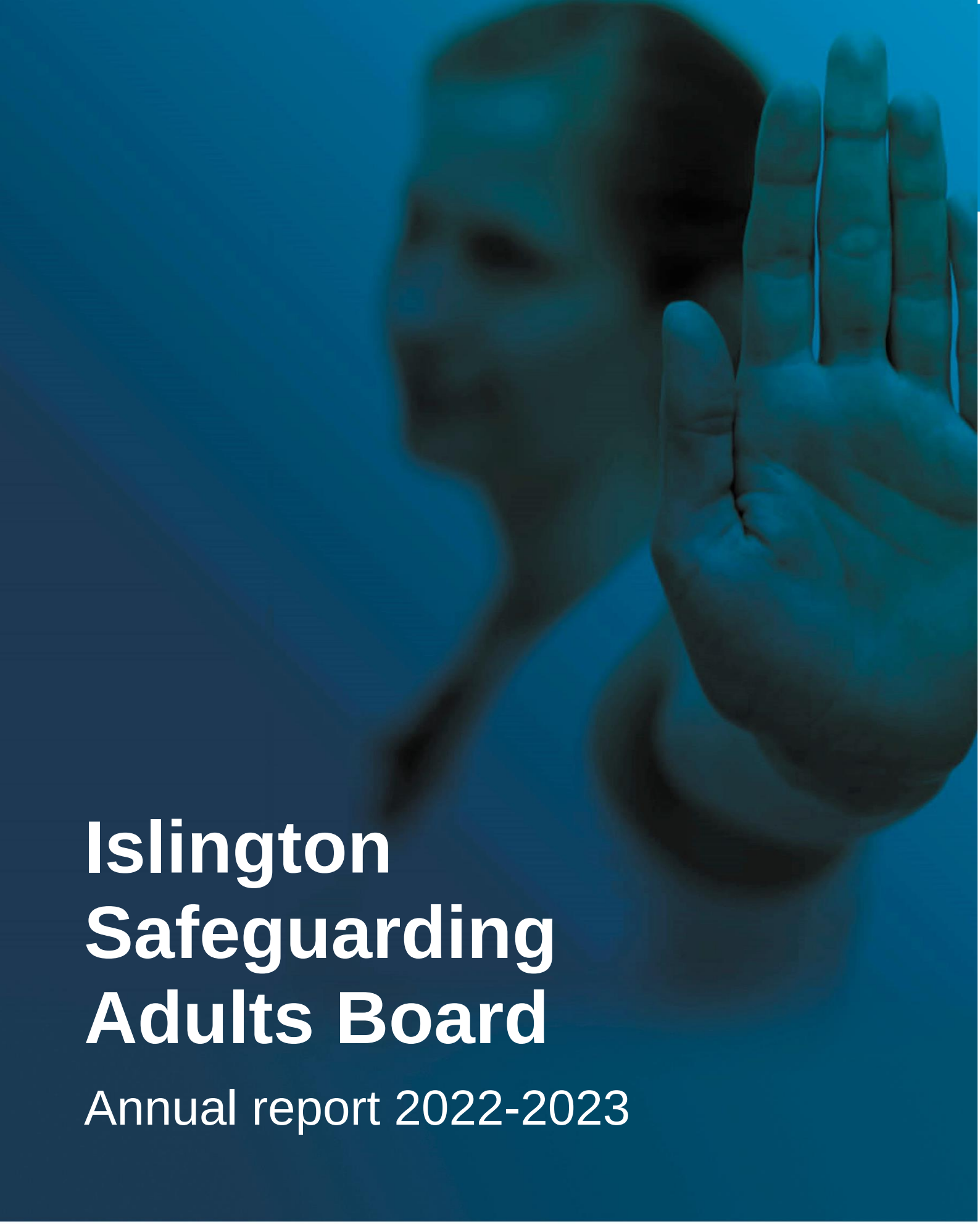

Islington Safeguarding Adults Board

Annual report 2022-2023

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Foreword

It is a great pleasure to introduce the 2022-23 Islington Safeguarding Adults Board's (ISAB) Annual Report. This report brings together the work of so many people from across our statutory, voluntary and provider sectors and sets out not only our key achievements for the year but also details the very real challenges that our workforce, carers and residents faced over the period.

This report also details the current risks and reports of abuse or neglect adults with care and support needs experience in our area and how well partners have responded to those harms to provide support in a manner that is meaningful and brings about outcomes that matter to the residents we support. This provides an opportunity for our Board to understand what is working well and what more might be needed to tackle abuse and neglect so that all our residents are safe. Most importantly, it provides us with a means to inform our residents and workforce, so I am very grateful to everyone who has taken time to read this report and who remain committed to ensuring that, in your day-to-day activities, you reduce risks and respond where an adult with care and support needs is at risk or experiencing abuse and neglect.

It is also important to acknowledge the considerable work that sits behind the headlines. I would like to pay tribute to the very many individuals who have contributed to the work detailed within this report, including service users who continue to help shape our agenda.

I want to take this opportunity to thank the ISAB team who have worked tirelessly this year to take forward key tasks and have gone above and beyond to ensure our shared strategic objectives are met. They are the engine of our partnership and, on behalf all our partners, I am grateful for their flexibility, hard work and professionalism all of which is evident in the delivery of our strategic aims and examples of their leadership are peppered throughout this report.

Please do get in touch if there are areas where you believe you or your organisation could contribute to activities. The ISAB are an inclusive and welcoming group and always keen to expand so that everyone in our area understands what we can all do to reduce risks for our most vulnerable residents.

Fiona Bateman
Independent Chair,
Islington Safeguarding Adults Board

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About us

We are a partnership of organisations in Islington - all committed to safeguarding adults better.

All our work is centred on safeguarding adults with care and support needs who need help to stay safe from abuse and neglect.

Who made up the partnership this year?

- Age UK Islington – Michael O'Dwyer, Head of Service
- Camden and Islington NHS Foundation Trust – Graeme McAndrew, Head of Safeguarding and Mental Health Law
- Camden and Islington Probation Service –Senior Probation Officer
- Care Quality Commission – Duncan Paterson, Inspection Manager
- Crown Prosecution Service – Borough Prosecutor
- Healthwatch Islington– Emma Whitby, Chief Executive
- HMP Pentonville- Safeguarding Lead
- Independent Chair – Fiona Bateman
- Islington Clinical Commissioning Group – David Pennington, Director of Nursing and Quality
- Islington Clinical Commissioning Group - Dr Deepak Hora, Named GP for Safeguarding
- Safer Islington Partnership – Johnathan Gallagher, Acting Head of Community Safety, Islington Council
- Islington Council – John Everson, Director for Adult Social Care
- Islington Safeguarding Children Board – Michael Daley, Board Manager
- London Fire Brigade, Islington – Karl Smith, Borough Commander
- Metropolitan Police, Islington – Sarb Kaur, Detective Superintendent
- Moorfields Eye Hospital NHS Foundation Trust – Tracy Foster, Interim Head of Safeguarding for Children, Young People and Adults
- Notting Hill Pathways – Pooja Aryal , Safeguarding Lead
- Single Homeless Project – Liz Rutherfoord, Chief Executive
- Voluntary Action Islington – Navinder Kaur, Chief Executive
- Whittington Health NHS Trust – Deborah Clatworthy, Deputy Chief Nurse

Introduction

This report looks at what we, the Islington Safeguarding Adults Board (ISAB), have done in the last year to safeguard adults in Islington.

Our work focuses on helping adults most at risk. Anyone can be vulnerable to abuse or neglect - but adults with care and support needs may need help and support to keep themselves safe.

Safeguarding in the headlines

The ISAB are vigilant in monitoring emerging local, national and international trends. Safeguarding adults is often in the news in one form or another. Also, public perception of safeguarding matters to us.

While never losing sight of the overall vision and mission, the ISAB swiftly adjust our annual delivery plan and responds to emerging themes. Below are some of the key media and national policy themes from the past year.

Under the Care Act, the three core (statutory) partners are the police, the local authority and health (Integrated Care Board). All three partner organisations have been in the headlines during the last year. At a time when public services are stretched, addressing these organisational shortcomings will be challenging. But the safety and wellbeing of the most vulnerable in our society must come first. Only by being open, reflective and working together can meaningful impact be achieved despite organisational challenges.

Baroness Casey Review

The final report of the Baroness Casey Review | Metropolitan Police was published in March 2022. Although the police and government are doing much to address the findings, shifting organisational cultures takes time. The Metropolitan Police has been providing assurance to the Board and our Service User and Carer subgroup about how they are taking this learning forward and transforming their organisational culture.

Confidence in Adult Social Care

Research by the Nuffield Trust has revealed an all-time low in the public's confidence in adult social care. This has been echoed by the Ombudsman and the Care Quality Commission, which have warned that too often people are unable to access the care they need.

Many public services are still recovering from the pandemic and adult social care is no exception. With an aging population, increasing complexity of cases and reduced care provision, adult social care has been stretched. There is no quick fix and Islington Council continues to lobby government for adequate, sustainable long-term funding arrangements for social care.

Integrated Care Systems

With the reorganisation of Clinical Commissioning Groups to Integrated Care Systems (ICS), there has been significant upheaval with health services. The Hewitt Review has proposed greater autonomy for ICS's to better prevent ill health, improve productivity and care, matched by renewed accountability.

The ISAB continues to seek assurances from the Integrated Care Board (ICB) as needed and work through other relevant networks and bodies to ensure that ICS's are sighted on relevant safeguarding issues both themselves and for the providers that they commission.

Online Safety Bill

The government intends to introduce new Online Safety laws and has published guidance to this effect. The aim of the proposed legislation is to make social media companies take more responsibility for the safety of adults and children online by removing harmful, illegal or exploitative content from their platforms.

Domestic violence law

Domestic abusers will face tags and tougher management under new measures proposed by the government to protect women and girls.

The law will be changed so that the most dangerous domestic abusers will be watched more closely. For the first time, controlling or coercive behaviour will be put on a par with physical violence, which will mean offenders sentenced to a year or more imprisonment or a suspended sentence will automatically be actively managed by the police, prison and probation services under multi-agency public protection arrangements (MAPPA). A range of agencies will have a legal duty to cooperate to manage the risks posed by these dangerous offenders.

Damp and mould

The Coroner issued a Prevention of Future Deaths Report in the case of Awaab Ishak because more could have been done by the housing provider to address the damp and mould in his home, thereby reducing the risks to his health. Although this case is related to the avoidable death of a child, the findings are equally applicable to adults with care and support needs.

In response to this, our Quality, Audit and Assurance (QAA) subgroup will be seeking assurance from Islington Council on how it is addressing damp and mould in its housing stock and how it is encouraging other housing providers in the borough on this important work.

Choking prevention

The Coroner also issued a Prevention of Future Deaths notice in the case of an avoidable death by choking of a resident in a care home in Islington.

Sometimes, well-meaning loved ones and carers give inappropriate food and fluids to people at increased risk of choking, without realising how dangerous this can be. The ISAB will continue to raise awareness with practitioners about the importance of identifying choking risks and following choking prevention guidance. Our webpages have been updated with information about choking prevention.

Deprivation of Liberty Safeguards and Liberty Protection Safeguards

The government announced an indefinite delay in the implementation of Liberty Protection Safeguards (LPS).

Much work had already been undertaken by the Local Implementation Network to prepare for the introduction of LPS. Until it becomes clearer what the intention is for LPS, our partners will continue to work in line with Deprivation of Liberty Safeguards and strive to achieve best practice within the current systems.

Summary

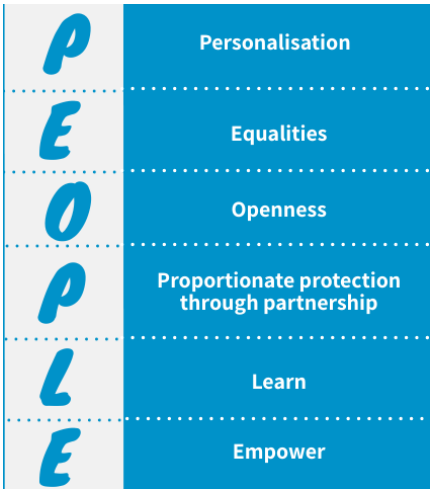
Our flexible, but focused approach, allows us to respond to the most important emerging national themes and challenges as they develop during the year.

In the following pages, we explain how the ISAB managed national developments alongside evolving local risks and challenges – all with the aim to prevent and stop abuse and neglect of Islington's most vulnerable.

About our strategy

Our strategy is our roadmap of where we want to get to and how we will get there.

People are at the heart of safeguarding, from those adults supported by partner agencies to stay safe, to the general public on the lookout for abuse and neglect, to the people who work with our community to keep adults safe.



Our strategy for 2022-25

The ISAB are pleased with the progress made in the first year of our ambitious three-year strategy.

You can read more about our three year strategy here. The strategy draws on six ‘people’ principles:

- Personalisation
- Equalities
- Openness
- Proportionate protection through partnership
- Learning
- Empowerment

As a roadmap, our strategy helps to keep us on track but it needs to be flexible too to keep it relevant. It needs to flex to accommodate emerging local and national themes and trends. Sticking too rigidly to the strategy risks missing out on pressing emerging trends and developments.

Communication is key and the Board needs to listen to stakeholders. Only by being open can the Board ensure it is not detached from reality. This means adjusting our priorities and aims along the way.

Feedback from our subgroups, in particular our Service User and Carer subgroup, helps to keep our strategic plan grounded in real-life experience. The ISAB monitor national policy developments to keep our strategic priorities aligned with external contexts. Our Quality, Audit and Assurance subgroup alerts us when local data suggests that we need to adjust our aims slightly. Similarly, our Safeguarding Adults Review subgroup and Prevention and Learning subgroups suggest adjustments to our strategic aims and incorporate important learning from serious cases into our workplans.

Partnership working

Although Islington Council leads on safeguarding adults in Islington, all partners contribute to our strategy. This section sets out how our partners went about achieving the aims and objectives of our ambitious strategic plan.

The ISAB value the work of our partners to keep adults with care and support needs safe from abuse and neglect in Islington. Each partner organisation has both a role within the Board and subgroups, but often they undertake other safeguarding activities aligned with the Board's main strategic plan.

We continue to monitor local situations, review multi-agency systems, processes and single providers or partners as needed. Where the Board has had concerns, assurances are requested from partners about their approach to emerging safeguarding adults risks and trends in abuse/neglect.

Below are the key achievements of each of our partners:

London Metropolitan Police

The London Borough of Islington is policed by the Central North Basic Command Unit of the Metropolitan Police Service who also deliver local policing for our neighbouring borough of Camden.

The Metropolitan Police accepts Baroness Casey's findings and accepts all 16 of the Review's recommendations. They are keen to rebuild and show the public and partners that they continue to focus on raising standards and ensure that they work together effectively. With a new Commissioner in place, the police are undergoing significant change and restructure in their workforce and priorities.

Safeguarding remains a priority for the Police at Central North and they are determined to achieve the best possible outcomes for those who are unfortunate enough to become a

victim of crime. They are also committed to work with partners to safeguard and protect the most vulnerable members of our society. Data continues to show that Islington compares relatively favourably to other London Boroughs suggesting Islington remains a safe place to live and work.

The police's mission is to deliver 'More Trust, Less Crime and Higher Standards'. The Police Commissioner is delivering a New Met for London, which sets out our three priorities for reform:

1. community crime-fighting
2. culture change and
3. fixing foundations.

Islington Integrated Care Board

The North Central London Integrated Care Board (ICB) became a legal body on 1 July 2022. The Executive Director is the Chief Nurse who has been given responsibility for safeguarding. The ICB has appointed a Director of Safeguarding to support the Chief Nurse to ensure statutory requirements are met. The safeguarding team comprises Designated Nurses, Doctors, Professionals and Named GPs for safeguarding.

The ICB has worked with the Safeguarding Adult Boards across North Central London (NCL), working with local community teams, including the borough's voluntary and community sectors to provide support to those in greatest need. From a health perspective, each designate works collaboratively with safeguarding leads across health providers, including Primary Care, supporting them to provide additional training and support to all staff to recognise and report concerns where they have a concern that an adult and/or child may be at risk of abuse, including malnutrition and neglect because of the current cost of living issues. The children's and adults safeguarding designates work together and with colleagues to support a single approach where families include adults and children.

In November 2022, the ICB hosted its first Safeguarding Adult and Children Conference, with a focus on safeguarding across a person's lifespan. Topics included lived experiences of a survivor of exploitation and domestic abuse, financial abuse, Mental Capacity Act updates and transitional safeguarding.

Learning from safeguarding cases is delivered via GP training forums and across the health system and work in partnership to ensure that lessons from reviews impact on care in practice. In 2022, the ICB developed a system wide Safeguarding resources webpage.

The ICB Quality and Safety Committee (QSC) is a subcommittee of the ICB and provides oversight, scrutiny, assurance and to provide robust recommendations and/or directions for action.

These include:

- The quality and safety of commissioned services
- Reducing inequalities in care
- The effectiveness of patient care and high-quality patient experience.
- Provider service quality performance and quality improvement initiatives
- Continuous quality improvement and shared learning across the system
- Since its inception the QSC have approved NCL Safeguarding Adults policies, overviewed maternity services across NCL, updated the Patient Safety Incident Response Framework, conducted a deep dive into Never Events, reported on Medicines Safety and reviewed delivering a dignified death for residents.

Moorfields Eye Hospital NHS Foundation Trust

- Safeguarding adults activity data infographic for quarterly safeguarding adults committee (SAC) meeting includes which agencies/partners/ services and where (UK wide) were generating queries and/or concerns. The complexity of concerns raised to the safeguarding adults team continues to increase, particularly from external sources
- Moorfields has continued engagement with Dementia Friendly Islington Partner Network, raising awareness of dementia by supporting the national Elf Day in December 2022, holding an information stall and promoting dementia-friendly messages and information to increase staff knowledge and response to support patients, carers and their families
- The Accessible Information Standards (AIS) project continues to develop processes to ensure that Moorfields captures information needs of patients and has a range of appointment letters and information in accessible formats, including Easy Read.
- Service Level Agreement with East London Foundation Trust has been strengthened to support further training and improve access to a mental health helpline to support staff to manage mental health cases.
- Successfully recruited to the Lead Named Nurse for Vulnerable Adults and Safeguarding Adults and Mental Capacity Act Practice Development Nurse roles after long term vacancies
- Delivery of bespoke safeguarding sessions to support development of varied staff groups and participated in delivery of safeguarding content as part of the care certificate and preceptor training.

- Facilitated three new cohorts of staff to complete their initial Safeguarding Champions training.
- Continued collaborative working with Safeguarding partners both locally and nationally.

London Fire Brigade

London Fire Brigade (LFB) frontline staff have continued to carry out Home Fire Safety Visits (HFSV). However, they have changed the way they deliver these to provide a more effective service to London. After consultation and engagement with communities, a new approach to HFSVs has been developed to align with the Community Risk Management Plan. Using data from incidents and fatal fires, LFB have expanded the high-risk individual criteria in order to triage people who request an HFSV for themselves - or are referred to the Brigade for an HFSV - into four new risk categories:

- very high
- high
- medium
- low

People will be placed in a risk category by asking them a series of triage questions, either through the online Home Fire Safety Checker or over the telephone.

People in the medium, high and very-high-risk categories will still receive an in-person HFSV and free smoke alarms as needed. LFB will respond to all very high-risk referrals within four hours, around the clock.

This out-of-hours facility will be a new service for London. These priority HFSVs for very high-risk individuals will help LFB to protect the most vulnerable people in the community. LFB criteria for these priority visits include the risk of arson, as well as a set of very high-risk characteristics and behaviours.

High and medium risk individuals will also be offered an HFSV within an agreed set timeframe, dependant on their level of risk. People in the low-risk category will be encouraged to use LFB's online Home Fire Safety Checker or take part in a telephone HFSV. They will still therefore have access to tailored safety advice that is directly relevant to their homes. However, to focus on the most at-risk people, LFB will stop providing in-person HFSVs and free smoke alarms for low-risk people.

LFB continues to work in collaboration with partners across the borough to identify those most at risk to inform our Borough Risk Management Plan and subsequent prevention activities.

LFB continues to monitor welfare and safeguarding referrals for emerging trends, which is undertaken by the central community safety team.

LFB's Safeguarding Adults Review (SAR) Champion continues to embed a more coordinated and consistent approach to learning from SARs. Internal and external action plans and review meetings are used to plan and monitor progress post SAR.

LFB continues to:

- Participate in the Community MARAC, Hoarding Panel, SAB and Safer Islington Partnership
- Review those risks within our communities to inform our prevention activities, raise awareness and support our communities.
- Offer fire safety awareness sessions to care workers and or other staff groups that visit residents at home,
- All staff, including frontline staff, were asked to re-visit and complete the LFB Online Safeguarding Learning package to refresh their knowledge.

Camden and Islington Mental Health Foundation Trust

- The Safeguarding Hub Domestic Abuse practitioner organised learning events that have included responding to communities with protected characteristics under the Equality Act and the intersectionality of these.
- The safeguarding hub undertook three audits, two of which related directly to safeguarding practice and processes, to ascertain where the gaps and challenges are. The audits had SMART action plans that are being progressed and will be reaudited for improvement.
- Professional Curiosity has been encouraged through case discussion, supervision and safeguarding training.
- The Trust, alongside its partnership Trust, (Barnet, Enfield and Haringey) organised and delivered a webinar on self-neglect and hoarding, which included a presentation from LFB. A self-neglect tool kit has also been distributed across the Trust.
- Ensuring the service user is empowered throughout the safeguarding process is central, as the section 42 forms include specific questions in relation to this that must record responses from the service user, as well as any advocacy requirements.

Islington Council

Islington Council continues to lead the borough on safeguarding adults. Specific initiatives and achievements carried out during the year include:

- Training was developed for Children's social workers as Best Interest Assessors, which will assist with transitional safeguarding and Deprivation of Liberty Safeguards (DoLS)
- A new integrated advocacy contract was designed to flex support around an individual's personal needs (for both non-statutory advocacy and statutory advocacy)
- A newly commissioned mental health accommodation pathway was mobilised embedding a strengths-based approach into the pathway; ensuring providers work with residents proactively to consider their strengths and aspirations, maximising independence and wellbeing
- A new homecare model was developed that engaged residents, service users and carers including a focus group of experts by experience.
- London Borough of Islington launched its 'See Me First' initiative that is aimed at driving real change in the organisation's culture by bringing visibility to race equality issues.
- Through the All-Age Mental Health Partnership Board a Mental Health Inequalities Toolkit was co-produced to promote addressing inequalities in services. The tool kit was officially launched in March 2023 at a public event led by Healthwatch Islington and Islington Mind.
- In the new Homecare specification, there is now a requirement for providers to implement the Equalities Toolkit.
- The Live Well Joint Commissioning Team successfully bid for challenging inequalities funding through the ICB to develop Severe Mental Illness health cafes in the borough and further expand the inequalities tool kit for 2023/24.
- For 2022/23 SMI and learning disability health checks were above the national targets.
- The council has increased investment in Violence Against Women and Girls (VAWG) services for Black, Asian and minoritised ethnic women and recently recommissioned the By and For service with an eight-year contract to improve sustainability in local 'by and for' Independent Domestic Violence Advocacy services.
- Commissioning published a market sustainability plan in March 2023
- Completed 100% of care and treatment reviews within timescales and in line with best practice
- Undertook a review of the RADAR forum and replaced it with a revised Provider Quality Oversight Board with improved systems for logging of emerging issues for providers

- Provided support to quality ratings of two local care homes inspected by the Care Quality Commission
- Started to audit home care spot providers
- Improved home fire safety processes, forms and risk assessments
- Drafted a co-produced carer's strategy
- The VAWG workforce development team provided training to 774 Islington practitioners during 2022/23 including police, health and professionals working with children and young people.

Single Homeless Project

- Single Homeless Project (SHP) set up a new internal safeguarding panel that meets quarterly to review, action plan and improve safeguarding practices across all key strategic areas
- SHP created a new organisational safeguarding dashboard on *SHP Inform* that supports monitoring and oversight at a senior level
- SHP added new fields to the Safeguarding Concern records to better evidence and monitor external partner responses, system blocks and barriers and key organisational learning
- SHP joined the DAHA accreditation pilot to support a focus on domestic abuse
- SHP launched an integrated process on SHP Inform to support the Philomena Protocol on SHP's Young People's services
- SHP agreed to join a 'Herbert Protocol' pilot in Islington, but this has been delayed through non-conformation agreement with MPS
- SHP Service Managers have attended and supported the new Islington 'Creative Solutions' panel

Healthwatch

- Healthwatch continued to collect caller feedback about residents accessing health services by phone or online
- Shared feedback with commissioners to help them decide how health services can be offered most effectively going forward, to ensure that no one gets left behind

Whittington Health NHS Trust

Whittington Health has continued to work hard to ensure the patient is at the centre of all patient care and decisions. Making Safeguarding Personal is a key part of the face-to-face safeguarding adults training sessions delivered on average three times a month, and there

has been a noticeable increase in safeguarding adult concerns clearly documenting the wishes of the patient around safeguarding.

Whittington Health is a member of both the London and national NHS Clinical Review Group for Liberty Protection Safeguards (LPS) and has also been involved in facilitating regional workshops for a range of organisations. In addition, Whittington Health has been a member of the Local Implementation Network Chaired by the local authority.

Whittington Health has shared data with the SAB demonstrating the demographic distribution of safeguarding adult concerns raised by them. This has allowed further exploration to be undertaken in relation to increases in certain demographic categories.

Transparency is central to all safeguarding adult practice. Whittington Health has an open relationship with the local authority and has shared concerns which have been raised and subsequent investigations and learning, with the SAB. Pressure ulcer care has been one of the Whittington Health's' key areas for improvement and targets have been set to ensure staff are aware of the risks and dangers related to pressure ulcer care. Training has been provided to care agency staff and families round pressure ulcer care and prevention by our community teams. Listening to the experiences of our patients helps us to develop our practice, and we are just concluding a project co-produced with patients with a learning disability, which aims to reduce anxiety of coming to hospital. A key part will also be building on learning disability awareness training for staff, using the voices of our patients.

Whittington Health has systems in place around safe recruitment, and a well-established 'Freedom to Speak up Guardian' network for staff to raise any concerns. Our Patient Advice and Liaison Service team is accessible for patients and carer, and trends of concerns can be quickly identified and acted upon as appropriate.

Whittington Health has an embedded structure for delivery of mandatory safeguarding adult training. Due to the face-to-face nature of the level two training, they continue to disseminate learning from Safeguarding Adult Reviews (SAR), and also each internal department disseminates learning from incidents across their teams. Additional, bespoke training has also been provided by the safeguarding adult team where appropriate.

Whittington Health has worked collaboratively with families and carers and a wide range of organisations to ensure the care provided is individualised. Supporting patients in recovery, for example via our therapy teams, looks at the goals and strengths of our patients, to ensure an achievable and agreed outcome. Staff are aware of advocacy services and the role they play in patient care which can include offering support to informal carers.

As an integrated care organisation, Whittington Health provides care in an acute setting, as well as the community. Staffing has been an issue across health and social care. This impacted on patient discharges due to limited placement availability and delays in packages of care. Staff shortages at Whittington Health required innovative recruitment, including from overseas, requiring additional support for those staff once they have arrived in the UK.

Morale of the workforce in the aftermath of Covid has been acknowledged and is an area Whittington Health continues to address.

The Domestic Abuse lead has been liaising with LBI's VAWG team and a plan has been put in place to ensure a designated Independent Domestic Violence Advocate is available for Whittington Health.

Voluntary Action Islington

Key messages continue to be promoted to local voluntary organisations via communication channels.

Our partners' annual reports

Health partners of the Safeguarding Adults Board have also published their annual reports for 2022/23:

- Whittington Health NHS Trust
- Camden and Islington NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- North Central London Integrated Care Board

The Islington Health and Wellbeing Board has oversight of this Safeguarding Adults Board annual report. Further information about the Health and Wellbeing Board can be found on the democratic services webpage.

Case example

Ali, a 67-year-old man, was admitted to hospital in a seriously ill condition from a flat where he had been living with his cousin for several years. Ali had been unable to get help himself as his health had deteriorated.

Professionals were concerned that Ali's cousin was taking no action to help Ali. Furthermore, he disclosed his cousin used drugs with friends in their home and became physically and verbally abusive to Ali when he was under the influence of drugs.

A safeguarding concern was raised and following a multi-agency meeting, a Duty to Refer homelessness referral was completed. Ali was then discharged to his own private flat when medically fit. He is now able to attend hospital appointments as he continues to require medical treatment.

** Names and some details have been changed to preserve anonymity*

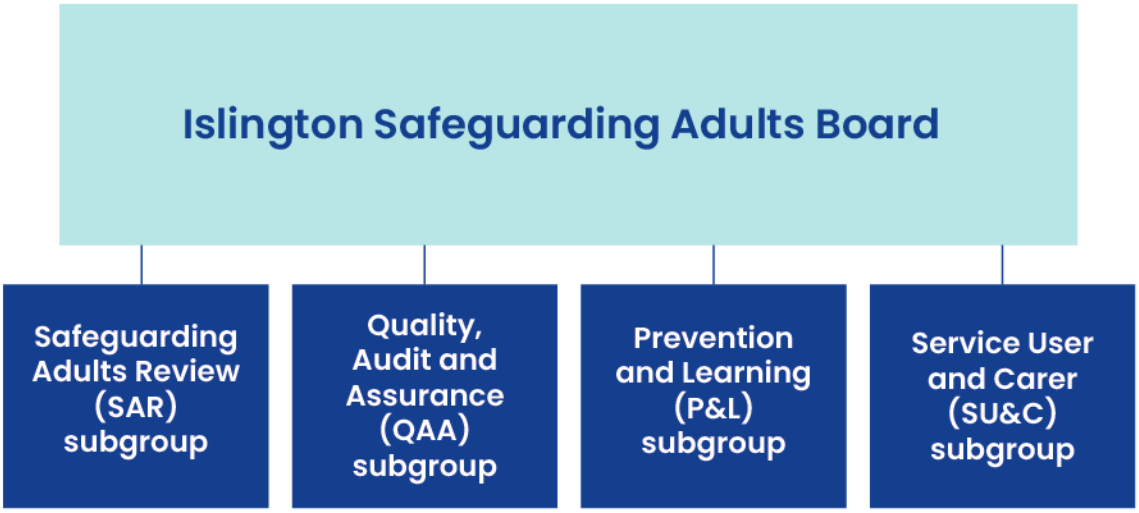
It would be impossible to list every single action and activity our partners took towards ensuring the safety and wellbeing of adults at risk. The specific achievements set out above are by no means all that partners achieved towards safeguarding adults, they are merely highlights.

For many of our partner organisations, safeguarding adults is routine and core to their every-day work, which they continued throughout the year.

Subgroups

While the Board oversees the implementation of its strategy, the subgroups carried out much of the actual work. They are the engines behind the Board.

This section sets out the work and achievements of each subgroup.



Safeguarding Adults Review subgroup

One SAR, given the name 'Liam', was carried out during the year 2022-2023. The SAR has since been published and an action plan is being developed.

Key recommendations arising from the report were:

- Mandatory 'Fire Safety in the home' training for all care staff in commissioned care providers and accommodation providers
- Improvements to assurance processes around refusal of care and refusal of home fire safety visits
- Routinely asking questions about patient/service user's smoking
- Escalation of medium to high fire risks and hazards to a multidisciplinary forum and ultimately to the newly formed Creative Solutions Panel if risks remain high
- Awareness-raising of fire risk mitigations

- Routinely linking Assistive Technology like telecare to smoke detectors for patients and service users who smoke
- Assurance around regular updating of care plans
- Ascertaining if there is sufficient evidence base for a change in the law to enable fire brigades to secure legal powers to apply for Fire Safety Prevention Orders, similar to the legal powers environmental health officers have to prevent harm or public nuisance.

Over the course of the next year, the progress against delivery of the action plan will be monitored.

The SAR subgroup also followed up with relevant partner organisations on learning recommendations from the Yi SAR. The Yi SAR action plan has been closed.

No new SAR referrals were received during the year under review.

Liverpool SAB published the Mr A SAR into the death of a former Islington resident placed in Liverpool area. The Supreme Court has since clarified the law around ordinary place of residence – Mr A's ordinary residence would have become Liverpool. Nevertheless, the Liverpool SAR report made some recommendations for the Islington SAB, that have been accepted. Implementation of the learning will be followed up.

Following our recommendation to implement a risk escalation pathway, the Board set up and trialled a Creative Solutions Panel for the most complex, high-risk cases. After a 9-month trial, the Creative Solutions Panel has proved to be effective in addressing the most serious cases in the borough and at reducing some of the risks. Therefore, it has been agreed to continue with the Creative Solutions Panel.

DCI Sarb Kaur

Chair, Safeguarding Adults Review subgroup

Quality, Audit and Assurance subgroup

The Quality, Audit and Assurance (QAA) subgroup continues to support the Board in providing a strategic overview of the quality of safeguarding activity within Islington. The group have continued to meet quarterly, with representation from core partners and assurance provided by partners.

During the year 2022 – 2023, the QAA subgroup has reviewed specific areas of interest, audit and self-assessment including:

- self-neglect
- carers assessments
- financial abuse
- transitional safeguarding and
- Safeguarding Adults Partnership Assessment Tool (SAPAT)

The QAA subgroup drafted, consulted on, refined and worked with partners to develop a data dashboard. This dashboard will form a good starting point for identifying data trends, not only for local authority data but across the partnership.

Although there is more to be done towards achieving a range of regularly reported partnership data, it is a significant step forwards in getting the assurance the Board needs to discharge its functions.

The subgroup also made recommendations to the Board regarding identified risks when appropriate.

Karen Brown

Chair, Quality Audit and Assurance subgroup

Prevention and learning subgroup

The Prevention and Learning subgroup continues working towards meeting the Board's strategic objectives around embedding learning from serious cases with the aim of preventing future similar cases occurring again.

The following key pieces of work were undertaken over the last year:

- Produced a suite of resources on mental capacity law learning from multiple serious cases for including
    - A video for practitioners
    - A seven-minute briefing for practitioners
    - Easy Read guidance on mental capacity for practitioners to use with service users and carers
- Held a very well attended and well-received multi-agency pressure ulcer prevention workshop led by a tissue viability nurse from Whittington Health
- Disseminated information about pressure ulcer prevention
- Developed multi-agency guidance on reducing restraint and restrictive practices

Graeme McAndrew
Chair, Prevention and Learning subgroup

Service user and carer subgroup

Engagement with people who have lived experience of safeguarding is essential. It ensures our work is relevant to people's lives and that our messaging is on target. Listening to their experiences is important for change and innovation. This process powerfully connects and then often drives what comes next on our workplan.

We are grateful to the small, but committed group of service users, carers and advocates who continue to give their time and share their lived expertise with us. Through their willingness to share, we gain unique end-user insights into how local safeguarding adults processes play out. Sometimes their feedback serves to confirm what staff and volunteers tell us and other times their feedback reveals a gulf between policy and practice. Either way, the feedback is shared with the Board and helps to shape the Board's plans.

A topic of great interest to the group continues to be fire safety and personal evacuation plans. The group took great interest in the 'Liam' Safeguarding Adults Review and has been keen to see the Board learn the lessons from it. Their clear message was that when they are in high-risk situations, professionals need to 'hear their voice but keep them safe'. Members of the group, with the support of Elfrida Society and London Fire Brigade, produced some easy read guides on fire safety.

As part of the parliamentary consultation, we consulted with the group on the government's proposed Liberty Protections Safeguards law. They shared concerns about how the proposed guidance would work in practice. They felt that the guidance was not sufficiently person-centred.

Other topics of discussion also covered were:

- The value of day centres to communities and their role in safeguarding
- Dignity in home care
- Advocacy

The group expressed concerns about the police's proposed Right Care Right Person approach to callouts to people in mental health crisis. Safe, compassionate and proportionate responses to people in mental health crisis are important to our group. In

response, the police and mental health services will be involved in discussions going forward.

Active representation on the Association of Directors of Adult Social Services (ADASS) London Safeguarding Voices group has been beneficial. It has helped to link local user voices to the wider London lived experience. At the suggestion of one of our subgroup members, Islington innovated videoconferencing hubs and live-streamed the ADASS safeguarding adults conference to over 100 residents. This model has been well-received and will now be rolled out across London for the next conference.

Eleanor Fiske

Chair, Service User and Carer subgroup

Experiences and Statistics

Statistics can be extremely useful to us in spotting trends, defining our strengths and highlighting areas for further analysis or development.

However, statistics do not tell the whole story of someone's safeguarding experience. No statistic can capture the trauma and impact of abuse, neglect and self-neglect.

1. Experiences

To put ISAB statistics in their proper context soft intelligence is used. We look behind the statistics at the human experience. Auditing case files, seeking feedback from people after a safeguarding case has been closed, analysing complaints and engaging with the public are just some of the ways this is done.

Honest feedback is also sought from service users and carers, for example during a Safeguarding Adults Review. Far from shrinking away from criticism, the ISAB actively encourages it. Although it can sometimes make for uncomfortable listening, the insights of services users and carers are a goldmine of information and help us identify what needs to be improved in the partnership.

Just because information has been collected from qualitative observations and feedback, doesn't mean it is unreliable. Service users and carers sometimes even identify trends ahead of the statistics.

What soft data lacks in rigour, it makes up for in its richness and ability to give insights into the human experience.

2. Statistics

This year's report contains data captured only by Islington Council. The Quality, Audit and Assurance subgroup has made some progress in collating a wider range of data to assure ourselves that adults with care and support needs are safeguarded in settings such as hospitals.

The Islington partnership data dashboard for safeguarding adults is still in development, but it is a positive step towards getting a clearer picture of abuse and neglect trends and activity across the borough. Work will continue with partners to harvest richer and wider sets of data from them.

Some people experience discrimination, disadvantage and/or additional barriers to accessing support. As in previous years, data will continue to be monitored on various groups to ensure that the needs of all victims are met and that no group is being overlooked.

Here, it is important to note that hard data can only provide concrete answers to the who, when, and what questions. What hard data fails to do is provide any reasons why. Only by interpreting the hard data together with other sources and soft data, a reasonably informed understanding can be reached of why a trend is going in a particular direction and what steps we might need to take next.

3. Safeguarding Concerns

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

During the year we had 2,179 **safeguarding concerns** reported to us, compared with 2,844 last year in 2022/21 and 3,353 in the previous year 2020/21.

Nationally, the long-term trend has been for a gradual increase in the number of safeguarding concerns over the years since the Care Act was introduced in 2015. In Islington, safeguarding concerns have decreased over the past couple of years. This may be due to a number of actions that have been taken including better awareness amongst our partner organisations about when to raise a safeguarding concern and when to make another type of referral and changes in internal processes. In comparison with other areas, Islington has always had a high number of concerns referred but a lower conversion rate. The decrease may therefore indicate that referrals are being appropriately signposted at an earlier opportunity.

4. Safeguarding enquiries

In 2022/23 we had 332 **safeguarding enquiries** (**15%** of the total concerns raised). Of these 332 enquiries, 324 were carried out as safeguarding enquiries under Section 42 of the Care Act 2014.

A further 8 enquiries were looked into under another type of safeguarding enquiry. It may turn out that the Section 42 duty is not triggered because the concern does not meet the statutory criteria, but practitioners are not comfortable with the level of risk so a non-statutory safeguarding enquiry is carried out.

Even when a Section 42 enquiry does not go ahead, every point of interaction with a victim offers an opportunity for positive intervention and a chance to give support. We frequently signpost those people to appropriate sources of support.

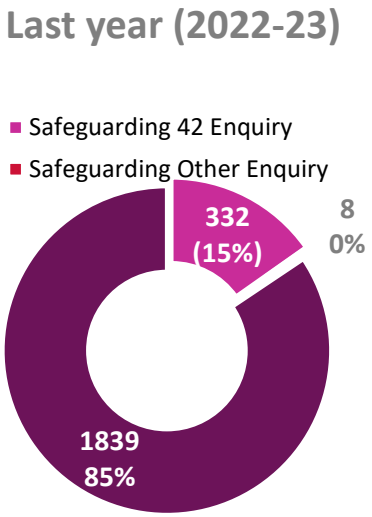
Case example

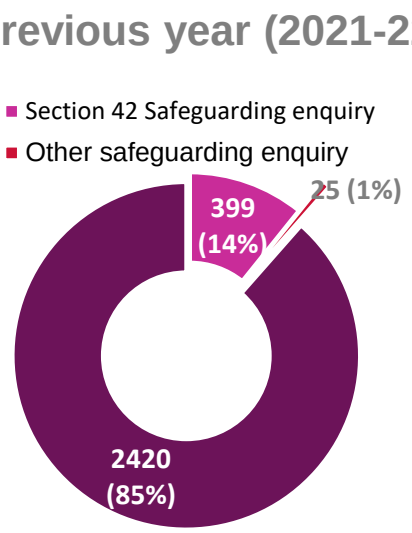
Agara is in her 80s requires a pacemaker. She has dementia and has been assessed as lacking capacity to make a decision about whether to have this procedure or not. Her niece Achala has Lasting Power of Attorney for health and welfare and is not agreeing to this procedure. Achala has stated her aunt has lived long enough and should be allowed to die.

The Office of the Public Guardian were informed by the hospital and are involved in the case, and a safeguarding adult concern raised. Agara has now had the pacemaker fitted.

* Names and some details have been changed to preserve anonymity

5. Safeguarding concerns to enquiries 'conversion rate'





A similar number of safeguarding concerns to last year and a similar 'conversion rate'

***** Some of the safeguarding concerns and enquiries shown in the above charts may have started in the previous year

ADASS in partnership with the Local Government Association (LGA) produced a framework to assist local authorities with making decisions on the duty to carry out Safeguarding Adults enquiries. The framework was created to support practice, reporting and recording and to give local safeguarding adult boards the opportunity to benchmark against neighbouring authorities, regionally and nationally.

The framework supports decision-making about whether a reported safeguarding adults concern requires a statutory enquiry under the Section 42 duty of the Care Act, 2014 or a non-statutory response by either the local authority or other partners. As closely as local authorities follow the framework guidance, there is inevitably a degree of variation locally about how it is applied.

Our conversion rates in recent years have ranged between 10 - 15%, which are considered to be at an appropriate level, but lower than some other areas.

Under the framework, outcomes of statutory enquiries can be referrals to other organisations, such as the Camden and Islington Mental Health Trust or a non-statutory response from the council or another organisation.

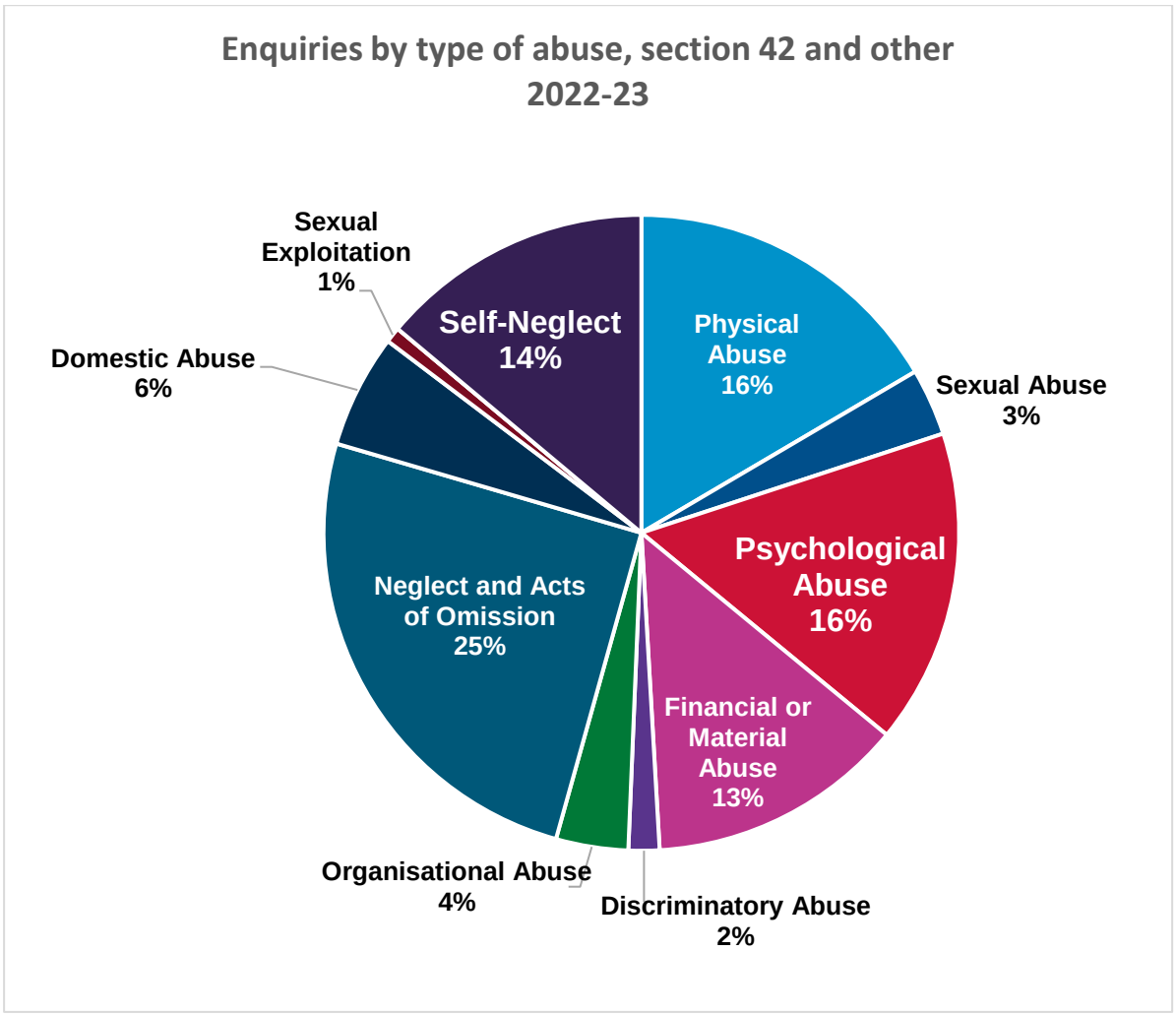
Staff and trained to ensure they apply the framework correctly. Case file audits and workshops for social workers around safeguarding adults are available to ensure decision-making processes are well evidenced and that people who have experienced harm and abuse have their risks reduced or removed. Continual reflection on the application of the ADASS and LGA framework takes place to help respond to any support or training needs that our social workers may have.

A weekly safeguarding closure panel and surgery takes place to support practitioners in their safeguarding practice.

The national data for 2022/23 allows us to benchmark our data. Data from previous years is also available from NHS Digital website.

6. Types of abuse

The different types of abuse about which we made safeguarding enquiries during 2022-23 are shown in the chart below. When we look into a safeguarding concern about an adult, we often discover there is more than one type of abuse taking place.



The chart above shows that in 2022-23 year, the three most common types of abuse we made enquiries into were neglect, physical abuse and psychological abuse. The data shows that for the first time in many years, financial abuse was no longer in the top three types of adult abuse in Islington. Anticipating that there may be a rise in financial abuse, work took place across North Central London partners to highlight the risks and advise on what preventative measures should be employed to reduce risk before harm arose.

Numbers of safeguarding concerns reported to us about modern slavery or sexual exploitation of adults with care and support needs remain low. Awareness of these types of abuse will continue to be raised. Our recording systems have also been modified so that it is easier to collect data and monitor trends in these types of abuse. The signs of modern slavery and sexual exploitation can be hard to spot, awareness of what to look out for will continue to be raised. Islington Council continues to provide well-received in-house training on modern slavery and human trafficking and will be carrying out an audit during the next

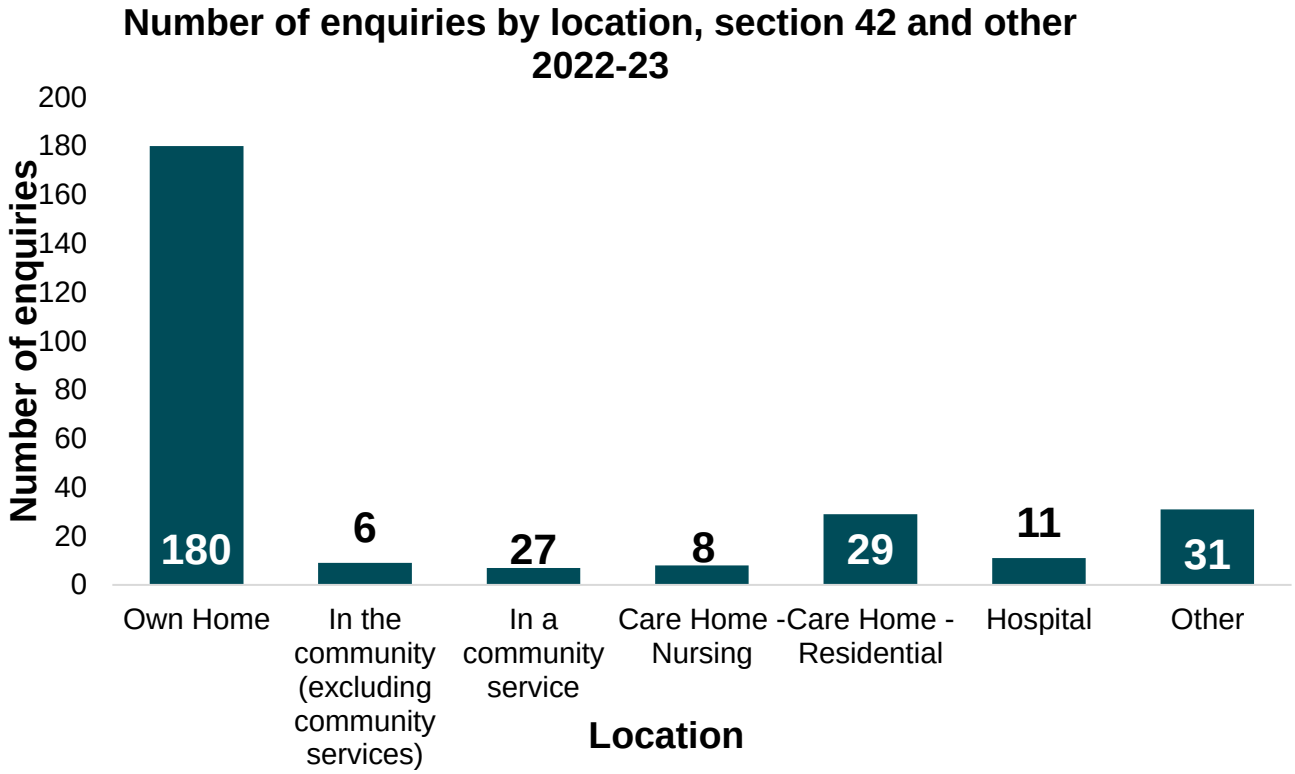
year. Given the reported rise of modern slavery concerns within the care sector nationally, this will be an area of specific focus next year.

Discriminatory abuse, in line with most other areas across the country, remains low. The Care and Health Improvement Programme is exploring the reasons whether and why discriminatory abuse levels are under-identified and under-reported. ADASS has issued guidance for practitioners which explains that “discrimination may not be recognised as abuse ‘in its own right’, because it manifests itself alongside / within other abuse types. As a result, the dynamics of discriminatory motives may be less recognisable than the abusive acts that are experienced.”

Monitoring of trends will continue over several years and data will be compared with that of similar boroughs in London to see whether there are any emerging differences that need to be acted on.

Feedback on training from participants

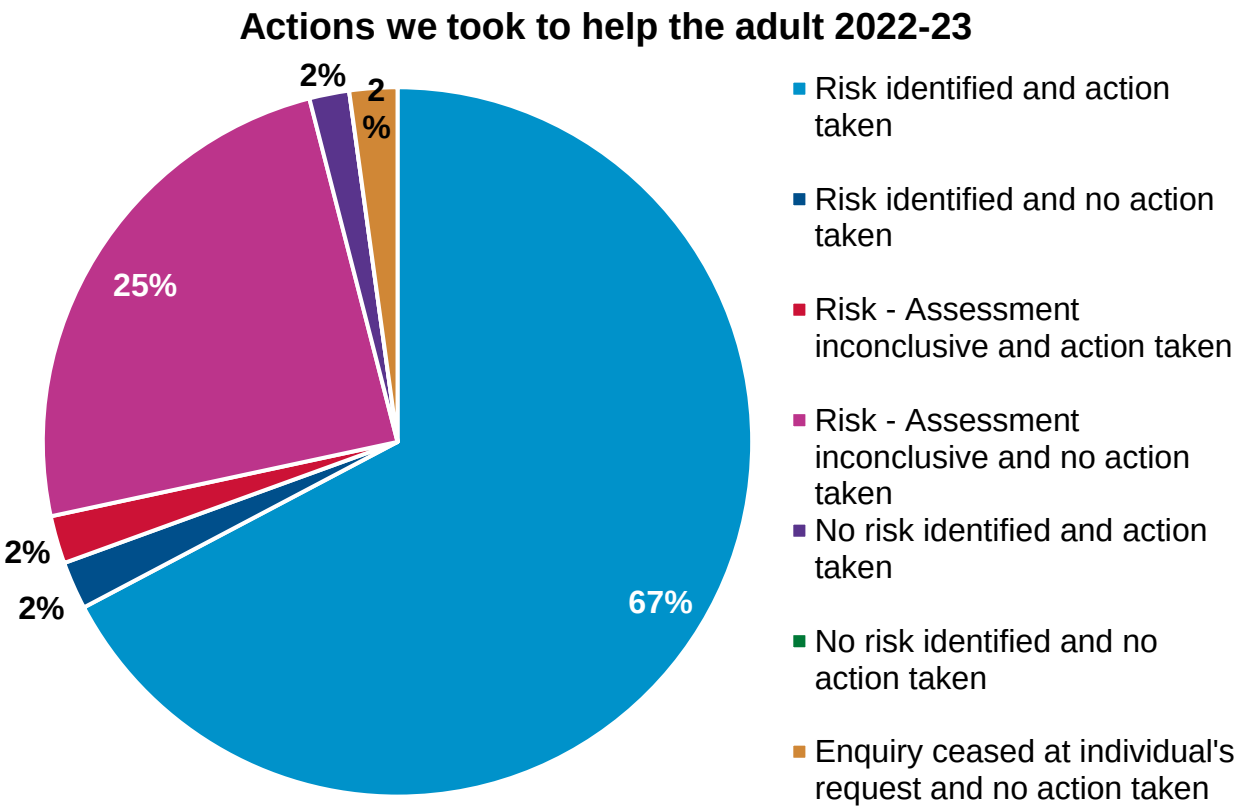
7. Where abuse took place



Note: Hospital admissions have been grouped together due to small numbers andpotentially

Abuse and neglect in care homes and hospitals tend to grab headlines and because of this people may assume that a lot of abuse and neglect takes place in care homes and hospitals. The graph above shows the opposite – that more than half of all cases of abuse and neglect take place in the person's own home. This is not just true in Islington, it's a similar picture across the country.

8. Action we took



*Due to the rounding of figures, figures may not total 100%

The graph above is based on the safeguarding enquiries that were closed in 2022-23. In nearly all of the cases we took some kind of action.

Recording the actions taken for all cases is now a mandatory field in the recording system. We identified and took action in 67% of the cases, compared with 89% of cases in the previous year. We are looking into the reasons for this and making sure social workers are correctly recording all the protective actions they take in a safeguarding enquiry. Through case file auditing, use of safeguarding surgeries and safeguarding case closure panel, we check that social workers have considered the full range of protective actions available to the adult.

The most common action is increased monitoring of the adult. Increased monitoring could include family and friends agreeing to visit an isolated adult more often. Or it could be a community nurse visiting patient at home regularly to check for pressure sores.

A wide range of other actions were also used. They included referrals to counselling, staff training, applications to the Court of Protection, change of appointee and restricting access to the person causing risk. In some cases, the concerns are serious enough for the Police to prosecute or caution the person who caused harm.

In 25% of cases, the assessment was inconclusive, and no action was taken. This is a large variance from the previous year when there were no such cases. Further work is being done with staff to ensure that all action and outcomes are recorded correctly. Now that the Quality, Audit and Assurance subgroup of the board has developed a data dashboard. The data dashboard will help us to understand all our activity in more detail, including numbers of inconclusive cases, and actions can be taken to address issues of concern.

In 2% of the cases a risk had been identified but no action was taken. But before reaching the decision to take no action, we would have assessed the risks and agreed that there was no significant ongoing risk to the adult. In this situation we expect partners to come to together to explore all options and, if the risks are high, consider escalating to the ISABs Creative Solutions Panel.

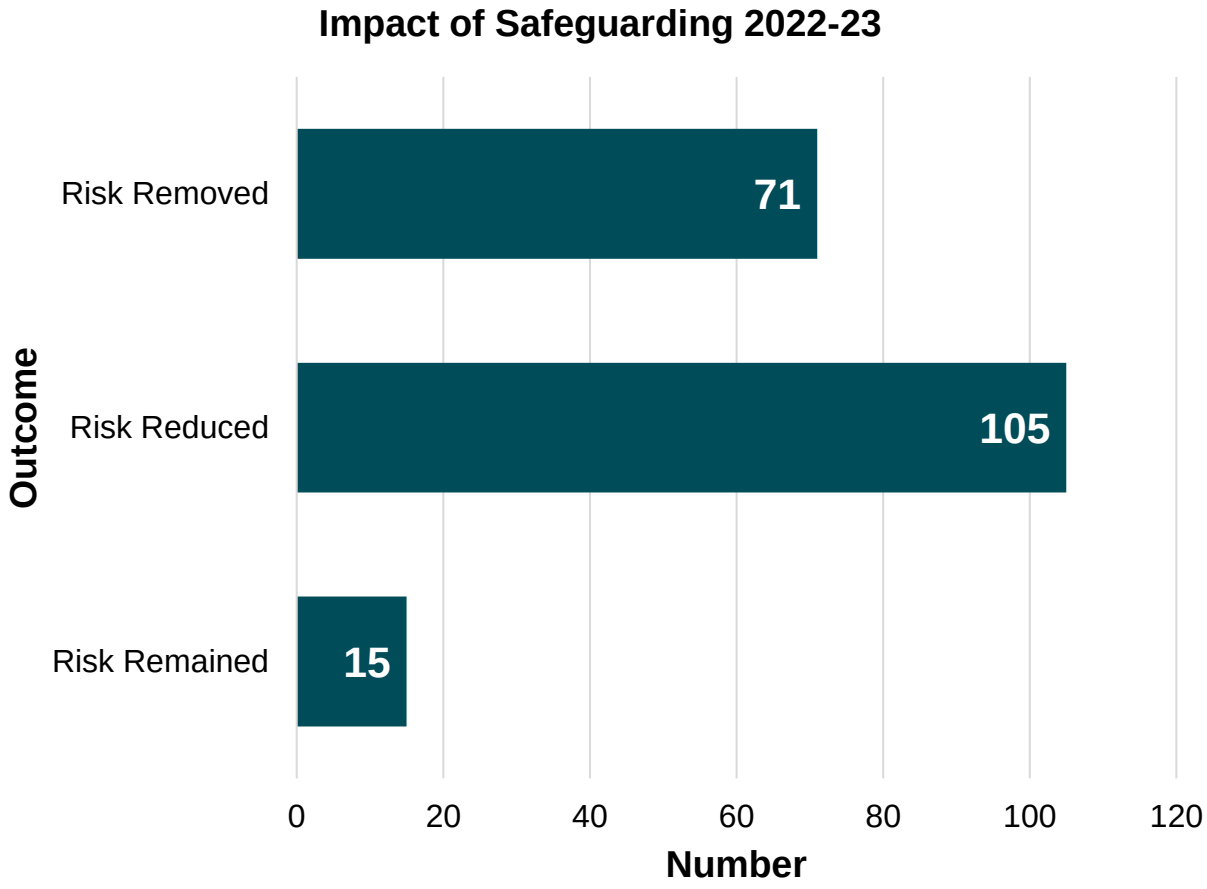
In 2% of the cases, the adult told us they did not want us to take any action. Wherever possible, we make safeguarding person-centred and follow their stated wishes. Occasionally, the risks to other people are too great and we need to act against someone's wishes. If this needs to happen, we carefully explain to the adult involved the reasons for our decision.

9. The impact of safeguarding

The purpose of safeguarding is to help people feel safer. One of the ways we measure this is by looking at our safeguarding actions to see if we have reduced the risk of future abuse or neglect happening. The chart below shows that in most cases, our actions have either removed or reduced the risk of harm.

In only a very few cases the risk remains. Usually this is the adult's choice. We always check first that the adult has the mental capacity to make decisions about the risk, is comfortable with the risk and understands the possible consequences of not taking steps to reduce the risk. We also factor in risks to other adults or children and whether the person causing harm

is a paid professional. We also ensure that in all safeguarding cases that we assess as 'risk remains', the safeguarding is reviewed soon after to further support the adult.



This graph is based on the number of closed Section 42 enquiries in 2022-23 and not the overall number of enquiries. This is because some enquiries take longer than others to investigate. We have excluded any enquiries which were still being investigated at the time of submission of the year end data to NHS Digital.

10. Making safeguarding personal

Putting the victim first is an important concept in criminal justice. So, it is also with safeguarding adults. Person-centred working, known as 'Making Safeguarding Personal (MSP)' is called for by the Care Act 2014. We continue to encourage with practitioners and board partners to adopt this crucial concept in the way they work with people at risk of abuse and neglect.

How do we know that staff are working in a person-centred way? Statistics alone will never give a clear picture of whether safeguarding enquiries have been carried out in a person-centred way. Only auditing case files and seeking feedback from people who have been through a safeguarding enquiry can really tell us. That is why our Board's Quality, Audit and Assurance subgroup together with our Service User and Carer subgroup are important mechanisms for overseeing the implementation of MSP across all partner organisations.

Islington Council's Adult Social Care has overall responsibility for all safeguarding enquiries. Adult Social Care has made changes to its internal reporting system to ensure that making safeguarding personal is captured as part of every enquiry.

At the safeguarding concern stage the adult (or their representative) is asked whether they want this concern to progress to a safeguarding enquiry and what outcome they want from the enquiry. The concern is also risk assessed and depending on this, it is progressed to a safeguarding enquiry.

We know from research nationally that being safe is only one of the many things people want for themselves. They may have other priorities too. That's why it's important that the person's views are taken into account.

To help us achieve this, every safeguarding enquiry has a set of seven 'I' statements that the adult at risk (or their representative) is requested to respond to during and towards the end of the enquiry. These statements not only address the issues of safety, but also of choice, control, respect and justice.

We also record whether we were able to achieve the adult's preferred outcome. Our data from previous years shows us that we need to continue transforming practice and shifting

work cultures to make our safeguarding work truly personalised. In the year ahead, we will be working with staff to explore more ways of enhancing an adult's choice and control as part of a safeguarding enquiry.

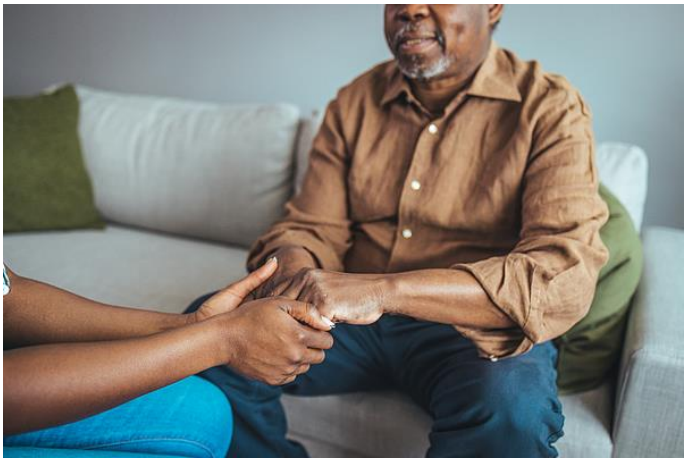
The previous year's data shows that we achieved either fully or partly the adult's preferred outcomes from the safeguarding enquiry. It shows that practice is transforming to keep the adult at the centre of all we do. People's preferences are indeed being considered.

Embedding an MSP approach remains a priority and forms one of the principles of our current 3-year strategy for 2022-25.

11. Safeguarding Adults Reviews

Sometimes when an adult with care and support needs has died or been seriously injured, we question whether services could have worked together better to prevent it happening. If we think that might be the case, we carry out a safeguarding adults review (SAR).

SARs are all about learning lessons; not about blaming people.



Under the Care Act 2014, the ISAB has a statutory duty to carry out a Safeguarding Adults Review (SAR) when an adult with care and support in its area dies; and the Board knows, or suspects the death was as a result of abuse or neglect and there is concern about how the SAB, its members or organisations worked together to safeguard the adult.

Referrals for Reviews

No new cases were referred to the SAR subgroup for consideration as a SAR.

Publication of Reviews

During the 2022-23 year, a 7-minute briefing of the 'Gertrude' SAR was published on the ISAB website so that key learning points could be disseminated with the public. The full SAR report was shared with relevant partners and the action plan for this case has been closed off, although work continues on regarding some of the key themes, such as encouraging partner organisations to identify carers and refer them for carer's assessments.

The 'Liam' SAR was conducted during the 2022-23 year and the full SAR report was published shortly after year end.

The Board has developed an action plan based on the recommendations made in the Liam SAR report. Several partner organisations had already identified steps they could take to improve fire safety prevention and fire hazard identification and began implementing changes before the SAR report was even published.

As there is still work to do, partners will continue to be held to account in achieving change over the coming year.

Key recommendations from the report included:

- training all staff who visit people in their homes on fire risks identification
- improving awareness of fire risk mitigations
- routinely linking Assistive technology like telecare to smoke alarms
- making use of the London Fire Brigade's Person-Centred Fire Risk Assessment
- escalating high fire risk cases to an appropriate multi-agency forum or panel
- recording and responding appropriately to refusal of care.

The report also identified that there may need to be a change in the law to allow fire brigades to apply for a fire safety prevention order when adults have mental capacity but refuse fire prevention support when the fire risks are high. The ISAB is working with the London Safeguarding Adults Board and National Chairs Network to raise this through the National Fire Chiefs Council.

Learning from other reviews

Learning from other types of review, such as Domestic Homicide Reviews, Coroner's Inquests, as well as SARs from other Boards is shared with our partners. This ensures learning from other places are embedded into practice and maintain good practice. One such case was the Coroner's Prevention of future deaths notice which related to a care home situated in Islington. As a result of this case, we published updated choking prevention guidance on our website.

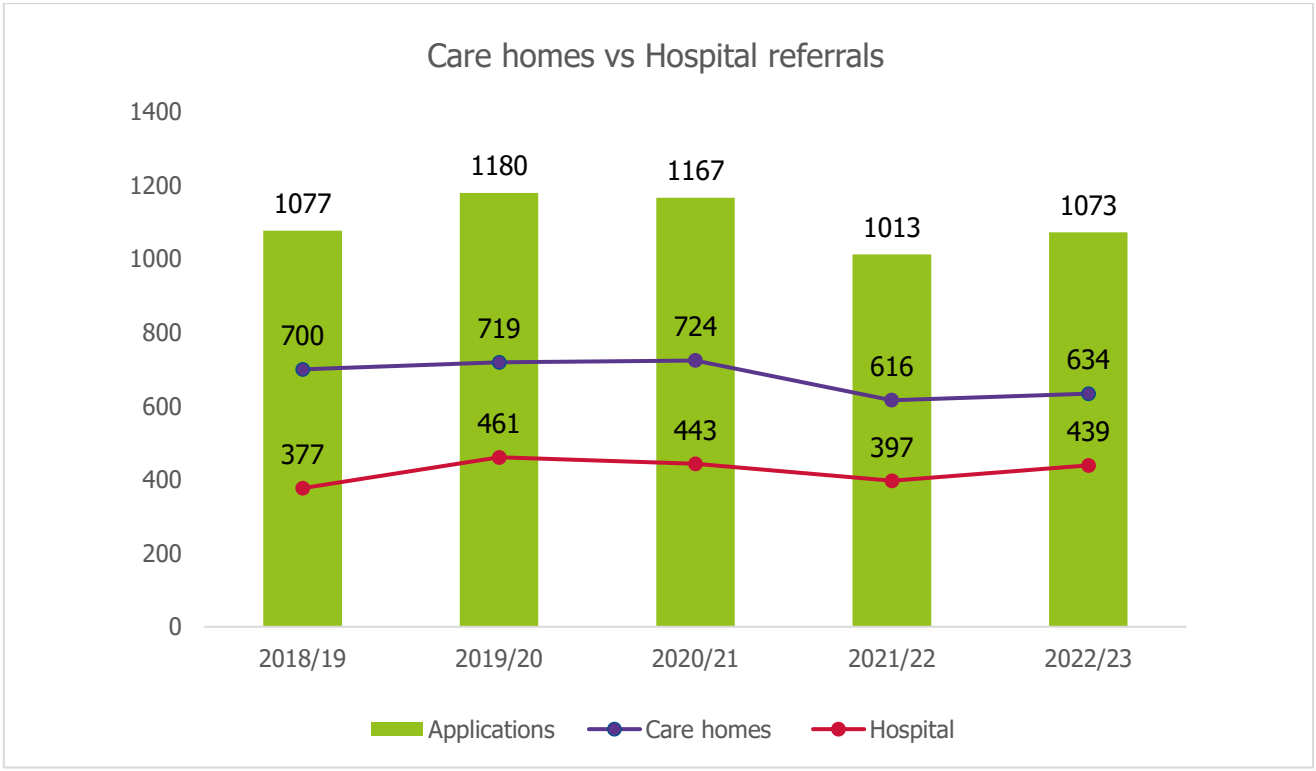
The Liverpool Safeguarding Adults Board carried out a SAR following the death of Mr A during the 2022-23 year, which was published shortly after year end. Because Mr A was previously a resident in Islington and had been placed in Liverpool under Section 117 of the Mental Health Act, the SAR author made some recommendations for the Islington Safeguarding Adults Board and partners to implement. The Islington Safeguarding Adults Board published a response accepting the recommendations of the SAR.

Subsequently, the Supreme Court has clarified the law around ordinary residence as it applies to Section 117, which puts a different slant on some of the report recommendations. Nevertheless, we are committed to learning from this case and ensuring practice improvements around Section 117 cases and choking prevention.

12. Deprivation of Liberty Safeguards

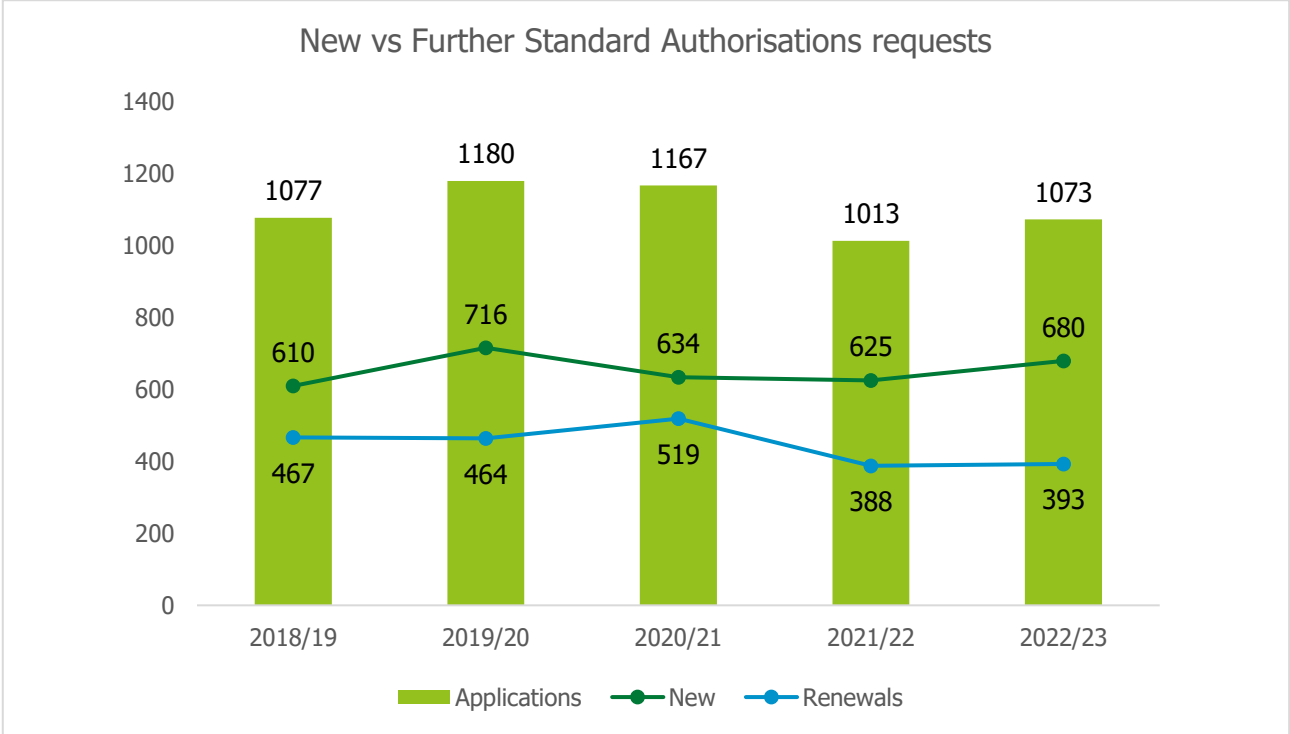
All adults should be free to live life as they want. If someone's freedom is restricted or taken away in a hospital or care home, there are laws and rules to make sure it is done only when necessary and in their best interests.

The rules are known as Deprivation of Liberty Safeguards (DoLS). We monitor how these safeguards are used in Islington.



The number of DoLS referrals for the period April 2022 to March 2023 was slightly higher than the previous year, but overall the number of referrals has been levelling off in last five years. Most DoLS referrals (59%) are from residential care homes.

New referrals and renewals have returned to levels broadly in line with pre-Covid pandemic levels.



Safeguarding through DoLS

The DoLS service is pro-active and skilled in ensuring that safeguarding issues identified within person's relevant person's representative reports or identified by the assessors are raised as safeguarding concerns when required. The team also ensures that they follow up on any recommendations or other issues raised by DoLS assessors or paid RPRs within their reports with the relevant social work teams or commissioning colleagues. This ensures that any concerns around a person's care or support are identified, shared and resolved to prevent potential safeguarding concerns developing.

If and when the resident under a DoLS authorisation or their representative expresses objection to their placement, the social work teams are notified, and where appropriate a paid Relevant Person's Representative is put in place to help facilitate a Court of Protection referral if appropriate.

Conditions and recommendations

Conditions are specifically attached to lessen the restrictions that the Relevant Person is subjected to. The decision around whether conditions are needed is always given careful consideration by the Best Interest Assessor (BIA). An additional level of assurance is provided by the DoLS team who are skilled at quality assuring all assessments and making further recommendations around conditions and having further discussions with the BIA.

Furthermore, the Supervisory Body Signatory also considers whether conditions are indicated.

During 2022-23 the Supervisory Body attached conditions to DoLS Standard Authorisations in 36% of all granted authorisations, a decrease of 14% on the previous year.

It is unclear why there has been a decrease in attached conditions, but it may reflect improving practice around the MCA and care being provided in a less restrictive way.

Over the next year, the DoLS team will continue to closely monitor using quality assurance mechanisms, including a sample audit of cases with no conditions attached.

Paid Relevant Person's Representative's support:

In October 2022 Islington, jointly with Camden, commissioned a new Advocacy Provider. One of the functions of the commissioned advocacy service is to provide Paid Relevant Person's Representatives to people who are under DoLS authorisation and who are without family or friends who would be able to represent them in regard to DoLS.

During this period of transition, the DoLS service implemented strategies to ensure service users were safeguarded as far as possible.

Proposed new DoLS scheme:

Locally, a lot of resource and effort had been expended since 2019 in preparation for introduction of the new Liberty Protection Safeguards (LPS) system. Our partner organisations were in a good position to implement the new system.

However, the government announced that the proposed system of LPS will not be implemented during this current parliament.

Next steps

We are proud of what we have achieved in the last year but as we look ahead, we have further to go in safeguarding adults. Ending adult abuse and neglect demands creativity, energy and commitment from all our partner organisations in Islington.

The ISAB is part-way through working towards achieving the aims set out in our 2022-25 strategy. Additional issues and areas for exploration are outlined below:

Rising cost of living

In our last report we had already identified the potential impact of inflation and resultant squeeze on living standards, as having potential consequences for adult safeguarding. Our Service User and Carer subgroup continues to share these concerns.

The SAB will continue to focus on this aspect of adult safeguarding and await with interest the outcome of the Local Government Association Safeguarding Adults Insight Project 2023 on the impact of hospital discharge, winter pressures and the cost-of-living crisis on safeguarding activity during the year.

Risk management and escalation

We have already made progress in addressing the most complex and high-risk safeguarding cases by setting up a Creative Solutions Panel. We will continue to keep this under review and ensure that escalation pathways are well understood and used by practitioners.

In Islington there are already several multi-agency issue-specific panels, such as hoarding panel and daily safeguarding meetings to name just a couple. We will consider whether there are any gaps for cases that do not neatly fit into these existing categories and how these cases get escalated where the risks remain high and unresolved.

Learning

The ISAB are committed to learning from serious cases. These cases are always sad and distressing for families, friends and the professionals involved, more so when the situations could have been prevented had agencies worked better together.

A large part of the focus for 2023-24 will be implementing learning from the 'Liam' Safeguarding Adults Review. All Board partners have work to do to ensure that the lessons from this case are learnt and we will be holding them accountable for implementing the report recommendations.

It is also important that we do not lose sight of learning from previous Safeguarding Adults Reviews and Coroner's Prevention of Future Deaths Notices.

Listening

Your views are important to us. The ISAB are committed to listening to what our community has to say. If you want to share your views with us, please get in touch. Our contact details are at the end of this report.

Appendix A

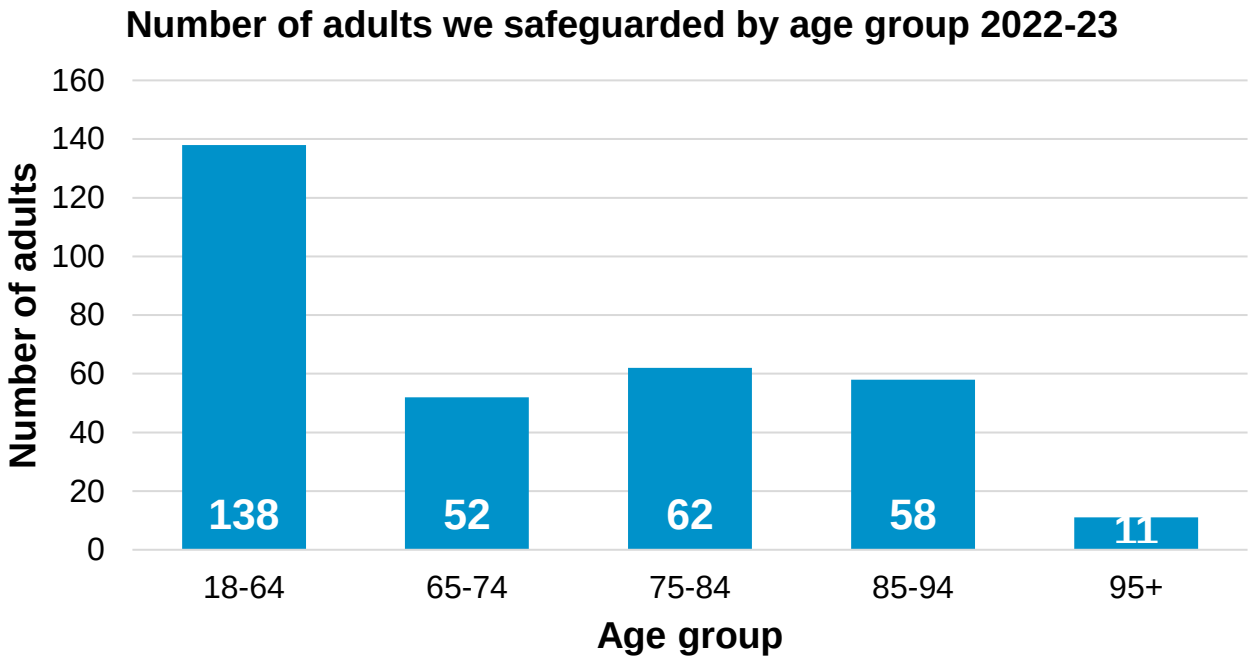
Making sure we safeguard everyone

Equality and diversity matter to us. We want to make sure that everyone who needs to be safeguarded is and that we are not missing people from some groups.

Keeping a watch on who needs safeguarding in Islington also helps us target our services at the right groups.

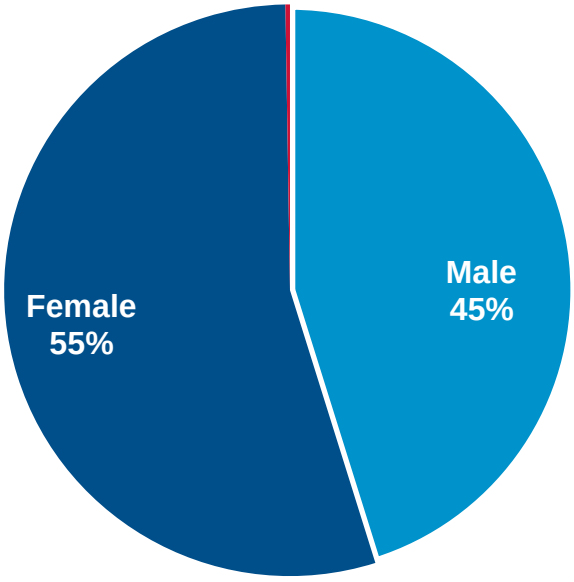
In this part of our review we look at how the Islington population is represented by the people who had safeguarding concerns raised about them.

With their consent, we capture information about their age, sex ethnicity, sexuality, mental capacity and service user category. Having a clear overall picture of who we are safeguarding and where there are gaps, helps us to decide where to focus our attention in the future.



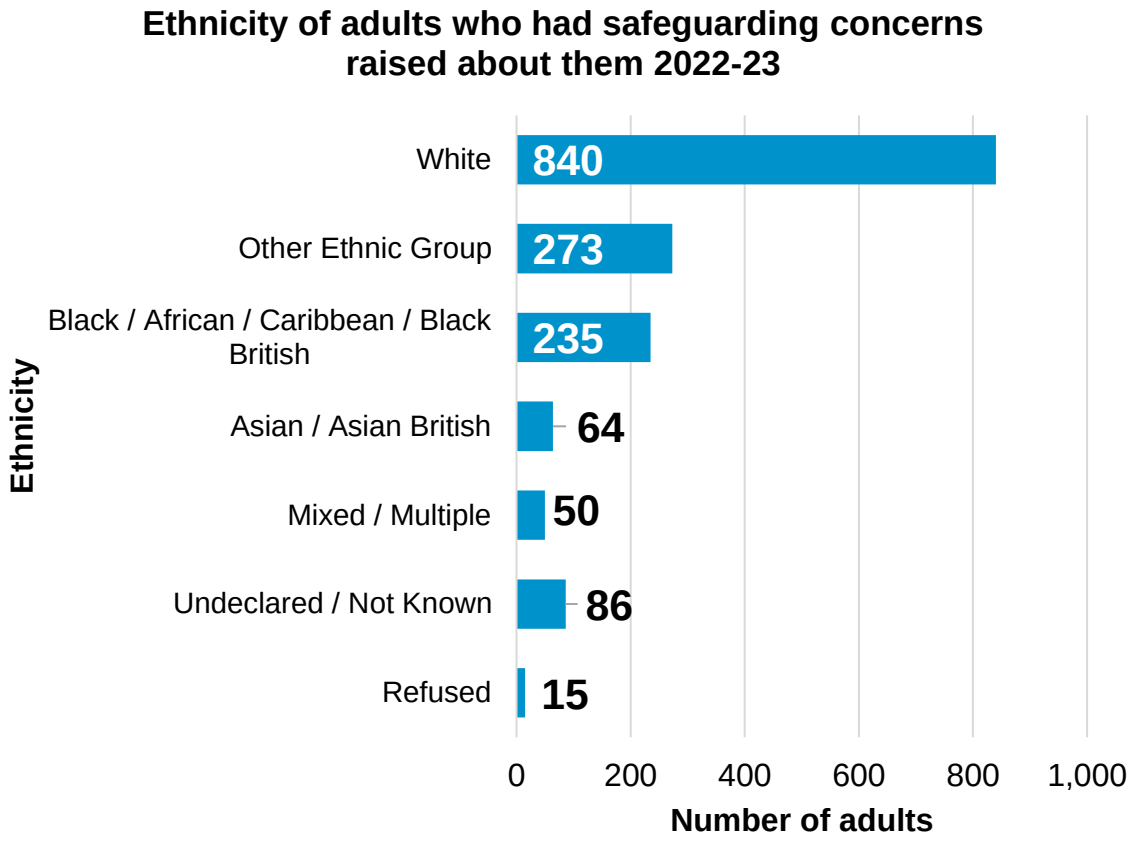
The chart above shows that this year (as in previous years) there were a lot of safeguarding concerns about people over 65 years of age. This is consistent with national and international research that shows the older an adult is, the more likely it is that they will come into contact with services trained to spot signs of abuse and neglect. We know that adults with care and support needs are more at risk of abuse, so as adults become frailer, sadly they also become more at risk. Therefore, it appears we are continuing to do well. Staff across our partner agencies, including voluntary, faith and community services, are vigilant and our awareness campaigns are encouraging people to come forward and report suspected abuse of older people.

Adults who had safeguarding concerns raised about them 2022-23



This chart shows the same gender proportions as last year. There were more concerns reported about women than men. It is difficult to know whether this is because women experience more abuse or whether abuse of women is more commonly reported than abuse of men. National research (Scholes et al, 2007) found that women are more likely than men to experience domestic abuse.

There were no safeguarding concerns about people who identified themselves as transgender. This may be explained by transgender adults being a statistically small group of people (estimated to be 0.1% of the population). It may also be because transgender adults chose not to disclose this information to us. We will continue to foster among practitioners the need to ensure appropriate opportunities for transgender people and other groups receive awareness raising information and share concerns.



The data in the chart above shows that concerns were raised for people from a range of ethnicities during the year.

Different ethnic groups have slightly different proportions of adults with care and support needs. For example, the average age varies across ethnic groups in Islington. In an ethnic group where there is a higher proportion of older people, we would expect to see more safeguarding concerns for that group.

Even though the safeguarding data above shows that the maximum concerns were received for people who identify as White, we need to compare this with the adult population data for Islington. Our data shows that adults who identify as Black/Black British and of Other Ethnicity are slightly over-represented in safeguarding data as compared to the adult population for this ethnicity in Islington. Asian/Asian British, Mixed Ethnicity and White residents had significantly lower proportion of safeguarding concerns raised, when compared to their proportion in the adult Islington population. We want to understand why some ethnicities are less likely to have safeguarding concerns reported about them. It may be that there are language barriers and that our awareness-raising materials are not reaching some communities, or it may be that some communities are less likely to trust services to respond

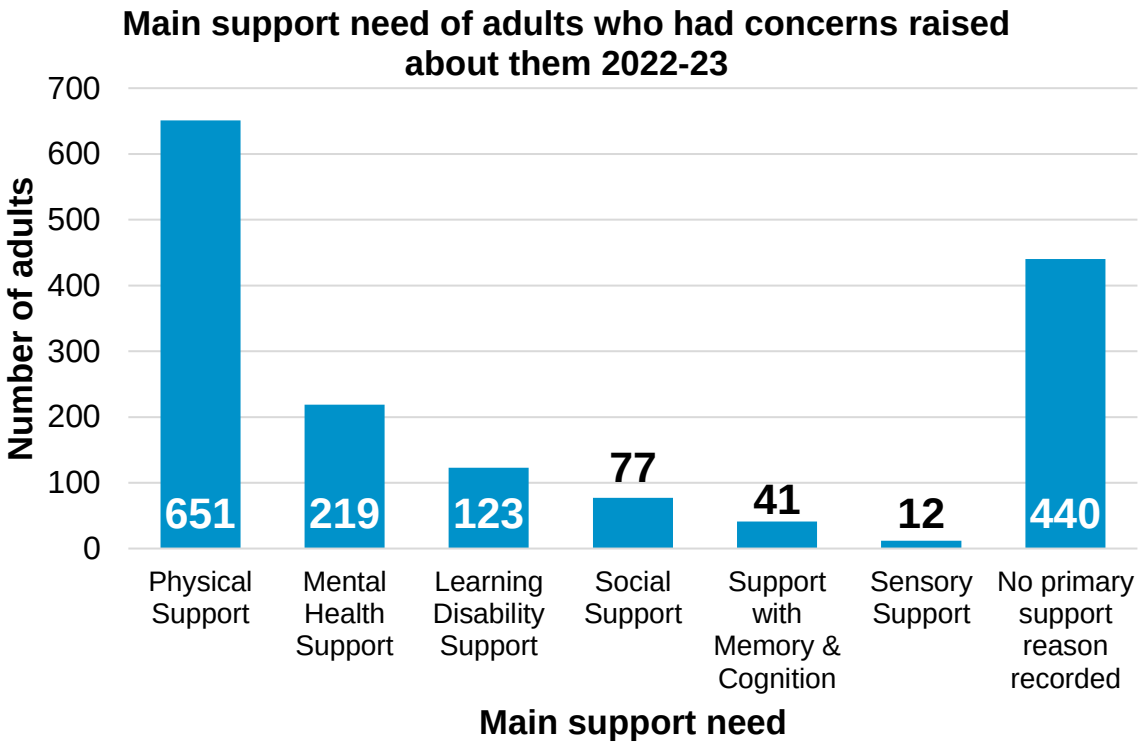
sensitively to their concerns. We have included an equalities strand of work in our current strategy and are working towards gaining a better understanding of the reasons some groups are less likely to have safeguarding concerns raised about them.

We continue to promote safeguarding adults through our range of leaflets and community language leaflets (Bengali, Chinese, Urdu, Greek, Turkish, Arabic and Somali). Through engaging with local communities, we aim to ensure that safeguarding concerns are not being missed.

Sexual orientation of adults safeguarded during the year

The government estimates that roughly 6% of the UK population is lesbian, gay or bisexual. Although the department of health does not require us to collect and report on sexual orientation, in recent years we have started asking some of the adults we safeguard about this. We continue to work towards creating an environment where staff feel confident about asking questions about sexual orientation and the adults concerned feel safe disclosing their sexual orientation.

Even though our data is not complete, there may be enough data to suggest that lesbian adults are under-represented in safeguarding enquiries. We continue to work on this strand of equality and diversity and will engage with partner organisations on this aspect of equalities in our strategy for 2022-25. This will allow us to get a better understanding of any barriers this group may experience in accessing safeguarding support.

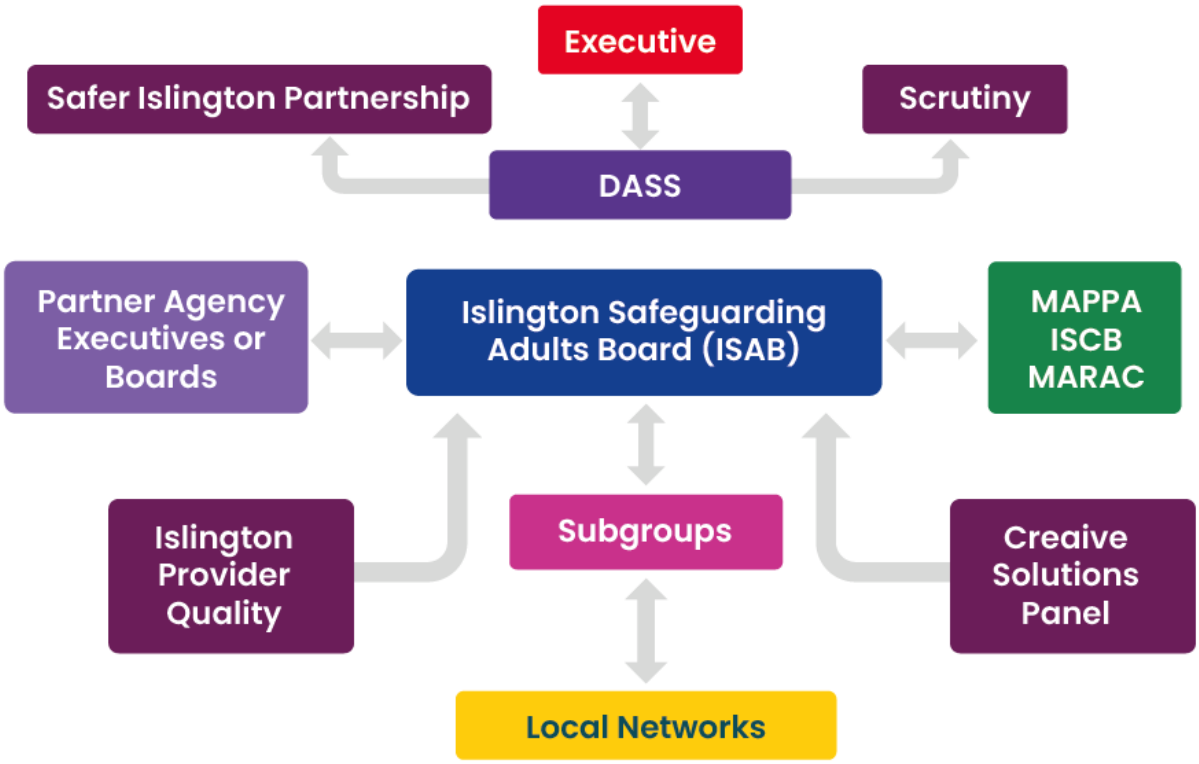


The above chart shows the main care or support needs of the adults who had safeguarding concerns raised about them. There continue to be more safeguarding concerns raised about adults with physical support needs than any other group of people. This is similar across the country. The chart shows that few concerns raised for people whose main need was that they care for someone else. It suggests we need to continue raising awareness amongst carers and organisations that support carers. We will continue to encourage practitioners to record the primary support reason of the person so that our data sets are more complete.

Appendix B

How the partnership fits in

The picture below shows how the Islington Safeguarding Adults Board (ISAB) 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.
SIP	Safer Islington Partnership - This group looks at crime and community safety. It involves the council, police, fire service, voluntary sector and others.
DASS	Director of Adult Social Services (DASS) is responsible for setting up and overseeing the ISAB.
ISAB	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.
IPQOB	Islington Provider Quality Oversight Board - this group looks at the quality of care providers in Islington.

Appendix C

Who attended our board meetings

Engagement from our partners is essential. While much of the work goes on behind the scenes, it is important for our partners to take part in our meetings.

We hold quarterly Board meetings.

The tables here set out the organisations represented at board meetings and subgroup meetings throughout the year

Islington Safeguarding Adults Board Meetings	**Board Meeting 04 May 2022**	**Board Meeting 20 July 2022**	**Board Meeting 19 Oct 2022**	**Board Meeting** 02 Feb 2023
Partner Organisation				
Independent Chair	P	P	P	P
Police	P	P	P	P
Islington Council	P	P	P	P
Islington Clinical Commissioning Group	P	P	P	P
Moorfields Eye Hospital NHS Foundation Trust	P	P	P	P
London Fire Brigade	P	P	P	P
Camden and Islington Mental Health FT	P	P	P	P
Whittington Health	P	P	P	P
Community Rehabilitation Company	A	A	A	A
Probation	A	A	P	P
Safer Islington Partnership	A	A	A	A
Co-Opted Organisation				
Age UK Islington	P	P	P	P
Notting Hill Pathways	A	A	P	P
Healthwatch Islington	P	P	P	P

Single Homeless Project	P	P	P	A
Attendees				
Care Quality Commission	P	A	A	A
NHS England	N/A	N/A	N/A	N/A
Islington Council - Elected Councillor	A	A	A	P
General Practitioner	N/A	N/A	N/A	N/A
HMP Pentonville	A	P	A	P
Voluntary Action Islington	A	A	A	A

Key

P = Present

A = Apologies no substitute

N = No apology/ substitute recorded

C = Does not attend; receives papers only

N/a = not applicable

Quality, Audit and Assurance Subgroup	Subgroup meeting 4 April 2022	Subgroup meeting 22 June 2022	Subgroup meeting 8 Nov 2022	Subgroup meeting 17 Jan 2023
Partner Organisation				
Chair (Clinical Commissioning Group)	A	A	A	P
Islington Council	P	P	P	P
Whittington Health	P	P	P	P
Moorfields Eye Hospital NHS Foundation Trust	P	P	A	A
Moorfields Eye Hospital NHS Foundation Trust	P	P	A	A
Camden and Islington NHS Foundation Trust	P	P	A	A
Notting Hill Housing	P	A	A	A
Police	P	P	P	P

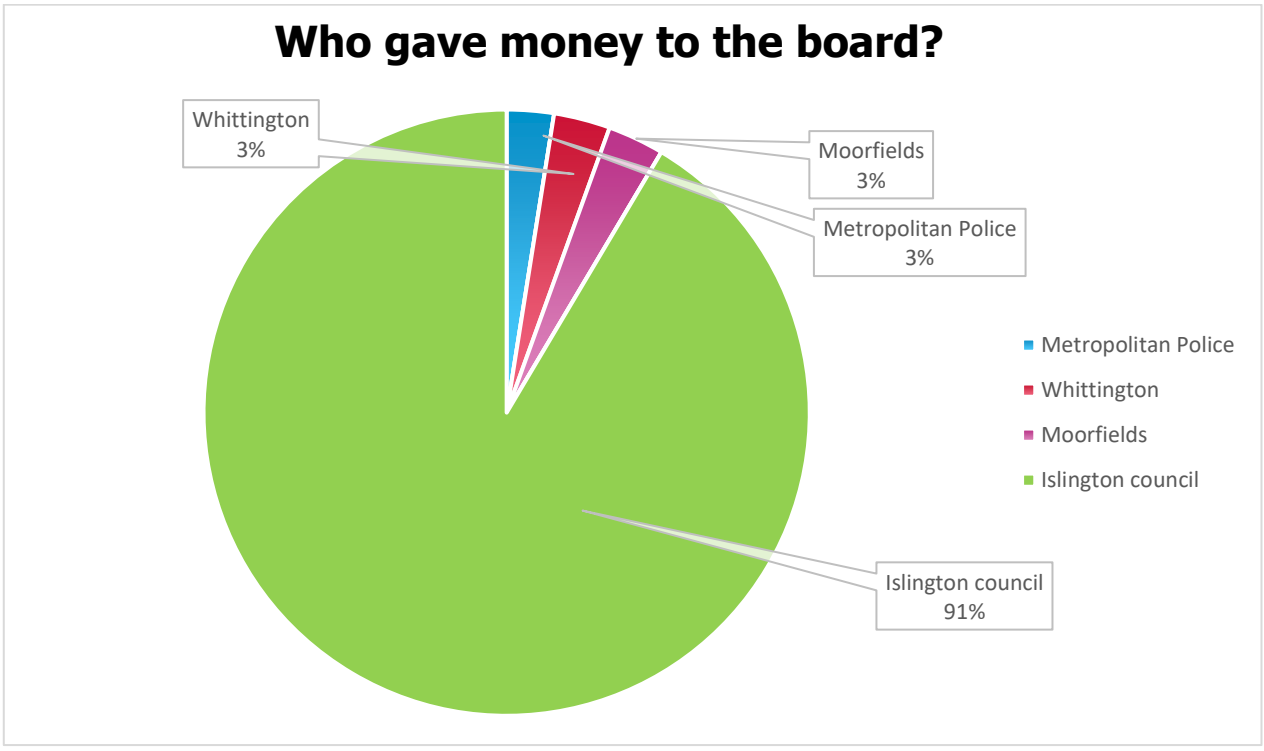
Quality, Audit and Assurance Subgroup	Extra ordinary Subgroup Meeting 13 April 2022	Extra ordinary Subgroup Meeting 08 June 2022	Subgroup Meeting 06 July 2022
Partner Organisation			
Chair (Police)	P	P	P
Islington	P	P	P
Single Homeless Project	P	P	P
Islington Clinical Commissioning Group	P	P	P
Age UK	N/A	N/A	N/A
Camden and Islington NHS Foundation Trust	P	P	A
Whittington Health	A	P	A
Moorfields	N/A	N/A	N/A

Prevention and Learning subgroup	Extra Subgroup meeting 12 April 2022	Subgroup meeting 14 June 2022	Subgroup meeting 09 August 2022	Subgroup meeting 31 October 2022	Subgroup meeting 30 January 2023	Subgroup meeting 15 March 2023
Partner Organisation						
Chair (Moorfields NHS FT)	P	P	A	A	A	A
Islington Council	P	P	P	P	P	P
London Fire Brigade	A	A	A	A	A	A
HMP Pentonville	A	A	A	A	A	A
Notting Hill Genesis	A	A	A	A	A	A
Camden and Islington NHS FT	P	P	P	P	P	P
Whittington Health	A	P	P	A	P	P
CCG	A	A	P	P	P	A
Met Police	A	A	A	P	P	A

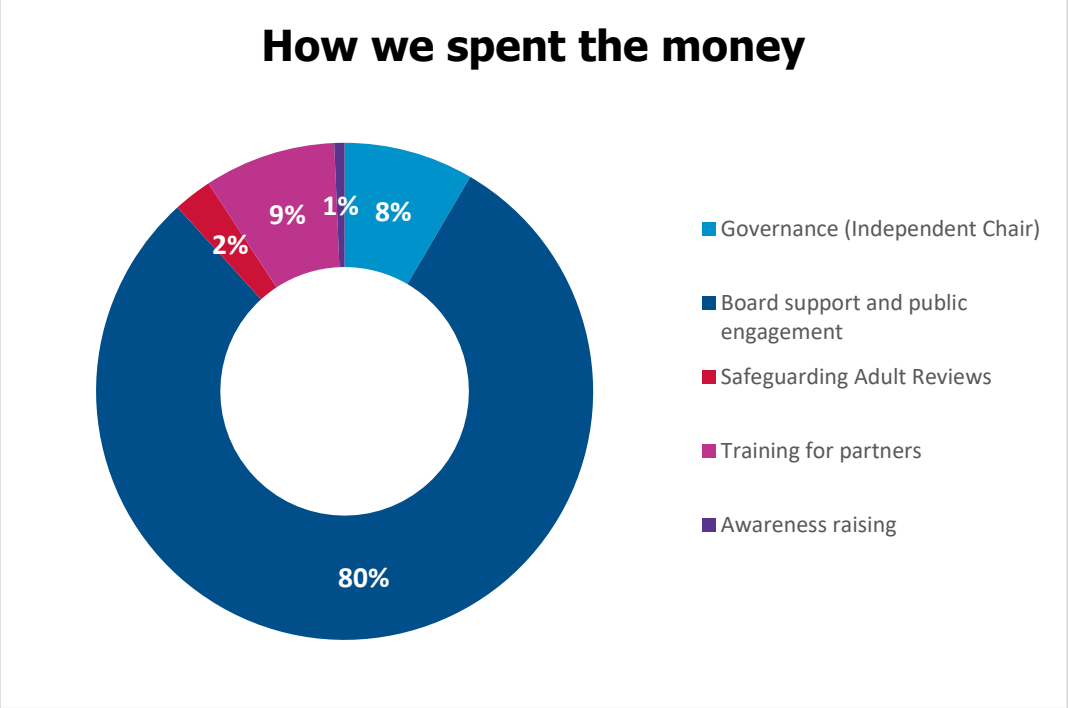
Appendix D

How is our Board resourced?

Primary responsibility for safeguarding adults rests with Islington Council. But all Board partners are expected to contribute to the resources of the partnership.



As the above chart shows, Islington council financed nearly 91% of the costs of the Safeguarding Adults Board in Islington. Discussions continue with other Board partners regarding future funding and resources.



It cost roughly £204,227 to support the work of the Board during the year. Last year's expenditure was £200,302.

The increase in this year's expenditure is because we commissioned an independent reviewer for the Liam SAR and rising cost due to inflation.

A significant amount of the basic awareness around MCA and DoLS, community DoLS and modern slavery training have been delivered by in-house staff, which helped to save on costs for external trainers. Some training has also been delivered online via e-learning modules. This included training on domestic violence, safeguarding adults at risk in Islington, and some MCA and DoLS training which have had a positive update. Some members of the public also completed this training.

Although direct costs for awareness raising account for only 1% of the board's expenditure, in reality several of the board support staff are engaged in awareness-raising work but these indirect costs are not reflected in the above chart because they are difficult to separate from the general board support functions.

Appendix E

Our impact on the environment

The work of the Safeguarding Adults 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. The use of active travel such as walking/cycling or public transport is promoted. Where vehicle use is necessary, the use of electric vehicles is encouraged. Wherever possible we try to minimise the impact on the environment. For example, wherever we can we avoid printing documents and send out electronic versions instead to reduce paper and energy use. From time to time we hold 'virtual' meetings online to cut our travel impact.

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 reduce fuel poverty and improve the health and wellbeing of residents, it supports lifetime behaviour changes and help with energy efficiency that can reduce carbon emissions.

For more information about SHINE, click here

Appendix F

Jargon buster

Abuse
Harm caused by another person. The harm can be intended or unintended.

Adult at risk
An adult who needs care and support because of their age, disability, physical or mental health and who may be unable to protect themselves from harm.

Care Act 2014
An Act of parliament that has reformed the law relating to care and support for adults.

Clinical Commissioning Group (CCG)
CCG's are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Channel Panel
Channel is multi-agency panel which safeguards vulnerable people from being drawn into extremist or terrorist behaviour at the earliest stage possible.

CRIS
This is a Police Crime Database. The CRIS database acts as a case management system for logging and recording crimes.

Community Risk Multiagency Risk Assessment Conference (CRMARAC)
A multi-agency meeting where information is shared on vulnerable victims of anti-social behaviour. The aim is to identify the highest risk, most complex cases and problem-solve the issues of concern.

Deprivation of Liberty Safeguards (DoLS)
The process by which a person lacking the relevant mental capacity may be lawfully deprived of their liberty in certain settings or circumstances. It operates to give such a person protection under Article 5 of European Convention on Human Rights (right to liberty and security).

Sometimes, people in care homes and hospitals have their independence reduced or their free will restricted in some way. This may amount to a ‘deprivation of liberty’. This is not always a bad thing – it may be necessary for their safety but it should only happen if it is in their best interests.

The deprivation of liberty safeguards are a way of checking that such situations are appropriate.

Female Genital Mutilation

Female Genital Mutilation involves any kind of procedure that partly or total removes external female genitals for non-medical reasons and without valid consent.

LeDeR

The LeDeR programme is a review of the deaths of people with a learning disability to identify common themes and learning points and provide support to implement these.

Liberty Protection Safeguards

A set of safeguards that were intended to replace the current system of Deprivation of Liberty Safeguards

Making Safeguarding Personal

A way of thinking about care and support services that puts the adult at the centre of the process. The adult, their families and carers work together with agencies to find the right solutions to keep people safe and support them in making informed choices.

Mental Capacity Act (MCA)

The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The MCA is designed to protect and restore power to those vulnerable people who lack capacity.

Merlin
Merlin is a database used by the Police to report persons who have come to notice due to any of a number of risk factors, such as going missing. Merlin is used to refer those concerns to partner agencies, such as mental health services.

Neglect
Not being given the basic care and support needed, such as not being given enough food or the right kind of food, not being helped to wash.

Safeguarding Adults Board
Councils have a duty to work with other organisations to protect adults from abuse and neglect. They do this through local safeguarding boards.

Safeguarding Concern
Any concern about a person's well-being or safety that is reported to adult social services. Safeguarding concerns can be reported by members of the public as well as professionals.

Safeguarding Enquiry
A duty on local authorities to make enquiries to establish whether action is needed to prevent abuse, harm, neglect or self-neglect to an adult at risk of harm.

Seasonal Health Interventions Network (SHINE)
SHINE aims to reduce fuel poverty and seasonal ill health by referring a resident on to services. For example, it may refer someone for energy efficiency advice and visits, fuel debt support, falls assessments, fire safety and benefits checks.

Provider Quality Oversight Board
A board that meets to look at the quality of care being provided in care homes, care in your home and hospitals for older people in Islington. They share information on services to improve the quality of care for service users.

Prevent
Prevent is part of the Government's counter-terrorism strategy. It involves safeguarding people and communities from the threat of terrorism and extreme views.

Section 136 of Mental Health Act 1983 (Mentally disordered person found in a public place)

This law is used by the police to take a person to a place of safety when they are in a public place. The police can do this if they think the person has a mental illness and is in need of care.

Section 135 of Mental Health Act 1983 (Warrant to search for and remove patients)

This law is used by the police to take someone to a place of safety for a mental health assessment.

Section 5 of Mental Health Act 1983 (Application in respect of a patient already in hospital)

This law is used by a doctor or Approved Mental Health Practitioner (AMPH) to stop an adult from leaving a hospital in order to treat them in their best interest.

Section 6 of Mental Health Act 1983 (Application for admission into hospital)

This law is used by a doctor or AMHP to admit an adult to hospital in order to treat them in their best interest.

Appendix G

What should I do if I suspect abuse?

Everybody can help adults to live free from harm. You play an important part in preventing and identifying neglect and abuse.

If you suspect abuse or neglect, it is always safer to speak up!

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

Adult Social Services Access and Advice Team

Tel: 020 7527 2299 or
complete an online safeguarding **concern form**

You can also contact the

Community Safety Unit (part of the police)

Tel: 020 7421 0174

In an emergency, please call 999.

For more information:

Islington Community Safety https://www.islington.gov.uk/community-safety

For advice on **Mental Capacity Act and Deprivation of Liberty Safeguards** contact:

Tel: 0207 527 3828

Email: dolsoffice@islington.gov.uk

For more information, click here

All the people whose faces you can see in the photographs in this review have agreed for their images to be used.

Thanks for reading!

We hope you enjoyed reading this review. For any questions, feedback or further detail, please email: safeguardingadults@islington.gov.uk or write to us at:

Islington Safeguarding Adults Board, 4th Floor, 222 Upper Street, Islington, London, N1 1XR