

Islington Safeguarding Adults Board

Summary Annual Review 2015-16

Our Achievements



Deprivation of Liberty Safeguards applications continued to increase sharply. We are one of the few local authorities that are managing to turn around applications mostly within timescales.



We developed a prevention strategy – each of our partners have committed to taking action towards preventing abuse and neglect from happening in the first place.



We've implemented a learning log to make sure that we learn the lessons from serious cases by sharing the learning among organisations in Islington.



We developed a policy checklist for partner organisations to ensure their policies comply with the Care Act 2014.



To hear people's views on the Board's work, a Service User and Carer subgroup has been set up.



We held a month-long series of different awareness-raising events at various places in the borough.

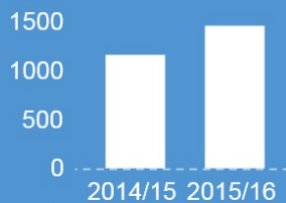


Self-neglect is a new category of abuse under the Care Act. We've done a small audit of these cases to get assurance on our practice.

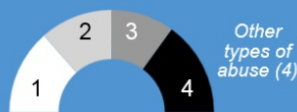


We set up multi-agency RADAR meetings to monitor care provider quality

Key Statistics



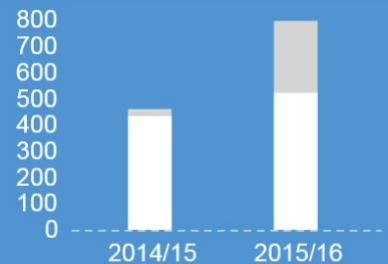
1464 concerns about possible adult abuse or neglect (26% increase in concerns on last year)



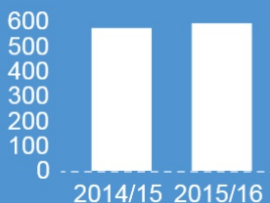
3 most common types of abuse in Islington are physical (1), financial (2) and neglect (3)



More than half of all cases (or 1 in 2 cases) of abuse and neglect took place in the adult's own home



73% increase in deprivation of liberty safeguard referrals



592 enquiries into suspected adult abuse (little change on last year)



1 in 4 cases we looked into were about physical abuse



In 100% of cases where we agreed abuse took place, we took action



100 people in mental health crisis were helped by the police and taken to a place of safety

Key Developments



The government has been raising awareness as part of a strategy to tackle modern slavery and human trafficking.



An independent inquiry in to Southern Healthcare (known as the Mazar's Inquiry) has been published. A key finding related to poor management oversight of unexpected deaths.



A new legal duty, known as the Prevent Duty has been introduced



The Care Act 2014 has lowered the threshold for review of serious cases. We have held multi-agency reflective workshops about 2 cases and a Safeguarding Adults Review is underway for another case.