Isle of Wight

Safeguarding Adults Board

Annual Report

2022-2023

Foreword from Teresa Bell, Independent Chair

- Welcome to the IOWSAB annual report for 2022/23. Our annual report shows what the Board aimed to achieve during 2022 to 2023 and what we have been able to achieve. It provides a summary of who is safeguarded on 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.

- I am very grateful to our partners for their continued commitment to the work of the IOWSAB, despite the wider pressures on their time and resources. In particular I would like to thank the chairs of the Board's sub groups, who work tirelessly to progress our shared priorities for adult safeguarding.

- This report of our work together over the last year evidences a commitment to effective partnership working, which provides a sound basis to approach our priorities for reducing the risks of abuse and neglect on the Island.

Contents

1. Board Membership

The Isle of Wight Safeguarding Adults Board (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. The Board meets quarterly, and these meetings have all been virtual in 2021-2022. The board has three statutory partners namely the **Isle of Wight Adult Social Care, Hampshire Constabulary, and the Isle of Wight Clinical Commissioning Group**. However the statutory partners are joined by a range of agencies, providers, and voluntary sector representatives who work with adults all across the Island:

2. Board Structure

The IOW board has sub groups:

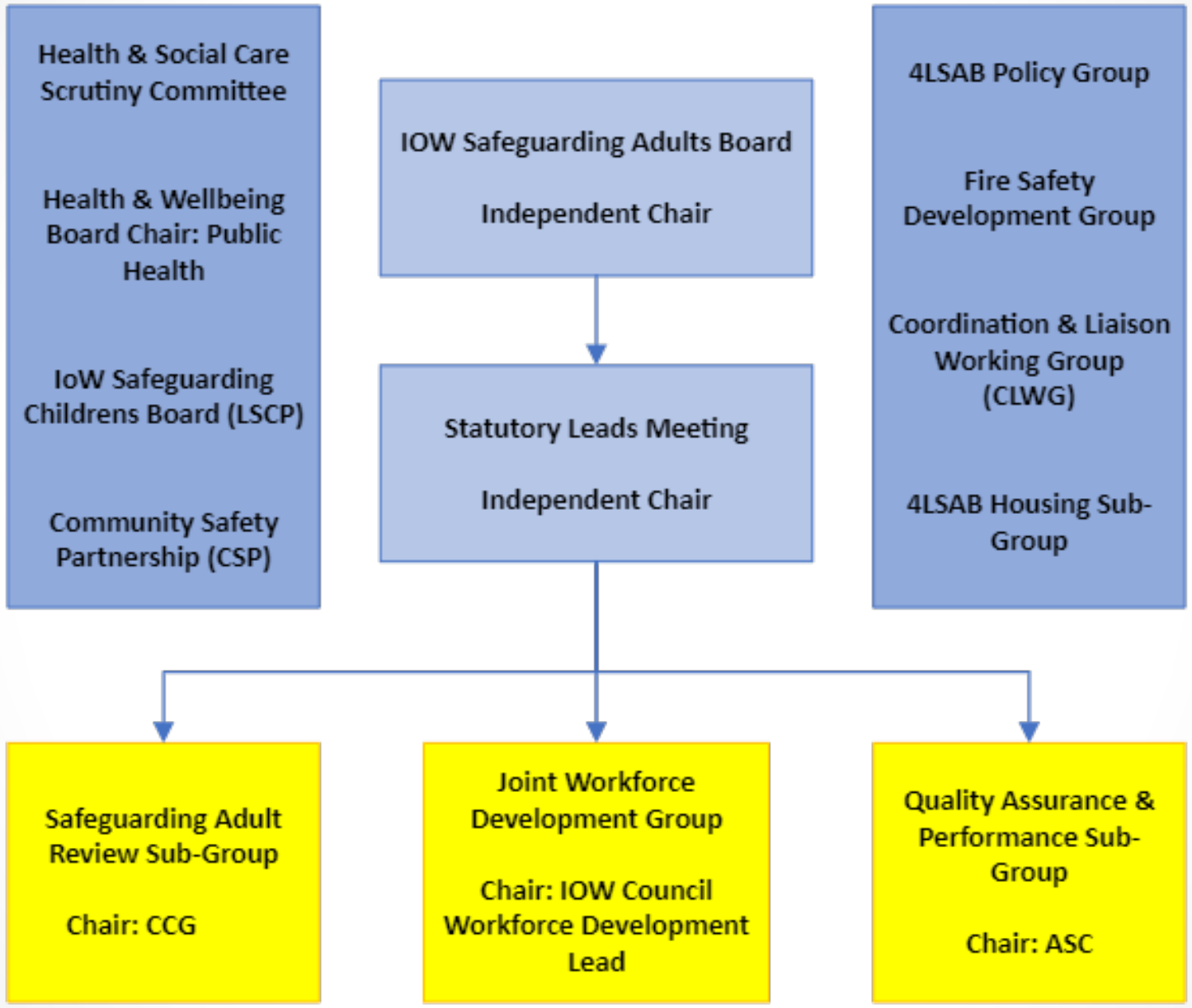
Much of the work of the Board is undertaken by members of the three sub-groups, in collaboration with the Board Manager and their administrative support.

2. Board Structure

- The Board maintains close links with the Local Safeguarding Children's Partnership and the Community Safety Partnership

- The Isle of Wight Board is also a core member of a range of 4LSAB Sub-groups, which have membership from the 4 Safeguarding Adults Boards across Hampshire, Isle of Wight, Portsmouth and Southampton.

- The Board 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 Director of Adult Social Services, the District Commander for the Isle of Wight, the Clinical Commissioning Groups Deputy Director of Quality, and the Chair and Board Manager of the Safeguarding Adults Board.



Isle of Wight Safeguarding Adults Board Governance 2022-2023

3. Safeguarding Adult Review Sub Group Activity

As part of its statutory responsibilities, the Board is required to undertake Safeguarding Adult Reviews (SARS). The purpose of a Safeguarding Adults Review is not to hold individual organisations or practitioners to account, nor to apportion blame, but specifically to identify areas of learning. SARs ensure that Boards have a full picture of what happened, so that all organisations involved can improve as a result. The goal is to move beyond the specifics of a case – what happened and why –to identify deeper underlying issues that are influencing practice more widely.

The Safeguarding Adults Review Group is one of the sub-groups of the Board with a multi-agency membership of agencies represented on the Board. The role of this group is to manage SARs. The group will receive referrals for reviews, collect appropriate information and make decisions about whether case meet the statutory criteria. The group will then determine the most appropriate method for identifying learning, which ranges from full written reviews with a commissioned independent reviewer, thematic reviews where several cases with similar themes are grouped together, to locally facilitated learning workshops.

The chair for the sub-group is a member from health, in April 2022, the chair changed from the interim designated nurse for adult safeguarding to the current chair who was new into post in the CCG/ICB.

Current mandatory Safeguarding Adult Review activity

- Ms L involves an individual with a long-term health condition who relocated from the mainland to the Isle of Wight and involves alleged abuse and neglect by a professionally registered carer. This case was agreed to meet the criteria for a mandatory Safeguarding Adults Review in June 2021.

- A joint review with Southampton Safeguarding Partnership is underway.

Referrals to the SAR Sub Group 2022-2023

- During 2022/2023, the Safeguarding Adults Review (SAR) sub-group on the Isle of Wight scoped 8 cases, none of which met the criteria for a mandatory Safeguarding Adults Review (SAR), however local learning was identified in 4 the cases, with scoping on 1 case being paused at the request of the Police whilst they further investigated.

- Scoping took place for 4 other cases that did not meet the criteria for a mandatory SAR with feed-back given to referrers of the outcome and rationale for the decision made. In one case referred by the Fire Safety Development Group feedback was provided for the 4 LSAB to gain assurance that the Fire-Safety Framework is embedded in practice, this a business priority for 2023-2024.

- Following a case referred in January 2022 which related to a victim of homicide, it was identified that they were open to several agencies. On scoping, the case did not identify any multi-agency system failings relating to the victim. They received support sporadically and were well at the time of the event. There was a criminal investigation in this case, and the potential for a Mental Health Homicide Review (MHHR). However, following a Not Guilty verdict at the criminal trial, the criteria for a MHHR was not met.

- A further case involves an individual who suffered serious harm during a domestic abuse incident. The case was referred in January 2022, as the individual has care & support needs and was known to several services. Following a criminal investigation and prosecution, a ‘near miss DHR’ is taking place under the discretionary SAR criteria, as scoping identified some potential points for intervention. This is an opportunity to gain the voice of both victim and perpetrator in a high-risk domestic abuse case.

- A health review took place involving an individual who was discharged from hospital with a package of care that they later declined. They sadly passed away shortly afterwards. The case had been referred in January 2022. This did not identify multi-agency system failure. The gentleman had been resident on the IOW for 16 days prior to hospital admission with positive work evidenced. A review of the health interventions post discharge took place by the Named GP for Adult Safeguarding, Lead professional for Adult Safeguarding for the IOW Trust and Designated Nurse. The health review identified good use of the mental capacity act and follow up on his reluctancy to engage. These are both board priorities.

SAR Sub Group Activity

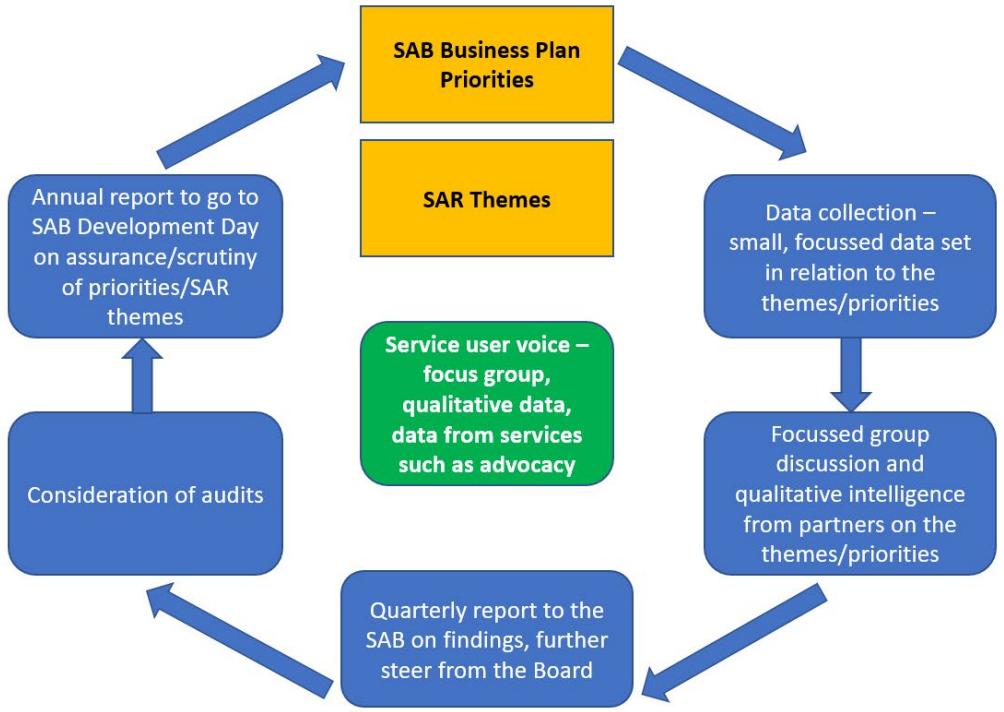
Update on previous work

In early 2022, a Thematic Review into 5 cases with common themes was completed. The themes identified were:

- Homelessness
- Mental health
- Alcohol/substance misuse
- Suicide/overdose

The review offered us an analysis of the cases and systemwide themes. A multi-agency workshop with the reviewer was held in May 2022 and the Board is implementing improvements and learning with a particular focus on application of the Mental Capacity Act in circumstances where people at risk may be resistant to accepting care and support.

A second Thematic Review into 4 cases with similarities, and an overall theme of neglect was completed. Two of the individuals included in the review are still alive and an executive summary has been published in August 2023.



4. Quality Assurance and Performance

As a sub group of the board, the Quality Assurance and Performance Group has membership from a number of agencies represented on the Board. This year new members from IOW Care Partnership, Inclusion and Public Health have been welcomed. The purpose of this group is to provide the Board with appropriate information so that it can assure itself that all partners are consistently safeguarding adults across the Island and are working is accordance with the Care Act (2014), Statutory Guidance and the 4LSAB Multi-agency Safeguarding Procedures and additional guidance.

Quality Assurance and Performance activity

The Quality Assurance and Performance group have held meetings every three months throughout the annual review period. A new workstream concentrating on individuals who find it difficult to engage with statutory services (Refusal to engage) has been commenced and this is in the planning stages, a terms of reference has been drafted and a workshop is being planned for January 2024.

This workstream will be accompanied by an anonymous staff survey which will be shared across all of the partner agencies. We will be exploring the best way as to how to capture the voice of the people with lived experiences throughout.

Our aim is to understand the decision making of all partner agencies in relation to the engagement of service users, with their services and the support provided for people who find it difficult to respond to appointments, have no reliable means of contact or have no fixed address.

Our staff survey will be asking questions around experiences working with people who are difficult to engage, the process of supporting decisions making related to ending or not ending involvement and understanding of Mental Capacity Act.

5. Workforce Development Sub-group

The joint Safeguarding Adults Board (SAB) and IOWSCP Workforce Development subgroup (WFD) is well established and there is synergy between the two workforce development agendas in terms of pooled budgets for areas of joint interest as well as separate courses that are relevant for the individual Board / Partnership. A cyclical process is in place for ensuring training meets the needs of the workforce. Learning Needs Analysis is undertaken annually, with feedback from a staff survey of workforce development needs considered alongside course evaluations, attendance numbers and observations of learning delivered. Learning needs are also identified through the Board's scrutiny and assurance programmes and learning reviews. Learning and development is delivered face-to-face, online or in an e-learning / briefing format. Some IOWSAB learning and development is shared with 4LSAB colleagues.

A range of training opportunities were offered throughout 2022/2023 which reflected the themes from the previous year's Learning Needs Analysis.

Themes identified as part of learning needs analysis and / or arising from learning taken from SAR's will be taken forward in a mixture of training, webinars, e-learning and resources which will be widely available through the Learning Hub

How have we progressed?

Learning from Covid (Safeguarding in a pandemic): executive summary report has been published and partners continue to monitor the impact of improvements .

A Learning Needs Analysis has been completed to ensure that the Board's training provision is based on analysis of need and links to SARS. All learning has been incorporated into proposed new training plan.

The SAR Sub Group have arranged a local training programme to be delivered by SCIE which will ensure a local pool of professionals are trained to carry out reviews ensuring a good basic understanding of local systems and processes

The Board committed to provide a comprehensive training package for multi-agency staff which took forward the learning for front line staff from the Alcohol Change UK workstream.

Between 2022 and 2023 a full programme of training with 3 separate courses was delivered. All of which were well received.

Consideration is now being given to a single amalgamated course in 2023/2024

6. Policy and Procedure updates

- One important duty of the Safeguarding Adults Board team is to ensure local and regional policies, procedures and guidance are fit for purpose.
- Most Board guidance used on the Island is applicable to the 4 Boards in Southampton, Hampshire, Isle of Wight and Portsmouth. Having all 4 Boards producing and embedding joint guidance is important for effective multi-agency working, with many partner agencies spanning more than one local authority area.
- The 4LSAB Policy Sub-group manages the updating of current guidance, as well as identifying gaps and overseeing the development of any new guidance. This group is currently chaired by Portsmouth. In 2021/2022, the following Policy work was undertaken

New Guidance and Revisions undertaken in 2022-2023

Key Policy and Guidance Documents developed or updated this year:

- Large Scale S42 Safeguarding Enquiry Protocol
- Homelessness Guidance
- Framework for Managing Risk and Safeguarding People Moving into Adulthood
- Revised Hoarding Guidance

What are the recognised challenges?

Learning identified through national and local case reviews often result in the need for new guidance or revisions to existing guidance, partners are committed to prioritising this work and supporting practice but acknowledge this work can take time.

What is the groups future focus?

- Finalising the review of Multi Agency Risk Management Framework.
- Development of Family Approach Toolkit.
- Engagement policy

7. 4LSAB Fire Safety Development Group

The four LSAB Fire Safety Development sub-group continues to review and share learning from serious fire incidents to ensure effective inter-agency processes, procedures and preventative practices are in place.

Key Achievements of the 4LSAB Fire Safety Development Group in 2022-2023:

- Publication of the Fire Safety Development Group Thematic review 2019-21 and Learning briefing
- Between April 22 and March 23 the Fire Safety Development Group conducted 15 case reviews for fire incidents where a serious injury or fatality occurred. 75% of incidents reviewed involved an individual who was living alone and 88% were male. 25% of cases were known to Adults Health and Care.
- Training from Hampshire and Isle of Wight Fire and Rescue Service through the 4LSAB's and to individual partner organisations raises professional awareness and knowledge to identify, assess and manage fire risk.

What are the challenges?
Learning identified in Fire Safety Development Group case reviews can identify themes of a similar nature. There is a challenge regarding the confidence and assurance that partners are reviewing the learning and embedding positive changes in practice

Priorities for the group in 2023-2025

- To provide assurance that the Fire Safety Framework and case review learning, has been embedded in practice within agencies across the 4LSAB
- To engage with the Care Quality Commission across the 4LSAB area to seek assurance of fire risk management within domiciliary care providers and the promotion of the 4LSAB Fire Safety Framework

8. 2022-2024 Business Plan

The areas of focus for 22-24 are:

- Preparation for Liberty Protection Safeguards (LPS)
- Service User Voice (building on Making Safeguarding Personal)
- Safeguarding in Transition
- Learning from Safeguarding in a Pandemic Report
- Safeguarding Concerns – complexity of referrals, abuse types, referral rates, identify underreporting, appropriate use of criteria
- Quality Assurance Framework
- Using the Homelessness, Mental Health, Substance Misuse and Suicide/Overdose Thematic Review to shape better multi-agency working and support people who are accessing multiple services. Consideration of SAR outcomes in the commissioning process.
- Managing the interface between SARs and Coronial Processes – National Workstream
- Alcohol Change UK – taking forward the learning
- MARM (Multi-agency Risk Management) and Safeguarding
- Impact of workforce capacity

Our strategic aims 2022-2024

- Prevent abuse
- Protect adults at risk
- Learn from experience
- Improve services

9. Safeguarding Adults Collection (SAC) 2022-2023 IWC Govt. Return

Introduction

- Records details about safeguarding activity for adults 18 and over
- Includes activity reported to or identified by Councils with Adult Social Services Responsibilities (CASSRs)
- Includes demographic information about the adults at risk & details of the alleged incidents
- Return is split into 5 sections covering: Demographics, Case details, Mental Capacity, Making Safeguarding Personal (MSP) and Safeguarding Adult Reviews (SARs)

Terminology

- **Safeguarding concern**
  Sign of suspected abuse or neglect that is reported to the council or identified by the council .
- **Safeguarding enquiries**
  The action taken or instigated by the LA 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.

  Two types of Enquiry:
  - **Section 42:** Where adult meets all of the section 42 criteria
  - **Other:** where adult does not meet all of section 42 criteria but the council considers it necessary & proportionate to have a safeguarding enquiry

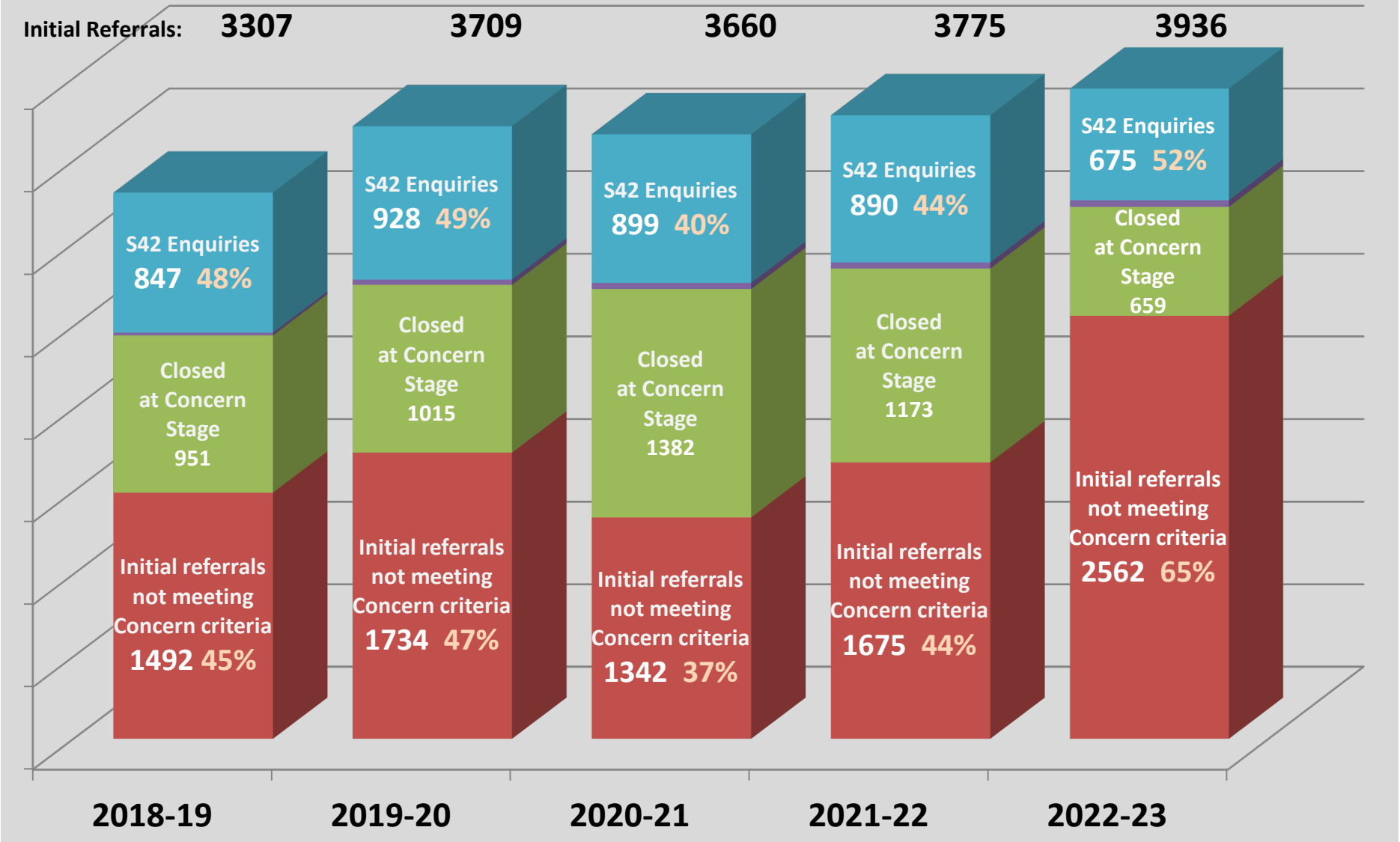
CIPFA comparators (Chartered Institute of Public Finance and Accountancy)

Comparator groups are a selection of 15 CASSRS considered to be similar to the chosen council. They are selected according to the CIPFA Nearest Neighbour Model, which identifies similarities between councils based on a range of socio-economic indicators

CASSR Name	Region
Cheshire East Council	North West
Cheshire West and Chester Council	North West
Cornwall Council	South West
Dorset Council	South West
East Riding of Yorkshire Council	Yorkshire and The Humber
Herefordshire Council	West Midlands
Isle of Wight Council	South East
North Somerset District Council	South West
North Tyneside Council	North East
Redcar & Cleveland Borough Council	North East
Sefton Council	North West
Shropshire Council	West Midlands
Stockport Metropolitan Borough Council	North West
Torbay Council	South West
Wirral Metropolitan Borough Council	North West

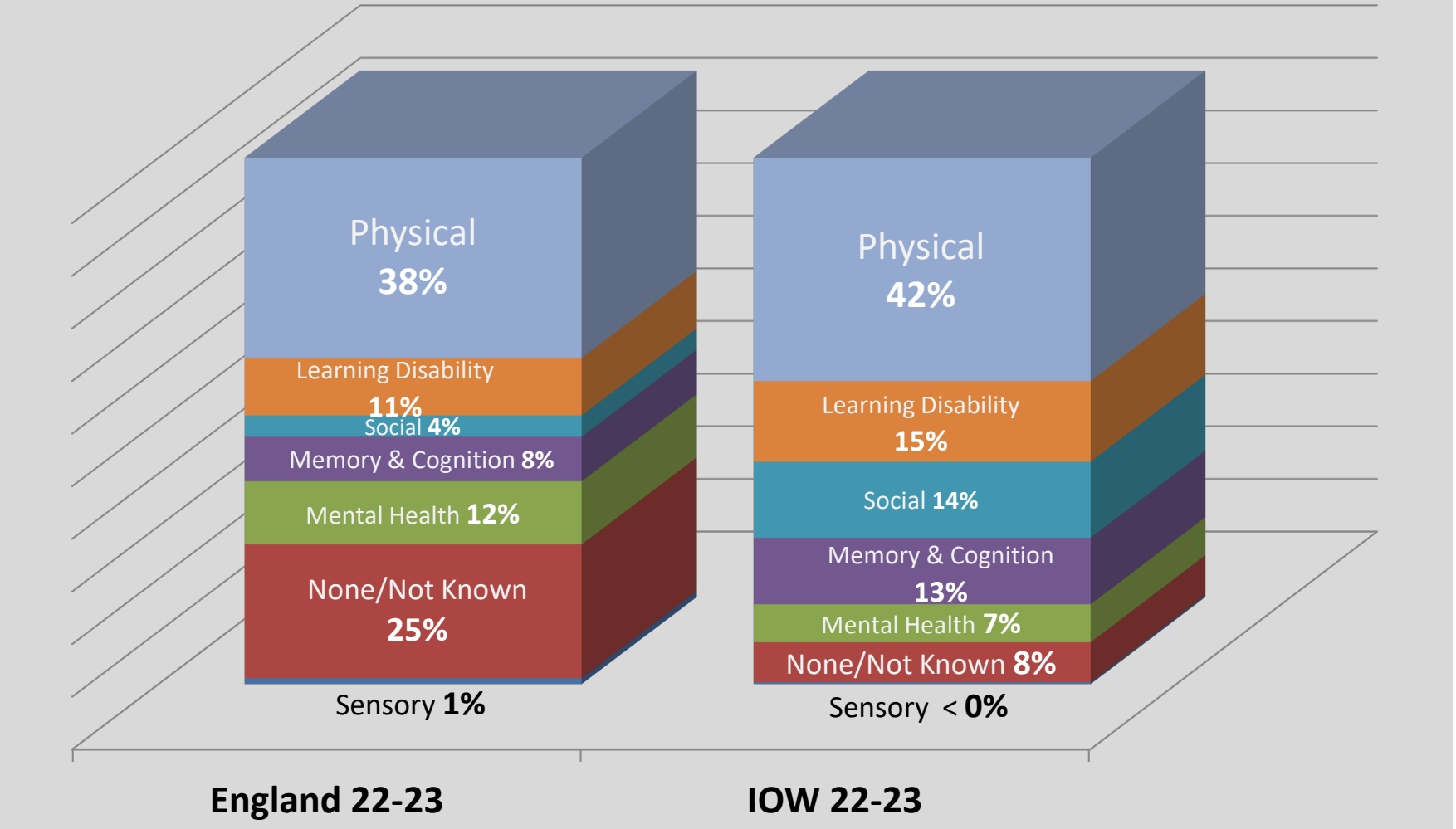
Overall Referrals Analysis

IWC Comparison with previous years



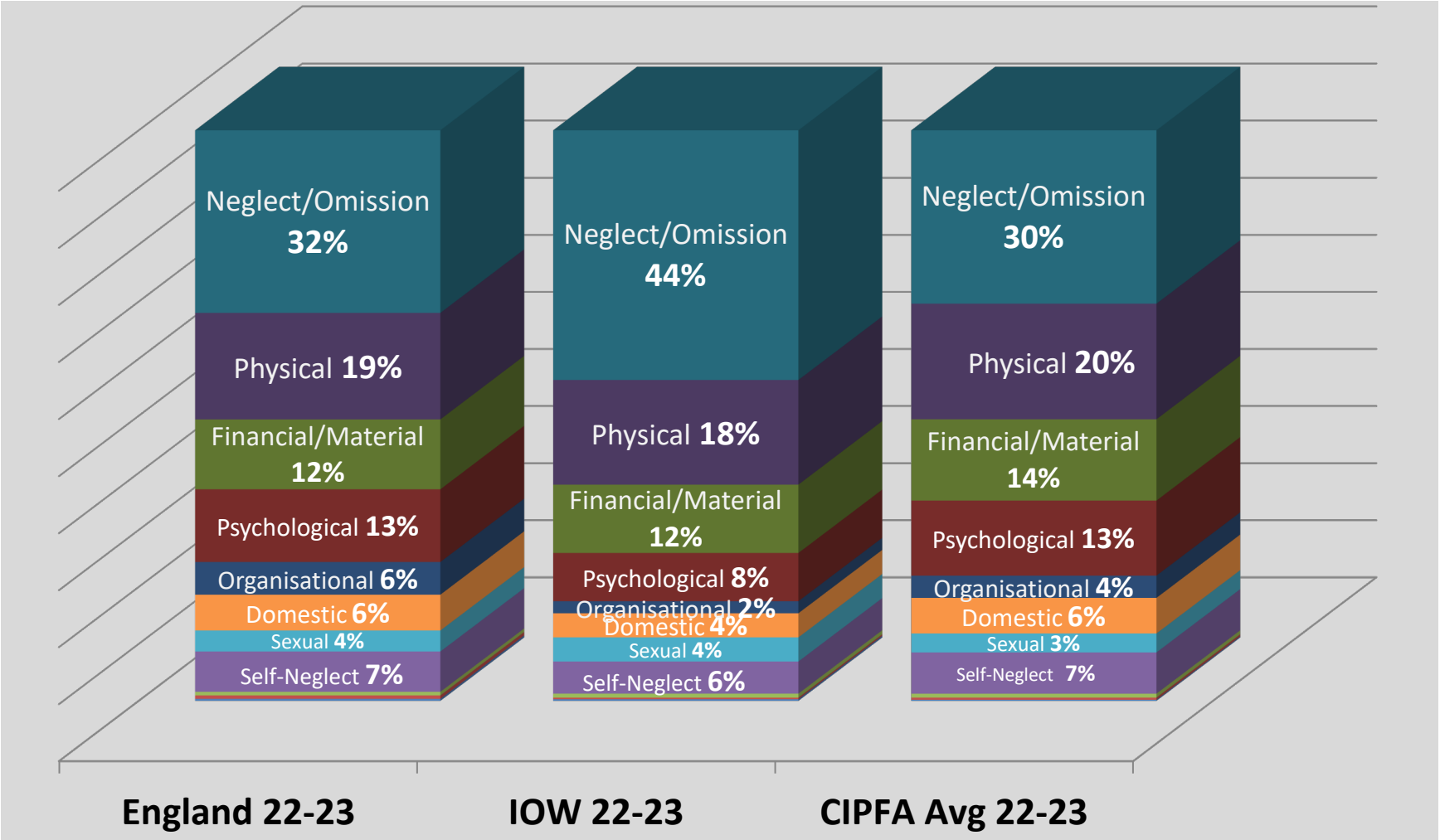
SAC return – Section 1

Individuals involved in S42 Enquiries - by Primary Support Reason



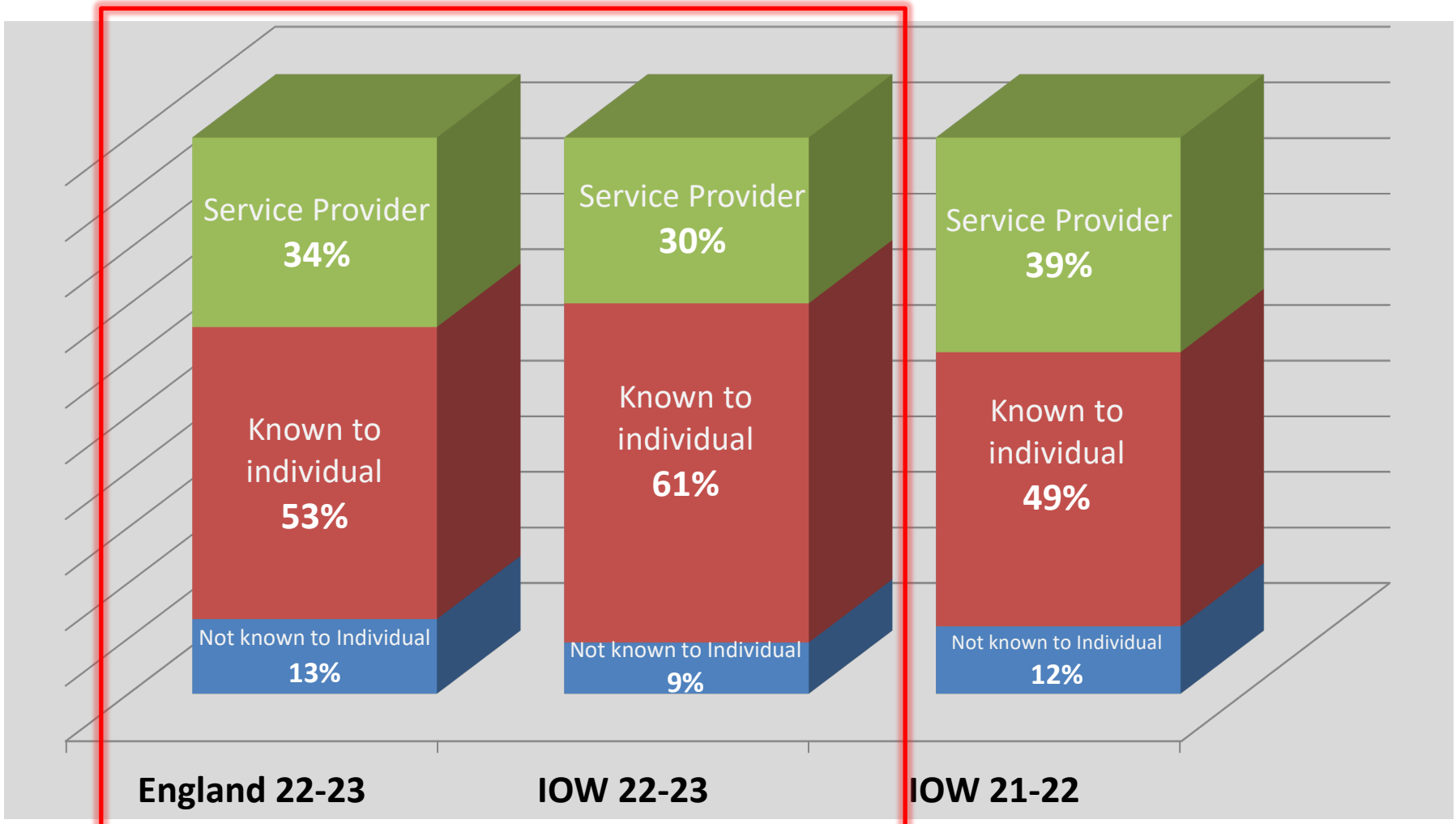
SAC return – Section 2

Section-42 Enquiries: Type of risk



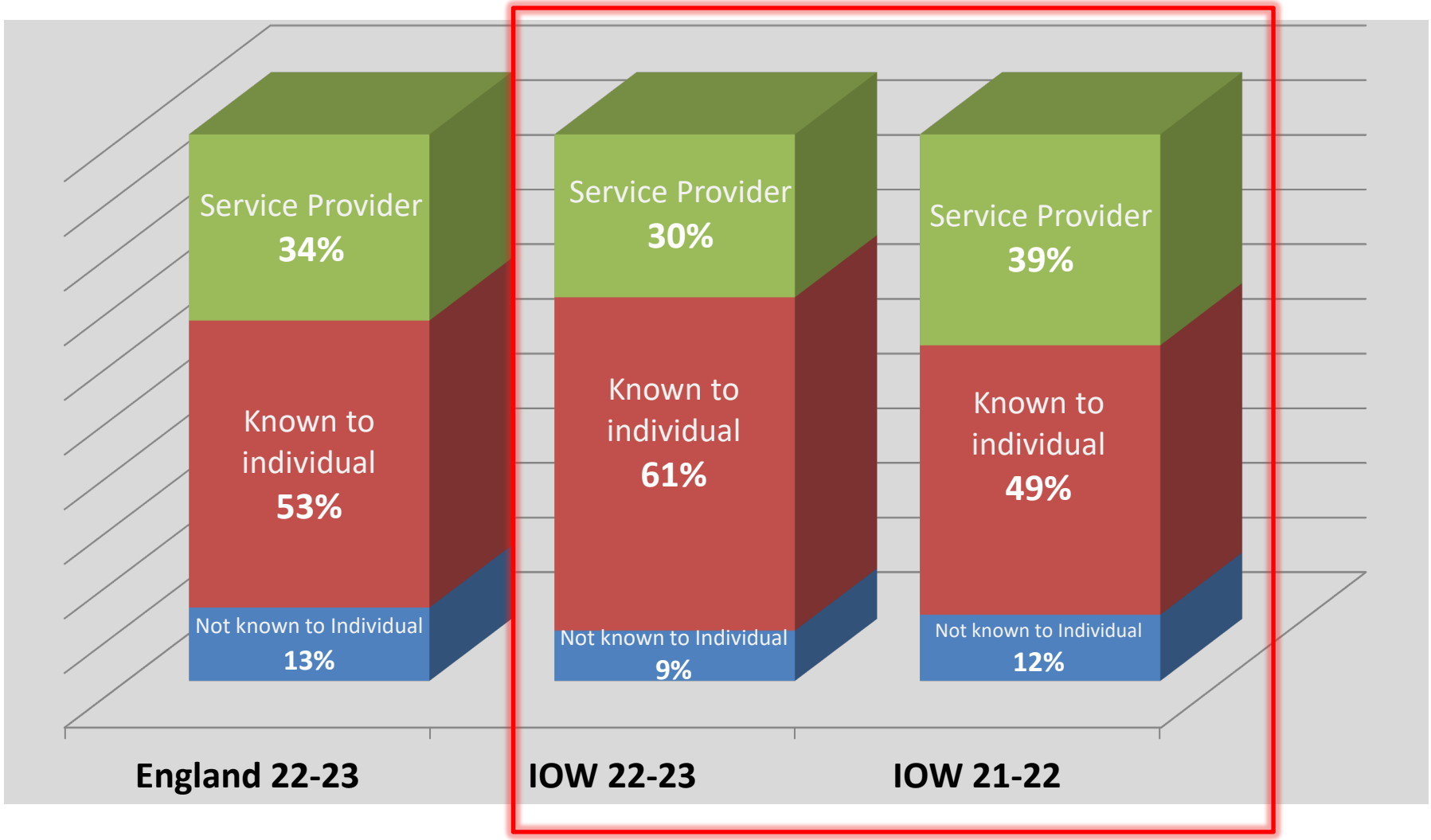
SAC return – Section 2

Section-42 Enquiries: Source of risk



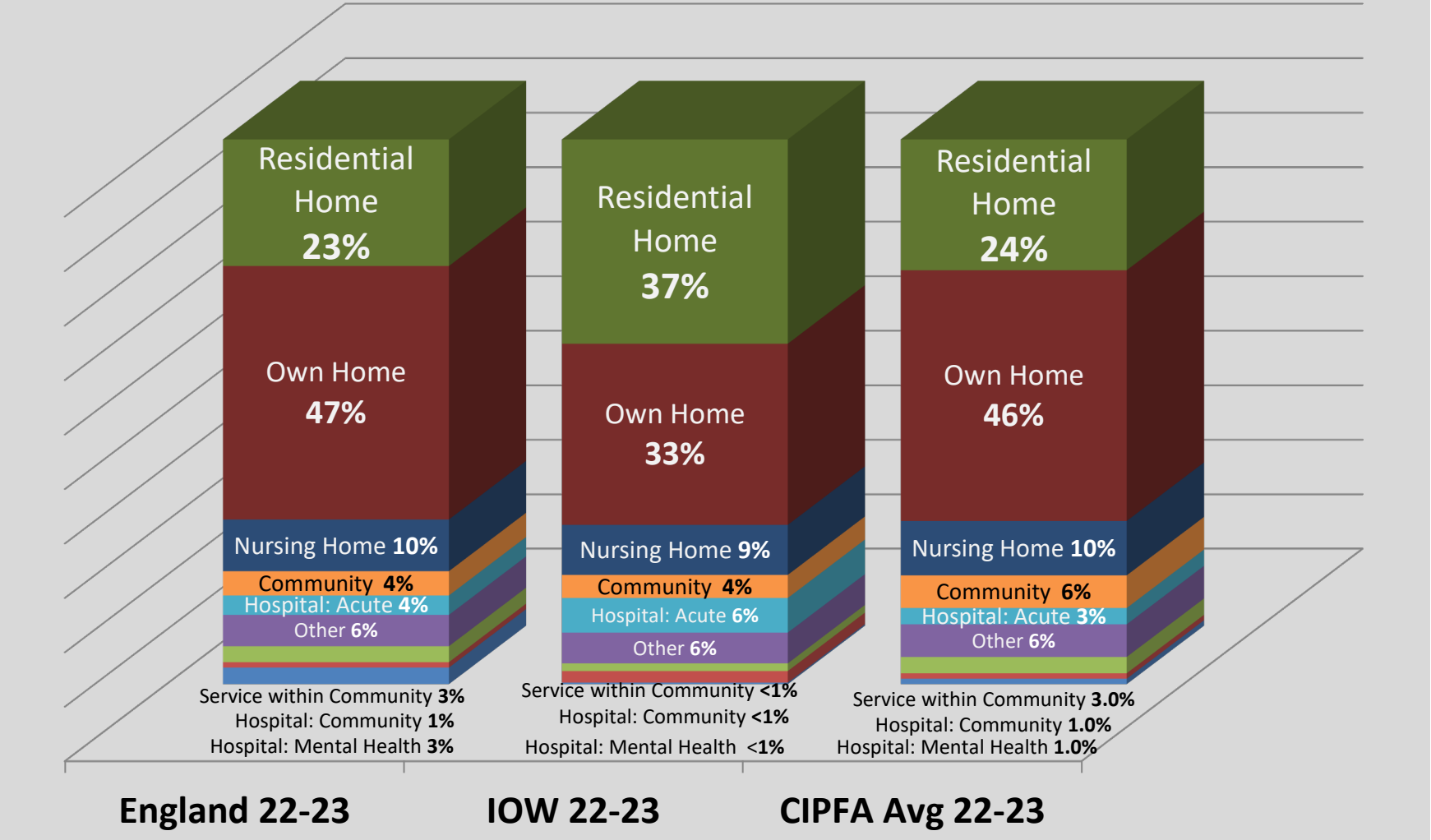
SAC return – Section 2

Section-42 Enquiries: Source of risk



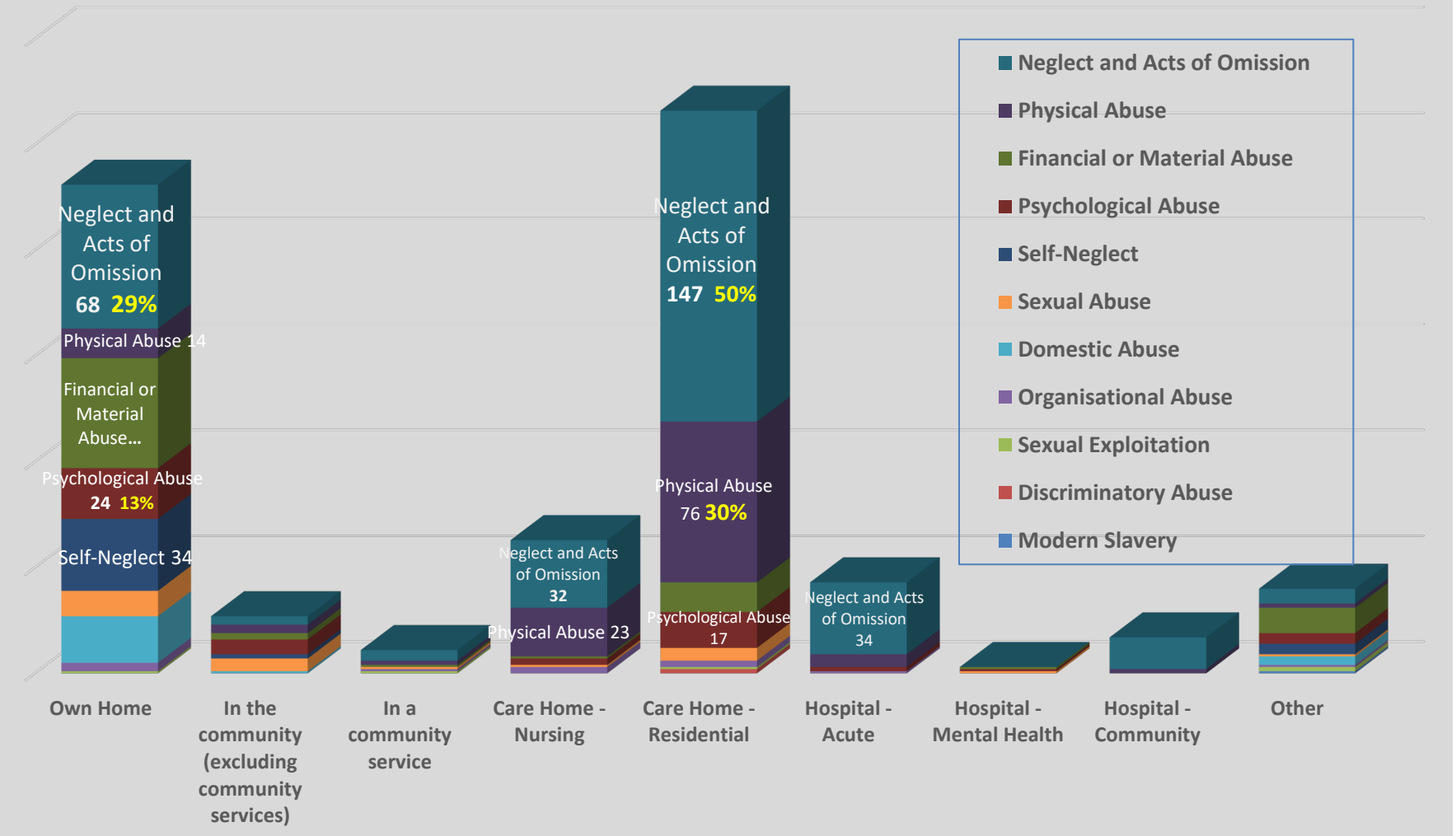
SAC return – Section 2

Section-42 Enquiries: Location of risk



SAC return – Section 2

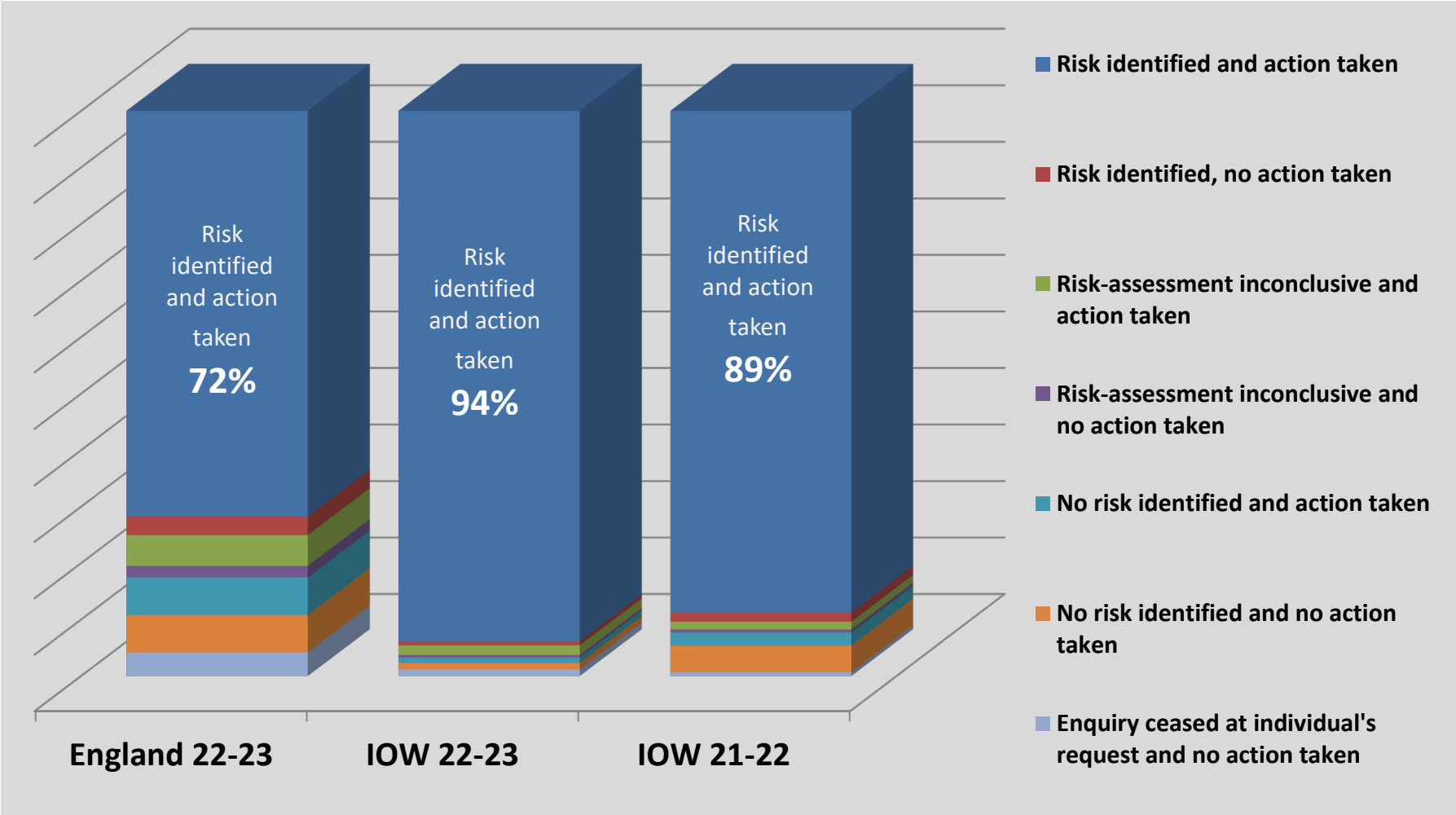
Section-42 Enquiries: Type and Location of Risk. **IWC 2022-23**



SAC return – Section 2

Section-42 Enquiries: Risk Assessment Outcomes

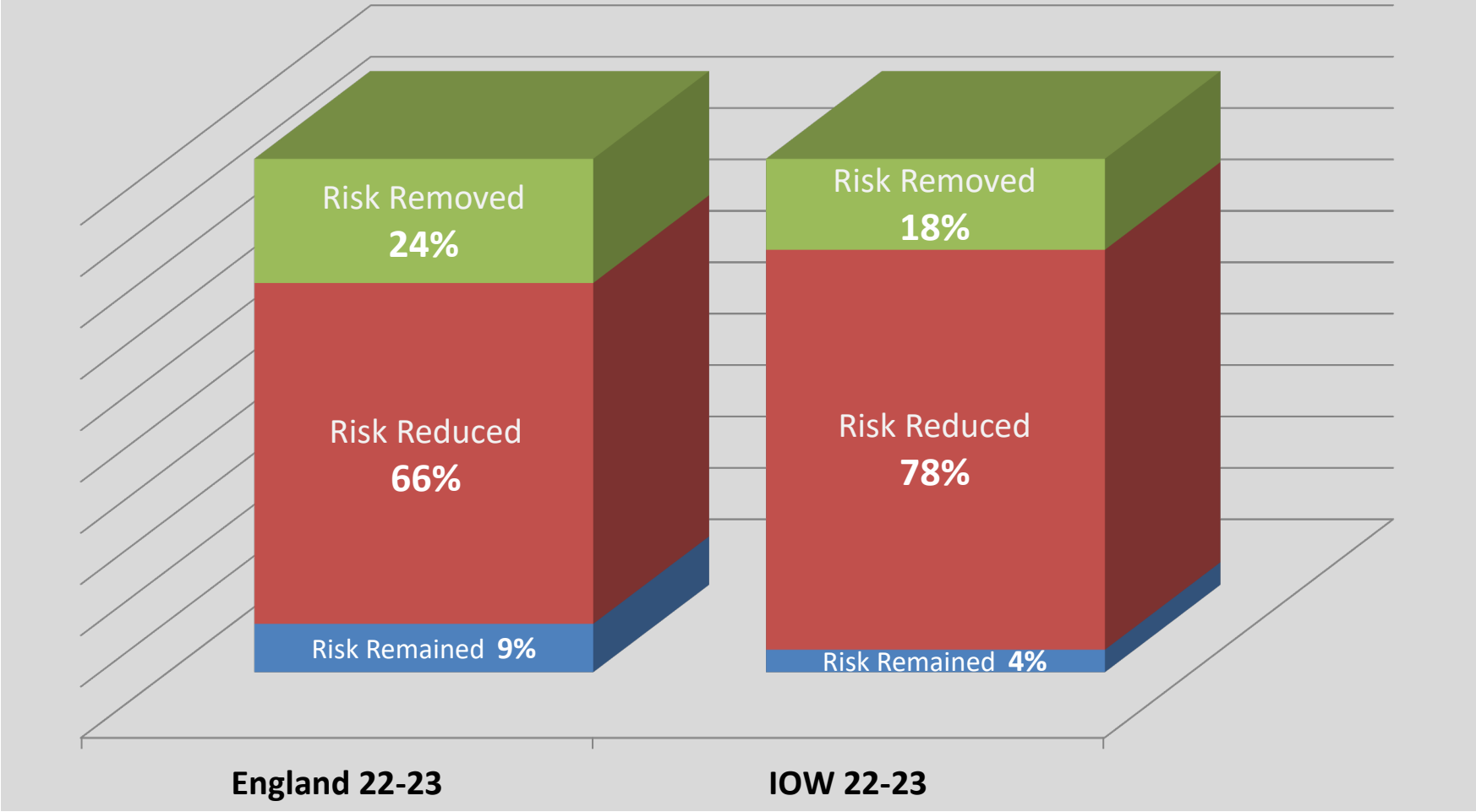
Was a risk identified and was any action taken / planned to be taken?



SAC return – Section 2

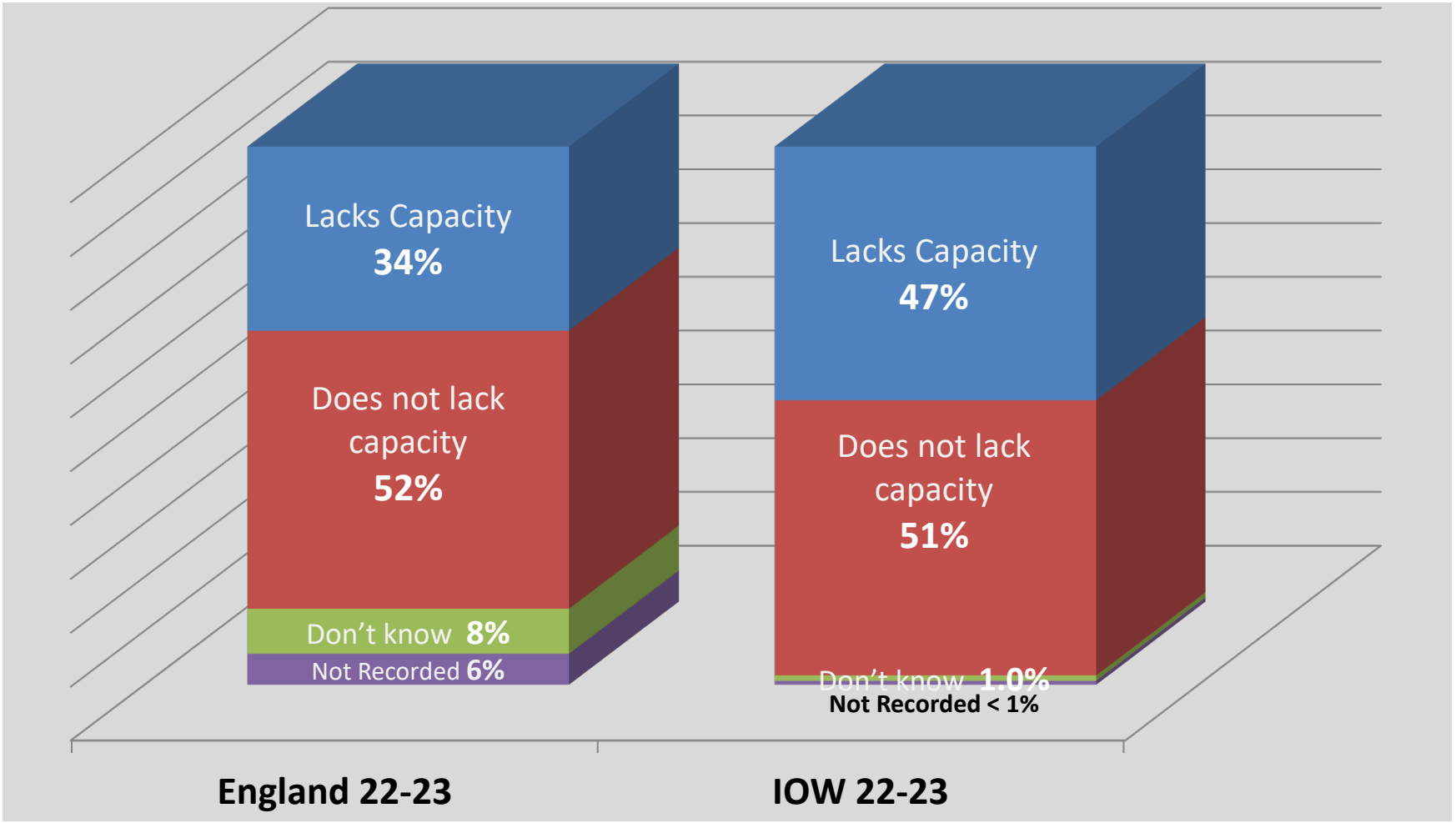
Section-42 Enquiries: Risk Assessment Outcomes

Where risk was identified (in previous slide), what was the outcome when the case was concluded?



SAC return – Section 3

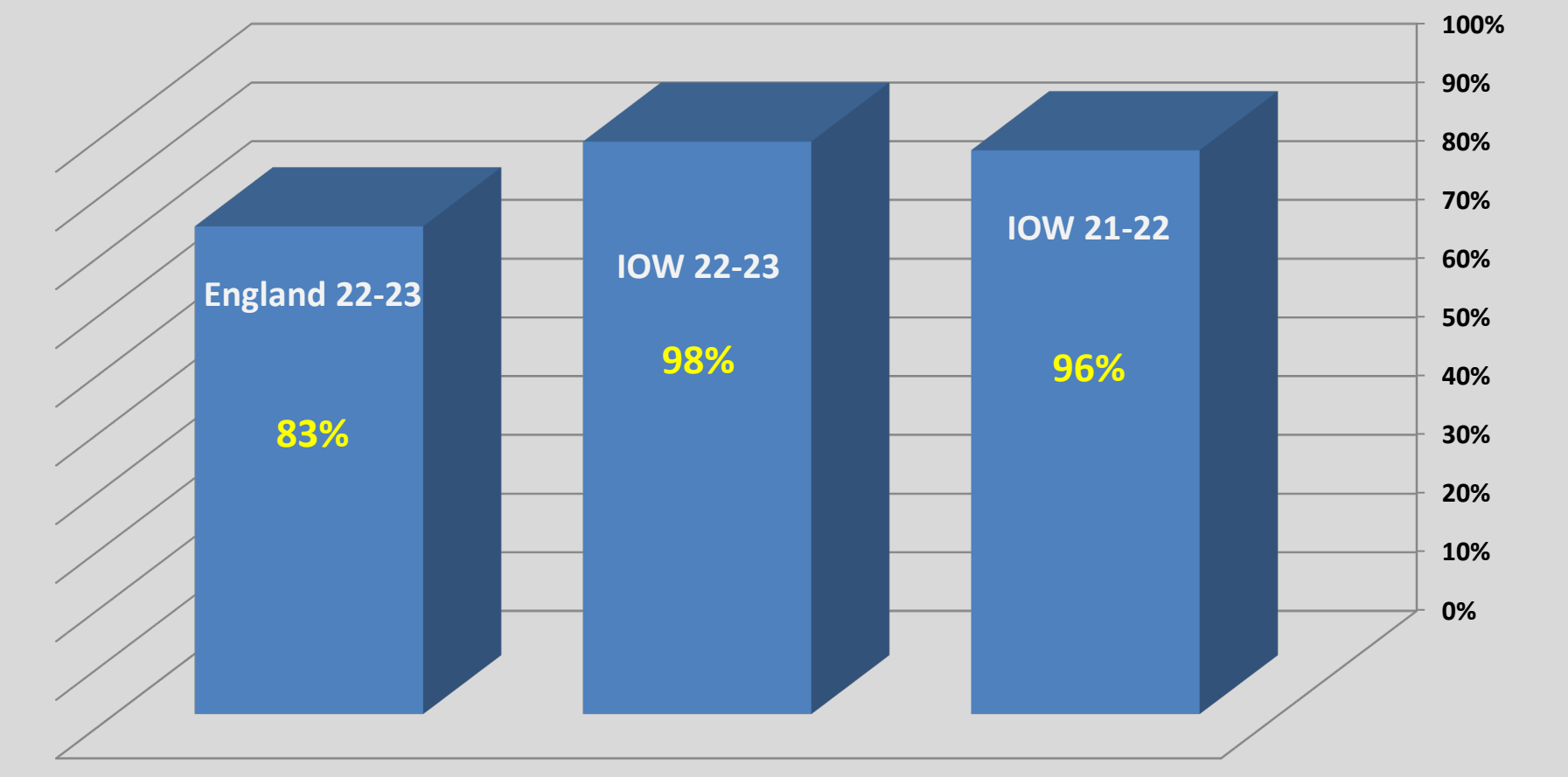
Section-42 Enquiries: By mental capacity of adult at risk.



SAC return – Section 3

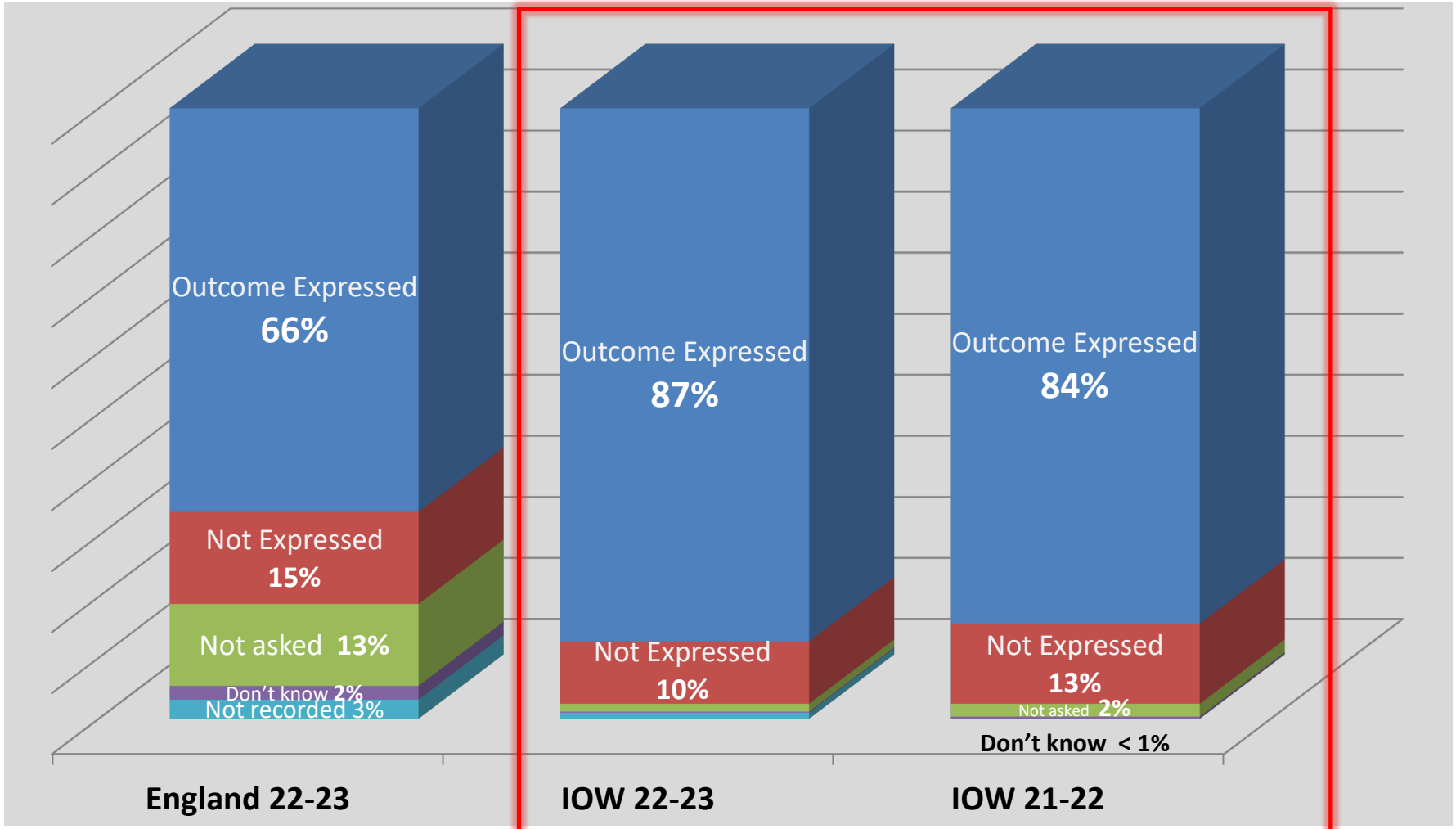
Section-42 Enquiries: Mental capacity of adult at risk

Those that lacked capacity were supported by advocate, family or friend?



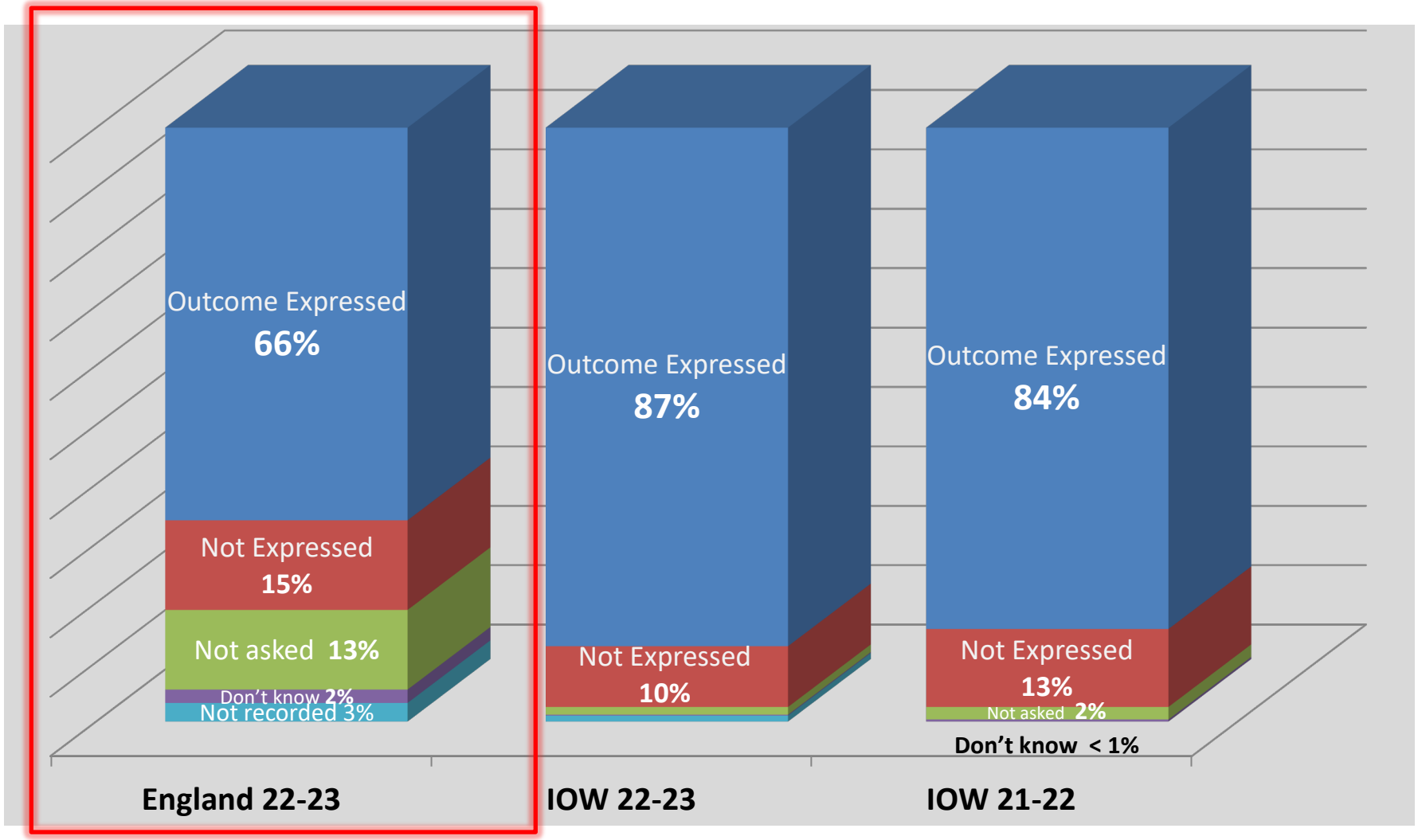
SAC return – Section 4

Section-42 Enquiries: Making Safeguarding Personal (MSP)



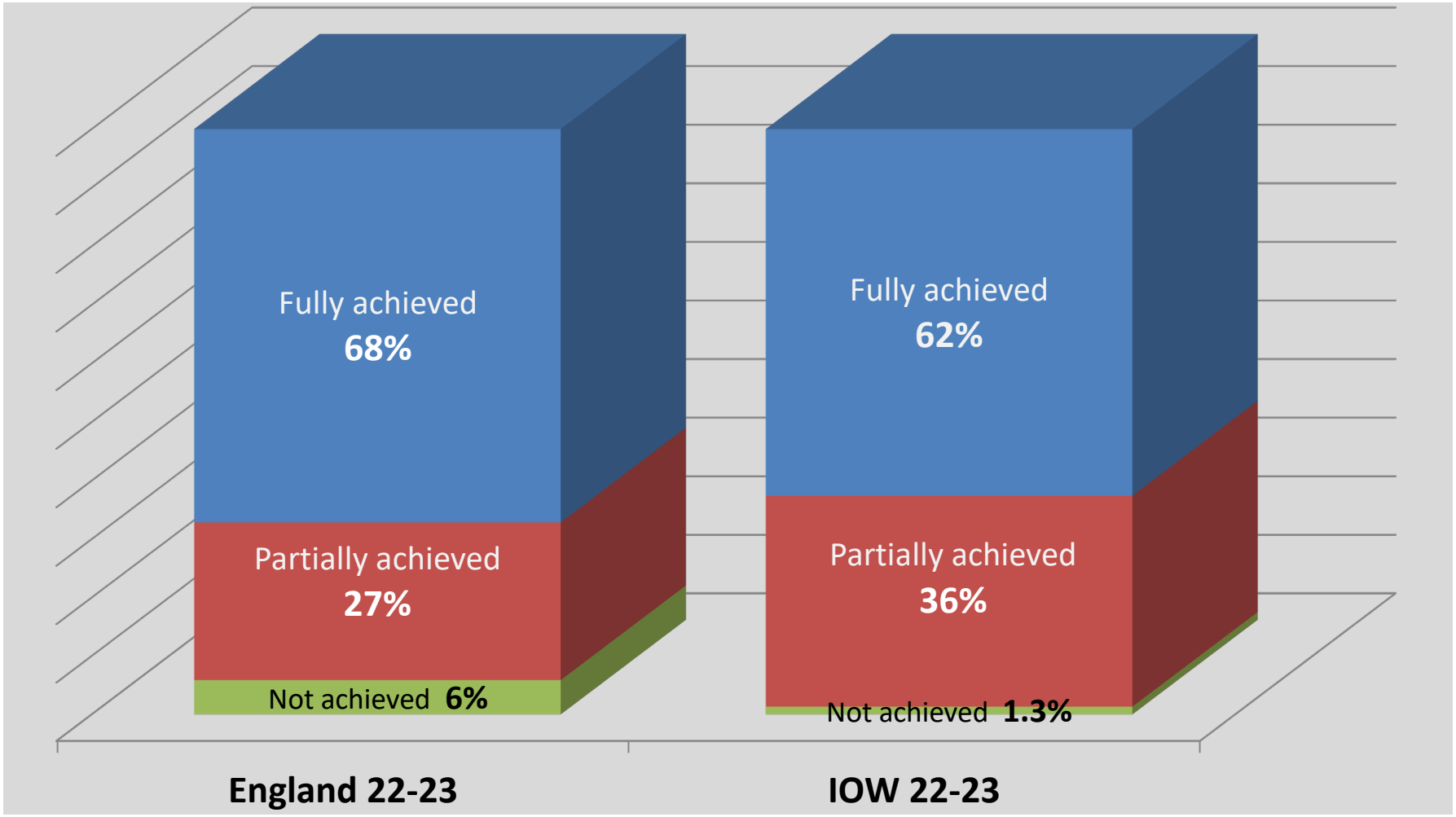
SAC return – Section 4

Section-42 Enquiries: Making Safeguarding Personal (MSP)



SAC return – Section 4

Section-42 Enquiries: Making Safeguarding Personal (MSP)



SAR – Safeguarding Adult Reviews

0 SARs reported this year IOW 22-23

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

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	0	0	0	0	0	0	0