Annual Report

2021-2022

Foreword

Welcome to the Annual Report for the IOWSAB 2021/22. As Independent Chair, it is my privilege to be working with such a committed and skilled group of partners who bring such a valuable range of perspectives and experience to the Board. Our annual report describes what we aimed to achieve during the year 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 five cases were considered for such a review, one of which met the legal criteria. We also managed two separate thematic reviews for referrals which did not meet the SAR criteria but from which the Board believed there would be valuable systems learning from the common themes within the cases.

As all Board partners became accustomed to different ways of working in the pandemic, we remained conscious of ensuring that we assess the impact Covid-19 had on our community, partner agencies and system pressures, whilst still seeking assurance of our statutory safeguarding obligations. To this end, we continued with our commitment to seeking to hear from people with lived experience of our services by establishing a task and finish group to undertake a review to understand more about the broader impact of the Covid-19 pandemic on adults with care and support needs who may be less likely to be seeking or finding easy access to services. Responding to the findings within the review in a coordinated, multi-agency way is a key priority in our new business plan.

2022/23 brings new challenges for all those involved with adult safeguarding. The Health and Care Act 2022 introduces inspections by the Care Quality Commission on quality assurance for Adult Social Care services, including a focus on adult safeguarding. The same legislation sees Clinical Commissioning Groups replaced by Integrated Care Boards (ICBs). The IOWSAB has been active in seeking assurance that place-based adult safeguarding will feature prominently in the new ICB arrangements. Local authorities, NHS Trusts and other partners must also prepare for the introduction of Liberty Protection Safeguards and a new Code of Practice that accompanies the Mental Capacity Act 2005.

Health and social care system partners face ongoing recruitment and retention challenges alongside high demand, placing extreme pressure on services. The cost-of-living crisis will, of course, exacerbate these problems. However, the IOWSAB remains determined to work together in a collective response to deliver our underlying purpose to keep adults at risk safe. As ever, I would like to thank Emma Coleman, IOWSAB Board Manager and Victoria Read, IOWSAB Administrator, for their enthusiasm and skills in managing the Board so creatively and effectively. I would also like to take the opportunity to pay tribute to all of the practitioners and managers who are committed to keeping people safe on the Isle of Wight.

Teresa Bell, Independent Chair, Isle of Wight Safeguarding Adults Board

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 Isle of Wight Safeguarding Adults Board has three statutory partners – **Isle of Wight Adult Social Care, Hampshire Constabulary, and the Isle of Wight Clinical Commissioning Group**. They are joined by a range of agencies, providers, and voluntary sector representatives who work with adults all across the Island:

- Isle of Wight NHS Trust
- Isle of Wight Council Public Health
- Hampshire & Isle of Wight Fire & Rescue
- Probation
- Healthwatch
- NHS England (Wessex)
- Isle of Wight Care Partnership as the representative for Residential and Nursing Homes
- Isle of Wight Council Housing
- Southern Housing Group Ltd.
- Voluntary Sector Representatives - Currently Age UK IW and Isle of Wight Youth Trust
- Isle of Wight Community Safety
- CQC (Care Quality Commission)
- HMP Isle of Wight, together with Practice Plus Group who provide healthcare within the Prison
- Cabinet member for Adult Social Care and Public Health
- Local Safeguarding Children's Partnership Manager
- Domestic Abuse Partnership Board Manager

2. Board Structure

The Board has four Isle of Wight 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. In addition, there are a number of smaller, bespoke Task & Finish groups running throughout the year which focus on specific projects and workstreams relating to the main Board, Sub-groups, or priorities within the Business Plan.

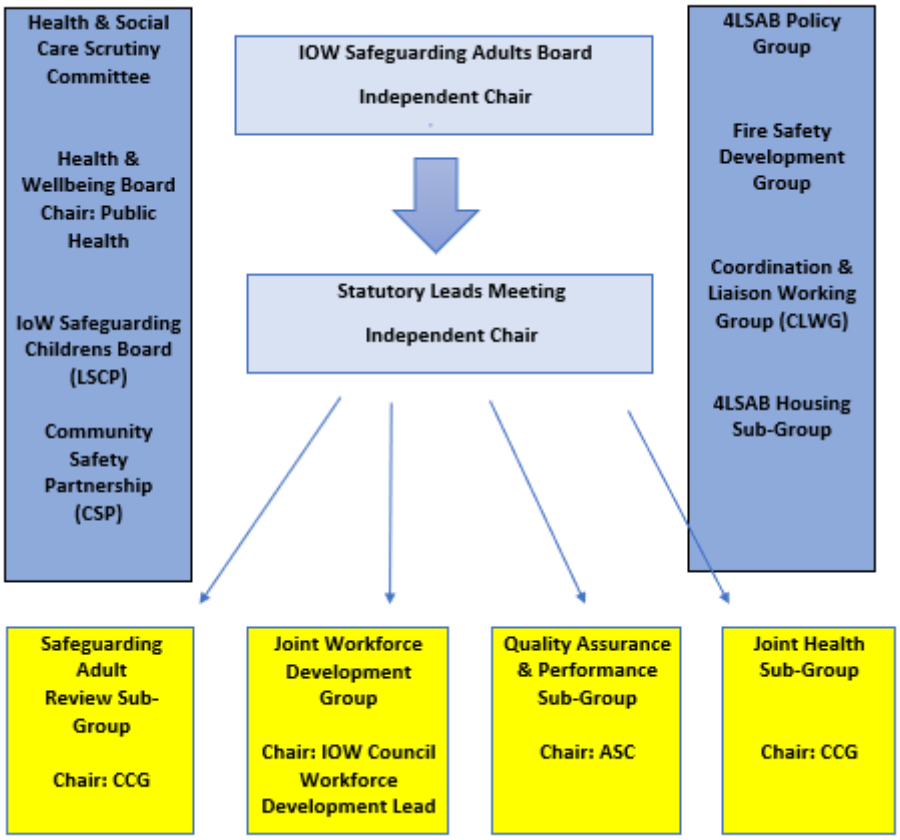
The Joint Health Sub-Group existed as part of the LSAB/LSCP structure and was set up after the CQC inspection in 2017. It gave an opportunity for health and safeguarding professionals to discuss and debate local issues across the health economy before reaching an agreed approach to be presented to LSAB/LSCP meetings. Following the CQC inspection report in 2021, and considering the changing relationship between the Trust and the CCG, the decision was made in January 2022 to remove this meeting from the structure and devolve the responsibilities into the existing sub-group 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 Southampton, Hampshire, Isle of Wight and Portsmouth. The work of these groups is discussed in more details in Section 11.

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 Hierarchy 2021-2022



3. Safeguarding Adults Review Activity

Safeguarding Adults Reviews (SARs) are a statutory responsibility of the Safeguarding Adults Board. 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 range 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.

During 2021/2022, the Safeguarding Adults Review (SAR) sub-group on the Isle of Wight received referrals for 5 new cases, one of which met the criteria for a mandatory Safeguarding Adults Review (SAR).

Case A

Case A 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 carer. This case was agreed to meet the criteria for a mandatory Safeguarding Adults Review in June 2021. A joint review has been started with support from colleagues in Southampton Safeguarding Partnership. Terms of Reference have been jointly drafted between the Isle of Wight and Southampton, and a jointly appointed Independent reviewer has been commissioned to carry out the review.

There is an ongoing criminal investigation in this case.

- **Case B**

Case B involves an individual that lived with type 1 diabetes who misused alcohol, and was discharged from hospital with a package of care that they later declined. They sadly passed away shortly afterwards. The case was referred in January 2022 as the person was known to several agencies, and scoping is currently underway with agencies both on the Island and the mainland. A decision is due later in 2022.

- **Case C**

Case C involves an individual who was a victim of homicide. The case was referred in January 2022 as the person was known to several agencies, and scoping for information is currently underway.

There is an ongoing criminal investigation in this case, as well as a potential Mental Health Homicide Review.

- **Case D**

Case D 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. Scoping for information has begun.

There is an ongoing criminal investigation in this case.

- **Case E**

Case E involves an individual with a history of mental and physical health needs who is thought to have taken their own life. A referral was made in January 2022 as they were known to several agencies. Scoping has been started with a range of Island-based and mainland-based agencies with a decision due later in 2022.

Update on work started in 2010/2021

This year also saw the completion of the initial phase of a Thematic Review into 5 cases with common themes:

- Homelessness
- Mental health
- Alcohol/substance misuse
- and suicide/overdose.

None of the 5 cases met the criteria for a mandatory Safeguarding Adults Review, however it was felt that there would be key systems learnings from the common themes within the cases. The review was split into two parts, with analysis of the cases and systemwide themes forming the first part, and a series of audits on the findings forming the second part. A multi-agency workshop with the reviewer to receive the initial report and formulate plans for the audits is scheduled for May 2022.

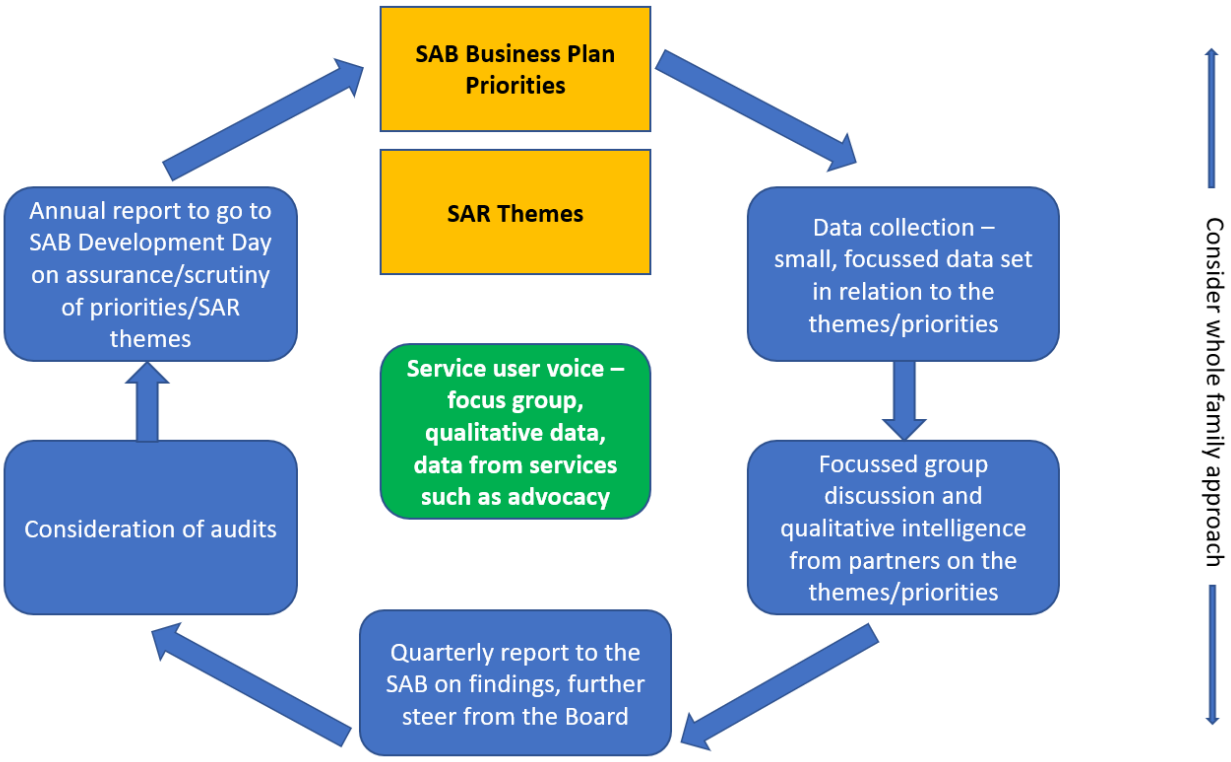
In this year, the group also managed a second Thematic Review into 4 cases with similarities, and an overall theme of neglect. Of the four cases, two were felt to meet the criteria for a mandatory Safeguarding Adults Review. Both of these individuals are still alive. This review is currently underway and expected to be completed in Summer 2022.

4. Quality Assurance & Performance

4.1 Group Structure

The Quality Assurance and Performance Group is one of the sub-groups of the Board, and the membership of the group of from a number of agencies represented on the Board.

The purpose of this group is to provide the Board with appropriate information to be assured 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.



In 2021/2022 following consultation and feedback from Board members and statutory partners, it was agreed that the format of the group would be refreshed to allow for more focussed assessment and understanding of key issues. The group will identify a maximum of 3 key themes every year for analysis and deep dive which reflect the priorities in the Boards business plan and themes from SARs.

In January 2022, the group discussed a range of themes and issues and determined the following two will be taken forward as key priorities for 2022/2023:

- Safeguarding Concerns

  Through requesting a bespoke set of data, conducting and audit and gaining qualitative feedback, the group aim to gain a better understand of
  - underreported abuse types
  - underreporting agencies
  - referrals not meeting criteria
  - whether Making Safeguarding Personal is being applied
  - whether agencies are correctly assessing 'Care & Support needs' and 'Abuse/neglect'
  - whether agencies are utilising the 4LSAB Safeguarding Concerns Guidance
  - whether there is confusion between safeguarding and Multi-agency Risk management (MARM)
  - whether there are barriers to making referrals
  - and whether staff have received enough training

- Engagement with Services

  This is a theme present in many Safeguarding Adults Reviews. Through an assessment of internal policies and processes via audit, a bespoke set of data, work with the voluntary and community sector, and feedback from front line staff and individuals, the group aim to gain a better understanding of the barriers that exist to make services difficult to engage with, and how agencies need to adapt to tackle these barriers.

Other themes considered were self-neglect and homelessness, however it was felt that they were already being picked up through the SAR sub-group. The findings from both of these workstreams will inform improvements in the wider safeguarding system.

4.2 MARM (Multi-agency Risk Management) Coordinator

The MARM Coordinator role was an 18-month project post funded by the Safeguarding Adults Board. As part of their role, the MARM Coordinator completed an in-depth audit, engagement work with a wide range of Island agencies, and development of a toolkit and

training. The end of the MARM Coordinator role was felt to be a risk to services and individuals, and a business case detailing the benefit of the role and how important it was to the continuous improvement in practice for all agencies was approved. Given the challenges faced by agencies implementing the 4LSAB MARM Framework, it was felt that a more operational role would be beneficial, and so a revised post sitting within the Local Authority Safeguarding Team was advertised and successfully recruited to in Summer 2021. The role continues to be jointly funded by Adult Social Care, Hampshire Constabulary, and the Hampshire and Isle of Wight Clinical Commissioning Group, with feedback regularly provided to the Safeguarding Adults Board.

4.3 4LSAB Self-audit

In January 2022, the 4 Safeguarding Boards of Southampton, Hampshire, Isle of Wight, and Portsmouth undertook a joint audit. Agencies are asked to undertake the audit every 2 years to help evaluate the effectiveness of internal safeguarding arrangements, and to identify and prioritise any areas needing further development.

Over 60 returns were received, including all four Adult Social Care departments, Police, all Clinical Commissioning Groups, Fire & Rescue, 10 individual NHS Trusts, advocacy services, housing providers, residential and nursing homes, and voluntary sector organisations. There were a number of particularly strong audit returns, highlighting some excellent practice across the area. These included safeguarding being embedded in internal policies, procedures and job descriptions, high quality internal safeguarding training offered and attended, and business continuity models in place to ensure safeguarding is maintained at a safe level during peak pressures. The audit also found some common areas where partner agencies may need some further support, including embedding the learning from Safeguarding Adults Reviews, better understanding and application of the Mental Capacity Act and a need for increased focus on Making Safeguarding Personal and the use of advocacy. The themes will be taken forward as priorities for the 4 Safeguarding Boards in 2022/2023.

5. Workforce Development Sub-group

5.1 2021/2022 Training Programme

A range of training opportunities were offered throughout 2021/2022 which reflected the themes from the previous year's Learning Needs Analysis.

Sessions were delivered virtually as a number of Covid restrictions were still in place.

- Safeguarding Concerns Webinar
  A series of 4 virtual half-day workshops were offered to practitioners across the whole 4LSAB area. The workshops were designed to give practitioners an opportunity to engage in discussions about the application of the 4LSAB Safeguarding Concerns Guidance, and the principles and the criteria to support the rationale for decision making for whether they or their agency should raise a Safeguarding Concern. This course was jointly commissioned with the other 3 Safeguarding Boards in Southampton, Hampshire, and Portsmouth.

- Choice and Control in Hoarding Behaviour
  Through 2021/2022, 5 virtual half-day workshops were delivered to a range of multi-agency staff on Choice and Control in Hoarding Behaviour. These sessions were delivered by a national charity, Hoarding UK, and covered areas such as understanding Hoarding disorder, case study work, risk/risk assessment/legislation, positive engagement techniques and policy and practice tools.

- Overcoming Barriers to Making Safeguarding Personal
  Expanding on the Making Safeguarding Personal course, this half day session gave participants an overall understanding of how staff should use their skills, knowledge and judgement to work with people to Make Safeguarding Personal and to improve and capture outcomes with them, rather than for them. This half-day session was offered to a range of multi-agency professionals twice in 2021/2022.

- MARM (Multi-agency Risk Management)
  Following the extensive work of the MARM Coordinator it was felt that a basic level course to introduce a range of professionals to MARM would be a good addition to the training calendar. The 'Introduction to MARM' was a basic level course for those unfamiliar with MARM, or for those professionals that needed a refresher and had a good working knowledge of Safeguarding. This course was offered in tandem with a more detailed MARM for Manager virtual session to ensure learning was available for all audiences.

- Self-Neglect
  Throughout 2021/2022, two half-day workshops on Self-neglect were offered to a multi-agency audience. These sessions provided a broad awareness of what Self-neglect is and the types of behaviour associated with it, as well as raising awareness about the difficulties of engaging clients who self-neglect, learning from Safeguarding Adults Reviews and wider research on Self-neglect and hoarding. These interactive sessions also gave attendees a better understanding of legal frameworks such as the Mental Capacity Act, Human Rights Act, the Care Act and local Board policies and procedures.

5.2 Learning Needs Analysis and future planning

A joint multi-agency Learning Needs Analysis was held with the Safeguarding Children's Partnership in November 2021, with professionals from Adult Social Care, Children's Services, Police, IOW NHS Trust, and Hampshire & IOW Clinical Commissioning Group in attendance. This annual meeting allows an in-depth analysis of feedback from the training offered over the previous 12 months, course attendance, engagement from different agencies, and qualitative input from agencies on how the workforce programme was utilised by their teams. The findings are strengthened further by considering learning from review and audits, as well as identifying learning needs around new policies and guidance. This joint initiative covering both adults and children allows development of not just adult-focussed and child-focussed training opportunities, but identifies and explores themes that cover both, and allows for the development of learning opportunities for the workforce as a whole.

Particular learning needs identified for 2021/2022 include:

- Safeguarding Dependent Drinkers
- Self-neglect
- Embedding the Safeguarding Concerns Guidance
- Multi-agency Risk management (MARM)
- Family Approach e-learning (to include Mental Capacity from age 16+)
- A Family Approach to Safeguarding and LGBT+
- Undertaking S42 Enquiries
- Hoarding

These themes will be taken forward in a mixture of training, webinars, e-learning and resources which will be widely available through the Learning Hub

6. Multi-agency Projects and Workstreams

7.1 Ethics Task & Finish Group

Throughout 2021/2022, the Safeguarding Adults Board continued to be a core member of the Isle of Wight Ethics Task Force, a multi-agency group set up and led by the Local Authority in 2020 to consider Covid-related issues such as complicated local and national Guidance and Legislation, Resilience and Wellbeing, Vaccine hesitancy and Covid-related workforce pressures. The group were finalists in the National LGC (Local Government Chronicle) Awards in November 2021, giving an opportunity to share some examples of the strong multi-agency approach here on the Island.

While Covid remained a presence throughout 2021/2022, the system as a whole moved beyond crisis management, and the group adjusted their focus to more long term Covid recovery. This has been reflected in the Task Force name change to the Social Care Partnerships Advisory Board from March 2022. One key workstream has been the development of a Wellbeing app linked to the Safeguarding Adults Board website, which will build on the Wellbeing and Resilience Toolkit published by the group in 2020. With much of the groundwork complete, we look forward to the launch in 2022.

7.2 Safeguarding in a Pandemic

In 2021, the IOW Safeguarding Adults Board (SAB) established a task and finish group to undertake a review to understand more about the broader impact of the Covid-19 pandemic on adults with care and support needs who may be less likely to be seeking or finding easy access to services. The review was undertaken when the impact of Covid 19 and the resulting lockdowns and restrictions on services was very present.

As significant work with agencies was already taking place to gain assurance of safeguarding arrangements, and an understanding of how agencies were adapting during the pandemic, this review was intended to focus on the less obvious, 'hidden' aspects of the impact of the pandemic. These were the challenges which were not disease related, such as access to services, impact on carers (paid, unpaid and family carers) and whether those most at risk but not currently in contact with services could be reached through other means, such as the voluntary sector.

The SAB Safeguarding Adults Review (SAR) group led a multi-agency task and finish group who identified the methodology to be used and how best to obtain the views of people with lived experience.

The review included 13 anonymised case studies provided by a range of agencies, an anonymous staff survey where health and social care workers could share their views and experiences, plus qualitative feedback from agencies about how their service coped with challenges associated with Covid. It was agreed that a broad range of health and social care agencies would be approached across the multiagency partnership and asked to provide case studies of examples of people who may be experiencing challenges associated with changes in services or other indirect impacts of the pandemic. They were also asked to share any verbal feedback on behalf of people being cared for, their carers, from staff within their agency or based on their own lived experiences. In order to understand paid staff experience specifically, a staff survey was also shared across the system asking staff a series of questions, for which they were also given the opportunity to share additional information and examples using free text. This survey was anonymized to promote full disclosure. Comments from working group discussions were also captured and included in the analysis.

The case studies, surveys and other qualitative feedback were individually analysed by the task and finish group. These individual findings and interpretation were combined to minimize the bias that subjective interpretation can lead to, ensuring a comprehensive interpretation of the material shared.

The review findings have been shared with the Board, and a workshop session to discuss the findings and agency responses to them is scheduled for Autumn 2022. Responding to the findings within the review in a coordinated, multi-agency way is a key priority in the 2022 – 2024 Business Plan. We expect the learning to be published in early 2023.

7. Policies and Procedures

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:

7.1 Review of Existing Guidance

- **4LSAB Allegations Against People in Positions of Trust**
  This existing guidance was reviewed and refreshed to ensure its principles were still useful and relevant. This work was led by the Isle of Wight, with input from nominated Safeguarding Allegations Management Advisors (SAMAs) across the 4LSAB area, and was completed and published in December 2021.

- **4LSAB Hoarding Guidance**
  The existing Hoarding Guidance has been in circulation since 2019, and so it was agreed to undertake a review and see if any updates or changes needed to be made. This work was led by Housing colleagues from a number of local authorities and housing associations, as it was felt that would be best placed to evaluate how the guidance works in practice. A number of updates have been made, including the addition of Isle of Wight photos for the Clutter scale, and a nationally recognised Risk Assessment from Hoarding UK. The updated guidance is due to be published in Summer 2022.

7.2 Development of New Guidance

- **4LSAB Fire Safety Framework**
  Following extensive work by Hampshire & Isle of Wight Fire and Rescue with support from the 4 Safeguarding Adults Boards, the 4LSAB Multi-Agency Fire Safety Framework was published in May 2021. The purpose of the framework is to provide all frontline staff with guidance to support the effective management of fire risks within the home

and other settings. It aims to provide an awareness to the key risk factors for individuals who have an increased vulnerability towards fire, and the early interventions and controls measures available to ensure such risks can be managed in the most effective way. The Framework had a multi-agency launch in October 2021 with 126 attendees from 31 different organisations. Feedback from the event indicated that 100% of the attendees found the event relevant to their role and felt they could now confidently use the guidance.

- **Guide to professional curiosity**

  Professional curiosity is an emerging theme in both local and national Safeguarding Adults Reviews. It has been described as the need for practitioners to practice 'respectful uncertainty', to enquire deeper using proactive questioning and challenge, to understand one's own responsibility, to know when to act and to not make assumptions or take things at face value. In response, a 4LSAB One Minute Guide to Professional Curiosity was published in June 2021, adapted from the existing Southampton Safeguarding Partnership guidance. This guide has been widely promoted with partner agencies.

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

Safeguarding Adults Collection (SAC) data has been collected and published by NHS Digital since 2013. It reports on the statutory duties of
local authorities under the Care Act to safeguard adults from abuse or neglect. It is published annually as a set of national, regional, and local data tables and via an interactive data dashboard providing comparative data.

- Records figures for 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), Safeguarding Adult Reviews (SARs)

The data and information for the Isle of Wight Local Authority is presented to the Safeguarding Adults Board every year. Through a comprehensive mix of data, qualitative information, and strategic overview from Adult Social Care, this annual presentation is a key activity allowing the Board to gain assurance around safeguarding activity and arrangements for the previous financial year. The following extracts are taken from the most recent presentation and data return, covering the period 1st April 2021 – 31st March 2022.

Some key 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 Local Authority in response to a concern that abuse, or neglect may be taking place. It can range from a conversation with the adult, to a more formal multi-agency plan or action.

There are two types of Enquiry:

- **Section 42 enquiry:** This is where the adult meets **all of the section 42 criteria** as set out in The Care Act (2014)**:**

    - (a) The adult has needs for care and support (whether or not the authority is meeting any of those needs)
    - **AND**
    - b) adult is experiencing, or is at risk of abuse or neglect
    - **AND**
    - c) as a result of those needs is unable to protect themselves against the abuse or neglect or risk of it

- **Other enquiry:** where the adult does not meet all of section 42 criteria, but the Council considers it necessary & proportionate to have a safeguarding enquiry

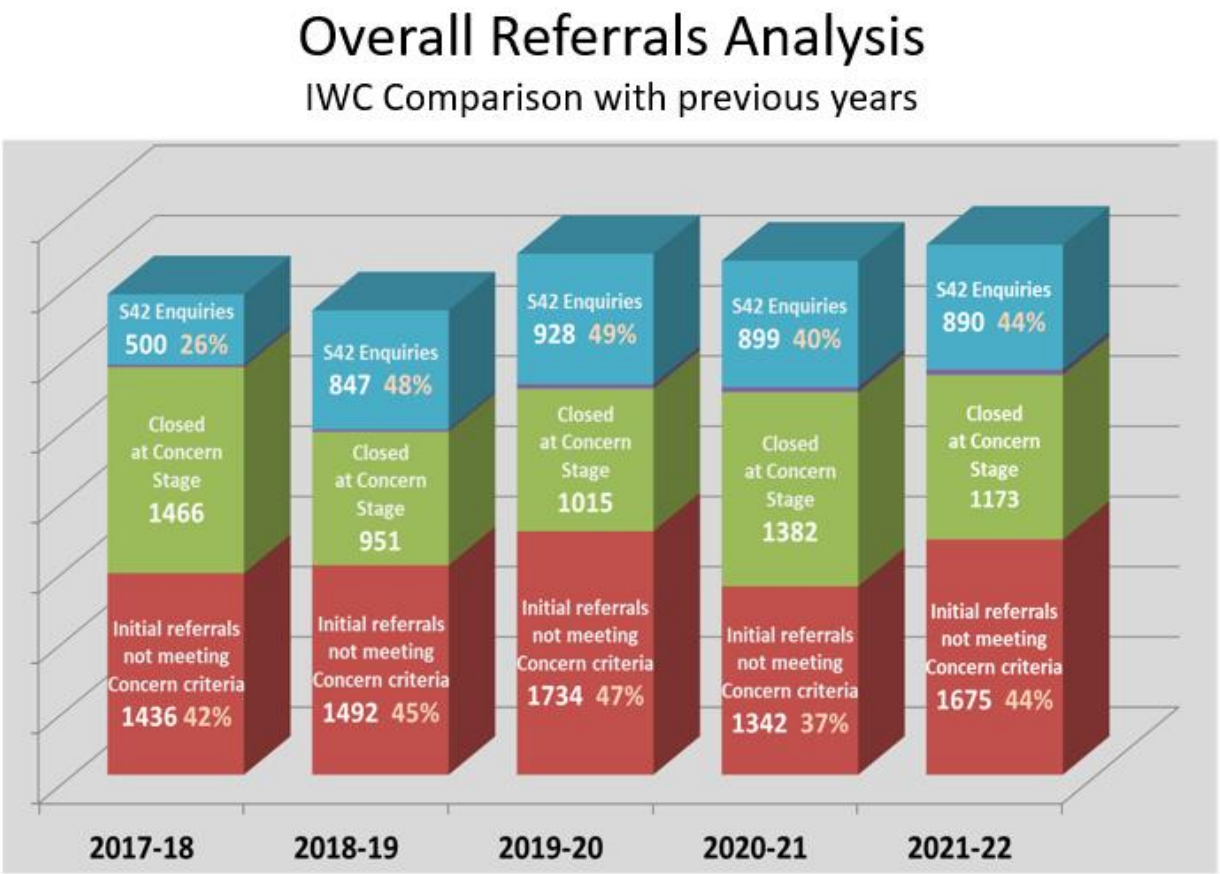


Figure 1.

Figure 1. above shows a Graphical representation of the numbers of Safeguarding referrals received by Isle of Wight Council in 2021-2022.

- The numbers in the brown area at the bottom are the number of referrals made to the Local Authority Safeguarding team that **did not meet the criteria** for a Safeguarding Concern.

- The numbers in the green area in the middle are the number of referrals that met the criteria for a **Safeguarding Concern**, but **did not** then meet the criteria for a Safeguarding Enquiry.

- The percentage in the blue area at the top is called the **conversion rate** – this is the percentage of **Safeguarding Concerns** (the green area in the middle) that **did meet criteria** and progressed to a **Safeguarding Enquiry** (both Section 42 enquiry, and 'other' enquiry)

- The preference would be to reduce the brown area to a narrow band, reduce the green, whilst increasing the blue.

- In 2022-2023, the Quality Assurance & Performance Sub-group will be undertaking a multi-agency audit and data review to help understand the dynamics behind the referral types and numbers.

The following tables show how Isle of Wight figures compare to the National average, as well as how they compare with a similar region, North Tyneside. North Tyneside has been chosen as a comparator on this occasion as they have the most similar number of Safeguarding Concerns per 100,000 of the population received by the Local Authority, and the most similar number of Section 42 enquiries per 100,000 of the population. Comparator areas may change from year to year, and are based solely on volume of referrals rather than areas having similar demographics and characteristics.

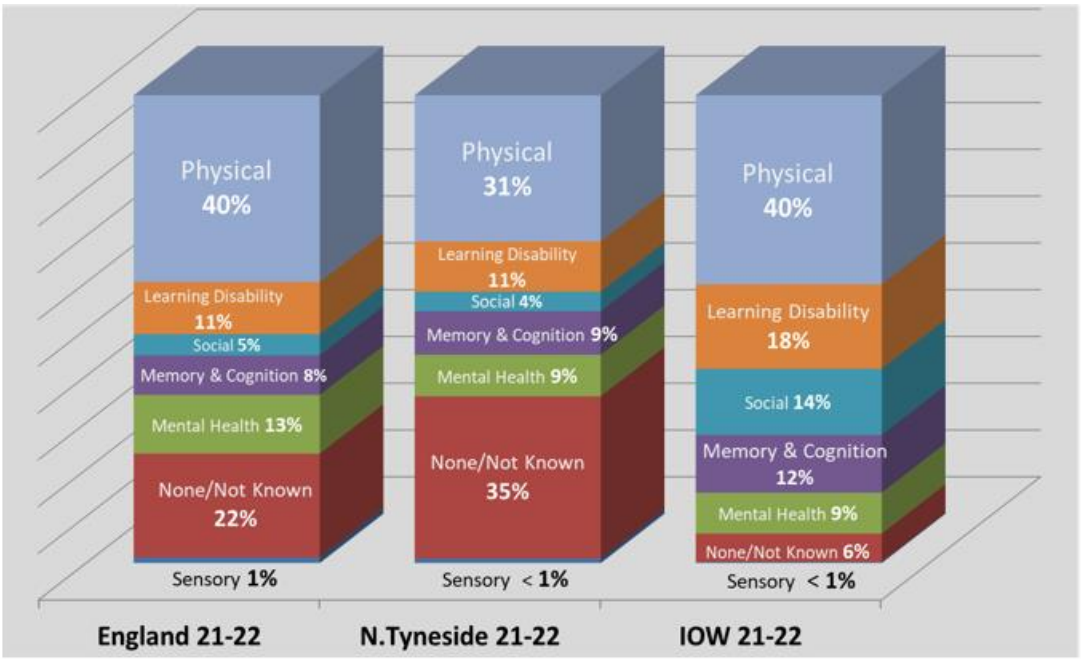


Figure 2. shows the figures for the Primary Support Reason for 2021-2022 for Section 42 enquiries.

Physical is the same as the average for England, but the none/not known is only 6%, significantly lower than both England and North Tyneside.

Figure 2.

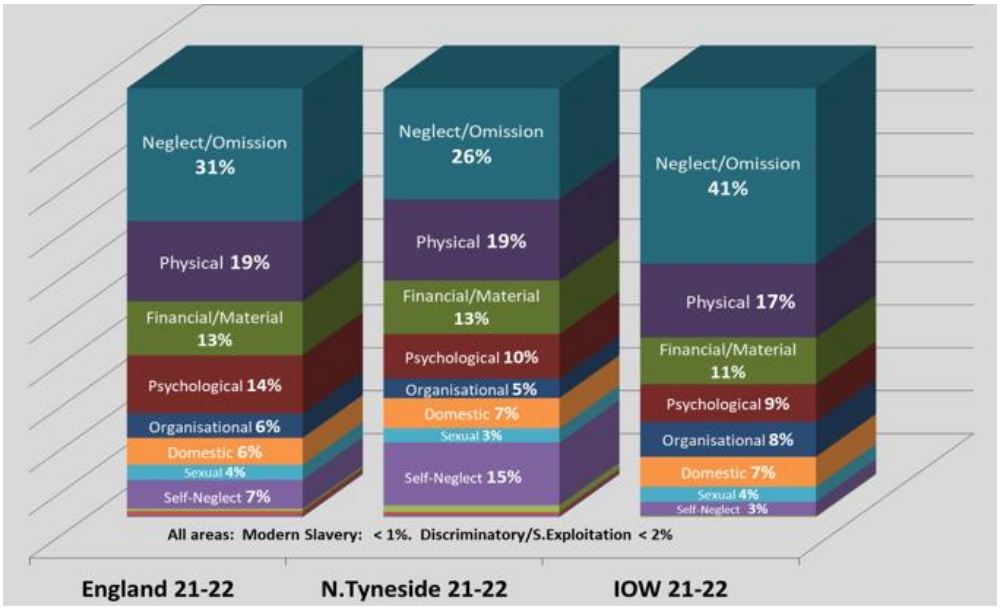


Figure 3. shows the figures for the Type of Risk for 2021-2022 for Section 42 enquiries. The Isle of Wight has higher numbers for neglect and acts of omission, but has a much lower than expected number for Self-neglect.

Throughout 2022-2023 the Safeguarding Adults Board will be offering Self-neglect training to professionals.

Figure 3.

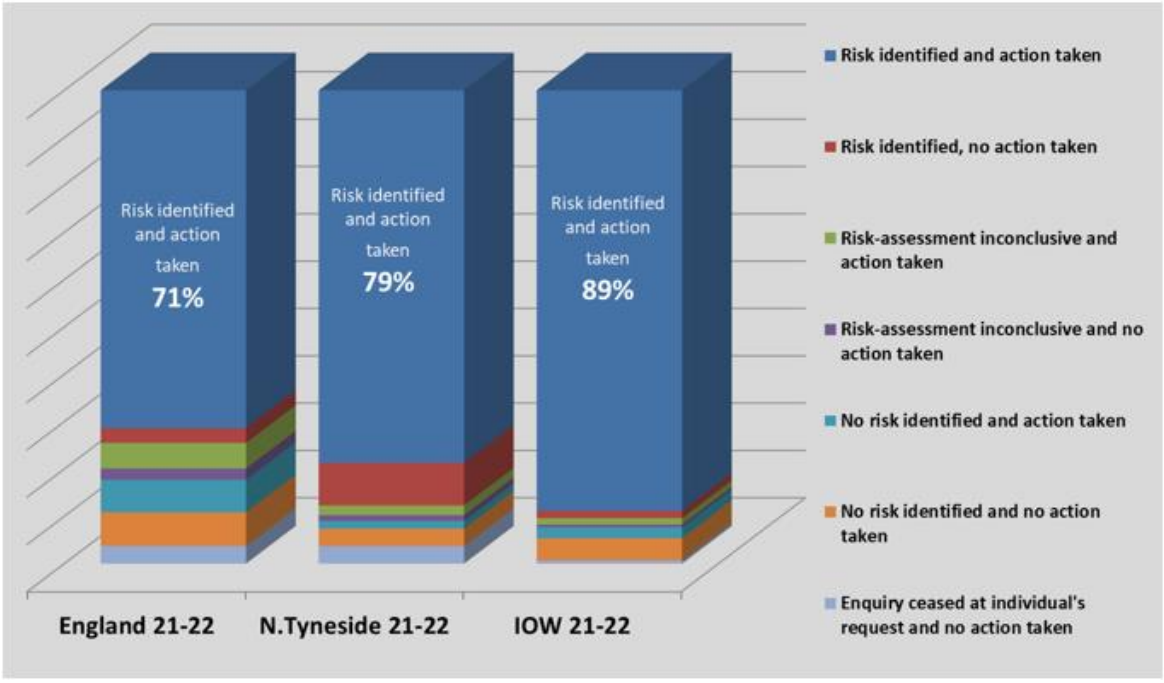


Figure 4a. shows the Risk Assessment Outcomes for Section 42 Enquiries in 2021-2022.

The Isle of Wight has a high figure for Risk Identified and Action Taken, at 89%. This compares to England at 71%.

Figure 4a.

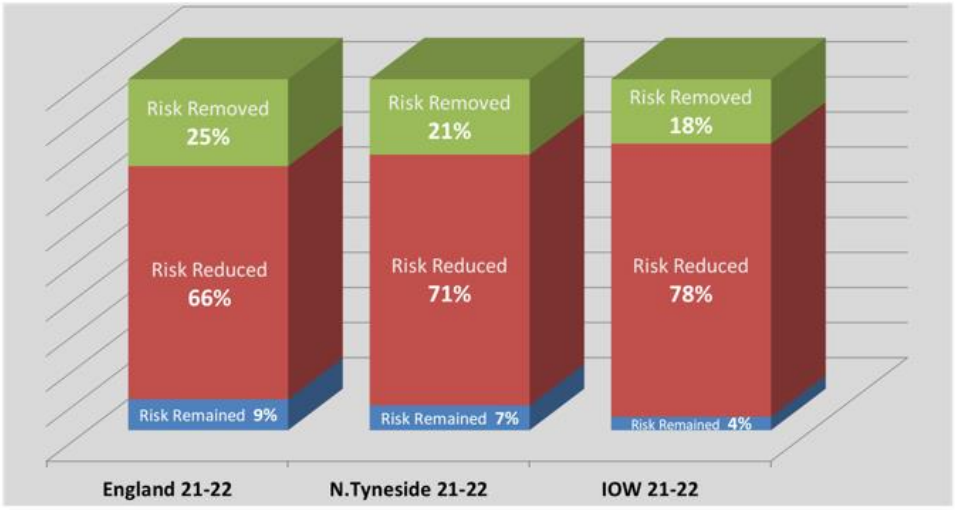


Figure 4b. shows the outcomes for the 89% 'risk identified, and action taken' in Figure 4a. The Risk Remained (4%) is unlikely to go any lower as there can be contention between removal of risk and the desired outcome. The adult at risk may not want the risk completely removed – e.g., the adult at risk does not wish for the removal of an abusive partner/carer.

Figure 4b.

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.

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 Work

The role of the Domestic Abuse Project Officer is to work alongside the forum to achieve a reduction in domestic abuse and an increase in awareness through 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.

The Domestic Abuse Project Officer post is funded by the Safeguarding Adults Board and hosted by the IOW Council's Community Safety Team. In line with strategic changes due to implementation of the Domestic Abuse Bill (2021), the Domestic Abuse Forum will change to the Domestic Abuse Partnership Board and will sit underneath Public Health from 2022. The role of the Domestic Abuse Project Officer will also move to Public health.

Project Officer Work Areas

The Project Officer has focused on several key work areas throughout 2021/22. These include:

9.1 - The Co-ordination of the Domestic Abuse Forum (DAF)

4 Domestic Abuse Forum meetings were held during 2021/2022 with over 20 different partner agencies represented. The DAF was chaired throughout 2021/22 by the IOW Police Superintendent. The project officer co-ordinates the meetings, pulling together the agenda and liaising with partner organisation on their individual actions and future items.

The key priorities outlined in the DAF action plan are:

- 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 that meet the needs of the local community
- To improve the data information collected to enable a better national comparison
- Staff are trained to an appropriate level

- To oversee and guide commissioning of services
- To have a better understanding of repeat victims and how they can be supported
- DA is prioritised across strategic partnership boards with recognition of the impact on outcomes and need for co-ordinated responses

The DAF process brings senior professionals together to ensure up to date service information along with any key messages or changes in legislation are circulated within teams.

9.2 - Training and staff development

Alongside the IWC Learning and Development Team a pathway of domestic abuse training has been created:

Step 1 - Domestic Abuse Awareness

- Two e-learning modules which aim to provide an understanding of domestic abuse and the impact that domestic abuse can have on children.

Step 2 - Building knowledge and skills

- **Coercive and Controlling Behaviour (CCB)** - An in-depth look into CCB, the impact it has on victims including the risk of harm, CCB law, typologies of abuse and support.

Step 3 - Those who regularly work with victims and/or perpetrators and require robust knowledge and skills

- **Stalking** - An in-depth look at stalking including the common myths, typologies, associated risks and support available for victims.
- **DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment) Masterclass** - To understand the DASH risk identification, assessment, and management model and how to use it.

These courses are free and available to all partners.

9.3 - Key campaigns

Sexual Violence Campaign – May 2021 – to increase awareness of sexual violence and the concept of consent. The campaign was social media based with a planned series of interactive

Instagram and Facebook story posts covering key information and signposting. 4 videos were created highlighting the support available for victims including an interview with the ISVA (Independent Sexual Violence Advocate) service. A recorded interview with Vectis Radio was used at the start of the campaign and was repeated over the month. A reach of 18,957 across social media platforms. ISVA service received 25 referrals between May and June which was an increase of 9 from the same period the previous year including 5 males which was an increase of 4. There were 3 self-referrals which were a direct result of individuals seeing the campaign material.

Young Persons Campaign – July 2021 – a 2-week social media campaign aimed at young people to raise awareness about keeping safe using 6 interactive Facebook stories around key themes. A staggering reach of 62,823 was achieved across Facebook and Instagram and health online debates on social media around coercive control.

Elder Awareness Campaign – October 2021 – This was a proactive campaign which looked to prevent domestic abuse in the elderly community, encouraging conversations about the issues that are important to them with signposting to local support from partners. A month-long campaign was held with a press release, 'That's TV' interview and social media messages. Additional adverts were placed in the Observer and County press to reach the target audience as well as the local Parish Council Bulletin. A reach of 14,986 was achieved across Facebook and Instagram. Carers IOW, a partner involved in this campaign, reported that their caseload increased from 415 in 2020/21 to 628 in 2021/22 for people receiving 1:1 support from a key worker. This does not include group session attendance and is not just specific to DA. Age UK are continuing to see high numbers and safeguarding referrals remain high and impact may be more noticeable once the data for this quarter is received.

16 Days of Action Against Domestic Violence – This ran from 25th November to 10th December 2021- to raise awareness of the effect that domestic abuse has, with an emphasis on how employers can support their employees/ . There was a focus on 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 training sessions to employers. Dragonfly Champions are trained people living and working in our communities who are there to offer an informal, supportive service.
- IOW Council MHFA (Mental Health First Aiders) are to receive Dragonfly training in January
- A presence at Tesco's on Wight Ribbon Day with Paragon, the commissioned Domestic Abuse service, and the Police.
- Rebrand campaign material with Paragon name and logo.
- Posters printed and distributed through Paragon to the hospital, supermarkets and hairdressers.
- Promote Paragon and Hampton Trust at Crimestoppers visit on 8th December.
- DA training encouraged and promoted across all networks including an email to all schools and learning providers
- Facebook and Instagram messaging with posts covering a wide range of key DA issues. The Facebook reach for this was 19,663 with 1,845 people viewing the stories which was double the statistics form 2021.

10. Awareness raising

10.1 Tricky friends

Friendships can be difficult, especially for people with learning disabilities who may be vulnerable to mate crime. A short 3-minute video was produced by Norfolk Safeguarding Board which helped to explain what good friendships look like.

The video was packed with good advice about how to spot if friends may be taking advantage of them, and what to do if friends are making them feel sad or angry. The video also advises when to talk to someone trusted about what is happening, and how to contact Adult Safeguarding.

The video was reproduced for the Isle of Wight with kind permission from Norfolk safeguarding Adults Board, and was published on our website in September 2021.

10.2 National Adult Safeguarding Awareness Week, 15th -21st November 2021

The National Adult Safeguarding Awareness Week is an opportunity for organisations to come together to raise awareness of important safeguarding issues. The aim is to highlight safeguarding key issues, facilitate conversations and to raise awareness of safeguarding best practice so we can all be better together.

In collaboration with the Ann Craft Trust and the Safeguarding Boards in Southampton, Portsmouth and Hampshire, The IOW Safeguarding Adults Board shared resources and

information for professionals on their website (www.iowsab.org.uk) and on twitter (@iowsab) throughout the week, with a focus on the following themes:

- **Monday – Emotional Abuse and Safeguarding Mental Health**

Emotional abuse can have a devastating impact on mental as well as physical health. To have safer cultures, we need to prioritise wellbeing, and create a culture where people can speak out, be listened to and respected. This focussed at an individual level on the importance of wellbeing and self-care. At an organisational level, the session can be used to explore how organisations can be emotionally aware and promote respectful cultures where people can speak out without fear of reprimand.

- **Tuesday – Domestic Abuse**

To raise awareness around domestic abuse and ensure professionals are aware of referral pathways.

- **Wednesday – Fraud, Scams and Cybercrime**

Over the past year an increasing proportion of our lives from work, education to sport and activity has moved online, this is likely to continue to some extent, even as lockdown restrictions ease. This session shared best practice in relation to how to create safe cultures online. On this day, we also highlighted the important work of IWASP (Isle of Wight Against Scams Partnership).

- **Thursday – Homelessness**

An opportunity to share good practice guidance and local pathways.

- **Friday – Safeguarding and You**

The focus was: Do you know what your role in safeguarding is? Safeguarding is for everyone. It is not just about knowing your role in an employment setting, but also knowing your role as a human being in everyday life to promote safer cultures in the community. We want to highlight that safeguarding is everyone's responsibility and everyone needs to play their part to effectively create safer cultures.

11. 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.

For the period of 1st April 2021 to 31st March 2022, there was 1 fatal incident which occurred that met the Fire Safety Development Sub-Group criteria for review from within the Isle of Wight Local Authority area. It should be noted that the cause of death is yet to be determined as the case is awaiting The Coroner's verdict.

A full review of the individuals risk factors, their supporting agencies and the cause of incident was conducted by the group. The following identified risk and vulnerability factors emerged from the review:

- The age of the individual involved was 57
- The gender of the individual involved was female
- The individual lived alone
- There was no identified risk factor for hoarding or self-neglect.
- The individual was not known or open to Care and Support Services
- Poor mobility was identified as a risk factor.
- There was no identified risk factor for poor mental health or substance misuse.
- The cause of the fire incident was determined to be 'accidental – carelessness with smoking material'

In December 2021, the sub-group reviewed its work and identified a series of best practice pointers:

Think…Person, Behaviour and Environment *– The most effective way to assess a person's vulnerability to fire is to identify the individual risk factors that impact their health, safety and wellbeing. This includes physical or cognitive impairments, behaviours and environmental considerations.*

Care Plans and Person-Centred Risk Assessments *– For individuals who are in receipt of a social care, the management of their fire safety should be risk assessed and embedded within their individual care plans. Ensuring an individual is kept safe from the risk of fire must be a key component to their overall care provision. As with all care plans, vulnerability to fire should be regularly reviewed and documented.*

Risk Management *– It should be recognised that there are situations where an individual may be presenting significant fire risks to themselves as well as others but chooses not engage with support services or adhere to the fire safety advice provided. In such cases, it is essential that agencies work together and consider using the* ***Multi Agency Risk Management Framework****.*

Suitable accommodation - *Consideration must be given to the suitability of the housing / accommodation in relation to the level of risk.*

Multiple health needs *- multiple health issues may result in fire risks not being fully considered due to a focus on health and social needs instead.*

Professional relationships *- Relationship building between service users and professionals is essential in order to obtain as much information as possible to aid understanding of risk.*

Hampshire and the IOW Fire and Rescue Service continues to work with partner agencies in providing fire risk management training, promoting Safe and Well (Home Fire Safety intervention) and targeting those organisations who regularly engage with individuals who, due to their individual, behavioural or environmental risk factors present a higher level of risk relating to accidental fire within the home.

For the reporting period of 1st April 2021 to 31st March 2022, Hampshire and IOW Fire and Rescue Service reported a total of 23 safeguarding concerns to IOW Adult Services.