GD2023/0125

SAFEGUARDING BOARD
ISLE OF MAN

Annual Report 2022/2023

Independent Chair's Introduction

Welcome to the Isle of Man Safeguarding Board Annual Report for 2022/2023, which covers the performance for the year April 2022 to the 31 March 2023. This was my second year as the Independent Chair and I have seen good evidence of collective working and improved working relationships between agencies and sectors. There were also a number of challenges for Board agencies, due to significant staffing changes throughout organisations including at senior levels, that also affected membership of the Safeguarding Board and its sub-groups. Despite the challenges, member agencies remained committed to ensuring that work on the Board's agreed priorities moved at pace, and there was significant progress on a number of pieces of work to improve multi-agency safeguarding practice.

My role as the Independent Chair is to receive assurance about safeguarding practice from the agencies to ensure there is effective joined up multi-agency work and to scrutinise the standard and quality of practice to safeguard, children, young people and vulnerable adults from abuse and harm. The Independent Chair can never be the sole provider of feedback, reflection or challenge, and the Board have been developing a culture of high support but high challenge across its groups, to ensure a culture of continuous improvement. In addition, the Board have been using their new Quality Assurance and Scrutiny Framework agreed in October 2022, to evaluate the quality and impact of multi-agency work.

I therefore led the Board's first Scrutiny Event focused on evaluating multi-agency practice, and providing a baseline against which to chart improvements. The detail of findings and issues raised is covered on page 33 of this report. In relation to children's scrutiny, the level of openness and reflection evidenced by senior operational leaders and participants was impressive. Safeguarding leads identified clear actions to address the areas requiring improvement and are providing leadership in driving these actions forward. As a result of the issues and risks raised in relation to adult safeguarding, the Board are receiving regular assurance reports from the Executive Director of Social Care and I will be undertaking additional scrutiny, including audits of adult safeguarding to be assured the necessary improvements are being undertaken.

The considerable multi-agency work undertaken to improve the safeguarding of adolescents, led to the development of the Board's Vulnerable Adolescent Strategy and Working Protocols that were launched at a Pan-Island Conference in September 2022. There was an excellent turn out with all agencies and sectors well represented and a real commitment to ensure that children and young people locally are protected from all forms of exploitation. Professionals were able to understand how a contextual safeguarding approach is critical to safeguard young people outside the home, and the media input was vital in helping to raise awareness about the risk of exploitation across the Island. The impact of the new ways of working on protecting young people, including the effectiveness of Daily Exploitation Meetings, weekly Risk Management and Strategic Exploitation Meetings, will be fully evaluated over the forthcoming year, using the Board's new Quality Assurance and Scrutiny Framework.

This year the Safeguarding Board published two Serious Case Management Reviews (SCMRs). The purpose of SCMRs is to identify good practice but also learning, to make improvements, to prevent future abuse and harm. The first, "A Thematic Review of Self-Neglect" was published in October 2022, and focused on seven deaths where self-neglect was evident. The second "Family K" involving a domestic homicide was published in November 2022. The learning identified from these recent reviews is covered in this report and work is being undertaken to address the learning and recommendations. Comprehensive multi-agency work is being undertaken to improve the identification and response to self-neglect, and immediate work has included training and a poster campaign across the Island. A conference is arranged for September 2023 to launch the new Self-Neglect Strategy and ways of working and will involve the voices of families who have experience of dealing with self-neglect.

Board agencies have continued to work hard to ensure there is an up to date set of both adults and children's policies and procedures. A full suite of new updated policies and procedures for children are now available via the website and final work is being completed on the adults' procedures. This has taken considerable time and commitment from front line practitioners, managers and the Board business support team, and I am grateful for all the work these individuals and their agencies have undertaken. I would encourage all agencies and sectors to

access these, as it is important the advice, guidance and direction they provide is adhered to, in order to ensure all Isle of Man citizens are appropriately safeguarded from abuse and neglect. The procedures include a new escalation policy to be used by any professional who has concerns about a child, young person or adult where they believe their concerns or the risks are not being adequately addressed.

Last year, considerable work was undertaken to develop a functioning website to provide useful information for children and young people, families and carers, professionals and the voluntary and community sector. The website went live in February 2022 and work is continuing to develop this further including developing a professionals' zone to go live in Autumn 2023, where professionals can access good practice tools and guidance to support their work. The Board also launched its Facebook page in September 2022, which is regularly updated with key messages in relation to safeguarding. They also launched their first newsletter and these will be published regularly, to provide updates on the work of the Board, interesting safeguarding articles, and details of forthcoming training opportunities. I would encourage you to access the website and newsletters on an ongoing basis www.safeguardingboard.im

Despite the work undertaken last year to improve information sharing including the production of a new Information Sharing Protocol, Guidance for Professionals, and a Myth busting Leaflet; effective information sharing continues to be inhibited by a misunderstanding of when information can be shared, and a level of fear about the consequences. The need for improved practice around information sharing was highlighted this year through scrutiny, professionals' feedback and is an emerging issue a the new Serious Case Management Review which has just commenced. The Board is taking a number of steps to support staff to feel confident in sharing information, including training, advice and is considering enhanced guidance in legislation.

Although, significant work has been undertaken this year to enhance the profile of safeguarding through use of the media, campaigns, engagement with a range of sectors and through the website , there is still work to do to ensure that professionals, all sectors and communities can recognise abuse or harm and feel confident in understand their safeguarding responsibilities. In particular, that "safeguarding is everyone's responsibility" Additionally, there is significantly

more work to do, to ensure the voice of service users and carers are at the heart of the Boards' work, and to ensure their feedback is informing practice improvement. The Board will need to ensure a real focus on this area over the next year.

Finally, there is still significant work to test the effectiveness of multi-agency practice using audits, performance data and the new scrutiny process. Most importantly, the Board agencies have significantly more work to do, to be able to measure the impact of their collective work and to evidence it is improving outcomes for children and young people and vulnerable adults. I am satisfied that plans are in place to support this, including a planned series of multi-agency practice audits and a re-run of the adult scrutiny process. As stated, I will also be leading scrutiny of the impact of the multi-agency work to protect vulnerable adolescents. I look forward to continuing to work with Board members, their agencies and all sectors to ensure effective safeguarding of the Islands most vulnerable citizens.

Lesley Walker

Ms Lesley Walker
Independent Chair

Isle of Man Context

SIZE

The Isle of Man is 221 squared miles

THE ISLE OF MAN IN NUMBERS

POPULATION

- The population size is 84,069
- 22% of the population is over 65
- 17% of the population is 16 or under
- 44,875 are currently economically active
- 94.7% are White
- 3.1% are Asian
- 1% are of Mixed race
- 1.2% are classified as other

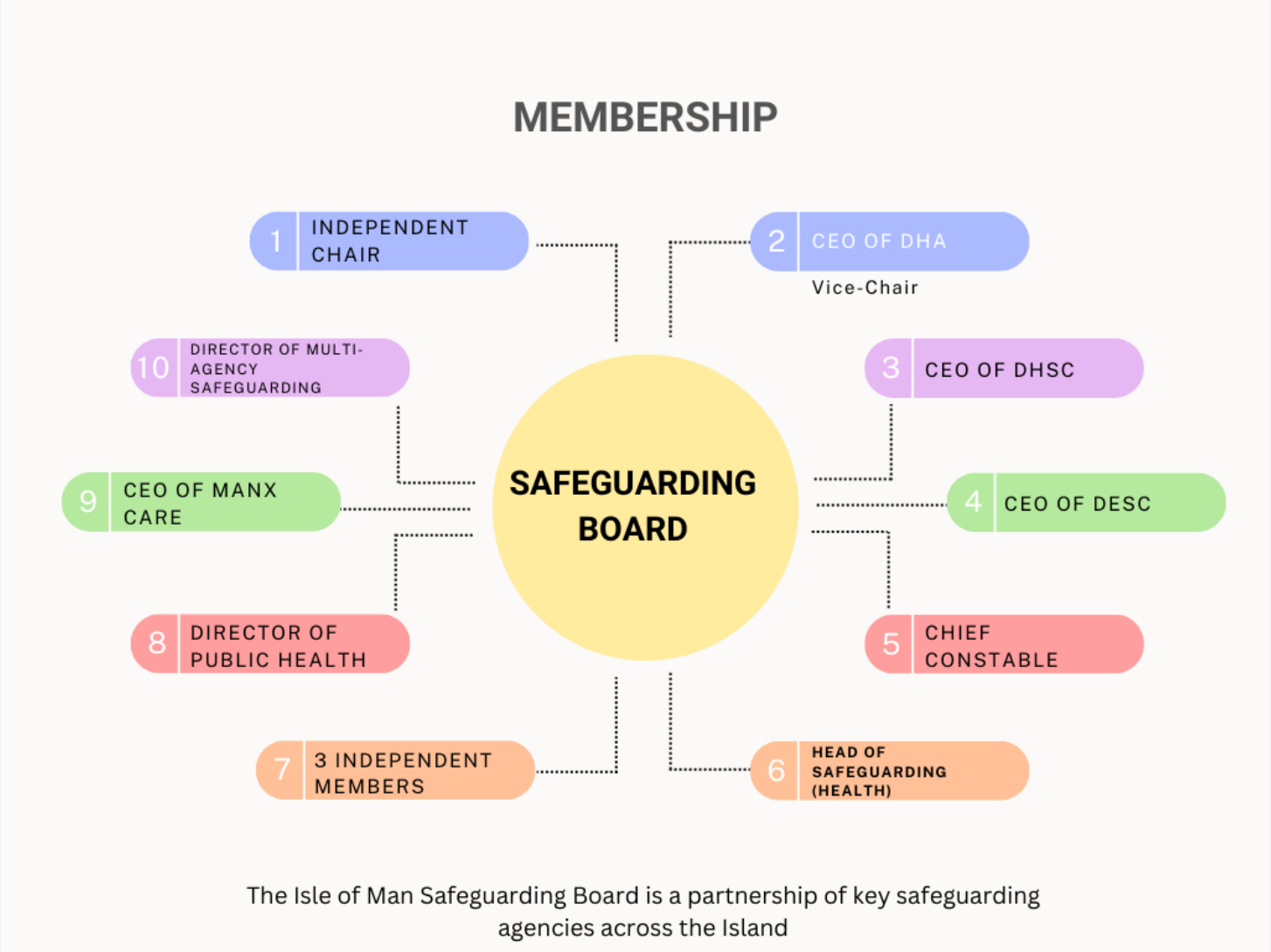
HOUSING

- The Average price of a house is £386,955
- The Average price of a flat is £187,002

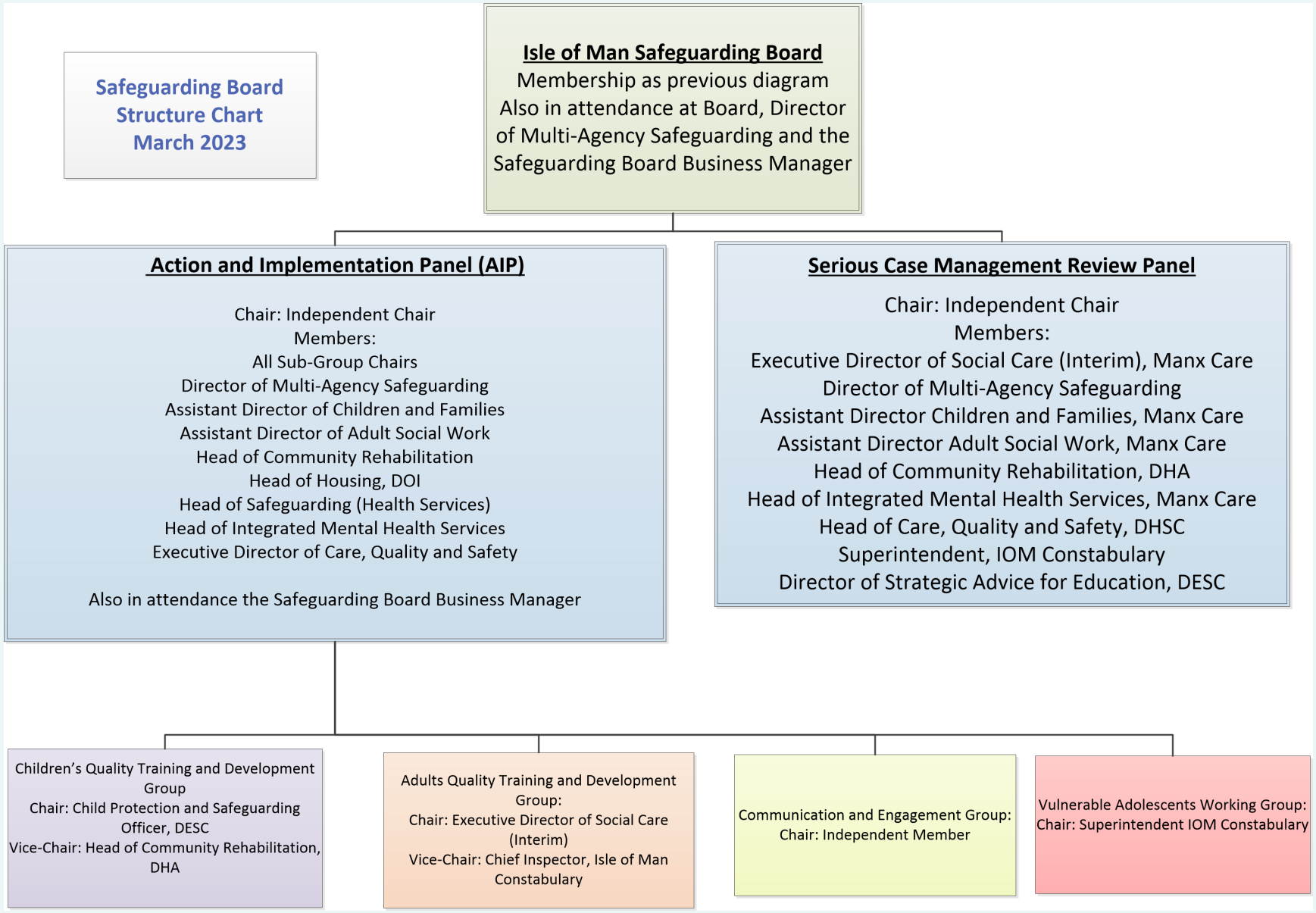
SOCIAL HOUSING

- There are 5,541 social housing properties across several different local authorities and the DOI
- Douglas City Council is the largest Social Landlord with the DOI being second.

The Safeguarding Board



The Isle of Man Safeguarding Board is a partnership of key safeguarding agencies across the Island


Safeguarding Board Structure Chart March 2023
Isle of Man Safeguarding Board
Membership as previous diagram
Also in attendance at Board, Director of Multi-Agency Safeguarding and the Safeguarding Board Business Manager
Action and Implementation Panel (AIP)
Chair: Independent Chair
Members:
All Sub-Group Chairs
Director of Multi-Agency Safeguarding
Assistant Director of Children and Families
Assistant Director of Adult Social Work
Head of Community Rehabilitation
Head of Housing, DOI
Head of Safeguarding (Health Services)
Head of Integrated Mental Health Services
Executive Director of Care, Quality and Safety
Also in attendance the Safeguarding Board Business Manager
Serious Case Management Review Panel
Chair: Independent Chair
Members:
Executive Director of Social Care (Interim), Manx Care
Director of Multi-Agency Safeguarding
Assistant Director Children and Families, Manx Care
Assistant Director Adult Social Work, Manx Care
Head of Community Rehabilitation, DHA
Head of Integrated Mental Health Services, Manx Care
Head of Care, Quality and Safety, DHSC
Superintendent, IOM Constabulary
Director of Strategic Advice for Education, DESC
Children's Quality Training and Development Group
Chair: Child Protection and Safeguarding Officer, DESC
Vice-Chair: Head of Community Rehabilitation, DHA
Adults Quality Training and Development Group:
Chair: Executive Director of Social Care (Interim)
Vice-Chair: Chief Inspector, Isle of Man Constabulary
Communication and Engagement Group:
Chair: Independent Member
Vulnerable Adolescents Working Group:
Chair: Superintendent IOM Constabulary

Priorities

The Safeguarding Board agreed two key practice priorities and three overarching priorities in the Business Plan for 2021-2023.

The main practice priorities are:

1. Working together to effectively safeguard vulnerable adolescents
2. Ensuring an effective multi-agency safeguarding response for vulnerable adults

The overarching priorities are:

3. Strong leadership and effective, well-functioning structures and subgroups that improve outcomes and have a measurable impact
4. A workforce equipped and fit for purpose to deliver effective safeguarding practice
5. An effective communication and engagement strategy

Shared principles that underpin our key priorities:

- Person Centred Practice - the Board will ensure that children and young people and adults have opportunities to participate and collaborate in the work of the Board and that their voice is embedded in multi-agency practice.
- High support high challenge - the Board will promote a culture of high support and high challenge to develop working environments where growth and learning is accelerated.
- Promoting Practice leadership - the Board will involve front line practitioners and managers in the continuous learning process in a supportive and challenging way, in order to build practice leadership capacity across the Board.
- Promoting a culture of continuous learning - the Board will create the environment for learning, recognising the way systems influence each other and the benefits of working together rather than in individual agencies. We will ensure that we learn from best practice, case reviews and multi-agency audits, including the monitoring of the implementation of recommendations.

Achievements

1. TRAINING

- Competency frameworks agreed
- comprehensive training package for children and adults delivered

2. POLICIES AND PROCEDURES

- Full suite of policies and procedures reviewed and agreed
- Joint MASM policy agreed to deal with allegations about those in a position of trust

3. EXPLOITATION

- Vulnerable Adolescent conference where new ways of working were launched. 120 people were in attendance
- Strategy and working protocols launched

4. SCRUTINY

- Quality Assurance and Scrutiny Framework agreed
- First scrutiny event very well attended and well received

5. AUDIT

- A children's multi-agency audit has been undertaken
- The organisational standards audit has been refreshed and undertaken
- Single agency audits are reported through the two Quality Assurance sub-groups

6. APPOINTMENTS

Appointments have been made to two key roles in the Business Team

- A Director of Multi-Agency Safeguarding
- A Training Officer

7. ONLINE PRESENCE

- The website has been published, and further updated
- A Facebook page has been launched

8. GOVERNANCE

- All Terms of Reference for the sub-groups have been reviewed and refreshed
- Action plans and progress reporting mechanisms updated

The Work of the Subgroups

Adult's Quality, Training and Development Group

The Purpose of the Adults, Quality Training and Development Group is to ensure effective multi-agency practice by member agencies of the Safeguarding Board, to ensure the Board fulfils its remit of ensuring that local safeguarding arrangements are effective.

The main challenge for this group has been acquiring the right representation from partner agencies, to contribute to moving forward the Boards priority of ensuring an effective multi-agency safeguarding response for vulnerable adults.

This year presented the Adults Quality, Training and Development subgroup with many challenges in changes in membership, including the number of changes of the Chair of the group, but partners were able to achieve a number of key pieces of work.

The group focused on developing a full set of policies and procedures to support and guide the work surrounding the multi-agency safeguarding response to vulnerable adults; and offering comprehensive safeguarding training at level 2 and 3 during the first half of this year, aligned to the revised Competence Framework. This training was delivered by a specialist from the UK and all sessions across four days were well attended.

In November, the Board published the Thematic review into Self-Neglect which identified the need for new working procedures and a development strategy. The group has been responsible for the majority of the recommended actions from that review, in particular developing and establishing how agencies will work together, when working with adults who self–neglect. The Self-Neglect Development Strategy has been published and the group worked collaboratively with a subject matter expert, to develop new working procedural guidance alongside supporting documents and tools. This work will be completed by July 2023 and launched at a planned conference in September, and the multi-agency approach and efficacy in managing self-neglect concerns will be measured via planned audit and scrutiny activity in early 2024, set against the new working pathways.

Further, the group worked hard in identifying a shared dataset to identify key performance indicators, trends or concerns which would be highlighted to the Board via exception reporting, to encourage a shared understanding of adult safeguarding across the Island.

The group continues to develop and monitor the delivery of its work plan which is dynamic and comprehensive in nature. This provides the focus for the group and helps to prioritise the work that is undertaken.

The group is aware of the need to deliver on the work plan and whilst there are many challenges associated with capacity and resources, members remain committed to continue on this improvement journey. There are plans to complete an independent evaluation via scrutiny following the launch of the new strategy, along with a planned baseline safeguarding practice audit, involving a number of key partner agencies exploring their own records and presenting the findings to a multi-agency learning session. This will initiate regular data and audit analysis which will identify trends and areas for development within multi-agency adult safeguarding practices.

The Children's Quality and Training Development Subgroup

The purpose of the Children's Quality, Training and Development Group (CQTD) is to support the Isle of Man Safeguarding Board to fulfil its remit of ensuring that local safeguarding arrangements are effective for children and young people.

In the year 2022-2023, the group has been able to celebrate a number of successes with only one outstanding action remaining on the work plan from this year. A positive culture of collective learning has underpinned the activities of the year and the good attendance and consistency of the group has helped to foster the mission statement of high support, high challenge.

One of the key objectives this year was to identify a consistent dataset that each agency could contribute to, that would help inform the Safeguarding Board about the effectiveness of ongoing work with vulnerable children and young people, and ensure early identification of new or emerging risks or harmful trends to children. The accompanying exception reports help analyse this data and inform the board of actions that need to be taken forward. This has provided us

with some detail of areas requiring audit or closer scrutiny in the forthcoming year, such as the categories under which children are placed on child protection plans and how the continuum of need document and accompanying training needs revisiting. Work on the continuum of need will strengthen agencies understanding of when it is necessary to make a referral to Children's Social Care or when the child or family would benefit from early help or support by other agencies or sectors.

The Quality Assurance events that have taken place this year, such as the multi-agency file audit, showed the developing maturity of the group. This exercise showed how open, honest and reflective participants could be, accepting constructive challenge as a learning and development opportunity to support better performance in their respective service areas.

A key action requiring particular effort, was the development of the training offer. This had been a delivery gap of the group since the previous incumbent of the training officer post had left. That post is now filled and there has been a developing programme of Level 2 and Level 3 training which has dealt with training needs from recent SCMR recommendations. Some of the more specialist subject matter has been delivered by external off island facilitators.

To accompany the programme of training, the Competency Framework underpinning this work has been updated and disseminated. This framework clearly sets out the key training needs for workers at all levels and will help ensure the right people receive the right training commensurate with their roles. The group is in the early stages of evaluating the quality and effectiveness of this training. Alongside this work is the need to develop the skill base of the pool of trainers delivering on behalf of the CQTDG. There is also a need to carry out a thorough training needs analysis for the workforce.

The subgroups future plans involve training/table top exercises on understanding reachable moments, a recommendation from the Child J SCMR, along with multi–agency child exploitation audits leading up to the next scrutiny event, that will evaluate the impact of the Vulnerable Adolescent Strategy on practice and whether it has improved outcomes for young people at risk of exploitation.

There will also be an improvement action plan from the Organisational Standards Audits that each agency/division carried out earlier in 2023, that evaluated and rated their effectiveness in addressing key safeguarding standards. It is hoped that this will provide a baseline of understanding where each area is at in relation to everything safeguarding. A further audit will be carried out in 2025 to assess changes that have taken place and to assure the Safeguarding Board that work is being progressed and is not static.

The Communication and Engagement Group

The Communication and Engagement Subgroup is responsible for ensuring that the key safeguarding messages are communicated with a far reaching audience covering government departments, Manx Care and Third Sector agencies. The Board has consulted with service users and families, regarding safeguarding matters to ensure that their views are taken on board as well as seeking feedback from families that have been involved in Serious Case Management Reviews.

In the last reporting year 2022/23, the group has reviewed its terms of reference and its membership. This now includes the DHSC, Manx Care (Health and Social Care), Youth Service (DESC), IoM Constabulary, Third Sector and Faith Sector.

Safeguarding work has really gained momentum in sharing key safeguarding messages and raising awareness of safeguarding across the Island. A Communication Strategy was launched and the Safeguarding Board website completed. The Board's Facebook page was also set up in order to share latest news and information.

The successful launch of the Vulnerable Adolescent Strategy at a conference in September 2022 provided an opportunity to raise awareness through the media about the risks of contextual safeguarding, and identify where young people, their families, professionals and citizens could find help and support. Similar opportunities to profile the importance of identifying safeguarding concerns and the need to strengthen practice, arose through the publication of two Serious Case Management Reviews (SCMRs). In particular, the Self-Neglect Thematic review served as a platform to organise a self-neglect awareness raising campaign. Local media (press and radio

stations), as well as social media, highlighted the importance of knowing what self-neglect is and how to deal with it. Information posters were distributed throughout the island. The campaign's effectiveness will be measured by the number of referrals to social care following the end of the campaign.

Mindful of the important message that safeguarding is everyone's responsibility, the first newsletter was drafted. It will become a regular, quarterly update on Safeguarding Board's work and the progress and the impact it has on improving the safety and well-being of children and vulnerable adults.

The Communication and Engagement Group is preparing its Engagement and Participation Strategy which will be completed and launched at the end of 2023.

It must be acknowledged that communication and engagement work is making progress thanks to the commitment of those members, who in addition to their every-day work commitments, give time and support to ensure that safeguarding is indeed everyone's responsibility.

The Vulnerable Adolescent Working Group

The group has continued to build on the early work completed in this area, with all relevant agencies taking part in the Exploitation meetings that run daily, weekly and quarterly. The meetings main focus, is to identify vulnerable adolescents where there is clear risk of exploitation, and agree a safety plan to ensure the young person is supported and any potential risks are managed and ensure the necessary disruption is carried out by the police. Operation YARROW, was a police initiative to collate concerns and intelligence to identify a growing concern regarding young people believed to be involved in exploitation and criminal activity. This initiative was adopted as the main template for identifying vulnerable young people, as well as referrals from other agencies.

The working practices of the pilot have continued to develop and the work has also assisted the planning for the formation of a Multi-Agency Safeguarding Hub (MASH). This work was led by the Assistant Director of Children and Families Social Work. This work has culminated into an agreed implementation plan and the Police, Manx Care and Department of Health & Social Care

will be co-located, with other agencies such as the Department of Education, Sport & Culture virtually located and able to become involved in early identification and management of safeguarding issues for our young people.

The group had a wide ranging and challenging work plan, which focused on the identification of contextualized safeguarding and exploitation, single and multi-agency training on the recognition and response to risks associated with grooming, missing from home, sexual exploitation, criminal exploitation, serious youth crime and the importance of identifying and acting on 'reachable moments' for children and young people.

Further work is being undertaken to ensure our information sharing protocols and practices are in line with the legal framework. All agencies are supported and encouraged to share relevant information appropriately within the confines of the law and to make guidance clear and easily accessible. However, further joint work is planned to offer clarity relating to processes and how to share information appropriately.

In September 2022 we launched the Vulnerable Adolescent Strategy & Working Protocol at the Board's annual conference which was an event that was well attended by statutory, third sector and voluntary organisations. Whilst the work plan and scope of the VAWG is nearing its conclusion, the work will still continue. The group will turn its focus on working with adult services to develop smooth transitional safeguarding processes for our young people experiencing or at risk of harm and open to services leading to continuation of relevant services when they reach 18 years of age.

It is planned to develop an all age Exploitation Subgroup which will focus on adult exploitation as well as further develop the work for children and young people.

Serious Case Management Review Panel

The Safeguarding Board is required to undertake Serious Case Management Reviews (SCMRs) in circumstances where a child or vulnerable adult may have died or suffered serious harm, and abuse or neglect are known or suspected, and there are concerns about how agencies may have worked together. The purpose is to identify learning and identify areas of practice improvement.

The Serious Case Management Review Panel is chaired by the Independent Chair of the Board, who is responsible for deciding whether the case meets the SCMR criteria, for commissioning an independent review author and ensuring the review addresses the terms of reference as agreed by the panel. The SCMR Panel is responsible for overseeing the publication of the SCMR where it is appropriate to do so, and ensure that an action plan is in place to address the review recommendations. Further, the panel hold a scrutiny and oversight role to establish that recommendations have been actioned and implemented.

The Board has completed two SCMRs in this reporting year; Family K which related to a domestic homicide which was published in October 2022 and a Thematic Review into Self-Neglect which was published in November 2022.

Family K concerned the homicide of Mrs K and a serious assault to Mr K by their son, who was suffering from mental ill health during the time leading up to the fatal incident. He was convicted of manslaughter of his mother and the attempted murder of his father, and has been detained in a secure hospital. The review highlighted a number of issues involving agencies working with the family – domestic abuse, alcohol misuse, mental health, and a lack of a 'think family' approach by professionals. A seven minute briefing has been published on our website.

The review concluded that the homicide could not have been predicted or prevented. Nonetheless the review highlighted areas of learning and made recommendations to reduce risks to others. The report has been published on our website

The thematic review into self-neglect focused primarily on the death of a vulnerable adult known as Mr M, where self-neglect was a significant factor and concerns were raised about how agencies worked together, along with a cluster of six other people whose circumstances leading to their death included self-neglect. The purpose of the review was to explore how effectively services and communities worked together to support people who may be self-neglecting and use the learning from the review to improve multi-agency responses and service delivery.

The review found that defining self-neglect can be open to interpretation, with subjective judgements about 'acceptable' living standards; that mean practitioners need to make

professional judgements about the level of risk, but also weigh up the wider considerations about an individual's wellbeing. The review identified a number of learning themes in regards to: building relationship and developing understanding of the complexities of self - neglect, working with risk, and working across agencies and communities. The report has been published on our website and a seven minute briefing can also be found there.

The review made two recommendations; one of which has required significant work by all agencies to develop a Self-Neglect Strategy and further work is planned in the coming year to develop pathways and procedural guidance for partners working together to support self-neglecting adults; which will be launched at the conference planned for September 2023.

Independent Members

The Safeguarding Board has three independent members whose role is to provide independent challenge and support of the Board's work. Below is an account of the Boards progress written by the current independent members.

"As the island returns to normality from the challenges of COVID, the Board has been able to make significant progress in a number of areas and has been able to advance the safeguarding agenda".

Progress:

"The Safeguarding Board Business team has been strengthened by the appointment of a Director of Multi-Agency Safeguarding, and is now better able to both challenge and lead. We are particularly pleased that after a long gestation, the safeguarding website is now operational.

A number of Serious Case reviews have highlighted deficiencies in adult safeguarding practice which are being urgently addressed by a number of organisations and services across the island.

There has to be a continued strong emphasis on improving and adopting safeguarding policies with partners. The reporting of data is being standardised and streamlined to ensure proper monitoring of problems and emerging trends".

Challenges:

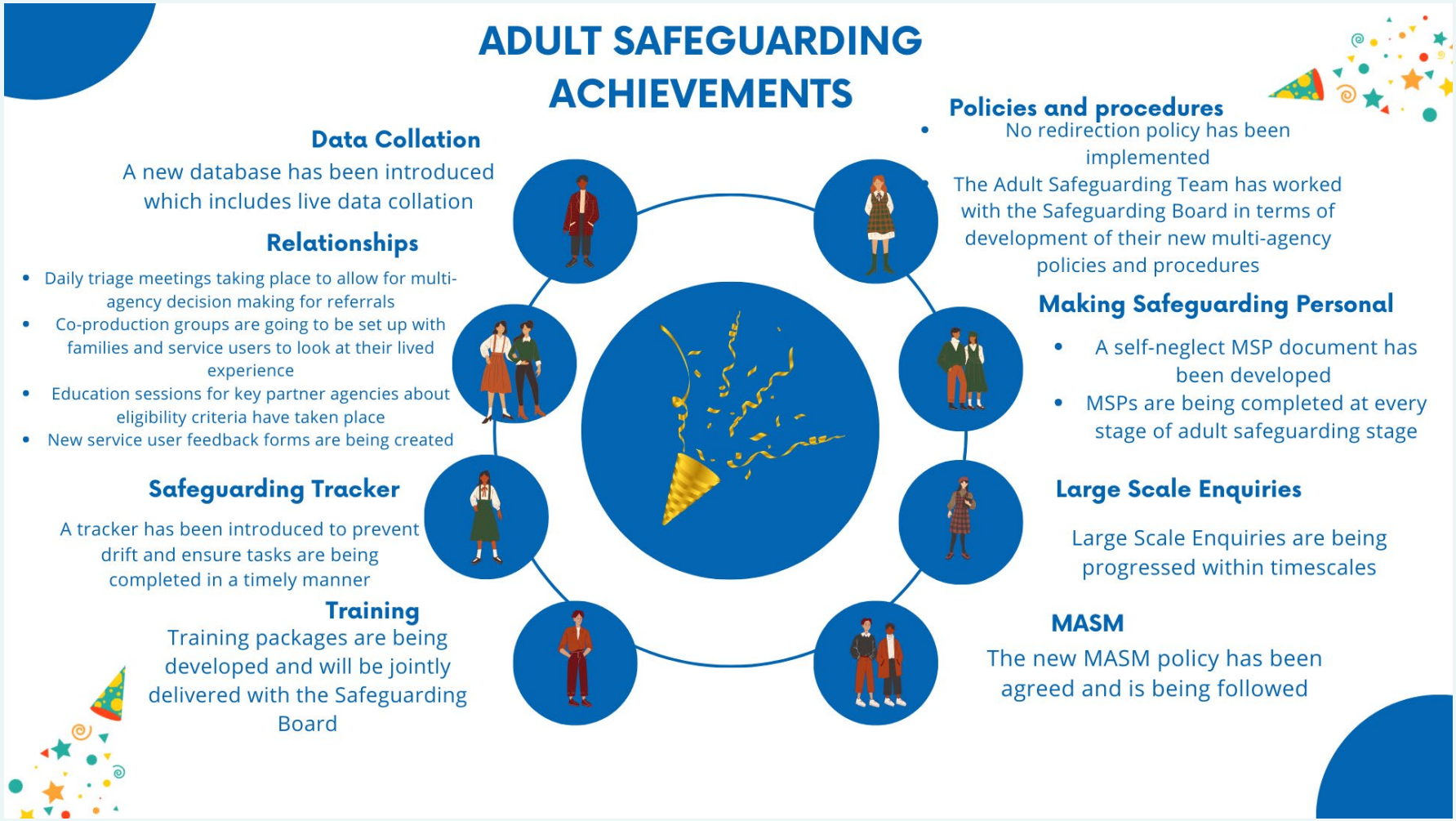
“Priority needs to be given to establish a shared understanding as to when personal data which can impact on a person's health, wellbeing and safety can be shared between practitioners and organisations”.

“Safeguarding is everyone’s responsibility which affects many aspects of island life; embedding a deeper cross island ownership of safeguarding remains a significant challenge. This requires a continued change of culture which prioritises safeguarding across both individual practitioners and organisations”.

“To maintain progress the Safeguarding Board Business team and agenda need continued resourcing with political support and involvement”.

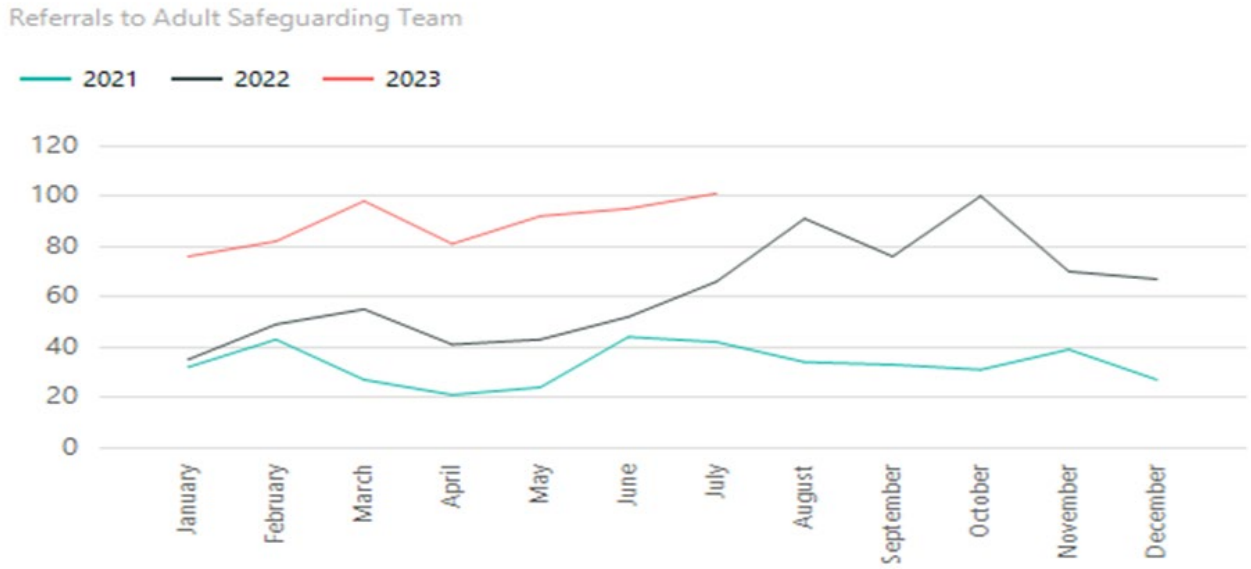
Safeguarding in the Isle of Man

Adult Safeguarding

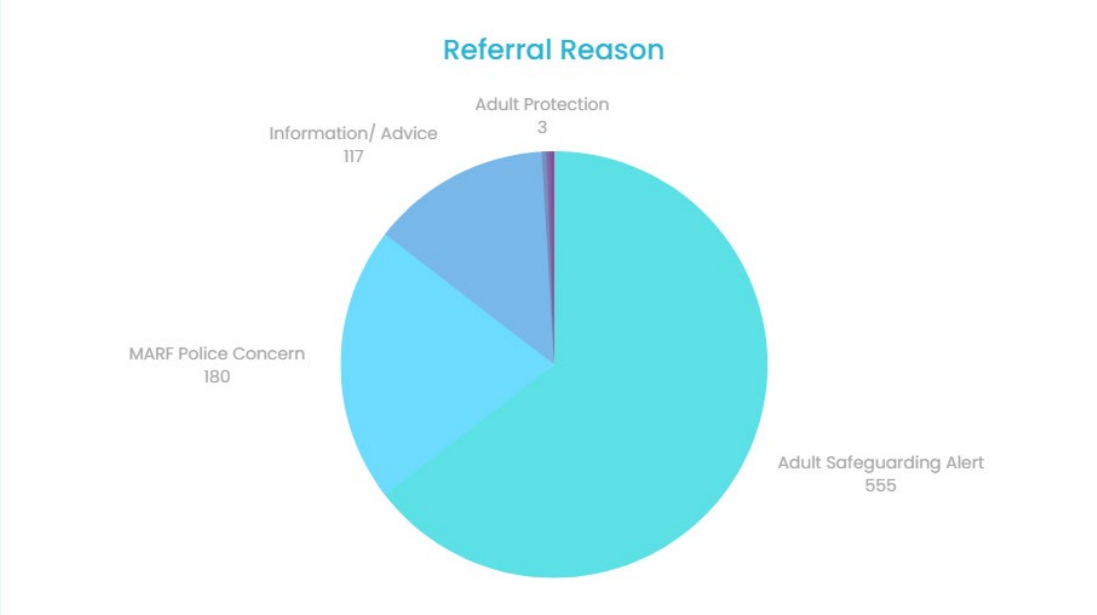


Referrals To Adult Safeguarding Team

Team Referred To	Referrals
Adult Safeguarding Team	862



From 1 April 2022 to 31 March 2023 the Adult Safeguarding Team (AST) received 862 referrals. The above graph clearly maps out the increase in referrals since 2021 and 2022 and demonstrates a 50% to 75% increase in the monthly intake of the team.

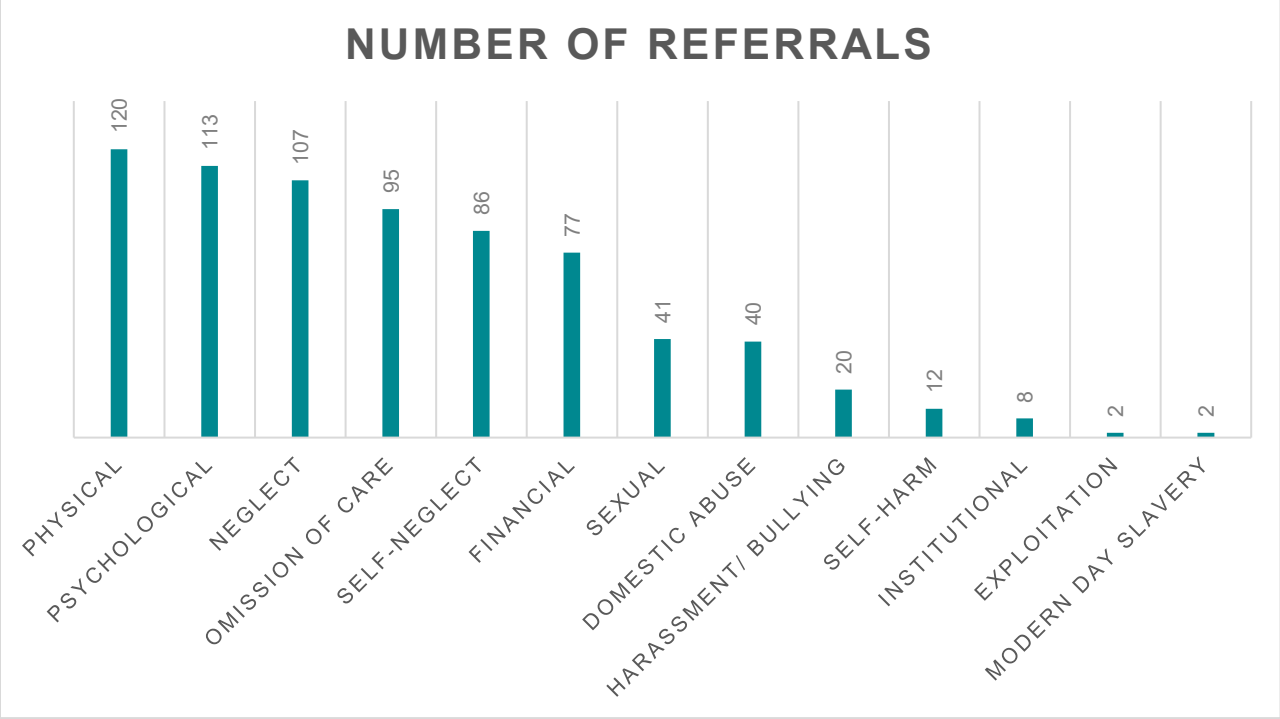


The Adult safeguarding team receive referrals over the phone or by email, and each referral is reviewed and triaged upon receipt due to the new no redirection policy within the team. This simplifies the safeguarding journey for the general public after the initial referral.

The most referrals have been submitted from the Police and Health and Social Work Practitioners from other service areas and teams, these agencies are represented at the daily triage meetings.

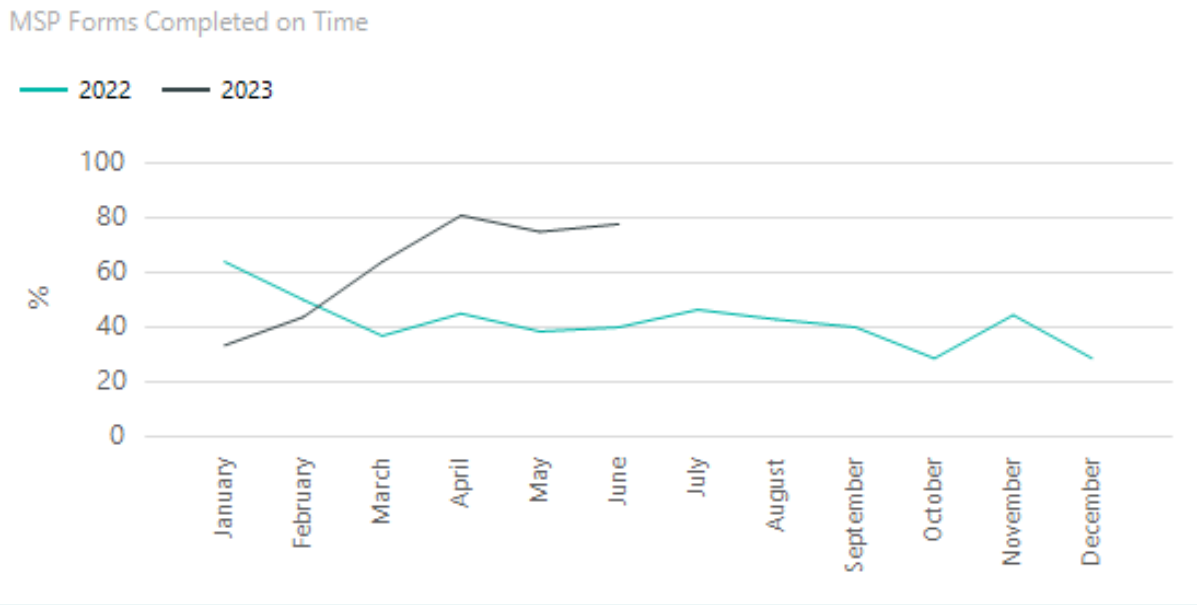
In terms of other referrals received, those from relatives have quadrupled from 8 received in 2022 to 37 received in 2023, the number of self-referrals have also quadrupled from 1 in 2022 to 4 so far in 2023. Referrals from friends have increased from 4 to 14. Additionally, referrals from housing and the GPs have also increased in the year to date.

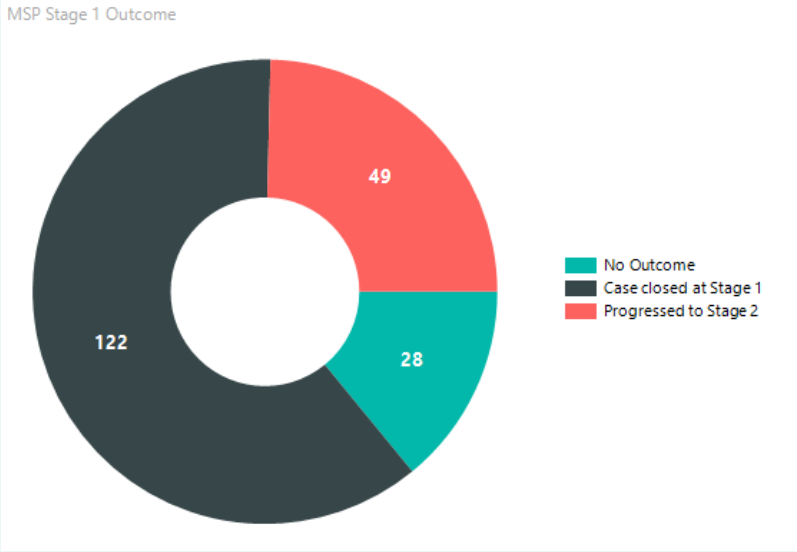
The below diagram categorises the type of abuse referred:



Making Safeguarding Personal (MSP) – is an approach to safeguarding that aims to ensure that the vulnerable adult and/or their advocate in relation to the safeguarding enquiry, is fully engaged and consulted throughout and that their wishes and views are central to the final outcomes as far as possible.

Following the reintroduction of planning meetings (Stage 2 – Enquiry), there is confidence that there will be an ability to demonstrate better outcomes for people, which is in line with MSP guidelines. Since this has been reintroduced, a number of referrals are managed at this stage and have not had to progress to case conference which evidences that multi-agency partnership working is improving on the Isle of Man. This demonstrates that during the enquiry stage and planning meetings partners are working together with the vulnerable adult to create a plan to work together to resolve the issues/ needs without the need to progress to a formal case conference.





Children and Families

CHILDREN AND FAMILIES ACHIEVEMENTS

Exploitation

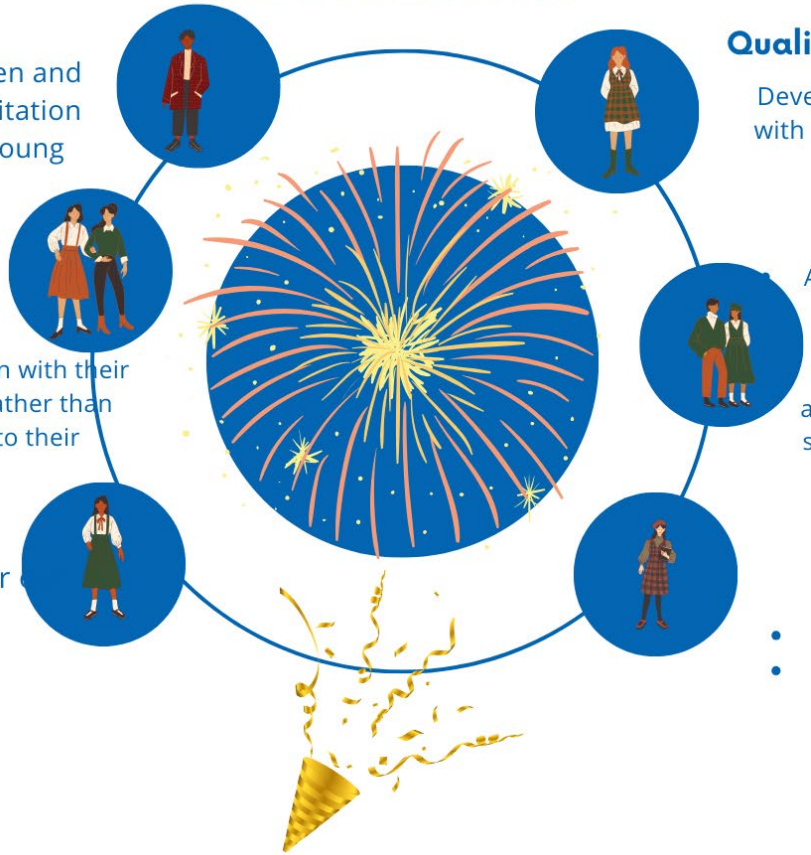
- Pilot of procedural protocol for children and young people who are at risk of exploitation
- Multi-Agency working to safeguard young people

Pilot of edge of care initiative

To ensure children and young people remain with their families when in crises rather than placed rather than placed into care; and children are returned to their families when it is safe to do so

Outreach

Developed an outreach service for children with disabilities



Quality Assurance Framework

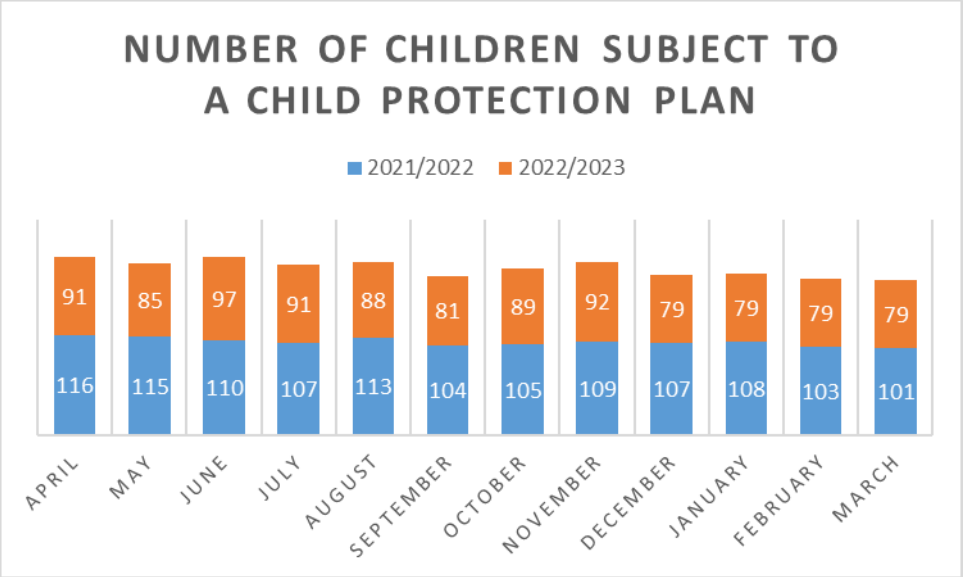
Developed a quality assurance framework with a robust audit schedule with the offer of learning workshops for staff

Training

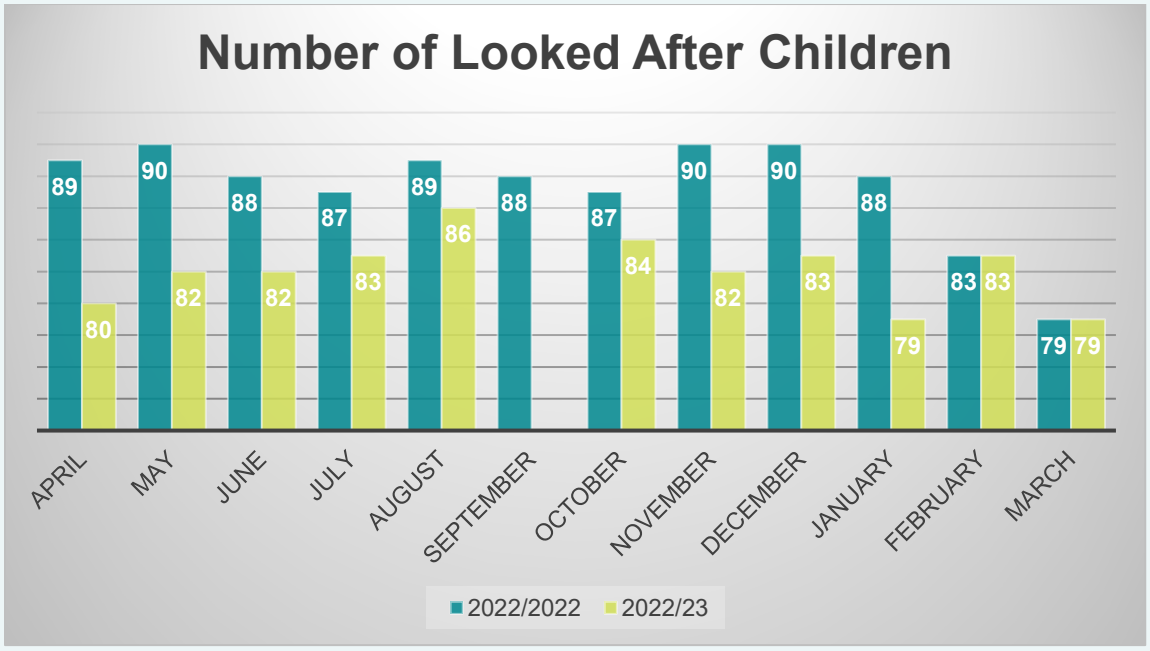
All staff provided with training in Achieving Best Evidence interviewing
Key staff provided with Assessment, Intervention and Moving on (AIM) assessments for young people who commit sexual assault or harmful sexual behaviour

Fostering

- Implementation of Fostering Strategy
- Recruitment drive for foster carers



Post pandemic, the numbers of children subject to Child Protection planning was significantly higher. 2022-2023 has seen more consistent numbers of children subject to plans, in line with what Children and Families would expect and had experienced pre-Covid.



The number of Looked After Children has remained relatively consistent over the period. The sudden decrease in numbers from the end of 2022 (90 in December 202 to 79 in March 2022) was due to a number of young people becoming adults over that time period.

There was a peak in contacts to Children and Families in May and June 2022, this was analysed at the time to try and find the rationale for this but no themes were identified.

Training

New Training Officer

The Board's new training officer, Sharon Willetts began in post November 2022 and shares her background. "My background is in Social Work mainly in Family Placement but I have experience and a keen appreciation for training. Within my new role I have had the opportunity to attend training by Subject Matter Experts which has been enlightening. I have also been involved in course development and presentation of Safeguarding Children training with our pool trainers".

Range of subjects

A key focus of the IOMSB is to provide a Multi-Agency Training offer of safeguarding training as well as responding by providing specialised training that may be required. The IOMSB was without a dedicated training officer from February 2022 until the beginning of November 2022.

- Following the publication of the Thematic Review into Self-Neglect; three 'awareness raising' sessions were held at the Sefton Hotel for over 150 practitioners exploring the issues around self-neglect and to share information regarding the multi-agency work to

develop the new strategy and procedural guidance. This is planned to be launched at a conference in September 2023.

- The Vulnerable Adolescents Strategy and new Working Protocol was launched in September 2022, which had been supported with a number of child exploitation training sessions at level 2 & level 3. Further sessions are planned in late 2023 and early 2024 to ensure that as many practitioners and managers are trained and aware of child exploitation and the new working protocols.

In January the Isle of Man Safeguarding Board's training offer for the year was widely circulated. From January until the end of March 2023 there were 15 training sessions available. There were 120 practitioners completing Safeguarding Children Training and 135 practitioners completed courses in relation to adult safeguarding. During the first 5 months of the new Training Officer's role around 455 practitioners booked onto and attended IOMSB training.

The following Level 2 courses have been run:

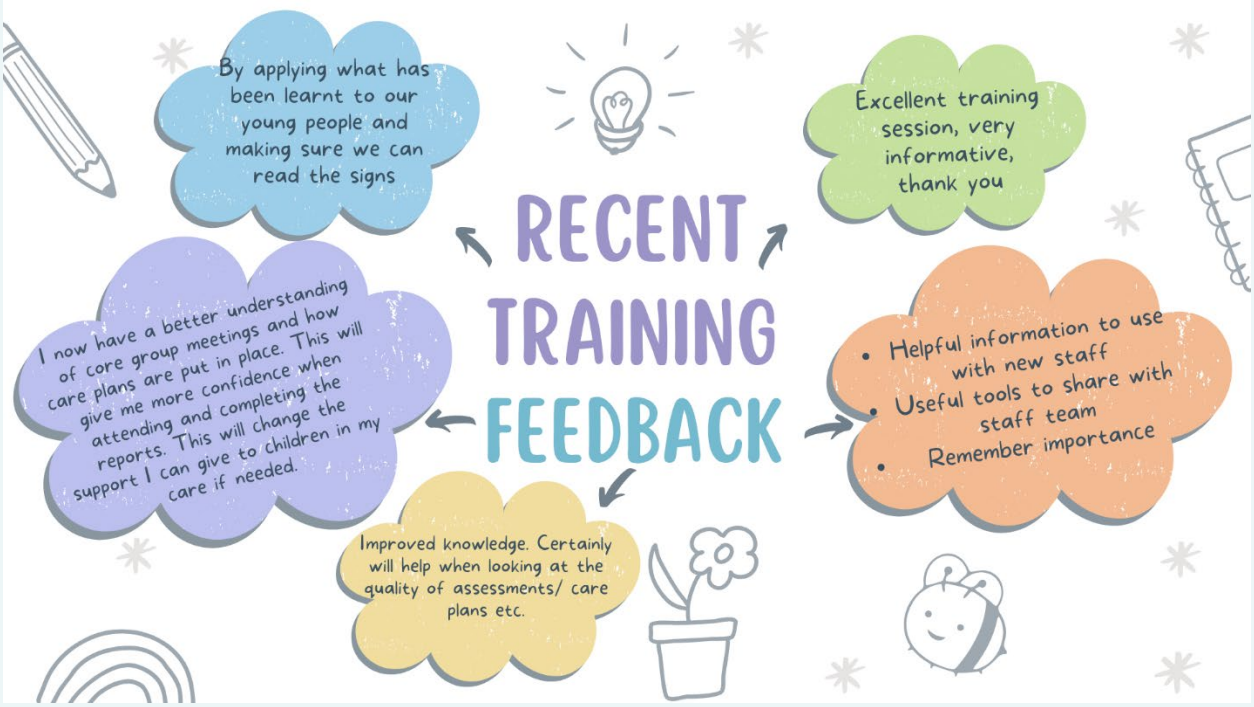
- Domestic Abuse (twice)
- Safeguarding Children (once)
- Safeguarding Adults (four times)

The following Level 3 courses have been run

- Child Exploitation (four times)
- Designated Safeguarding Leads (once)
- Core Groups and Conferences (once)
- Safeguarding Adults (twice)

The focus has been to develop top quality training that is up to date, relevant, evidence based, using local and national learning, and evaluating the impact of training.

Examples of Feedback from recent courses



There has been dissemination of the key messages and learning from the two published Serious Case Management Reviews via Learning Briefings and training delivered to a wide range of agencies and sectors.

In addition to the training courses, the Children's and Adult Competency Frameworks have been developed with practitioners and managers to support the identification of necessary levels of multi-agency training required by various roles across agencies. Improvements have been made to the booking form , the evaluation form has new questions aimed at analysing impact for the practitioner and a 3 monthly update evaluation is due to be launched to better analyse the impact of training in the short and longer term.

Future Planning

All future training will be shaped by the annual Training Needs Analysis which is scheduled to take place in the autumn by all key Board agencies, along with any identified key learning from SCMRs. Professional Curiosity Training is being developed to ensure enhanced curiosity by all

professionals and sectors who have contact with citizens and will be offered in half day workshop sessions.

The Self-Neglect Strategy and new working procedures will be launched in September via a large scale conference. This launch will be coupled with 3 full day and 3 half day sessions of self-neglect awareness raising & training presented by Sylvia Mason, an experienced consultant and trainer who completed the thematic review.

November 2023 will mark the first IOM Safeguarding Board Safeguarding Week, which is an incredible opportunity to improve children and vulnerable adults safeguarding awareness across a wider range of agencies and sectors who provide services for children and vulnerable adults. This is a great opportunity to share best practice and showcase the work within a variety of agencies across the Island.

Quality Assurance & Scrutiny

The Board developed and introduced its first Quality Assurance and Scrutiny Framework in October 2022, which sets out the process by which the Board can be assured about the effectiveness of safeguarding activity for children, young people and vulnerable adults. The overall aim is to ensure the very best practice possible in the Isle of Man. There have been several key elements that have been a focus for the Board this year:

- Developing a performance dataset
- Undertaking an organisational standards audit across all key agencies
- Undertaking multi-agency audits to evaluate the strengths in practice and areas for improvement
- Independent Scrutiny to evaluate the overall impact of agencies work and key Board initiatives
- Identifying and embedding learning from Serious Case Management Reviews

- Drawing up an Engagement Framework to obtain feedback from service users, their families and carers about what is working well in terms of safeguarding practice and what needs to improve

Performance Dataset

A dataset is critical to assist Board members in understanding the performance of agencies, in key areas of safeguarding practice. It allows Board members to be aware of key trends, to help them identify new and emerging risks, and support challenging questions about the impact of practice on local citizens' outcomes.

The Board held a series of workshops this year with adult and children services partners to agree a performance dataset for both adults and children. This enabled data and statistical reporting for quarter three and four, the last half of the year. Although, the data shows information which is already known or collected by agencies; by putting this information together it allows an overview of multi-agency effectiveness. It is clear that improved safety and outcomes can only be achieved by effective joined up multi-agency practice.

The dataset has been discussed by partners in the subgroups and has identified early trends, concerns and risks that have been shared with the Board. The subgroups are analysing and reviewing the current data measures to ensure they are relevant, applicable and suitable to current practice outcomes.

Organisational Standards Audit

The Organisational Standards Audit (OSA) is a mechanism to evaluate and monitor the effectiveness of what agencies do to safeguard and promote the welfare of children and vulnerable adults. All agencies represented on the Safeguarding Board were asked to undertake a self-assessment and provide evidence of how they comply with eight key safeguarding standards when undertaking their day to day business.

A number of key themes for improvement were identified in the overall analysis:

- The dissemination of audit and SCMR findings / learning to frontline staff and the evaluation of impact on practice.
- The analysis and learning from complaints and cascading to frontline staff to assist with service development.
- Development of service user engagement and participation in consultation processes.
- To ensure an appropriate training offer to meet need and mechanisms to evaluate impact.
- Overall awareness of the Information Sharing protocol and associated documents, including the management of data on agency records; supported by training and workshops.

These areas for improvement are being worked on via the subgroups, with progress being reported regularly to Board. There will be a further organisational standards audit in two years, to evaluate whether the areas for improvement have been sufficiently addressed. Moreover, the scrutiny process will through time independently evaluate whether the necessary changes in practice can be evidenced.

Practice Audits

Single-agency and multi-agency practice audits are critical to provide both insight into the effectiveness of safeguarding practice and assurance that it is of the required standard. It also provides a baseline against which to measure and monitor any necessary improvements.

The Board have undertaken a baseline audit of allocated cases across a selection of open adult and children's services. The audit findings formed the basis of the scrutiny process, in that the analysis informed the children's scrutiny event findings highlighted later in this report.

Further work is planned to develop a more comprehensive audit plan over the next year that will provide a real window on practice. The children's and adults Quality, Training and Development Groups will be focusing on this work and the planned audits will bring a real insight into practice and the Board and Independent Chair will be driving forward action to address any required improvements.

Independent Scrutiny

Scrutiny consists of analysing and triangulating information from a range of sources, including; learning from serious case management reviews, performance data, organisational standards audit evaluations, single agency audits, multi-agency audits, feedback from service users and frontline practitioners. The evaluation and analysis developed from this information, identifies what is working well and where improvements are required to multi-agency practice at an operational and strategic level. The evaluation is then fed into an interactive scrutiny event led by the Independent Chair involving senior operational leaders and relevant representatives. During the event, those present work together to agree the key findings and develop an action plan to address areas of practice that require strengthening.

Children's Scrutiny

The Board facilitated the first ever scrutiny event in March 2023 following a practice audit at the end of January. A group of senior managers from children's services joined the Independent Chair and the Director of Multi-Agency Safeguarding to triangulate information from all sources and evaluate against 5 key success factors:

- Procedures are known about and being followed
- Risk is identified and responded to in a timely manner
- Information is shared effectively
- Voice of the child and lived experience is evident
- Multi-agency working has a positive outcome for the child.

The scrutiny event reflected on various aspects of good practice as well as the areas of development. The Independent Chair who is experienced in undertaking scrutiny, reflected that the children's leads present were the most open and reflective group she has worked with, and were evidencing the behaviors and expectations set out in the Quality Assurance and Scrutiny Framework

The following key areas for improvement were identified and a detailed evaluation report was provided by the Independent Chair:-

- The need for further compliance with procedures which are aligned with the Safeguarding Boards policies & procedures
- The need to strengthen professional challenge and consistency of agencies attendance at key safeguarding meetings
- That direct work with children is enhanced by the introduction of 'day in my life' tools to ensure that children's voices and their lived experience are informing necessary improvements in multi-agency risk assessments and planning
- That further work is required to ensure understanding of thresholds and the continuum of need
- That further work is undertaken to improve effective information sharing.

The work to address these areas of improvement will be actioned through 2023/24 via the subgroups and regular progress and assurance will be provided to Board. At the time of writing, we have been developing the Quality Assurance and Scrutiny plan for 2023/24.

Adult's Scrutiny

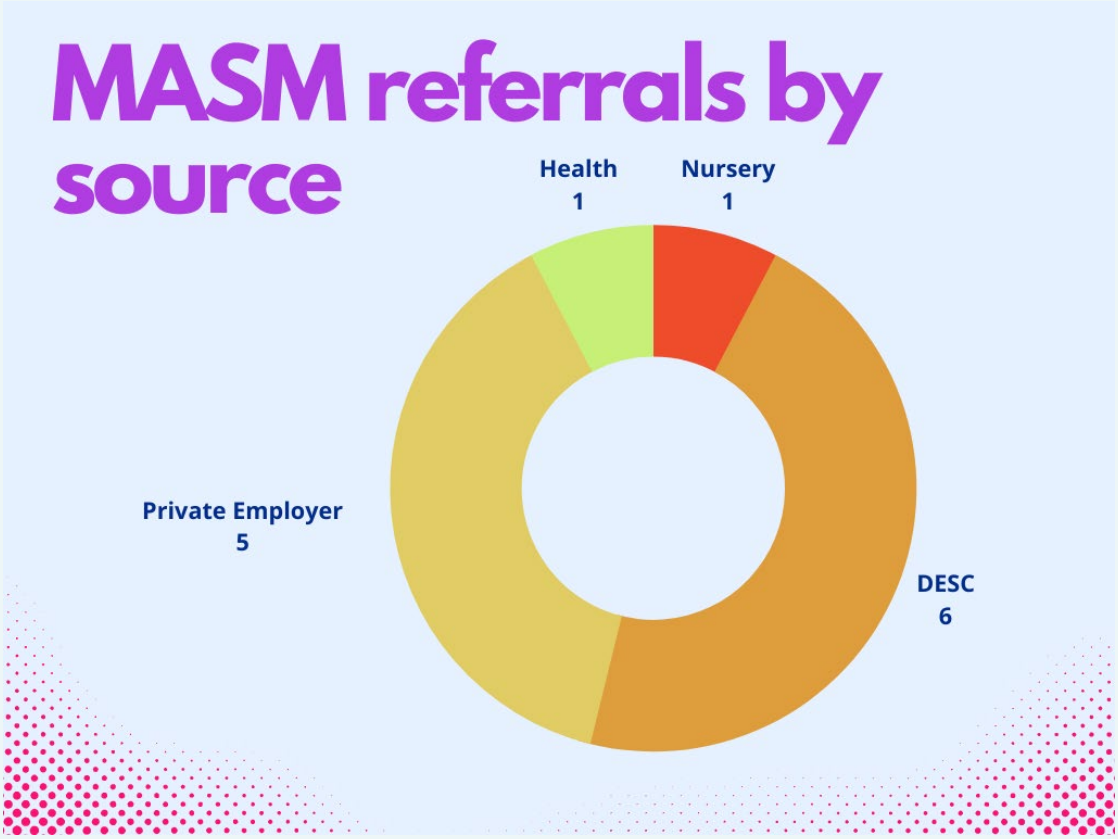
As highlighted in the Chairs' introduction the scrutiny process to evaluate safeguarding practice in respect of vulnerable adults had to be suspended after insufficient audits were undertaken to provide assurance about practice and issues were identified about the clarity of understanding by all agencies about the role of the adult safeguarding team in Manx-Care. It was agreed that there was further focused work to be undertaken in Social Care before a further multi-agency audit would be undertaken. Also, Manx Care would provide regular assurance reports to the Board to provide evidence about work being undertaken to develop clear pathways for referrals, feedback and communication with other agencies and reviews of existing safeguarding cases.

The Board will keep a necessary focus on this work and will undertake a further multi-agency event that will again include feedback from practitioners and stakeholders.

MASM – Managing Allegations against a Person working with Children & Vulnerable Adults Procedure.

The MASM procedure is a coordinated process following allegations being made and provides oversight of those robust multi–agency investigation of risk posed by people considered to be in a position of trust in organisations and settings providing services to children and vulnerable adults, following an allegation being made. This mechanism is used to ensure that all agencies are providing a safe service and explore all issues relating to conduct, risk and potential abuse of children and adults. The Board had included data pertaining to MASM activity in its dataset to provide assurance that the safeguarding processes across agencies were aligned to the MASM procedure and seek assurance regarding the management of allegations, following the Knottfield enquiry into institutional abuse.

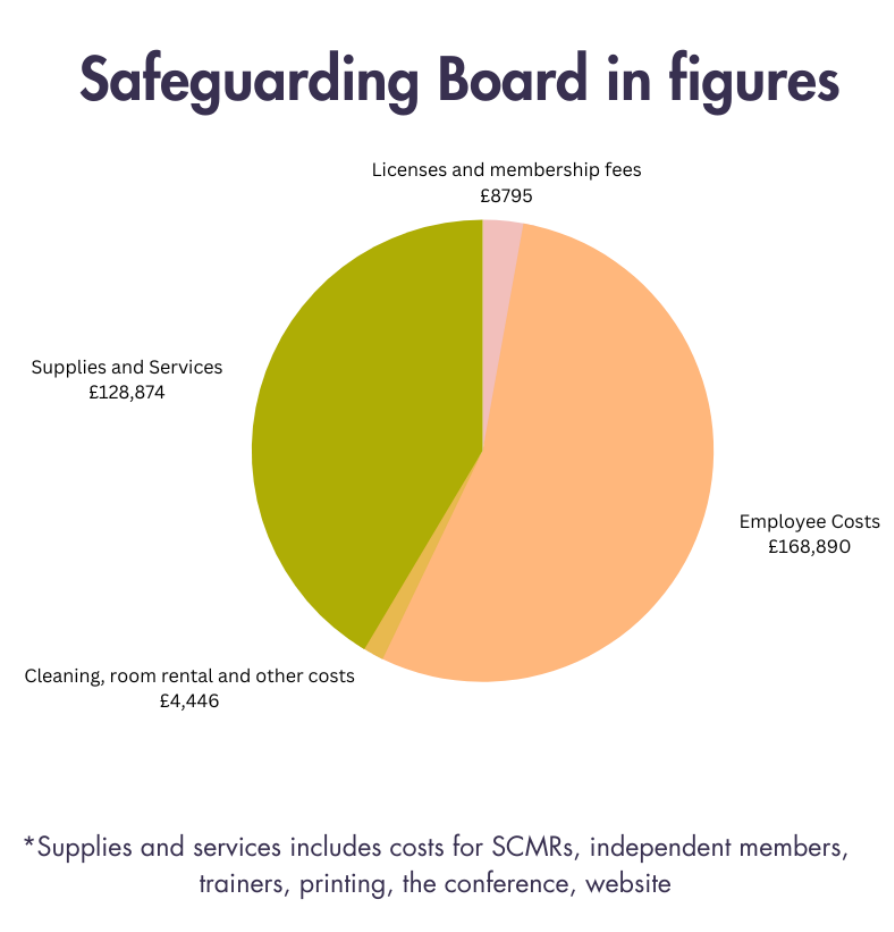
In the reporting period, there have been 13 MASM (Children) referrals made and 10 allegations were considered via the MASM process, of which 5 were substantiated, 3 were unsubstantiated, and 1 unfounded, with one remaining within the process.



There has been significant development in respect of MASM, with the approval and publication of a joint MASM policy for professionals working with Children and those working with Vulnerable Adults and bespoke referral forms. The new joint policy was launched in February 2023 and will be supported through MASM awareness training sessions facilitated via the Safeguarding Board training programme later in 2023 and 2024. The training and awareness raising is aimed at all sectors and agencies where professionals, employees or volunteers are working in positions of trust with Children and/or Vulnerable Adults.

This will promote the MASM process and ensure that all agencies and sectors including voluntary, third sector and faith based organisations are aware of their safeguarding responsibilities aligned to the policy and will support working together to safeguard children and vulnerable adults.

Budget



Future Plans

The Board had a busy 2022/ 23 with many developments and successful achievements set against the plans set in last year's report. Moreover, the Board are committed to ensure that work continues to drive forward this work on into 2023/24 to ensure it is embedded and making a real difference for local citizens.

Key work planned to meet the Board's priorities:

Working together to effectively safeguard vulnerable adolescents

- Further develop the contextual safeguarding approach to working with vulnerable adolescents at risk of exploitation.

- Develop a transitional safeguarding protocol to ensure vulnerable young adults are offered continuity of support services when reaching 18.
- Establish an all age exploitation subgroup to ensure further development and improvement of multi-agency work

Ensuring an effective multi-agency response for vulnerable adults

- Develop multi-agency self-neglect procedural guidance and pathways, and training programme.
- Lead an adult safeguarding scrutiny event which would include new self-neglect procedures and pathways
- Launch the self-neglect strategy and new working procedures via a multi-agency conference.
- Ensure specialist adult safeguarding training is provided covering topics such as mental capacity and consent

Work to meet the overarching priorities

- Launch the multi-agency safeguarding policies and procedures manuals
- Provide specialist training as highlighted in SCMRs
- Launch the engagement strategy and plan for 2023 /24 to ensure the voices of service users and their families / carers and views from practitioners are at the centre of the Board's work as well as informing priorities and identifying practice improvements.
- Develop a revised Threshold and continuum of need for children's services
- Develop a multi-agency threshold document for adults services
- Ensure a comprehensive learning cycle is evident where the aims of training outcomes are measured against the impact in practice and service delivery / improvement and this is further tested out via the quality assurance and scrutiny process.

The Board would like to thank staff across all sectors and communities that have contributed to the work of the Board. We welcome feedback about how to improve safeguarding practice and protection for our children and vulnerable adults. The Board can be contacted at safeguardingboard.co@gov.im