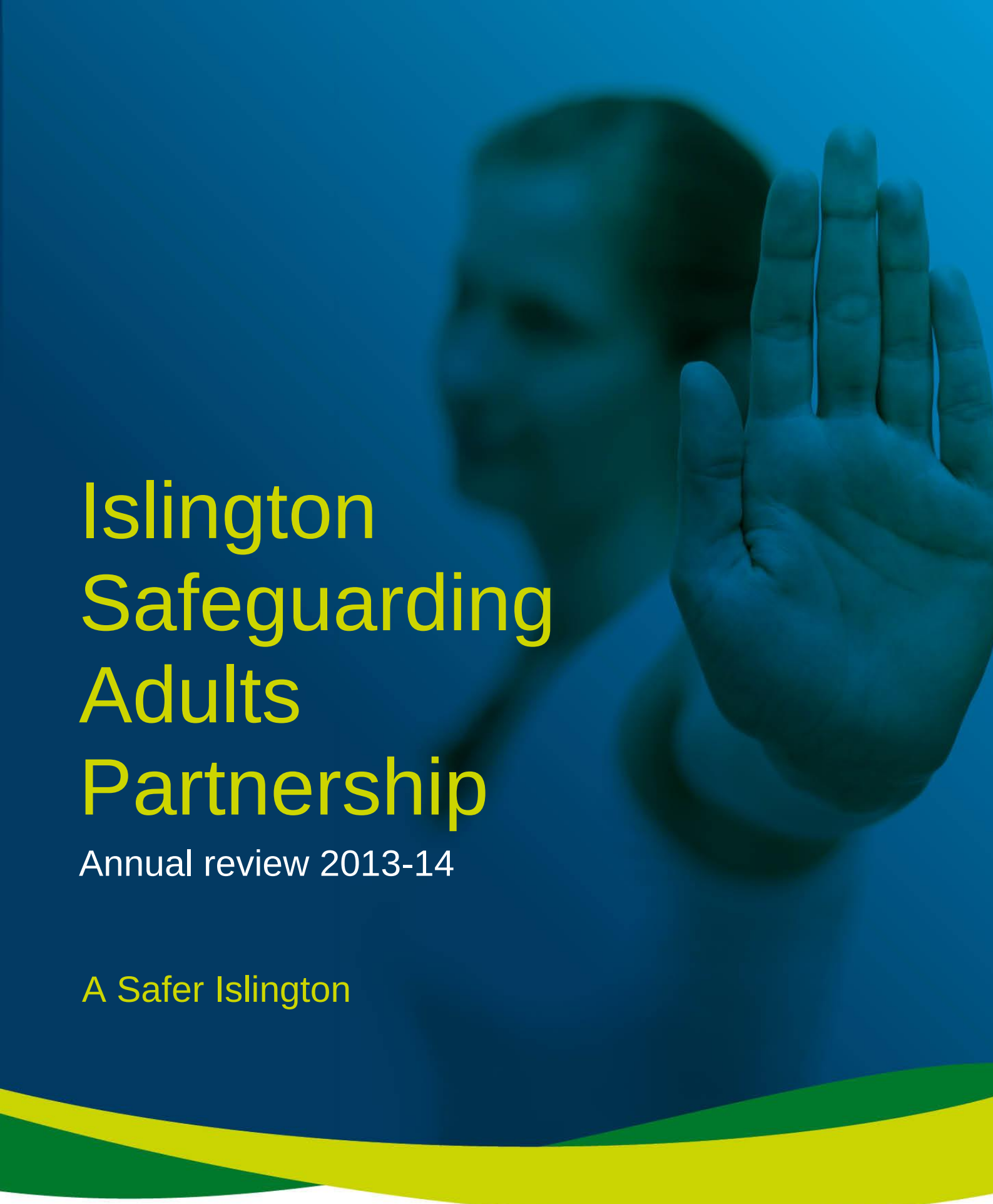

Islington Safeguarding Adults Partnership

Annual review 2013-14

A Safer Islington

NHS

METROPOLITAN POLICE

ISLINGTON
Working in partnership

About us

We are a partnership of organisations in Islington all committed to working together to safeguarding adults at risk from abuse and neglect.

Who makes up the partnership?

Age UK Islington – Andy Murphy, Chief Executive Officer

Camden and Islington NHS Foundation Trust – Colin Plant, Director of Integrated Care

Camden and Islington Probation Service – Donna Jones, Senior Probation Officer

Care Quality Commission – Jane Ray, Compliance Manager

Crown Prosecution Service – Philip Fernandez, Borough Prosecutor

Healthwatch – Geraldine Pettersen

Independent Chair – Marian Harrington

Islington Clinical Commissioning Group – Martin Machray, Director of Quality and Integrated Governance (and Vice Chair)

Islington Clinical Commissioning Group - Dr Rathini Ratnavel

Islington Council – Melissa Friedberg, Islington Safeguarding Children's Board manager

Islington Council – Sean McLaughlin, Corporate Director of Housing and Adult Social Services

London Ambulance Service, Islington – Patrick Brooks, Community Involvement Officer

London Fire Brigade, Islington - Rhys Powell, Borough Commander

Metropolitan Police, Islington – David Hutcheson, Detective Chief Inspector

Moorfields Eye Hospital NHS Foundation Trust – Tracy Luckett, Director of Nursing & Allied Health Professionals

NHS England – Joanne Hillier

Notting Hill Housing Trust – Lyn Lewis, Head of Operations

Safer Islington Partnership – Alva Bailey

Single Homeless Project – Liz Rutherfoord, Chief Executive

Voluntary Action in Islington – Emma Whitby

Whittington Health NHS Trust – Alison Kett, Deputy Director of Nursing & Patient Experience

Foreword

This is my first year as Independent Chair of the Islington Safeguarding Adults Board. The Board partners have had a challenging year with austerity affecting all organisations. Despite this you will see from this report that they have been able to achieve a great deal. However there will always be more to do.

We held a Community Conference this year to hear the views of local people, particularly those who use adults services. This event also helps to raise public awareness of adults safeguarding and encourage people in Islington to report any concerns they may have.

We have seen a significant increase in the numbers of referrals for an investigation of an adult at risk. This has put pressure on the teams investigating these situations. We have been pleased to see that they have responded appropriately.

This year we have made great efforts to ensure the voice of people who use services is heard. We are organising opportunities for groups of people to feed their views into the Board on a regular basis. People who have been part of safeguarding investigations have been asked about their experiences and the findings have been fed back to the social work teams to improve their practice.

We have tried to ensure better outcomes for people who have been abused or exploited. We have met with police, local prisons and the Crown Prosecution Service to make sure the criminal justice system works more effectively for vulnerable victims.

The Clinical Commissioning Group, Whittington Health and Islington Council have been working together to improve standards in local care homes. A senior nurse visits the homes, meets with staff and advises the homes to ensure the very best care practices. There have also been a range of training events for staff from all partner organisations to make sure they are aware of recent legal decisions and supported to do their work effectively.

The partnerships represented by the Board have become stronger over the year. All agencies have reported back to the Board on practical ways in which they have been able to make vulnerable adults safer and have been able to learn from and encourage each other. The Clinical Commissioning Group has been hugely valuable in helping to ensure standards are improved in nursing and medical care. The police in Islington have shown strong commitment to keeping vulnerable people safe.

I would like to thank all partner agencies for their support in this work. I particularly thank the Chairs of our sub groups for their huge contribution to the Board. I would like to thank Sean McLaughlin Corporate Director of Housing and Adult Social Services at Islington Council for his constant support and commitment, to the Councillors in Islington for their interest and encouragement and to the people of Islington for their vigilance.

Marian Harrington
Independent Chair
July 2014

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Introduction

This review looks at the work we have done to safeguard adults in Islington from April 2013 to March 2014. As well as being a chance to celebrate our achievements, it gives us a chance to review areas for further development. We look at the national context, at people's experiences of safeguarding in Islington and analyse some of the data we collect.

Safeguarding in the Headlines

Safeguarding Adults has featured in the news this year for a number of reasons.

Mid Staffordshire Hospital In February 2013 the Francis Report into the failings in the Mid Staffordshire Hospital Trust was published making some 290 recommendations to address issues around staffing, compassion, training, leadership and safety. As a result the SAPB has focused on how our local NHS providers and commissioners embed and demonstrate the principles enshrined in the Francis Report.

Jimmy Saville and others On-going criminal investigations into the abuse victims of Jimmy Saville and other high profile abusers has continued to keep abuse and safeguarding in the headlines.

Mental Capacity Act, and the Deprivation of Liberty Safeguards The House of Lords called for evidence into the application and effectiveness of the Mental Capacity Act 2005 (MCA). The consultation was responded to by local authorities, NHS trusts, advocacy organisations and Service User representative groups. The findings revealed the Committee was unanimous that the MCA 2005 is important - indeed visionary - legislation, with the potential to transform lives. However, they were equally clear that the Act is not working well, because people do not know about the Act and, where they do know about it, they do not understand it. The Committee has made a number of important recommendations to bring about the effective implementation of the Act, chief among them being that:

(1) Overall responsibility for the Act be given to an independent body whose task will be to oversee, monitor and drive forward implementation;
(2) The Deprivation of Liberty Safeguards (DoLS) regime to be re-drafted.
(3) A higher profile on training and standards, increase of resources, reconsideration of non-means tested legal aid.

The deprivation of liberty safeguards are in place to ensure that for people who lack capacity and who may need treatment or care in a hospital or care home have their rights protected.

At the end of March 2014 the Supreme Court reviewed two decisions relating to DoLS. This decision has changed the interpretation of DoLS significantly, it is anticipated that next year's annual report will reflect substantially greater numbers of assessments and authorisations.

The Care Bill (which came into law as the Care Act in May 2014) requires Local Authorities to set up Safeguarding Adults Boards and gives a clear legal basis for this for the first time. The Care Act also aims to put in place a legal framework so that key organisations and individuals agree on how they work together. We are confident that the new legislation will strengthen and enhance the work that we do with adults who have been abused or exploited.

Achievements

Audits
We have established an audit framework for care management teams. Teams have been auditing cases for a year and findings have revealed strong practice in keeping people safe from the beginning of a safeguarding investigation. Auditors have been taking learning from the audits back to teams to further improve practice.

Financial Abuse Toolkit
In light of the prevalence of financial abuse we have produced a financial abuse toolkit for service users and carers to help keep themselves safe.

Work with Trading Standards
We have started working with trading standards on supporting victims of scams and doorstep criminals.

Domestic Violence
We have continued to work closely with colleagues in community safety improving the number of MARAC referrals and creating a safeguarding adults and domestic violence flowchart for practitioners.

Sprinklers
Following a fatal fire in 2013 involving an adult at risk, we are working to install domestic sprinklers into homes for the people most at risk.

Hoarders
We have created a forum to address the needs and issues of hoarding. The aim of this group is to develop local policies and procedures and interventions to address and reduce the risks from hoarding behaviours.

Home Fire Safety Visits
During 2013-14, London Fire Brigade received from agencies within Islington, the highest recorded number of home fire safety referrals of any Borough across London. The majority of these came from partners represented on the Adult Safeguarding Board. As a result, 2093 home fire safety visits were carried out in the Borough, smoke alarms were fitted where needed and 98% of these visits were carried out in the homes of the most vulnerable members of our community.

Community Risk MARAC
We are working closely with colleagues in the Police and Community Safety to address concerns resulting from anti-social behaviour where the victims are vulnerable and at risk of serious abuse or harm. The aim of this group is to prevent incidents like those experienced in the high-profile case of Fiona Pilkington.

SAPB partner safeguarding meetings
Moorfields Eye Hospital, Whittington Trust and Camden and Islington Mental Health Trust have all established senior level Safeguarding Adults meetings.

CCG involvement in Safeguarding Adults Unit
The CCG has contributed funding to the Safeguarding Adults Unit and has produced a work plan that addresses areas of learning and development for commissioners, compliance with regulations and updating of policies and procedures.

Themed SAPB Meetings
We have introduced themed Board meetings which have resulted in some very interesting presentations from partners about how they contribute to the safeguarding adults agenda.

Delivering our strategy

.The partnership agreed a three-year strategy. Represented below are the six strategic aims of the strategy. Much of the work involved in meeting these aims is carried out by the subgroups of the partnership Board.

1. Effective partnership

We continue to show that the partnership is well governed, accountable and improving safeguarding in Islington. The annual review is just one example of the way that we are accountable for how we safeguard adults.

As a partnership, we continue to engage with the local people and raise awareness of safeguarding adults. We did this through ongoing talks to local community groups and our community conference for the public.

We stepped up our engagement with local service users and carers and held a community briefing event explaining how local people can get involved in the work of the partnership.

Our conferences for professionals are another way of bringing staff in partner organsations together to focus on safeguarding adults. We held a Mental Capacity Conference and a safeguarding conference for professionals and invited several highly-regarded national specialists to speak. These conferences were well-attended by a range of health and social care staff and have

been a way to both increase knowledge and to build links between different professionals.

We agreed a range of audit programs, which were then overseen by the Quality, Audit and Assurance Subgroup. These included monthly audits in relation to safeguarding practice for care management teams across health and social care. Themes emerging from audits are then discussed at the Partnership Board.

Effective partnership is also about learning together from cases where there has been serious harm or a death. Our partners demonstrate their commitment to learning by sharing openly what went wrong so that all partners can play a part in preventing future harm. Learning from a recent Domestic Homicide Review and will be embedded from this across all our partner agencies once the Reviews have concluded.

This work was led by the Chair of the Board.

2. Protection, prevention and risk management

The Quality Assurance and Audit sub group has met regularly throughout the year and has focused on leading and delivering two of the key objectives in the Borough's strategy. That is

- Promoting effective partnerships and enabling all interested parties to work together and link well with others
- Undertaking an audit programme for the year that will include all partner audits that look at prevention and risk management.

The sub group recognises that there will always be improvements to make in safeguarding the most vulnerable in our communities and progress has been made over the year. An audit programme was carried out across a range of statutory and council services as well as within all other agencies.

One specific focus for the group over the year has been the response within Islington to the Winterbourne View inquiry of the Castlebeck Hospital in South Gloucestershire. The sub group has been receiving and scrutinising reports based upon all these audits, making recommendations for action.

The Department of Health issued a safeguarding adults self-assessment framework (SAAF) in January 2014. All partners, not just health partners, were invited to use the SAAF as a Board Audit tool. A joint Islington & Camden Boards Challenge event was held to validate the SAAF responses. Themes from partner organisations were analysed and areas for improvement will form part of the Board's work plan for next year.

Many of the findings arising from the committee's work have been used throughout this annual report.

Martin Machray
Chair of Quality, Audit and Assurance Sub Group

3. Awareness, empowerment and accountable policies

The Policies and Procedures subgroup's remit covers two elements of the partnership strategy:

- Ensuring safeguarding adults polices and procedures work for local people
- Helping people in Islington to know what to do if abuse or neglect happens

We continued to actively raise awareness among local people on how to spot abuse. The general public, staff, volunteers and a number of local groups participated in our awareness surveys. We received a large number of responses from the Islington Older People's Reference Group. Thanks to these responses, we now know how and where to best target our communications and have a solid foundation to build next year's communications strategy on.

As financial abuse remains one of the most prevalent types of abuse in Islington, we produced a range of guidance for professionals and the public around preventing financial abuse.

The policies and procedures subgroup continues to keep a close eye on national and local developments in safeguarding adults and receives regular reports on this. Where any implications are identified for policies and procedures, local partners are advised and updated through a newsletter or through training. The passage of the Care Bill (now the Care Act 2014) has been particularly closely monitored because of its relevance in placing safeguarding adults on a statutory footing for the first time.

Audits of partner policies and procedures give assurance that partner policies and procedures work for local people and help to identify further areas for partners to work on.

Colin Plant
Chair of Policies & Procedures Sub Group

4. Compassionate, proportionate & skilled

The Learning & Development Subgroup's focus is to ensure that skilled staff and volunteers spot abuse and take timely, compassionate and proportionate action to ensure protection.

During the year we ran several Safer Recruitment courses for managers who recruit in partner organisations. Follow-up surveys show that managers now have a better understanding and awareness of the new legislation and how to make sure they recruit the right people to work with adults at risk.

We surveyed staff and volunteers across the partnership to gauge understanding of safeguarding adults, such as recognising the signs and symptoms of abuse and neglect and how to report it. The results of this survey have helped to give assurance on staff competence, identify training needs and inform future training we commission.

We also set up a mini-evaluation audit to check and ensure that staff maintain skills and values. Responses confirmed that staff have greater confidence and better knowledge around safeguarding practices since attending a learning event.

Our conferences remain a core part of our activity and are a useful way of delivering learning and maintaining interest in safeguarding adults. Feedback from our conferences has been overwhelmingly positive.

Neil Chick
Chair of Learning & Development Sub Group

Community Conference

Community Conference 2013 'Compassionate Care and Safeguarding'

Our annual community conference is always well-received. This year's conference took place June 2013 to coincide with National Carers week.

The aim of the conference was to focus on compassionate care and dignity to improve experiences for service users and carers.

There was good attendance again for this with 112 people at the event. There was a good representation from all sectors of the community with service users, family carers, Fire Brigade, Islington Council, NHS and third sector organisations.

Feedback from the Conference

"We need more awareness in the community"

"My awareness of peoples' needs has been raised"

"Good input from service users"

Annie Stevenson from Integration in Care (My Home Life) talked about compassion and quality of life for adults at risk within safeguarding.
There was a table exercise on what delegates' understood by compassionate care, respect, dignity, choice and listening.

The audience participated fully in the event and really enjoyed talking to staff who were manning information stalls from Islington Council Safeguarding and Mental Capacity Units, London Fire Brigade, Centre 404, HealthWatch Islington. Penrose Options, Islington Children's Safeguarding Board, Daylight Centre and Age UK.

We were delighted with the feedback we received - **100%** of delegates said the conference **met their expectations**. Delegates said that the conference made them think about:

- putting themselves in the shoes of the service user
- letting service users vocalise their views.

Professionals' Conferences

Mental Capacity Act Conference September 2013

Approximately **100** people attended this conference, the majority from Islington Council and its partners. The presentations included a legal update by Aasya Mughal Barrister, Embedding the MCA in practice by Lucy Bonnerjea at the Department of Health, Applying the MCA in care homes by Jane Wray from CQC and Working with the Court of Protection by Professor Anselm Eldergill District Court Judge.

Feedback from the event was very positive, and **98%** of delegates said they had a better understanding of the MCA from attending, and **75%** thought the event was **excellent**.

"I teach MCA, but issues were brought up that made DOLs clearer"

"Very useful to be reminded to check recent decisions in court and to use judgements as a guide"

"Thank you for providing this valuable networking and learning opportunity."

"It was excellent and the need for such a Conference was further evidenced by the fact that there were people attending from other Boroughs as well as Islington - there is clearly a demand that is not being met elsewhere outside Islington - well done Islington Counci"

Moving Towards Prevention Conference March 2014

Identifying and developing constructive approaches to preventing abuse and neglect was the theme of this conference. Delegates were also given the opportunity to meet other leads and professionals and share knowledge and good practice.

The conference was attended by 100 professionals across many disciplines. Safeguarding leads, social workers, care managers and team managers in Islington Council, the police and partner organisations in the borough and safeguarding leads and police officers from other neighbouring boroughs who work to safeguard adults at risk.

There were 3 speakers:
Julie Bailey (founder of Cure the NHS) gave a profoundly moving presentation about her and her mother's experiences in the Mid Staffordshire NHS hospital.

Stephan Busch Professional Safeguarding Adult at Risk Advisor for NHS England spoke about how NHS England and adult social services should be working together to improve care and practice.

Amjad Malik – QC (Criminal barrister) spoke about wilful neglect and looking at lifting the barriers to bringing more cases to court.

"The conference was excellent. The atmosphere was most welcoming"

"An effective tool in delivering a reminder as to the reality and necessity of safeguarding from a 'making it real' human perspective and from a front line aspect upwards".

Partnership Challenge Event

Islington and Camden Joint Challenge Event March 2014

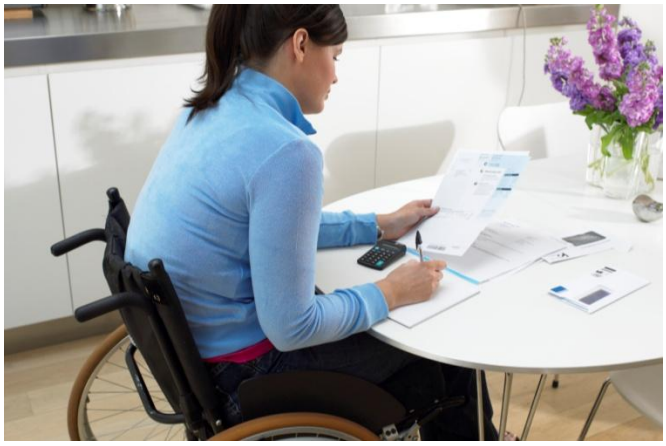
For the first time this year, we held a partnership challenge event with Camden Safeguarding Adults Partnership Board.

This proved to be a highly constructive way of comparing our progress with a neighboroughing borough. Naturally, the two boroughs face different challenges because we have differing populations, differing geographical sizes and different ways of working. But there were common themes that emerged.

We used the NHS England Safeguarding Adults Board Audit tool as a basis for comparison. Partner organisations from Islington and Camden were split into sector-based groups for group-work on audit responses. Many partner organisations commented that it was helpful to compare, scrutinise and challenge with their counterpart organisation in the other borough. The sector-based groups then presented their findings to all present for support and challenge.

The event concluded with discussion on action planning, common themes and priorities for the following year.

Experiences and statistics



Statistics are important to us - they help us understand how we are doing and which areas we need to improve on. But we also want to understand people's experiences.

This section reviews both aspects.

1. Experiences

It is important we look at the real people behind the statistics and try to understand their situation and the experiences they have. To do this, we use a variety of methods to get the information we need about people's experiences.

We carry out monthly audits of a sample of safeguarding cases. We do this to get a better understanding of what has happened in cases and to make sure that wherever possible, people who were at risk of harm or abuse, got the outcome they were seeking. Learning and good practice from these cases is shared with professionals.

Our work engaging with service users and carers also helps us to get feedback on people's feelings of safety and experiences of safeguarding.

The Quality, Audit and Assurance subgroup also triangulates patient and service user compliments and complaints with data to get a fuller picture of people's experiences.

We have included some anonymised case examples in this report to convey some safeguarding adults experiences.

Case example

There were concerns that a residential care home had a resident with a pressure sore. A safeguarding alert was raised and an investigation completed. Care staff were concerned that they needed more information on how to recognise the early signs of pressure sores and what action they should take as this one had developed very quickly.

The specialist nurse for care homes, provided training to staff and charts they can use to recognise early signs of pressure sores developing and what action to take. This training was provided to all care homes to give staff the knowledge and resources they need with an aim to prevent residents in all care homes developing pressure sores wherever possible.

2. Statistics

Alerts

When someone reports a concern about abuse or neglect of an adult with care and support needs, it is known as a 'safeguarding alert'.

In April-March 2012/13 we had **815 alerts** about possible abuse.

In April-March 2013/14 we had **1165 alerts** concerning a total of **904 individual people**. This is an **increase of 43%.**

This increase in the number of alerts is positive in that it shows that professionals and members of the public are reporting situations to us that they are concerned about in relation to an adult with care and support needs. We have been working hard to increase the awareness of members of the public and colleagues around abuse and neglect.

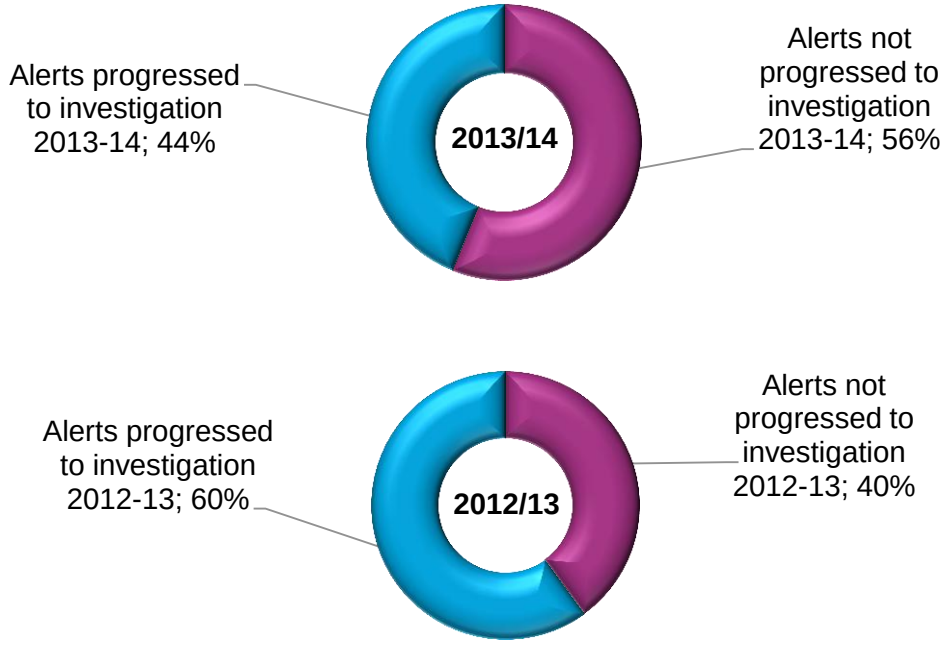
Referrals

After an alert has been received, we then gather more information about the person and the concern. Once this has been done, we decide whether the case needs to be referred for investigation. A case that goes on to be investigated is known as a 'referral'.

In 2012/13 we had **489 investigations (60% of the total alerts raised)** about suspected abuse.

In 2013/14 we had **511 investigations (44% of the total alerts raised)**. This is an increase of 4% on last year.

Safeguarding Adults 2013/14 & 2012/13: Alerts Proceeding to Investigations



When we receive a safeguarding alert we gather more information about the person, their situation and the concern which has been raised. This is to see if further investigation is needed.

In 2012/13 we **completed 489 investigations** (60% of the total raised). In 2013/14, we **completed 511 investigations** (44% of the total raised). This means we completed slightly more investigations than last year.

However, fewer of the alerts we received went on to be investigated. This is for a number of reasons. In a number of cases, initial information gathering has shown that when the situation was clarified, there were no concerns which needed further investigation. Safeguarding and abuse of adults has a high profile in the media at present. As people are more aware, it may be that more safeguarding concerns are being raised with us. The teams look at all the alerts which come in to decide if further investigation is needed.

In some situations, further discussion revealed that the person was not an adult at risk and further investigation was not required under safeguarding procedures. In a number of cases, the safeguarding concern was being investigated, but the investigation was being completed by another local authority. This is because the person is living in a care home which is located outside of Islington.

Sometimes, an investigation has taken place and action was taken, but it was not recorded as such. We will continue to monitor this to ensure that staff are recording information correctly and taking appropriate action where this is required.

Case example

Ms K is a 70 yr old woman with serious health issues and is dependent on alcohol.

Ms K was referred to a local homeless charity, SHP, by her landlord because her tenancy was at risk due to anti-social behaviour.

Ms K disclosed to her worker that she was allowing "friends" to use her property to drink and that there was a male who was visiting her on a regular basis and this person would often stay over and take her money. There was evidence to suggest several people were using Ms K's spare room to stay over, sex work and store stolen goods.

A safeguarding alert was raised and Islington Social Services carried out an assessment. As a result of this Ms K was allocated a care co-ordinator who worked with SHP to assist Ms K.

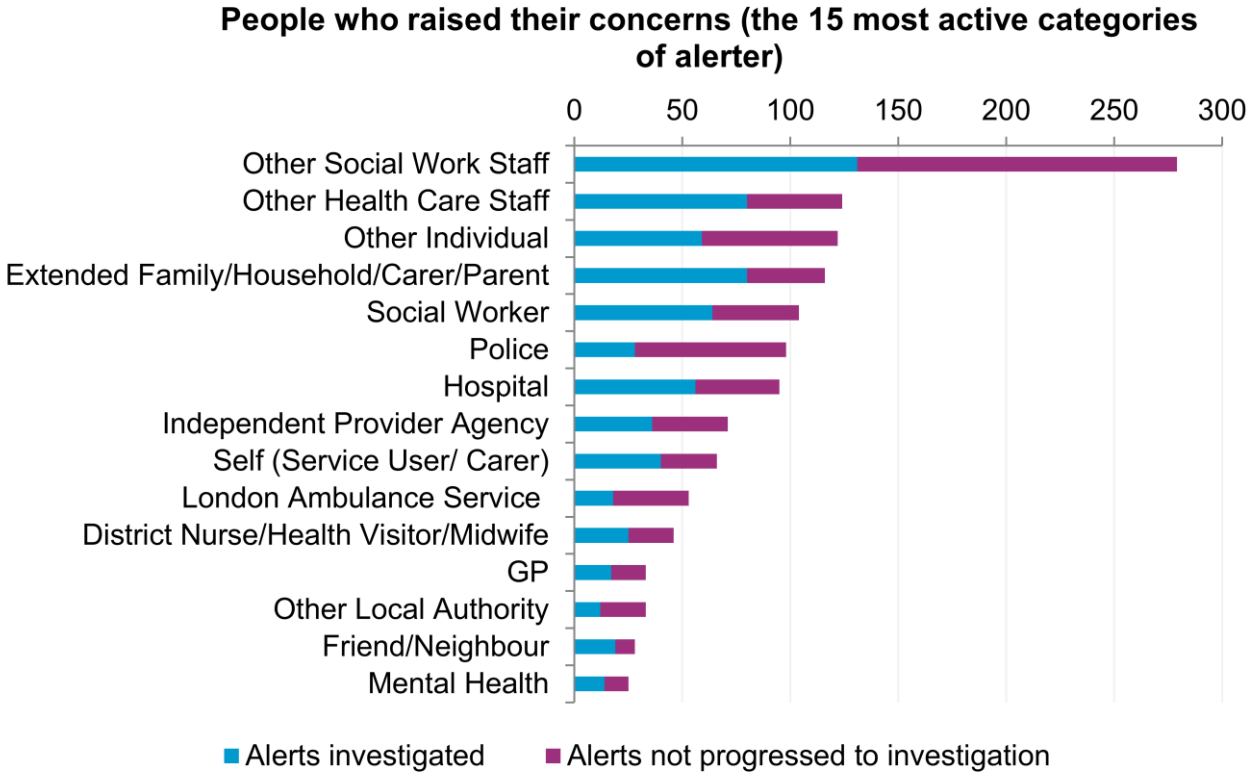
Although Mrs K was reluctant to involve the police, it was agreed with the local police Safer Neighbourhood Team that they would carry out regular welfare checks at her home. Since then no incidents have been reported at the property.

Ms K was also given support and advice around how to stay safe to help reduce the risk of further exploitation - not answering the door before checking who it is, keeping windows closed etc.

Adaptations were also made to the flat to help with Ms K's mobility issues. And for the first time in more than 3 years, she agreed to engage with her GP.

A priority referral to sheltered accommodation has also been submitted and Ms K will be supported to move as soon as a flat becomes available.

3. People who raised their concerns



This chart refers to 575 investigations which were completed during the year. It includes some cases which were started in the 2012-13 year, but completed in 2013-14. It excludes cases which had not been completed because the outcome had not been decided yet.
Some cases involved more than one type of abuse.

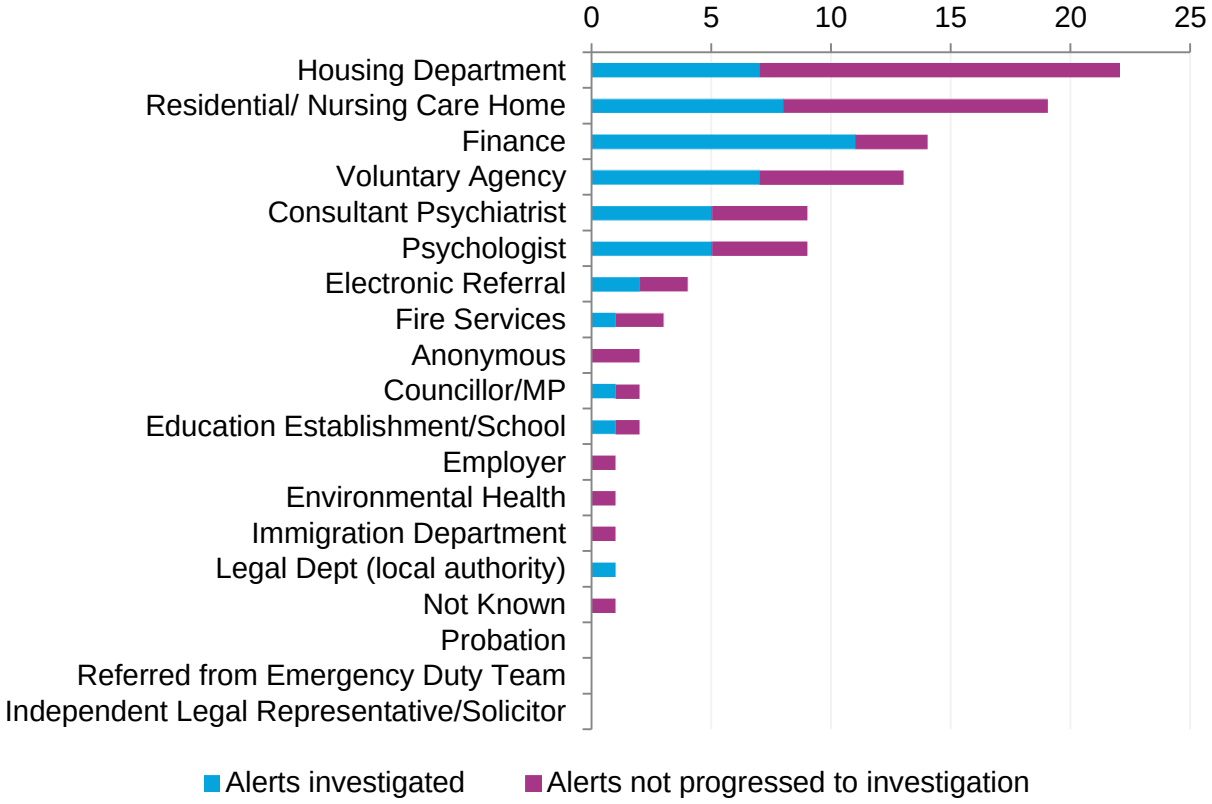
A wide range of people raised their concerns about adult abuse or neglect. This chart shows the people who raised the most alerts.

The highest number of safeguarding referrals came from other social work staff (for example home care, social services occupational therapist) and other health care staff such as. physiotherapists, hospice staff and support staff.

The third highest referrer was 'other individual'. We have had a closer look at this and most of these people belong in a different category. This is a recording issue and we will continue to work with staff around this. It is important that we have accurate data about alerters so that we know where to focus our training and awareness-raising.

Extended family and carers continue to be frequent alerters. Where they have raised an alert, the majority have progressed to investigation, suggesting that the professionals involved shared the concerns that abuse or neglect may have taken place..

People who raised their concerns (the 19 least active categories of alerter)



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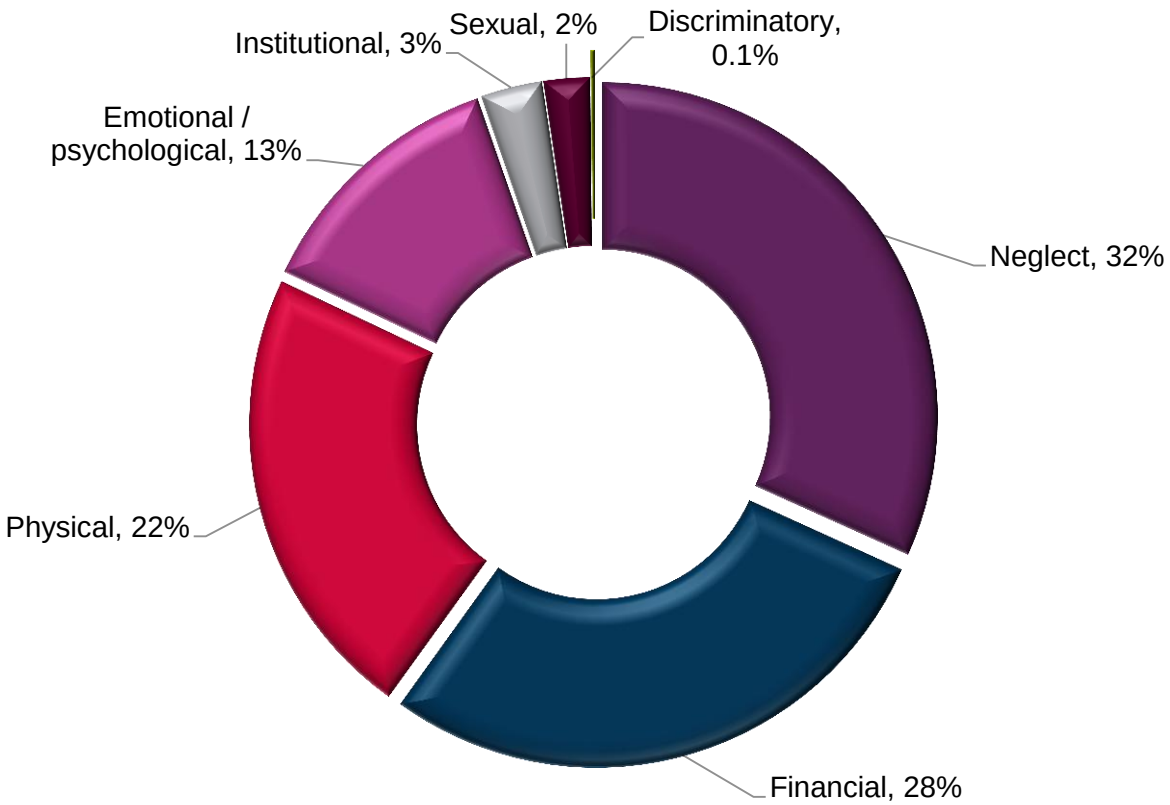
Some cases involved more than one type of abuse.

More than three-quarters of alerts from Police and two-thirds of alerts from housing, did not go on to be investigated. We will continue to work with different organisations to ensure that they know when to raise a general social services enquiry and when to raise a safeguarding alert.

4. Types of abuse investigated

The different types of abuse that we investigated during the year are shown in the chart below:



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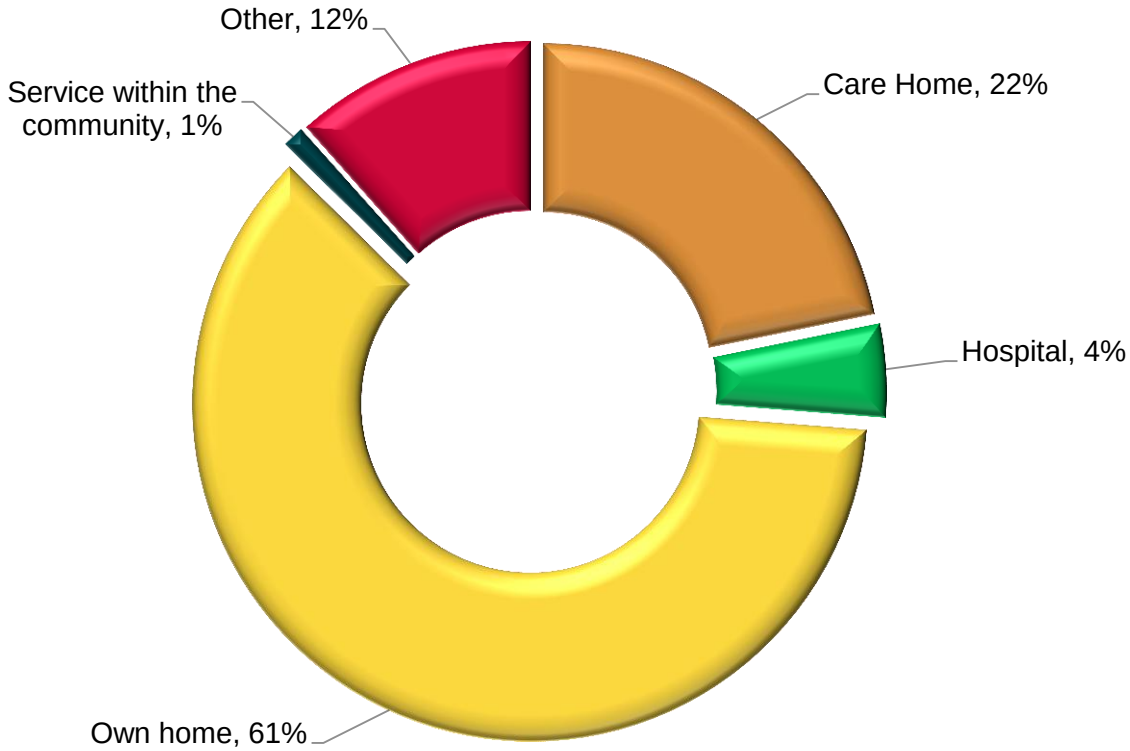
Physical abuse, financial abuse and neglect remain the top three categories for abuse. This has been the picture for several years and reflects the national picture. Since last year, neglect and financial abuse have been nearly equal in the number of investigations completed.

Tackling financial abuse is a priority in our 3-year strategy. Financial abuse can take many forms and can be difficult to spot. We are raising awareness about financial abuse and have produced a leaflet for the general public and produced guidance for professionals.

What is neglect?
Neglect is not giving reasonable or agreed care. It includes poor hygiene, poor standards of care and failing to give medication in the way prescribed by a doctor.

5. Location of abuse investigated



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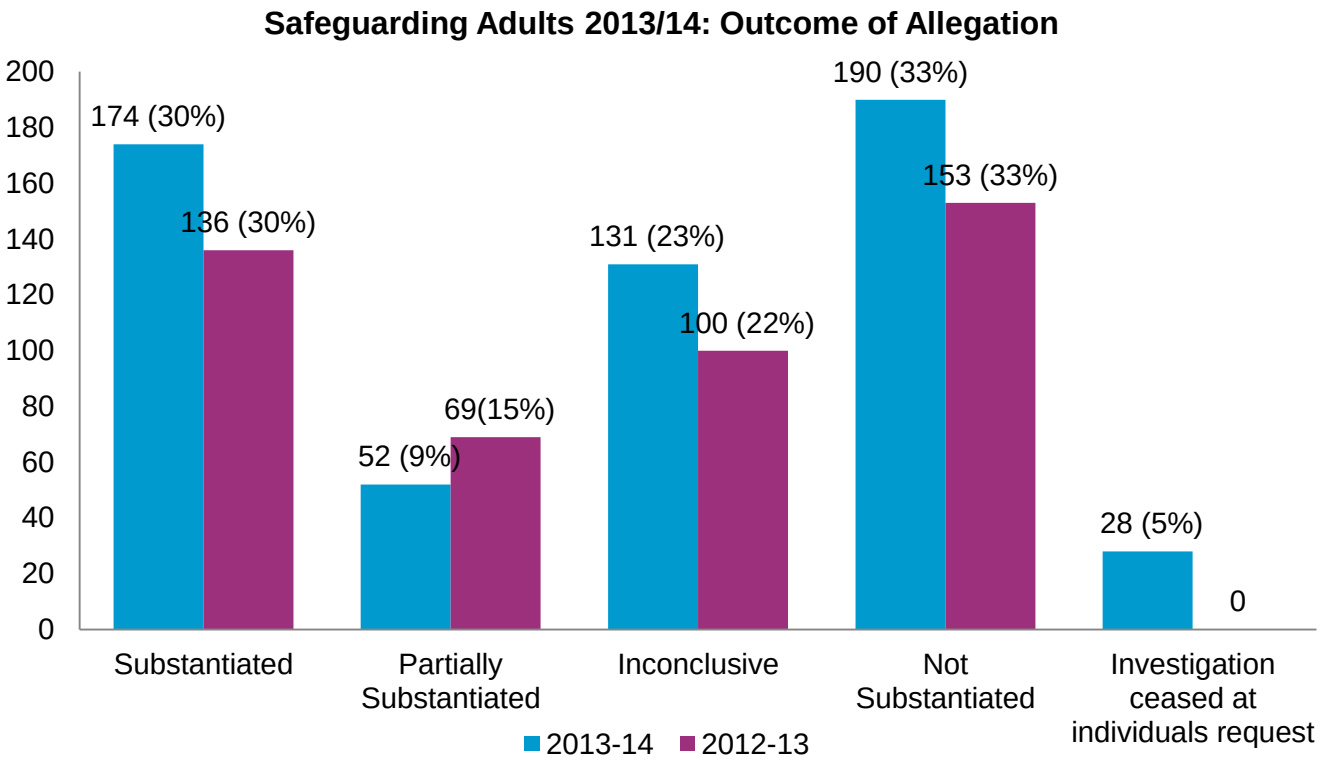
Some cases involved more than one location of abuse.

Nearly two thirds of cases we investigated took place in the person's own home. Sometimes, people experience abuse at the hands of family or friends; sometimes, it is the action of a care worker from a home care agency which is the concern. People should feel safe in their own homes and where possible we would support the person to stay safely at home. If the abuse involves a care worker we may provide a different care worker or provide care from a different agency. We would continue to monitor the situation. Where the adult at risk receives home care services contracted by the Council or NHS there are monitoring processes to keep a check on standards of care.

Care homes were the location of abuse or neglect in 22% of the cases we investigated. Sometimes, the abuse may have been caused by another resident in the care home. We continue to carefully monitor the number and types of alert relating to each care home in Islington.

6. Decisions taken

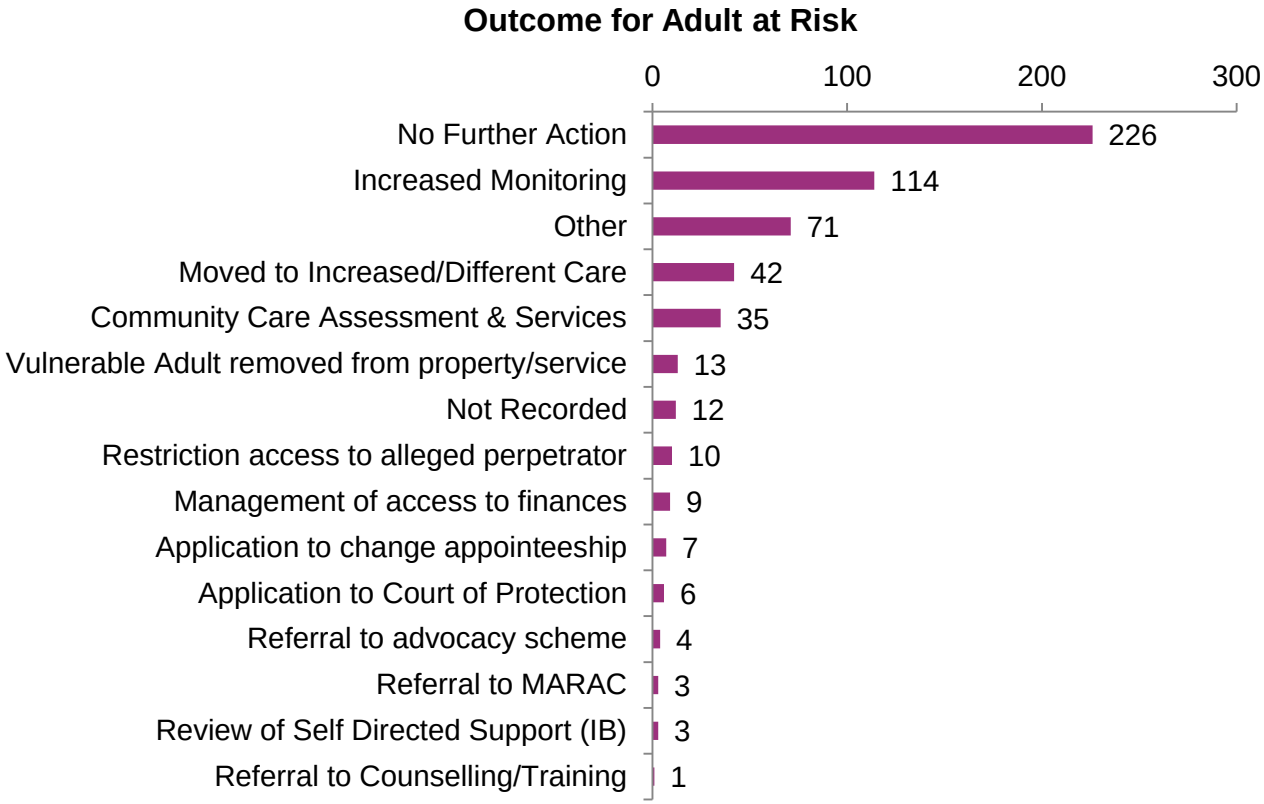


This chart refers to 575 investigations which were completed during the year. It includes some cases which were started in the 2012-13 year, but completed in 2013-14. It excludes cases which had not been completed because the outcome had not been decided yet.

At the end of the safeguarding investigation, the agencies involved weigh up the information and decide whether it is likely that abuse took place or not. Many factors are considered when reaching this decision.

The percentage of cases which were substantiated, (that is, the abuse was likely to have taken place) has remained the same as the previous year at 30%. This is the same picture for cases which were not substantiated and inconclusive. Fewer cases were partially substantiated this year. This is the first year we have recorded data where the investigation ceased at the individual's request. In these cases, the person had the capacity to make this decision. Sometimes, they made this decision because a family member was the person alleged to have caused harm and the person did not want to take things further. Where possible staff put other measures in place to manage the risk with the person's agreement. For example, the person's home care package might be increased or a referral made to 'client's affairs' so that their money is managed in a safer way. Investigations are inconclusive where, despite the evidence gathered, it is difficult to reach a decision. Where this is the outcome, we would still look at what action needs to be taken.

7. Action to help the adult at risk



***** *MARAC is an acronym for Multi Agency Risk Assessment Conference.*

This chart refers to 575 investigations which were completed during the year. It includes some cases which were started in the 2012-13 year, but completed in 2013-14. It excludes cases which had not been completed because the outcome had not been decided yet.

Similar to last year, in nearly half the cases we investigated (226 cases) we took 'no further action'. We have audited a sample of these cases and this shows that in a number of cases, no further action was taken because the investigation was not substantiated. On other occasions, the person was able to tell us that they did not want further action taken. A closer look at some cases revealed that action was indeed taken, but not correctly recorded. For example, arrangements were put in place to manage finances or monitoring was increased.We will continue to work to improve recording.

Increased monitoring is a typical outcome for a safeguarding investigation. The monitoring may be done in a variety of ways. For example, where the abuse involved anti-social behaviour from neighbours, the police may increase their patrols in the area for a period of time. Or, for a frail patient, the community nurses may increase visits to the patient. Or we may have made a referral to Linkline so that monitoring can be done remotely.

8. Action taken against people alleged to have caused harm

This chart refers to the 174 completed investigations where abuse was substantiated.
*There may have been more than one outcome for each person alleged to have caused harm.

The percentage of cases where there was no further action recorded continues to decrease. Last year, in 36% of completed investigations it was recorded that no further action was taken against the person who was alleged to have caused harm. This number has fallen to 28% this year. The recording of no further action needs continued monitoring to ensure that correct recording is taking place. All of these cases have been looked at and, on the whole, action was in fact taken. Where no action occurred, this was usually because the person had capacity and asked us not to take further action.

The most common action taken is increased monitoring. This could mean, for example, where a member of staff has been found to have caused harm, then they may be supervised more closely. It is noticeable this year, that it is more likely that other courses of action are also followed such as training, removal from property, police action or disciplinary action.

9. Serious Case Reviews

This year we received a request for a serious case review. The review is happening as this report is being written. Once the review is completed the Safeguarding Adults Partnership Board will be briefed on the outcome and any lessons learned and actions to be taken. The serious case review outcome will be reported in next year's Annual Report.

During the year there was also a serious case review held in Haringey relating to an Islington placed resident in a care setting. As a result of the review comprehensive training around choking has been set up. Also a new protocol has been developed between Islington and Haringey around transfers of care arrangements. Where the service user is subject to the care programme approach the reviews are now authorised by senior managers as well as psychiatric services.

Also during 2013 we participated in a Domestic Homicide Review. Actions to come from this review include reviewing the safeguarding policies and procedures to ensure that domestic violence is appropriately included; carers issues are addressed; and reviewing the non engagement and refusal of service policies. The action plan is being quality assured by the Home Office as the report is being written.

During 2013 we invoked our Establishment Concerns process in respect of three care homes in Islington. The care homes had a number of safeguarding concerns involving neglect, delays in responding to changes in residents' medical conditions, poor recording and medication errors. All three care homes have demonstrated significant improvements and have worked to detailed improvement plans. At the time of writing this report no new safeguarding concerns have been raised at any of these homes for some time.

10.Equality & Diversity

Please see Appendix B for a full report on how different people in Islington are represented in safeguarding alerts.

11. Deprivation of Liberty Safeguards

Overall DoL application levels in 2013/14 are similar to previous years, with more referrals from care homes and fewer referrals from hospitals.

In summary:

- The percentage of referrals resulting in an authorisation being granted was higher this year reflecting more appropriate referrals.
- The majority of authorisations granted (65%) were for less than three months. The trend over recent years has been to recommend and grant shorter authorisation periods and this reflects best practice.
- The vast majority of referrals from care homes (85%) are on behalf of people who have dementia.
- Most hospital referrals were on behalf of people with mental health conditions other than dementia, such as brain injuries.
- There has been a decrease in referrals for people who have a learning disability. However, with the recent Cheshire West judgement this is likely to change significantly.

The vast majority of referrals (82%) were on behalf of people who are white British. A significant number of these (48%) were also for people of Irish origin.

Highlights 2013/14

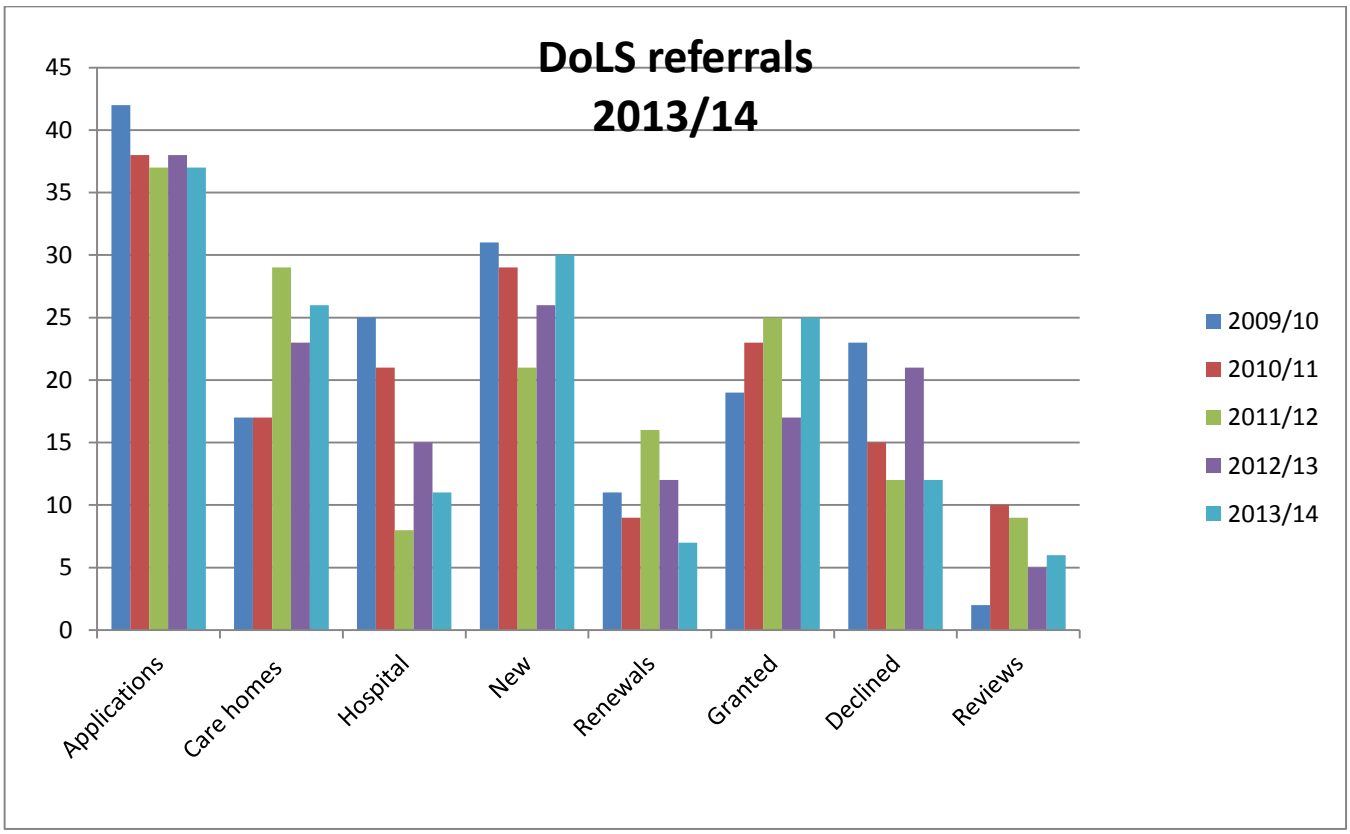
It's been a full year now since the **Islington Supervisory body** took on responsibilities for DoLS referrals and authorisations for Islington residents in hospitals. The transition has been very smooth and there are no concerns or issues to report. The Supervisory body expanded this year to include service managers. This should help promote the deprivation of liberty safeguards across Islington.

Training on the Mental Capacity Act 2005 (MCA) & Deprivation of Liberty safeguards has increased significantly with 503 delegates attending MCA & DoLS training. This is a **173% increase** on the previous year. We have also commissioned and delivered some new courses in direct response to national developments, for example applications to the Court of Protection and the Cheshire West judgement.

All managers of **residential care homes** in Islington were visited last year to deliver a briefing on DoLS. This helped to raise the profile of DoLS in the homes.

What is the 'Cheshire West' judgement?

In March 2014 the Supreme Court made a long awaited decision in a case concerning the living arrangements of three mentally incapacitated individuals. It decided that all three were subject to a deprivation of their liberty. This judgment is important because it clarified the law around DoLS and introduced an 'acid test' to work out whether or not a deprivation of someone's liberty is taking place.



Applications and authorisations

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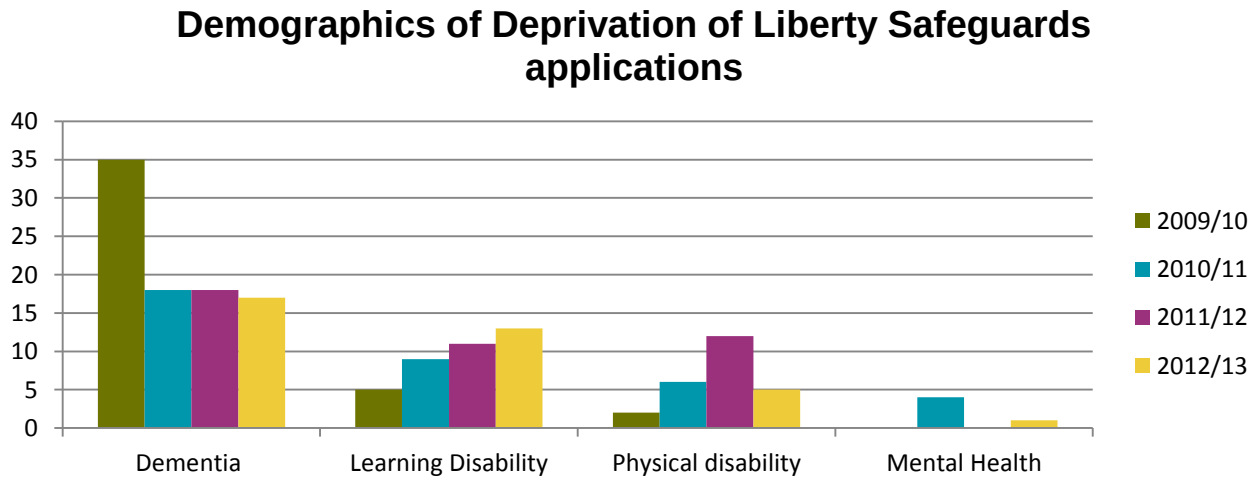


Next steps for the partnership

We have agreed an action plan for the coming year. We wanted the 2014-15 action plan to reflect what people in Islington and partner organisations told us needed to improve.

So, in forming the action plan, we took into account:

- responses from partner organisations in the self-audits they completed
- themes from the Islington/Camden Challenge Event
- feedback from our Community Conference
- feedback from the service user and carer involvement event
- table exercises at the Professionals' Conferences
- responses to the staff and general public awareness surveys
- recommendations from a Domestic Homicide Review

Three key areas for development were identified:

- hearing the service user voice
- making more information on safeguarding accessible
- embedding safeguarding on staff supervision

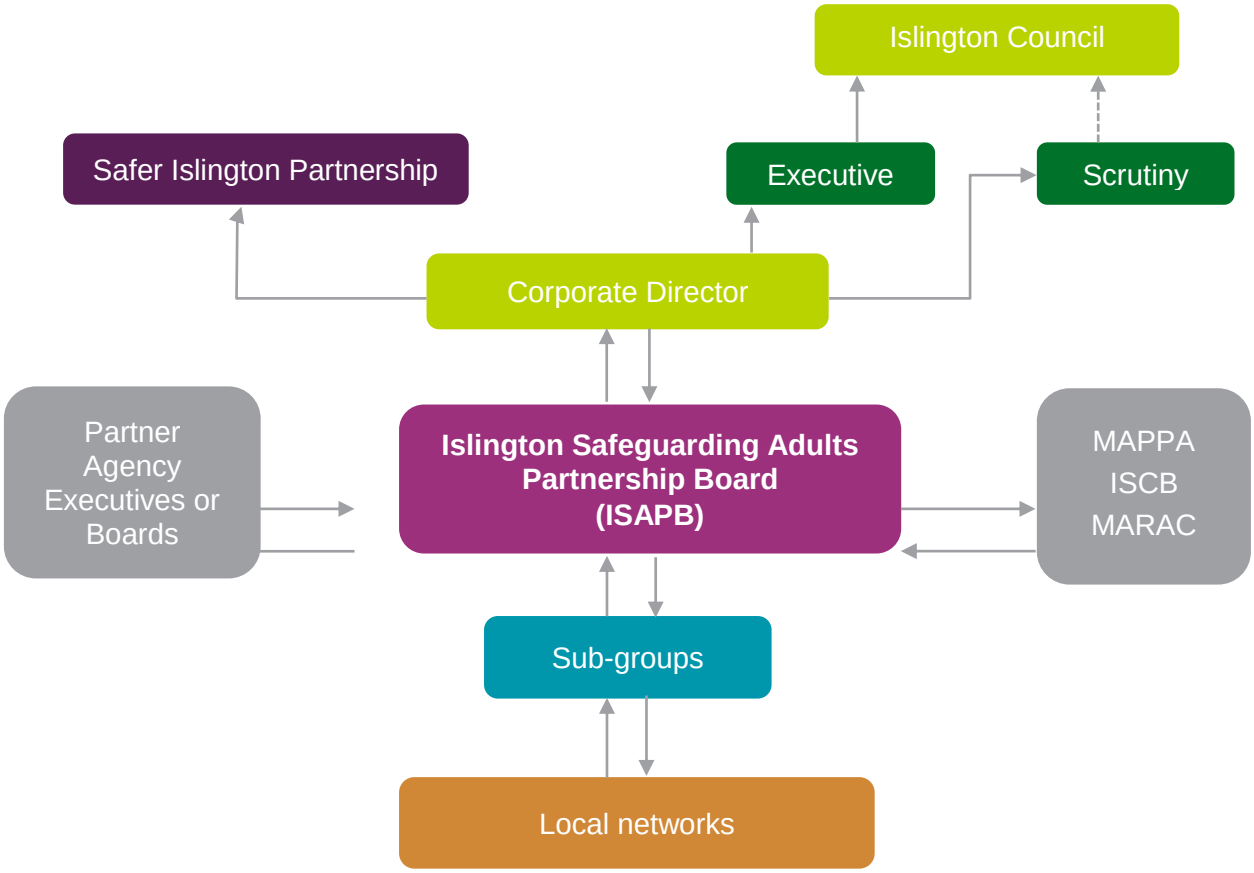
Every partner organisation has undertaken to achieve something concrete to further the aims of the partnership. Through this action plan we will ensure we keep our partnership aims on the agenda of every partner organisation.

Safeguarding is everyone's business and we will continue to raise awareness among the public. By partners and the public all playing their part in stopping abuse and neglect, adults at risk will be safer in Islington.

You can read our action plan on our website. http://www.islington.gov.uk/services/social-care-health/adultprotection/Pages/sap_board.aspx

Appendix A
How the partnership board fits in

The picture below shows how the Islington Safeguarding Partnership Board fits in with other organisations and partnerships. The arrows and lines show who reports to whom.



Council – All elected councillors. It is the lead body for the local authority.

Executive – Eight councillors who are responsible to the council for running the local authority.

Scrutiny – This is a group of 'back bench' councillors who look very closely at what the council does.

Safer Islington Partnership – This is a group which looks at crime and community safety. It involves the council, police, fire service, voluntary sector and others.

Corporate Director (for Housing and Adult Social Services) – Is responsible for setting up and overseeing the ISAPB.

ISAPB – This has an independent chair who does not work anywhere else in the council or partner organisations.

MAPPA – Multi-Agency Public Protection Arrangements is a group which oversees management of offenders who pose a serious risk to the public.

ISCB – Islington Safeguarding Children's Board works to safeguard children in the borough.

MARAC – Multi-Agency Risk Assessment Conference. This group responds to high risk domestic abuse.

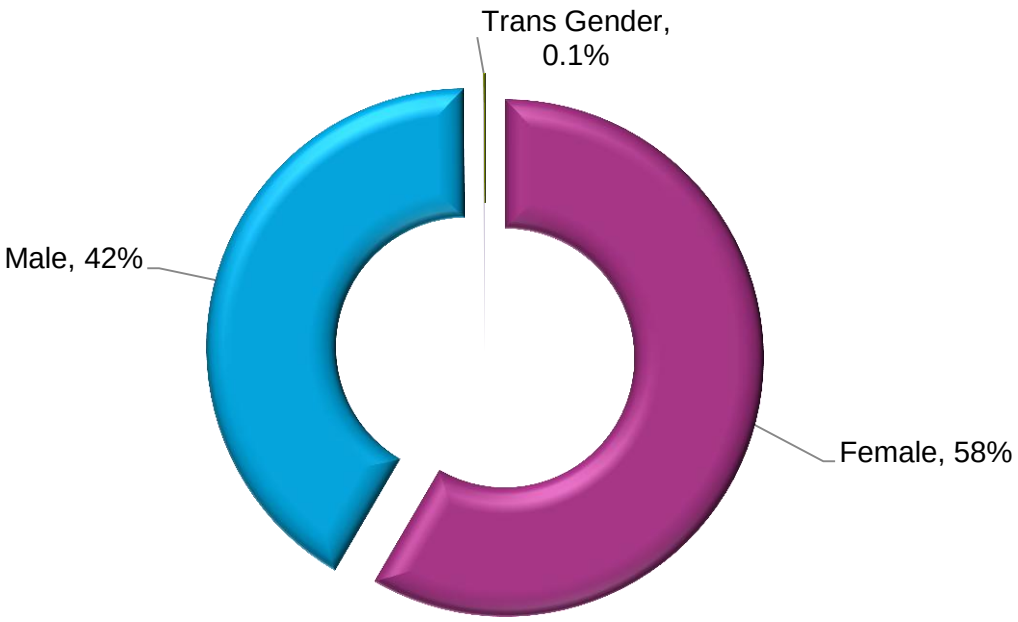
Appendix B
Making sure we safeguard everyone

Table showing recorded age of service users April 2013 – March 2014

Age	Adults subject to safeguarding alerts	Islington adult population*	%
18-64 *	332	162,552	0.2%
65-74	140	9,489	1.5%
75-84	229	5,761	4%
85+	203	2,271	8.9%

This table refers to the 904 adults who have had alerts raised about them
The population data was released from the 2011 Census during the second, third and fourth data releases, which took place during 2013. Data was downloaded from http://www.nomisweb.co.uk/
* The 2011 Census data is based on an age category of 20-64 years; whereas the data we collect is for the 18-64 years age group.

Chart showing recorded sex of service users April 2013 – March 2014



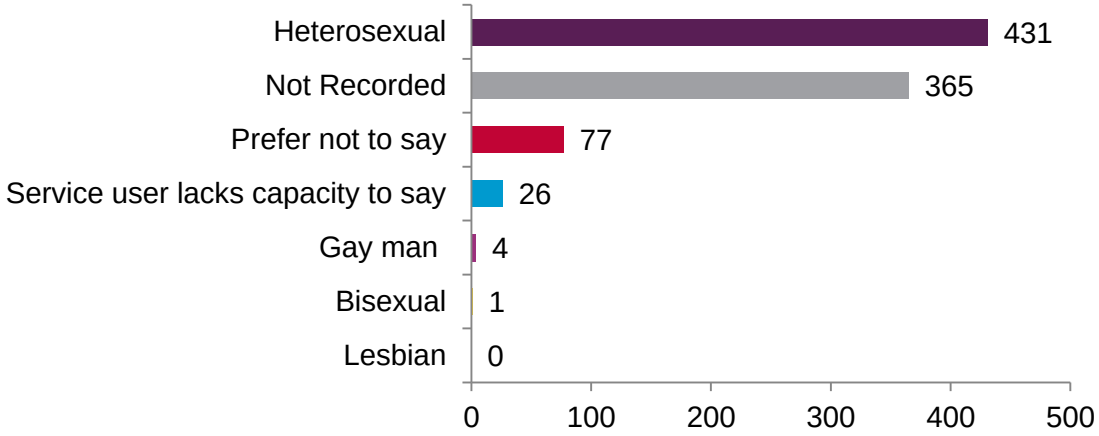
These charts both refer to the 904 adults who have had alerts raised concerning them.

Table showing recorded Ethnicity of Service Users April 2013- March 2014

Ethnicity	Adults subject to safeguarding alerts	Islington adult population*	%
White British	445	98,322	0.45%
White Irish	80	8,140	0.98%
Other White (includes traveller of Irish heritage, gypsy/Roma and any other white)	51	34,053	0.15%
Black Caribbean	76	7,943	0.96%
Black African	42	12,622	0.33%
Any other Black background	7	5,729	0.12%
Asian Indian	23	3,534	0.65%
Asian Chinese	7	4,457	0.16%
Asian Pakistani	5	951	0.53%
Asian Bangladeshi	5	4,662	0.11%
Any other Asian background	11	5,430	0.20%
Mixed/multiple ethnic groups	20	13,339	0.15%
Other (includes any other ethnic group, information not yet obtained, refused to say,	132	6,943	1.90%
Totals	904	206,125	0.44%

This table refers to the 904 adults who have had alerts raised about them.
The population data was released from the 2011 Census during the second, third and fourth data releases, which took place during 2013.
Data was downloaded from http://www.nomisweb.co.uk/

Chart showing recorded Sexual Orientation of Service Users April 2013- March 2014



These charts both refer to the 904 adults who have had alerts raised concerning them.

Appendix C
Our impact on the environment

The work of the Safeguarding Adults Partnership Board has a low impact on the environment in Islington. Environmental impacts include fuel use for vehicles visiting service users, carers and their family and other general office impacts such as paper and energy use. Wherever possible, we manage the impact on the environment.

Sometimes our work also highlights opportunities to reduce household environmental impacts. For example, we might refer adults at risk to the Seasonal Health Intervention Network (SHINE). SHINE gives energy saving advice to residents. Not only does this help the environment, but it also reduces fuel poverty and improves the health and wellbeing of residents in Islington.

For more information about SHINE, see http://www.islington.gov.uk/services/parks-environment/sustainability/sus_awarmth/Pages/shine.aspx

Appendix D

What should I do if I suspect abuse?

If you suspect abuse of a vulnerable adult, please contact:

Adult Social Services Access Team
Tel: 020 7527 2299
Email: access.service@islington.gov.uk
Fax: 020 7527 5114

You can also contact the Community Safety Unit which is part of the police:
Tel: 020 7421 0174

In an emergency, please call 999.

For more information please see:
www.islington.gov.uk/safeguardingadults