0 | 0 | **105** | **5** |
| Care Home - Residential | 166 | 125 | 23 | 4 | 5 | 0 | **314** | **9** |
| Hospital - Acute | 1 | 15 | 26 | 0 | 3 | 2 | **42** | **5** |
| Hospital - Mental Health | 0 | 8 | 1 | 0 | 0 | 1 | **9** | **1** |
| Hospital - Community | 1 | 2 | 15 | 0 | 0 | 1 | **18** | **1** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Other | 4 | 30 | 2 | 0 | 0 | 0 | **36** | **0** |

| **Table SG2a_b1** | **Concluded Section 42 Enquiries** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Counts of Enquiries by Type and Location of Risk** | **Location of Risk** | | | | | | | | | |
| | **Own Home** | **In the community (excluding community services)** | **In a community service** | **Care Home - Nursing** | **Care Home - Residential** | **Hospital - Acute** | **Hospital - Mental Health** | **Hospital - Community** | **Other** | **Total Section 42** |
| Physical Abuse | 17 | 6 | 4 | 31 | 90 | 0 | 3 | 3 | 2 | **156** |
| Sexual Abuse | 12 | 1 | 1 | 2 | 1 | 0 | 0 | 0 | 1 | **18** |
| Psychological Abuse | 37 | 4 | 1 | 9 | 22 | 1 | 2 | 1 | 9 | **86** |
| Financial or Material Abuse | 64 | 5 | 2 | 3 | 5 | 0 | 1 | 0 | 11 | **91** |
| Discriminatory Abuse | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| Organisational Abuse | 5 | 0 | 1 | 1 | 12 | 2 | 0 | 1 | 1 | **23** |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Neglect and Acts of Omission | 107 | 5 | 18 | 59 | 183 | 39 | 3 | 13 | 8 | **435** |
| Domestic Abuse | 41 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | **45** |
| Sexual Exploitation | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| Modern Slavery | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **2** |
| Self-Neglect | 18 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **20** |

| **Table SG2a_b2** | **Concluded Other Enquiries** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Counts of Enquiries by Type and Location of Risk** | **Location of Risk** | | | | | | | | | |
| | **Own Home** | **In the community (excluding community services)** | **In a community service** | **Care Home - Nursing** | **Care Home - Residential** | **Hospital - Acute** | **Hospital - Mental Health** | **Hospital - Community** | **Other** | **Total Other** |
| Physical Abuse | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | **1** |
| Sexual Abuse | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Psychological Abuse | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Financial or Material Abuse | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| Discriminatory Abuse | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Organisational Abuse | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| Neglect and Acts of Omission | 3 | 0 | 0 | 5 | 9 | 5 | 0 | 1 | 0 | **23** |
| Domestic Abuse | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **2** |
| Sexual Exploitation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Modern Slavery | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Self-Neglect | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |

| **Table SG2c** | **Concluded Section 42 Enquiries** | | | **Other Concluded Enquiries** | | | | |
|---|---|---|---|---|---|---|---|---|
| **Risk Assessment Outcomes: Was a risk identified and was any action taken / planned to be taken?** | **Source of Risk** | | | **Source of Risk** | | | **Total Section 42** | **Total Other** |
| | **Service Provider** | **Other - Known to Individual** | **Other - Unknown to Individual** | **Service Provider** | **Other - Known to Individual** | **Other - Unknown to Individual** | | |
| Risk identified and action taken | 299 | 428 | 84 | 4 | 11 | 3 | **811** | **18** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Risk identified and no action taken | 1 | 3 | 1 | 0 | 0 | 0 | **5** | **0** |
| Risk - Assessment inconclusive and action taken | 4 | 6 | 1 | 4 | 0 | 0 | **11** | **4** |
| Risk - Assessment inconclusive and no action taken | 1 | 1 | 1 | 0 | 1 | 0 | **3** | **1** |
| No risk identified and action taken | 21 | 5 | 2 | 1 | 0 | 1 | **28** | **2** |
| No risk identified and no action taken | 8 | 7 | 2 | 1 | 3 | 0 | **17** | **4** |
| Enquiry ceased at individual's request and no action taken | 0 | 3 | 0 | 0 | 0 | 0 | **3** | **0** |

| **Table SG2e** | **Concluded Section 42 Enquiries** | | | **Other Concluded Enquiries** | | | | |
|---|---|---|---|---|---|---|---|---|
| **Risk Outcomes:**<br>**Where a risk was identified, what was the outcome / expected outcome when the case was concluded?** | **Source of Risk** | | | **Source of Risk** | | | | |
| | **Service Provider** | **Other - Known to Individual** | **Other - Unknown to Individual** | **Service Provider** | **Other - Known to Individual** | **Other - Unknown to Individual** | **Total Section 42** | **Total Other** |
| Risk Remained | 5 | 36 | 1 | 0 | 1 | 0 | **42** | **1** |
| Risk Reduced | 225 | 323 | 68 | 3 | 7 | 1 | **616** | **11** |
| Risk Removed | 70 | 72 | 16 | 1 | 3 | 2 | **158** | **6** |

| Table SG3a | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Mental Capacity Table for Concluded Section 42 Safeguarding Enquiries** | **Age Group** | | | | | | |
| For each enquiry, was the adult at risk lacking capacity to make decisions related to the safeguarding enquiry? | **18-64** | **65-74** | **75-84** | **85-94** | **95+** | **Not Known** | **Total** |
| Yes, they lacked capacity | 101 | 34 | 103 | 150 | 24 | 0 | **412** |
| No, they did not lack capacity | 196 | 56 | 87 | 98 | 18 | 0 | **455** |
| Don't know | 2 | 0 | 1 | 0 | 0 | 0 | **3** |
| Not recorded | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| | | | | | | | |
| Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases was support provided by an advocate, family or friend? | 96 | 32 | 101 | 145 | 21 | 0 | **395** |

| Table SG3b | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Mental Capacity Table for Other Concluded Safeguarding Enquiries** | **Age Group** | | | | | | |
| For each enquiry, was the adult at risk lacking capacity to make decisions related to the safeguarding enquiry? | **18-64** | **65-74** | **75-84** | **85-94** | **95+** | **Not Known** | **Total** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Yes, they lacked capacity | 1 | 1 | 4 | 6 | 2 | 0 | **14** |
| No, they did not lack capacity | 4 | 0 | 1 | 2 | 1 | 0 | **8** |
| Don't know | 1 | 0 | 1 | 2 | 2 | 0 | **6** |
| Not recorded | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| | | | | | | | |
| Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases was support provided by an advocate, family or friend? | 1 | 1 | 3 | 3 | 1 | 0 | **9** |

| **Table SG4a** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **MSP Table for Concluded Section 42 Safeguarding Enquiries** | **Age Group** | | | | | | |
| **For each enquiry, was the individual or individual's representative asked what their desired outcomes were?** | **18-64** | **65-74** | **75-84** | **85-94** | **95+** | **Not Known** | **Total** |
| Yes, they were asked, and outcomes were expressed | 204 | 63 | 128 | 166 | 23 | 0 | **584** |
| Yes, they were asked but no outcomes were expressed | 71 | 22 | 49 | 70 | 12 | 0 | **224** |
| No | 15 | 4 | 9 | 8 | 5 | 0 | **41** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Don't know | 2 | 0 | 0 | 0 | 1 | 0 | **3** |
| Not recorded | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases were the desired outcomes achieved?** | **18-64** | **65-74** | **75-84** | **85-94** | **95+** | **Not Known** | **Total** |
| Fully Achieved | 146 | 48 | 98 | 131 | 17 | 0 | **440** |
| Partially Achieved | 57 | 15 | 29 | 32 | 5 | 0 | **138** |
| Not Achieved | 1 | 0 | 1 | 3 | 1 | 0 | **6** |

| **Table SG4b** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **MSP Table for Other Concluded Safeguarding Enquiries** | **Age Group** | | | | | | |
| **For each enquiry, was the individual or individual's representative asked what their desired outcomes were?** | **18-64** | **65-74** | **75-84** | **85-94** | **95+** | **Not Known** | **Total** |
| Yes, they were asked, and outcomes were expressed | 4 | 1 | 3 | 3 | 3 | 0 | **14** |
| Yes, they were asked but no outcomes were expressed | 2 | 0 | 1 | 1 | 1 | 0 | **5** |
| No | 0 | 0 | 2 | 6 | 1 | 0 | **9** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Don't know | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Not recorded | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases were the desired outcomes achieved?** | **18-64** | **65-74** | **75-84** | **85-94** | **95+** | **Not Known** | **Total** |
| Fully Achieved | 1 | 0 | 1 | 1 | 1 | 0 | **4** |
| Partially Achieved | 1 | 1 | 2 | 1 | 2 | 0 | **7** |
| Not Achieved | 2 | 0 | 0 | 1 | 0 | 0 | **3** |

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

| **Table SG5b** | **Age Group** | | | | | | |
|---|---|---|---|---|---|---|---|
| **Counts of Individuals Involved in Safeguarding Adult Reviews** | **18-64** | **65-74** | **75-84** | **85-94** | **95+** | **Not Known** | **Total** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Count of individuals involved in SARs who suffered serious harm and died | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Count of individuals involved in SARs who suffered serious harm and survived | 1 | 0 | 0 | 1 | 0 | 0 | **2** |

**Appendix B – Outline Business Plan 2020/2021**

# Isle of Wight
# Safeguarding Adults Board

# Business Plan
# 2021 - 2022

## 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 act 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

**Our strategic aims for the next three years.**

- **Prevent abuse** - how can we engage with the community so that they recognise abuse; how can we reduce social isolation (so that people and communities are stronger)
- **Protect adults at risk** - staff are trained properly; raise community awareness of what to do; maximise the use of technology in practice (e.g., online tools)
- **Learn from experience** - MSP; quality assurance systems; learn from service users and carers; review when things go wrong.
- **Improve services** - information sharing and intelligence; consistent policies with neighbouring Boards in Southampton, Hampshire, and Portsmouth; national best practice; performance reporting to SAB.

## 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 area of focus for the Isle of Wight Safeguarding Adult Board over the next financial year. Much of the current business plan has been informed by the priorities in the 2020/2021 business plan which were carried over due to Covid.

### Safeguarding and Covid-19

We respect and acknowledge that services will be prioritising their response to Covid-19, and that some of the timescales for other SAB business may need to change as a result. As a Board, we will be seeking assurances around individual agency Covid response and recovery as one of our priorities.

**The areas of focus for 21/22 are:**

- Covid response and recovery
- Liberty Protection Safeguards (LPS)
- Making Safeguarding Personal
- Safeguarding Concerns

**Other work:**

- Health outcomes for people with a Learning Disability (including LeDer)
- Health outcomes for people who are homeless
- Links between SIRI's, SARs and Coroners Processes
- Meta-analysis of 'safe' CQC findings in care and nursing homes over the last 12 months – (to be started once the Quality Framework is up and running)
- Transitions (including care leavers)
- Learning Needs Analysis
- MAST (Including how the new Channel/Prevent Strategy will work without a MASH)
- Any other Audit work from SAR recommendations and themes identified by the QA&P Sub-group
- Continuing the lessons learned workshops for practitioners after Safeguarding Adult Reviews
- Themes identified from the Hidden Harm Task & Finish Group

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

**Safeguarding Adult Board – Main Board**

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

**Areas of Focus:**

- Covid recovery and response
- Liberty Protection Safeguarding (LPS)
- Making Safeguarding Personal
- Transitions
- Hidden Harm

| Area of Focus | Outcome | Action required | Lead | By when | Evidencing the outcome | Red/ Amber/ Green rating |
|---|---|---|---|---|---|---|
| Covid recovery and response | | | | | | |
| Liberty Protection Safeguarding (LPS) | | | | | | |
| Making Safeguarding Personal | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Transitions (including care leavers) | | | | | | |
| Hidden Harm | | | | | | |

| **Subgroup: 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<br><br>**Areas of Focus:**<br>• Safeguarding concerns<br>• MAST (Including how the new Channel/Prevent Strategy will work without a MASH)<br>• Meta-analysis of 'safe' CQC findings in care and nursing homes over the last 12 months<br>• Making Safeguarding Personal<br>• Any other Audit work from SAR recommendations and themes identified by the QA&P Sub-group<br>• Hidden harm |

| Area of Focus | Outcome | Action required | Lead | By when | Evidencing the outcome | Red/ Amber/ Green rating |
|---|---|---|---|---|---|---|
| Safeguarding concerns | | • | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| MAST (Including how the new Channel/Prevent Strategy will work without a MASH) | | | | | | |
| Meta-analysis of 'safe' CQC findings in care and nursing homes over the last 12 months | | | | | | |
| Making Safeguarding Personal | | | | | | |
| Any other Audit work from SAR recommendations and themes identified by the QA&P Sub-group | | | | | | |
| Hidden harm | | | | | | |

**Workforce Development Sub-Group (Joint with the LSCP)**

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

**Areas of Focus:**

- Liberty Protection Safeguarding (LPS)
- Making Safeguarding Personal
- Learning Needs Analysis
- Hidden Harm

| Area of Focus | Outcome | Action required | Lead | By when | Evidencing the outcome | Red/ Amber/ Green rating |
|---|---|---|---|---|---|---|
| Liberty Protection Safeguards (LPS) | | | | | | |
| Making Safeguarding Personal | | | | | | |
| Learning need analysis | | | | | | |
| Hidden harm | | | | | | |

**Subgroup: Safeguarding Adults Review (SAR)**

**Core Business:** supporting the IOW SAB Independent Chair in commissioning and overseeing Safeguarding Adult Reviews (SARs) and other reviews of practice and recommending ways in which the learning and improvement from such reviews can be embedded into practice.

- SARs and other learning reviews
- Links between SIRI's, SARs and Coroners Processes
- Monitoring of SAR and DHR action plans
- Continuing the lessons learned workshops for practitioners after Safeguarding Adult Reviews
- Responding to the National SAR Analysis

| Area of Focus | Outcome | Action required | Lead | By when | Evidencing the outcome | Red/ Amber/ Green rating |
|---|---|---|---|---|---|---|
| SARs and other learning reviews | | | | | | |
| Links between SIRI's, SARs and Coroners Processes | | | | | | |
| Monitoring of SAR and DHR action plans | | | | | | |
| Continuing the lessons learned | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| workshops for practitioners after Safeguarding Adult Reviews | | | | | | |
| Responding to National SAR analysis | | | | | | |

| **Health Sub-Group (Joint with the LSCP)** | | | | | | |
|---|---|---|---|---|---|---|
| **Core business:** The overarching purpose of the group is to safeguard and promote the welfare of children and adults across the Isle of Wight health economy in line with the statutory duty under the Adult Care Act (2014) and Section 11 of the Children Act (2004). The Health Subgroup has been established to enable health representatives, including NHSE Wessex, Clinical Commissioning Group (CCG), Public Health and the NHS Trust, Primary Care, CAMHS, Health Watch, IOW Prison, and IOWSCB and SAB members to meet together in order to fulfil their responsibilities to keep adults and children safe across the IOW.<br><br>**Areas of Focus:**<br>• Health outcomes for people with a Learning Disability<br>• Health outcomes for people who are homeless<br>• Hidden harm<br>• LPS | | | | | | |
| **Area of Focus** | **Outcome** | **Action required** | **Lead** | **By when** | **Evidencing the outcome** | **Red/ Amber/ Green rating** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Health outcomes for people with a Learning Disability | | | | | | |
| Health outcomes for people who are homeless | | | | | | |
| Hidden harm | | | | | | |
| Liberty Protection Safeguards | | | | | | |

| **IWSAB Business Unit** |
|---|
| **Core Business:**<br><br>• Ensure IWSAB meetings are convened, support agenda setting for board meetings and arrange accommodation.<br><br>• Arrange secretariat to the IWSAB and the circulation of appropriate papers.<br><br>• Advise and update IWSAB on the policy and practice implications of any new legislation, government policy or guidance. |

- Attend all of the IWSAB subgroups, support the chairs in setting the agenda. To also maintain an overview of the work of all the subgroups and ensure respective work programmes and activities are co-ordinated and consistent with the IWSAB Safeguarding Strategy and Business Plan.

- Provide advice to the IWSAB and subgroups on professional issues.

- Co-ordinate the production of the Business Plan, undertaking reviews of progress and reporting to the IWSAB.

- Co-ordinate the production and publication of the Strategic Plan and Annual Report.

- Refine and maintain strategic links with agencies whose function supports adult safeguarding work and the protection of adults at risk but who do not sit on the Board.

- Act as the first point of contact to receive and triage for learning review referrals.

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

**4LSAB Groups with Southampton, Hampshire, and Portsmouth (SHIP)**

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

4LSAB Coordination and Liaison Working Group

- To identify shared topics that enable a consistent approach between the 4LSABs in relation to Adult Safeguarding across the 4LSAB area.
- To consider any national guidance that has been released that may lend itself to a collaborative approach or response across the 4LSABs.
- To identify and respond to any issues or challenges that have the potential to undermine the effectiveness of Adult Safeguarding work locally.
- To share any local learning that each LSAB may have identified as a result of Safeguarding Reviews that has been carried out in their area.

- To share any general learning and best practice across the 4LSABs, in relation to Adult Safeguarding.
- To receive regular updates from individual Boards on key themes, priorities, and delivery of plans.
- To identify any opportunities for joint events within the 4LSAB area in relation to Adult Safeguarding and shared themes across the area.

4LSAB Policy Group:

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

4LSAB Workforce Development Group

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

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

4LSAB Fire Safety Development Group

A partnership led by Hampshire & Isle of Wight Fire and Rescue Service (HIWFRS), to ensure that fire safety risk management is embedded into partner working practices to reduce people being killed or seriously injured in fires.

Aim

- Ensure that fire risk is managed as a priority by all partners represented through the 4LSABs
- To provide consistency in how the fire safety of vulnerable groups is managed across the 4LSABs.
- To implement event learning strategy as a means of reducing avoidable fire deaths and near miss fire incidents, ensuring a 'systems learning' approach is applied by all members for the development of effective fire safety practices within their own agencies / organisations.