Barnet Safeguarding Adults Board
Annual Report 2022-23

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Foreword from the Independent Chair, Fiona Bateman

It is always a pleasure to introduce our annual report. We really welcome interest from a wide cross section of our community across Barnet. I have no doubt that you will find much within this report of interest, as the report details the wide range of activity undertaken by the BSAB, our members and wider partners to tackle issues as they arose across the year.

I am privileged to work with partners who, despite very real challenges, never cease to inspire and impress me with their dedication, energy and sense of social justice. This year we have complimented our usual report with case studies to try to bring to life the everyday practice from across the partnership to identify possible abuse or neglect and work collectively with the adult so that responses are person-centred and effective in reduction risk.

We have also been able to show an impact of previous BSAB activity. We can see from the first section of the report (which details the profile of risk in Barnet) that safeguarding concerns have increased both in terms of the numbers of cases reported and in their complexity. Despite this, our data provides reassurance that people are identifying concerns and reporting these, that responses to those concerns are timely and are increasingly meeting the outcomes that matter to the adult.

You will also see that as a partnership we have 'lifted the lid' on topics often considered too difficult to really explore how we can work not just across our member agencies, but pro-actively with the voluntary, faith and community sector organisations, our carers and residents to understand what might be needed to ensure the system is better connected and focused on keeping adults with care needs safe.

Over the coming year we intend to publish a fresh new strategy to continue to build on these solid foundations, influenced by our engagement activities with frontline practitioners, carers, residents and experts by experience who have so generously given their time to support the work of the BSAB. We pride ourselves on being an inclusive partnership, where parity of esteem is a core value. We are particularly keen to hear from adults with care and support needs who have experienced abuse or neglect or cared about someone who has, understanding what works to keep people safe from lots of different perspectives really does help shape our system into a fairer, safer one.

Best wishes for a safer future,

Fiona Bateman
BSAB Independent Chair

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Safeguarding activity in Barnet 2022-23

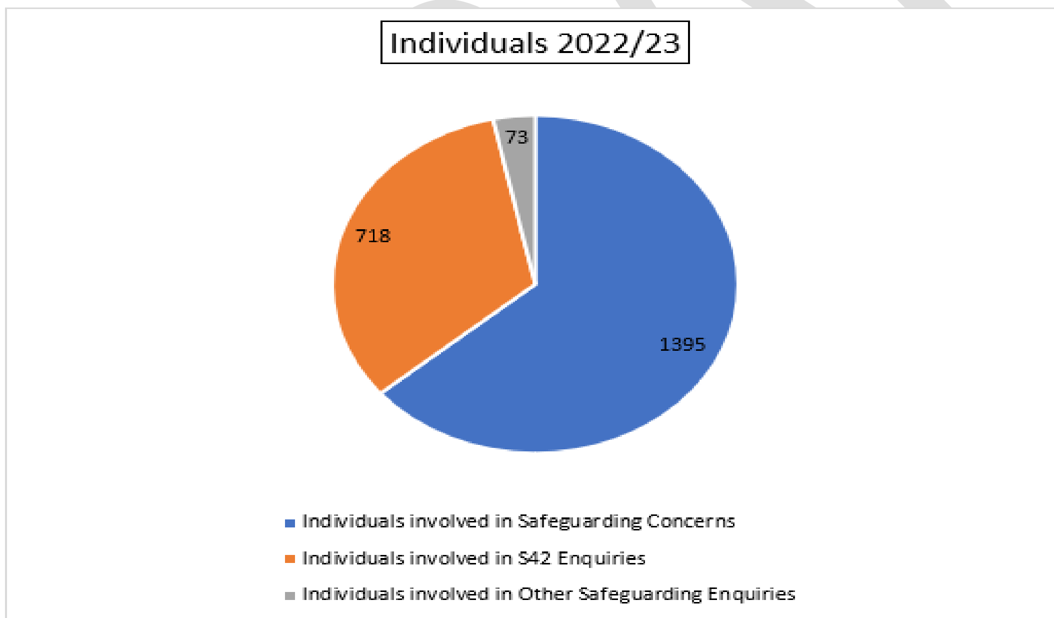
Summary

The following data comes from the Council's 2022-23 Safeguarding Adults Collection (SAC) which records details about safeguarding activity for adults aged 18 and over in England, reported to, or identified by, Councils with Adult Social Services Responsibilities.

This year increases were observed in both safeguarding concerns and enquiries. This was in part due to a change in ICT process in April 2022 to speed up the timeliness of recording safeguarding activity down to 3 days or less for concerns and 30 days or less for enquiries. Previously, staff were recording tasks that were aligned to an enquiry as part of the 'safeguarding concerns' process. This is in part linked to the principles of 'Making Safeguarding Personal', which require proportionality and prevention approaches. However, in line with guidance issued by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), this activity is now recorded under the enquiry process.

Although the location of abuse ranked order has not changed significantly, the proportions have, with the 'own home' location accounting for 57.4% this year compared to 46.2% in 2021-22. Care Homes for both residential and nursing equated to 25.6% of all enquiry locations compared to 36% in 2020-21. Adult safeguarding partners may not have high levels of access to people's own homes, but the data demonstrates the ingenuity of our frontline staff across partner agencies in seeking to keep adults with care and support needs safe.
For those with recorded desired outcomes, the proportion of people fully or partially achieving these outcomes increased to 89.8%, from 87.8% in 2021-22.

Individuals

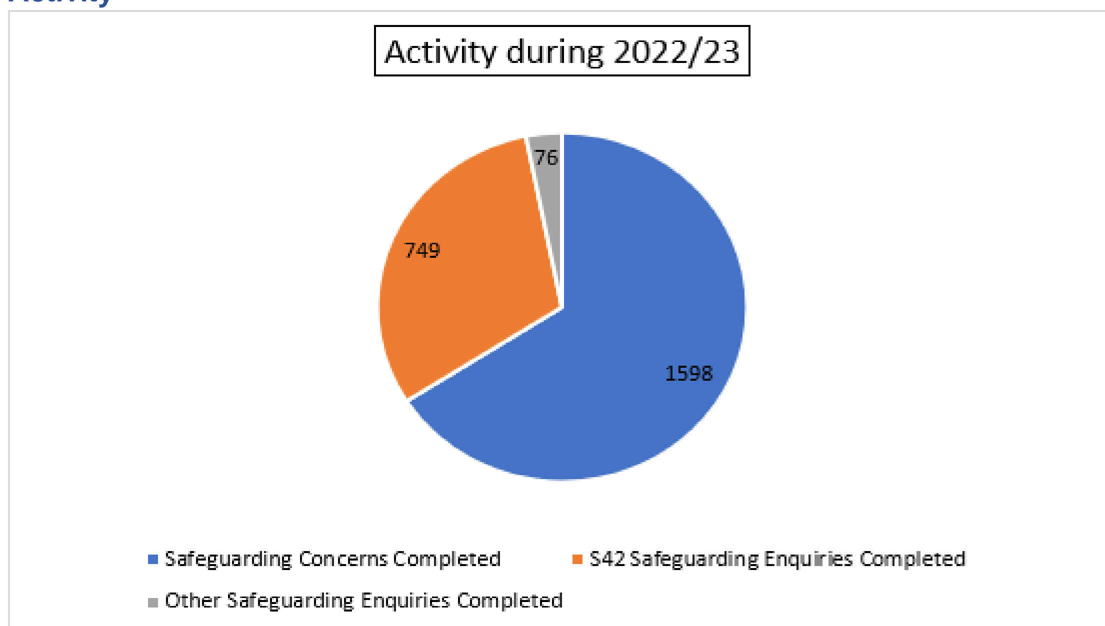


🠉 A total of **1,395** individuals were involved in safeguarding concerns during 2022-23, an increase from **1,265** in 2021-22 (10.3% increase equivalent to 130 more individuals).

🠉 A total of **718** individuals were involved in Section 42 Safeguarding Enquiries, an increase from **303** in 2021-22 (137% increase equivalent to 415 more individuals. This is as a result of the ICT recording change outlined in the introduction to this section above).

🠉 A total of **73** individuals were involved in other Safeguarding Enquiries, an increase from **11** in 2021-22 (563.6% increase equivalent to 62 more individuals).

Activity



- ⬆ **1,598** Safeguarding Concerns were completed during 2022-23, up from 1,464 in 2021-22 (9% increase equivalent to 134 more Safeguarding Concerns).
- ⬆ **749** S42 Safeguarding Enquiries were completed during 2022-23, up from 318 in 2021-22 (135.5% increase equivalent to 431 more S42 Safeguarding Enquiries, but this is due to the change in process described above).
- ⬆ **76** Other Safeguarding Enquiries were completed during 2022-23, up from 11 in 2021-22 (590.9% increase equivalent to 65 more non statutory enquiries completed).

Safeguarding Enquiries by Source of Risk

- **Neglect and Acts of Omission** continues to be the highest proportion of source of risk accounting for 32.7% (⬇ down from 39% last year) of all the source of risk types.
- **Financial or Material Abuse** was the second highest proportion of source of risk accounting for 16.8% (⬆ up from 14.6% last year) of all the source of risk types. This is likely due to the significant focus given to this form of abuse within NCL, following the changes in legislation under the Domestic Abuse Act 2021.
- **Physical Abuse** was the third highest proportion of source of risk accounting for 15.1% (⬇ down from 18.5% last year) of all the source of risk types.
- **Psychological Abuse** continues to be the fourth highest proportion of source of risk accounting for 13.0% (⬇ down from 13.4% last year) of all the source of risk types.
- **Self-Neglect** continues to be the fifth highest proportion of source of risk accounting for 9.9% (⬆ up from 5.6% last year) of all the source of risk types.
- **Domestic Abuse** continues to be the sixth highest proportion of source of risk accounting for 6.2% (⬆ up from 4.5% last year) of all the source of risk types. Currently BSAB partners are working on a theory that a higher proportion of adults experience domestic abuse than is recorded within the SAC data. This is because data available from the Metropolitan Police would indicate that domestic abuse is far higher. It is likely that requirements in respect of the data collection means that often the form of abuse (physical, emotional, financial etc) will be the defining characteristic when choosing a categorisation, rather than the fact that the abuse occurs between people who are 'personally connected'. [1] We are hoping to work, over the coming year, with NHS England to improve consistency in recording so that this can be better understood in the years ahead. Locally BSAB's board manager is also an active member of the VAWG strategic partnership to ensure that we continue to work collectively to support adults with care and support needs access the right support at the right time.

[1] *This is the term used to define domestic abuse within the Domestic Abuse Act 2021.*

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- **Sexual Abuse** continues to be the seventh highest proportion of source of risk accounting for 3.8% (⬆ up from 2.6% last year) of all the source of risk types.
- **Organisational abuse** is the eighth highest proportion of source of risk accounting for 1.2% (➡ same as last year) of all the source of risk types.
- There were 9 recorded Safeguarding Enquiries for Modern Slavery in 2022-23 after 2 years of 0 recorded safeguarding enquiries in both 2020-21 and 2021-22. Modern Slavery has the ninth highest proportion of source of risk accounting for 0.8% (⬆ up from 0% last year).
- **Sexual Exploitation** was the tenth highest proportion of source of risk accounting for 0.4% (⬇ down from 0.5% last year) of all the source of risk types.
- **Discriminatory Abuse** was the eleventh highest proportion of source of risk accounting for 0.1% (⬇ down from 0.2% last year) of all the source of risk types.

Safeguarding Enquiries by Location

- ⬆ **Own home** continues to be the highest proportion of location of abuse in safeguarding enquiries (57.4% up from 46.2% in 2021-22).
- ⬇ **Care Home** – Residential continues to be the second highest proportion of location of abuse in safeguarding enquiries (17.3% down from 18.6% in 2021-22).
- ⬇ **Care Home** – Nursing continues to be the third highest proportion of location of abuse in safeguarding enquiries (8.3% down from 17.4% in 2021-22).
- ⬇ **In the community** (excluding community services) was the fourth highest proportion of location of abuse in safeguarding enquiries (6.3% up from 4.1% in 2021-22).
- ⬇ **Other** accounted for the fifth highest proportion of location of abuse in safeguarding enquiries 22 (4.1% down from 6.4% in 2021-22).
- ⬇ **In a community service** continues to be the sixth highest proportion of location of abuse in safeguarding enquiries (2.9% down from 3.8% in 2021-22).
- ⬇ **Hospital** – Acute continues to be the seventh highest proportion of location of abuse in safeguarding enquiries (1.8% down from 2.3% in 2021-22).
- ⬆ **Hospital** – Community continues to be the eighth highest proportion of location of abuse in safeguarding enquiries (1.4% up from 1.2% in 2021-22).
- ⬆ **Hospital** – Mental Health continues to be the ninth highest proportion of location of abuse in safeguarding enquiries (0.5% up from 0% in 2021-22).

Risk Assessment Outcomes

- ⬇ Risk Identified and **action taken** continues to be the highest proportion of outcomes with 72.8% (down from 75.1% last year) of risk outcomes falling into this category.
- ⬆ No risk identified and **no action taken** was the 2nd highest proportion of outcomes (was 3rd last year) with 7.7% (up from 6% last year) of risk outcomes falling into this category.

  For the next two indicators, it may be helpful to explain that these outcomes describe cases where they have been referred as a safeguarding concern, but on closer enquiry there is no risk of abuse. However, it is accepted that the adult may require social care or health input and so are referred onwards for an assessment of their needs.
- ⬆ No risk identified and **action taken** was the 3rd highest proportion of outcomes with 6.7% (up from 5.7% last year) of risk outcomes falling into this category.
- ⬇ Risk – Assessment inconclusive and **action taken** was the 4th highest proportion of outcomes with 4.4% (down from 9% last year) of risk outcomes falling into this category.

- ⬆ Risk identified and **no action taken** was the fifth highest proportion of outcomes with 4% (up from 2.7% last year) of risk outcomes falling into this category. A case audit has shown that these were either well justified or recorded incorrectly and action was taken.
- ⬆ Risk – Assessment inconclusive and **no action taken** was seventh highest proportion of outcomes with 2.4% (up from 0.6% last year) of risk outcomes falling into this category.

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- Enquiry ceased at individual's request and **no action taken** was the sixth highest proportion of outcomes with 2% (up from 0.9% last year) of risk outcomes falling into this category.

Risk Outcomes

Where risks were identified the outcome/ expected outcome when the case was concluded were as follows:

- Risk Reduced in 58.3% of the time (down from 60.4% last year)
- Risk Removed in 33.5% of the time (up from 32.7% last year)
- Risk Remained in 8.1% of the time (up from 6.9% last year)

Mental Capacity for concluded S42 Safeguarding Enquiries

- 27.8% of concluded S42 Safeguarding Enquiries lacked capacity (down from 46.1% last year)
- 58.9% of concluded S42 Safeguarding Enquiries did not lack capacity (up from 41.3% last year)
- 9.3% (70 recorded as 'Don't know') of concluded S42 Safeguarding Enquiries it was not known what their mental capacity was (up from 5.8% last year)
- 4% (30 not recorded) of concluded S42 Safeguarding Enquiries their mental capacity was not recorded (down from 6.8% last year)
- 96.6% of people who were identified as lacking capacity were provided support by an advocate, family, or friend (up from 95.8% in 2020-21).

A case audit of cases recorded as don't know or not recorded has shown a mixture of adults who had died or were at end of life. That audit concluded that the main area for practice improvement was a procedural one regarding better record keeping, but that usually a person's capacity was determined.

Making Safeguarding Personal

- 78.7% of concluded S42 Safeguarding Enquiries (587) the individual or individual's representative **were asked, and outcomes were expressed** (up from 74.2% last year).
- 10.6% of concluded S42 Safeguarding Enquiries (79) the individual or individual's representative **were asked, but no outcomes were expressed** (down from 20% last year).
- 8.4% of concluded S42 Safeguarding Enquiries (63) the individual or individual's representative **were not asked about desired outcomes** (up from 3.5% last year).
- 2.1% of concluded S42 Safeguarding Enquiries (16) the individual or individual's representative **did not know about desired outcomes** (up from 0.6% last year).
- 0.1% of concluded S42 Safeguarding Enquiries (1) it was **not recorded** that the individual or individual's representative were asked about desired outcomes (down from 1.6% last year).
- A case audit of cases recorded as 'were not asked' or 'not recorded' has shown a mixture of adults who had died, again, this was addressed by providing advice on recording issues.

Of those cases where desired outcomes were achieved the proportion of them that were recorded as:

- Fully achieved – 59.6% up from to 47.8% last year.
- Partially achieved – 30.2% down from 40% last year.
- Not achieved - 10.2% down from 12.2% last year.
- 89.8% of cases where desired outcomes were recorded were fully or partially achieved up from 87.8% last year.

SARS

2 SARS were recorded in 2022-23. In 2021-22 1 SAR was recorded. Detailed of the findings of these reviews and what steps the BSAB and our partner agencies have taken are detailed later in this report.

Barnet Safeguarding Adults Board: Our vision and purpose.

The Barnet Safeguarding Adults Board ['BSAB'] is a partnership of voluntary, statutory and community organisations. The BSAB's purpose is to enable partner agencies to review practice across the entire health, social care and criminal justice system to provide positive cross agency challenge, to encourage accountability and strengthen a culture of continuous improvement.

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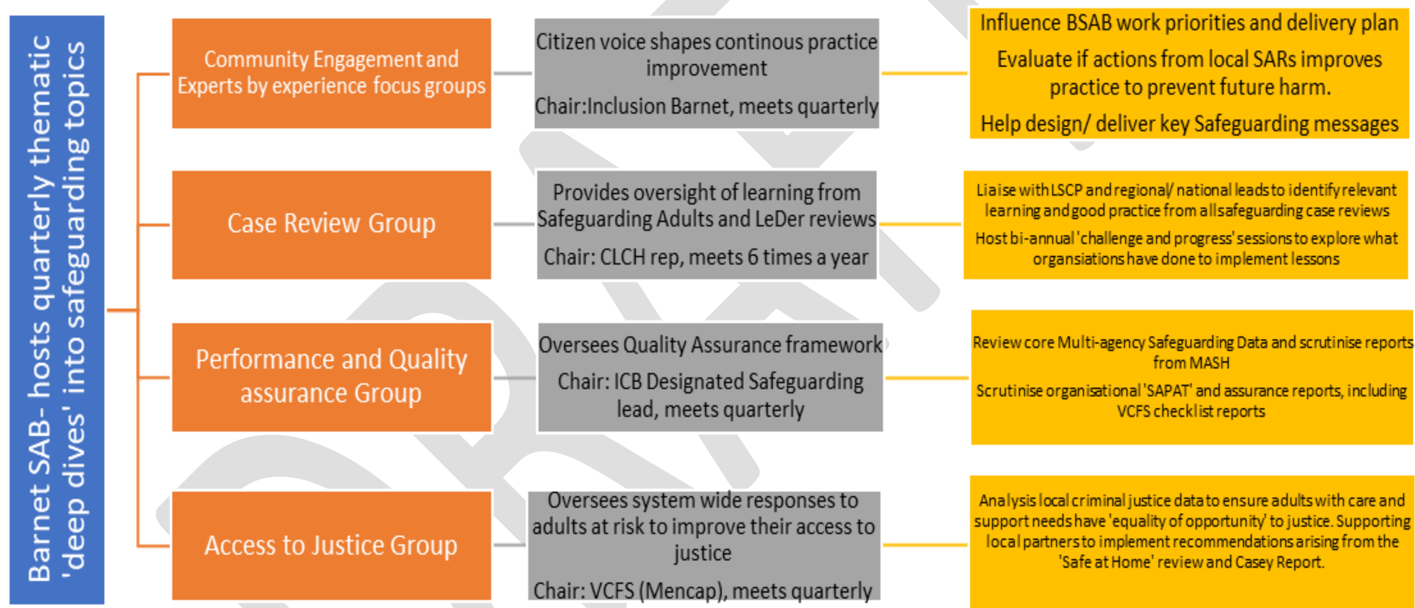
Our vision is for all ‘adults at risk’,[2] in Barnet to be safeguarded from abuse and neglect in a way that supports them to make choices and have control about how they want to live safely. We set out three key priority areas, namely:

- Establish consistent practice across partnership agencies which reflect the ‘Making Safeguarding Personal’ principles[3]
- Ensure ‘adults at risk’ are heard and understood and their experiences and views shape continuous improvement.
- Advance equality of opportunity, including access to justice for ‘adults at risk’

In recognition of the wide-ranging impact of the Pandemic and the way in which services will be delivered, (e.g., migration over to Integrated Care Systems) the BSAB reviewed how sub-groups and the main meetings of the board will interact to complete key tasks to fulfil our joint statutory functions. That work continued to be complemented by community engagement activities and multi-agency sector- led workshops so that we could demonstrate effective, proportionate safeguarding practice across our partner agencies.

The Board retained the current structure of sub-groups to enable practitioners across the statutory, voluntary and community sectors come together to build on the innovation and strong partnership collaboration so evident in the response during the Pandemic.



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A summary of the work completed, and the impact is given below.

BSAB meets as a whole group every three months.

The BSAB identified four safeguarding topics to provide a focus for the quarterly BSAB meetings, namely financial abuse, fire safety, multiple exclusion homelessness and modern day slavery. These themes were chosen because of national and local learning from safeguarding adults reviews or to take forward our local strategic plan. Theming meetings in this way afforded partners an opportunity to reflect on activities undertaken by their organisations to address systematic or persistent levels of harm experienced by adults at risk in Barnet. Agencies were asked to provide assurance on the steps taken to implement policies, disseminate practice guidance and monitor service delivery to ensure they were working collectively to safeguard adults at risk in Barnet.

[2] Defined by s42 Care Act 2014 as adults with care and support needs who are at risk of abuse or neglect and unable to protect themselves

[3] Set out in more detail at: https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

In June 2022 the BSAB discussed 'Intrafamilial' Financial Abuse, following on from our 2020 survey of adults with learning disabilities' experience of financial abuse, and a subsequent lunch and learn where participants had explained they find it hardest to respond effectively to financial abuse concerns if this had occurred within family or 'friendship' groups. On the 21.06.22 we hosted an on-line workshop for practitioners from across all 5 boroughs. There was representation from Mencap, DWP, Age UK, trading standards, Police officers, social workers, community and hospital-based health practitioners, local authority finance officers and deputyship teams. The workshop explored the prevalence of abuse by family members, those posing as friends or informal carers who exploit adults at risk for their own financial gain, including deception or coercion in respect of money or assets, including the misappropriation of property, possessions or welfare benefits.

The workshop started by hearing from one of our experts by experience about the impact that financial abuse by his family had on him. Following this there were plenary sessions exploring:

- Financial/ Economic coercion as a form of domestic abuse
- Prevention is the best cure- ways to stay safe from financial abuse.
- A system- wide approach to identifying and responding to financial abuse.

97 people registered interest in the workshop and 77 attended the session, with a satisfaction rating of 4.7 (out of 5). Practitioners at the workshop reported a lack of public and professional awareness of the risks and nature of economic/ financial concerns. The importance of diversity and difference in key messages was also considered, with practitioners recommending that SABs engage from the start of any 'product design' with our community or faith group leaders to take advice about the best formats and use of language to ensure this work has a wide and impactful reach. Attendees explained, taking such an approach will build trust and help us all to understand issues from different cultural perspectives.

- We identified good practice examples across social care, Department of Work and Pension [DWP] and VCFS colleagues.
- We agreed a way forward to raise public awareness.
- We presented our findings to BSAB, Community Safety Partnership, North Central London Integrated Care Board's [NCL ICB] safeguarding conference and London SAB's conference.

The full report with recommendation can be found Report The importance of this work was underlined by interest from the Home Office and Department for Health and Social Care within their 'Safe Care at Home'[4] Link report into the obligations for public bodies to protect those in receipt of care within their own home. That national guidance drew on, amongst other sources, the case studies and the NCL findings. Our Access to Justice sub-group will explore over the coming year how we implement the recommendations of the Safe Care at Home report locally.

In September 2022 the BSAB discussed the theme Safeguarding and the Cost of living. The Community Care survey reported rising cost-of-living is 'severely' affecting people accessing children's and adults' services fuelling a host of issues including poverty, debt, mental ill-health and domestic conflict. Locally partners have raised concerns that rising costs, particularly with respect to food and fuel costs, could have a significant impact on the safety and wellbeing of adults with care and support needs, including increasing the risks of financial abuse, fire safety (as people use more risky light and heat sources) and self-neglect as a result of poor heating or nutrition. The focus of discussions was on steps taken by partner organisations to respond to anticipated safeguarding risks. Partners gave assurance about what is being done for example,

- The London Probation Service recognised that people are having challenges and difficulties in getting to appointments for finances, leading to further or different criminal activity and exploitation of more vulnerable people.
- The NHS through the ICB were exploring personal health budgets and there's a discretion to use small personal health budgets to support discharge from hospital.
- The Local Authority confirmed they were working in partnership with Voluntary and Community sector and health partners to give extra support and signpost for support. Practitioners are encouraged not to signpost without introductions or support being given to ensure that access to information and advice is as smooth as it can be. Practical support with heating and keeping warm is also available.

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[4] *Available at: https://www.gov.uk/government/publications/safe-care-at-home-review*

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- The Barnet Group confirmed it was also taking steps to ensure that tenants accessed available support through its own services and via partners.

In December 2022 the BSAB discussed the Reframing Safeguarding project following a successful bid to the Barnet Prevention Fund. The BSAB had agreed they needed to draw on the expertise and established networks within our diverse communities to better understand how different types of risk affect diverse communities and what BSAB partners need to do differently to improve awareness, identification, reporting of safeguarding concerns and access to support within those communities. The aim of the project is to:

- Increase understanding about safeguarding and knowledge about the BSAB.
- Reframe the local narrative on safeguarding to 'Keeping All Adults safe'.
- Encourage Barnet's diverse communities to confidently raise safeguarding concerns in respect of adults with care and support needs to the Barnet MASH.
- Establish a feedback process between the MASH and local residents when safeguarding concerns do not reach S42 thresholds.
- Create a culture of community understanding about safeguarding.
- To establish an 'Expert by Experience' Group of Barnet residents to support and guide the BSAB.

The project is being led by the BSAB's manager and CommUnity Barnet, a partner on the Board using their experience of carrying out similar work in Newham. An Oversight group including Barnet Carers, Inclusion Barnet, Barnet Mencap and LBB's VAWG strategy manager is overseeing the project. An initial engagement programme consisting of focus groups, face-to-face conversations, social media campaigns, and a survey to scope understanding has been developed. It has been shared with people who draw on care & support and residents in Barnet. This will be used to capture residents' knowledge of safeguarding. Click here **BSAB - Community Engagement Survey November 2022 .** The project is due to be completed December 2023.

In March 2023 partner agencies reported on activity within their organisation to address SAR recommendations and BSAB strategic priorities. The BSAB also discussed strategic planning for the next 3-5 years. Since SABs became statutory bodies in 2015, there has been significant pressures experienced by most (if not all) SAB member organisations because of austerity, the Covid-19 Pandemic and the present cost of living/ workforce capacity issues. As a partnership therefore, we explored whether our current structures, resources and ways of working remain effective in achieving shared aims as a board.

The new BSAB Strategic plan 2023-2026 can be found here Barnet Safeguarding Adults Board

THE CASE REVIEW GROUP ['CRG']:

This group provides oversight of learning from Safeguarding Adults Reviews and Learning Disability Mortality Review [LeDeR]and is currently chaired by CLCH's (Director of Safeguarding & Childrens Public Health Nursing) representative. They liaise with LSCP and regional/ national leads to identify relevant learning and good practice from all safeguarding case reviews and host 'challenge and progress' sessions to explore what organisations have done to implement lessons from Safeguarding Adults Reviews completed by the BSAB.

Fire safety- Mr A and thematic review

In order to raise wider awareness of fire safety, the task and finish group designed a Fire Safety Practitioner Survey and Fire Safety Audit Tool to determine practitioners' knowledge of fire safety procedures and aid with organisational self-assessment. This was circulated to care providers across Barnet. Some of the answers to both the Practitioner Fire Safety Questionnaire and the Fire Safety Audit Tool were encouraging, but others provided a very mixed picture. There were, unfortunately, very few responses received which suggests staff may have very little capacity to refresh themselves on issues like

fire safety training, or that competing priorities mean that fire safety and prevention is not receiving the attention it needs.

It also highlighted too few people across our partner agencies knew how to access smoking cessation support or knew to refer cases to the BSAB Risk panel or considered raising safeguarding concerns. For many of our partner agencies, their fire safety training is focused on employer responsibilities and does not consider the personalised risk management that adults with care and support needs may benefit from. This will remain an area of focus for the BSAB.
Our case review group, through the regular 'challenge and progress' events will continue throughout 2023-24 to seek assurance that partner agencies are highlighting learning from the thematic review and that this is having a positive impact on practice within partner agencies' services. Knowledge of fire safety and fire prevention is crucial and numerous safeguarding adults reviews have shown the value in this being a partnership approach, not limited to adult social care or local fire services. We know that because of a high turnover of staff in the sector it is crucial training is refreshed on a regular basis. In addition, our lunch and learn Fire safety session

will continue to be available for agencies to use within team meetings as part of staff inductions.

Gabrielle- This review was completed following harm suffered by an adult with care needs after family members refused pressure ulcer care during the Covid-19 lock down. This highlighted the importance for professionals communicating effectively with each other, and of using a multi-disciplinary approach, including psychology services as appropriate to develop whole-family plans.

We have developed guidance for family carers and continue to work with the Carers Centre to ensure family carers are provided the right information to safely meet care needs. We also received assurances from partner agencies regarding changes they have made to their policies so that adults who are dependent on others to bring them to health appointments are not discharged from necessary services if they do not attend. CLCH have shared with other provider trusts and members of BSAB their 'was not bought' policy as a model of good practice. This case, and the thematic review detailed below, highlight the importance of practitioners taking time to ensure they hear the voice of the adult when looking at how (and if) their needs are being safely met and, if there are any concerns, considering the wider professional or social network around that adult so a holistic plan to reduce risk can be agreed.

Thematic learning disabilities review- this review explored how we could work more closely to prevent harm for adults with learning disabilities who are not receiving health and social care support. In one of the two cases explored, professionals recognised the risk of harm, but failures to correctly explain both the level of risk and previous attempts made to reduce this risk to legal advisors hindered escalation, leaving practitioners feeling powerless to intervene and support the adult at risk and their families.

In addition to the reviews detailed above, the CRG considered two new referrals in respect of two adults with care and support needs associated with multiple exclusion homelessness, who had died. The CRG were satisfied both cases met the mandatory review criteria (under s44 Care Act) as there were concerns regarding the ways relevant agencies worked together to safeguard both individuals. BSAB commissioned an independent reviewer to follow a 'learning together' approach. These cases are still in the process of being reviewed, so will be reported within next year's annual report but initial findings have already been used to inform strategic planning in respect of Barnet Council's public health approach to homelessness.

Challenge and progress report on SAR implementation: On 14th March 23, Barnet Mencap, Central London Community Healthcare [CLCH], Barnet Enfield Haringey Mental Health Trust [BEH MHT], Adult Social Care and Barnet Homes attended a challenge and progress meeting. They reported:

- BSAB's multi-agency risk panel is an effective mechanism for resolving very complex cases.
- The revised Escalation processes had a positive impact for VCFS staff and cases of concern.
- BEH MHT have new domestic abuse and sexual safety lead. Have improved their discharge process, developed a self-neglect toolkit.
- CLCH reported changes made to their 'no access' policy. Completed fire safety audit identifying areas from practice improvement.
- Barnet Mencap commended the SLIP review and safeguarding for carers work.

- ICB reported that the Mr A action plan resulted in assurance that all GPs and all Continuing Health Care staff had training by the Fire Brigade on how to refer patients for Fire Safety assessments. Emollient prescribing was reviewed by pharmacists and warning notices put on the GP system when writing prescriptions.
- LFB also highlighted local training they had delivered to increase fire safety awareness and that recent fire deaths demonstrated how important it was for this to remain on the BSAB workplan.

Organisations have also set out within the annual Safeguarding Adults Partnership Self-Assessment Audit ['SAPAT'] the steps they have taken to implement lessons from local reviews. Feedback from that tool has also been used to help BSAB partners work more collaboratively to implement improvements to practice, further refine relevant policy and shape our lunch and learn programme for workforce development.

What our partners say:
'*The partnership in Barnet is strong with an energy and enthusiasm to make a difference to those in greatest need. There is also a focus on innovative working and use of themed approach to learning. The use of webinars has extended the reach and access to BSAB work and messages.*'

CLCH SAPAT return

Professional and Quality Assurance 'PQA' Group

This Group oversees the BSAB's Quality Assurance framework and is chaired by the ICB Designated Safeguarding lead. They meet quarterly and review core Multi-agency Safeguarding Data and scrutinise reports from the MASH, organisational 'SAPAT' and assurance reports, including VCFS checklist reports.

To progress the BSAB 3 strategic aims for 2022-23, the PQA reported they:

- Secured regular reporting of key performance indicators so that we can better monitor how well services work together to recognise, report and respond to abuse and neglect.
- Monitored access to advocacy, seeking assurance from partners that adults at risk without friends and family to support them get the correct support in a timely manner.
- We have reviewed key partner agencies SAPAT (safeguarding audit tool) to gain insight into shared challenges and opportunities to work together.
- Held a Voluntary Community & Faith Sector [VCSF] Safeguarding Adults Assurance Event. This event took place on 15th March 2023 and the event was hosted by the BSAB with support from the MASH. This gave us an opportunity to have a face-to-face conversation with VCSF organisation representatives. The agenda covered Safeguarding Assurance for the Voluntary Community & Faith Sector with reference to the Safeguarding Adults checklist, Safeguarding Community Engagement and a discussion to help shape BSAB's Strategy for 2023-25. The event was attended by 19 people.

Next Steps: In the coming year, the PQA will work to broaden BSAB's dataset to include KPIs from partner agencies demonstrating their practice is MSP compliant. This will require commitment from partners to identify reportable indicators and then regularly provide the appropriate data sets.

Partner assurance on thematic safeguarding concerns:

CLCH: In Q4 a dip sample audit was completed with the aim of identifying actions taken to safeguard patients who are smokers and where health treatment or equipment may increase the risk of a fire related incident. There was limited evidence of referrals to Fire Services where there was an identified risk. Actions are being implemented including review of caseloads, new Safeguarding Fire Safety Hub page and posters and stickers being developed with direct links / QR codes to the LFB referral web page.

BEH MHT: A partnership wide workshop on 'Responding to Male Survivors of Sexual Abuse' was held and in total 203 colleagues attended, 117 of these were BEH staff. It was found that throughout the trust there are minimal reports of men disclosing sexual abuse and therefore this session looked at the barriers that men face, how to have sensitive conversations, and what support can be offered to those who have experienced SA.

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Royal Free Hospital: Overall safeguarding referrals have decreased for both Barnet and Royal Free Hospital sites. The staff process for notify the safeguarding team of safeguarding concerns changed in July 2022 from using an online incident reporting system to using Electronic Patient Records. The team used a variety of communication platforms to support the change to ensure staff understood how to refer to the safeguarding team.

Cross sector learning opportunities or community engagement events

The Board hosted monthly 'lunch and learn' webinars for all practitioners working across Barnet. The following topics were covered: safeguarding during rising costs of living, continuity of care & safeguarding, fire safety, compassion fatigue, continuity of care & safeguarding: learning from SARs, safeguarding duties to those with 'No Recourse to Public Funds' & safeguarding adults at risk of multiple exclusion homelessness. The sessions were attended by 160 people overall, mainly practitioners from the local authority and external staff and partners. The feedback from these sessions has been good and practitioners value the information shared by our independent chair who usually delivers the session.

Some feedback given is "*the sessions encourage us to look at safeguarding more broadly and from a different perspective, the Lunch & Learns encourage professional curiosity".*

National Safeguarding week in 21st-27th November 2022 took place jointly across London, SABs came together to provide a range of free online learning events to raise awareness of key safeguarding issues, start conversations and share best practice throughout safeguarding week. We covered the following areas: transitional safeguarding, learning from Safeguarding Adults Reviews, Serious Care Reviews and Child Safeguarding Practice Reviews, safeguarding adults with mental health needs, learning from SARs: autism, suicide and safeguarding and self-neglect: applying s42 & risk assessment.

The local authority continue to provide external safeguarding training for organisations and provided 2 external Safeguarding courses 3 times last year. These covered policy and procedures for providers attended by 28 people and provider-led enquiries attended by 20 care providers.

THE ACCESS TO JUSTICE GROUP

The Access to Justice sub-group meets every quarter and is chaired by the CEO of Barnet Mencap. Uniquely, this subgroup sits across both the BSAB and Barnet's Community Safety Partnership so as to directly inform the complementary work of both partnership boards. The group enjoys representation from some of the key stakeholders in Barnet. The group continues to be committed to identifying the barriers that adults with care and support needs face in accessing justice. The group also seeks to improve the collaboration of agencies across social care, health, and the criminal justice system, and reports its findings and proposals to the BSAB and community Safety Partnership.

To progress the BSAB 3 strategic aims for 2022-23, the Access to Justice group reported:

Hate Crime Report: April 2022 – March 2023

The Access to Justice group provided oversight of the Hate Crime Project, which focused on the interface between safeguarding, disability hate crime and, increasingly, violence against women and girls, and to increase the understanding of what this means when keeping people safe. The Hate Crime Reporting Coordinator has also developed the Safe Places scheme for adults with learning disabilities. Key Objectives of the Zero Tolerance to Hate Crime Project include:

- Increasing reporting of Disability Hate Crime, Racist and Religious Hate Crime and Anti LGBT Hate Crime.
- Providing ongoing support to victims, in particular adults-at-risk.
- Increasing community confidence in reporting.
- Improving cross agency working to tackle hate, including working with the Metropolitan Police to improve communications with adults-at-risk and those more likely to be impacted by disability hate crime.

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- Safeguarding vulnerable adults and children from the impact of hate crime.
- Co-ordinating and monitoring a network of Hate Crime Reporting Centres across Barnet, where vulnerable adults can access support to report hate crime to the Police. Victims are also offered ongoing support and are signposted to the appropriate community support organisation.

The table below sets out hate crime incidents recorded by the Metropolitan Police for the borough of Barnet.

Category of Hate Crime	April 2021- Mar 2022	April 2022- Mar 2023
Race and Religion	826	733
Anti-Semitism	154	142
Islamophobic	33	28
Disability	23	16
Transgender	67	81
Homophobic	13	11

The Project delivered:

- Staff Training Workshops for 65 staff at 6 organisations / service providers
- 7 Hate Crime Awareness Raising Workshops/Webinars for 75 residents, clients, carers and professionals.
- Engagement with over 300 residents at Hate Crime Awareness Week Information Stands
- 32 new Hate Crime Reporting Champions.
- Engagement with over 30 residents and bus drivers at the Vulnerable Bus Users Day at Edgware Bus Station.
- There are now 12 Hate Crime Reporting Centres operating across Barnet.
- Barnet Mencap recorded 12 hate crime incidents and supported clients to report these incidents to the Police.
- There are 40 registered sites to be designated Safe Places across Barnet.

During 2022/23 the Access to Justice group also sought assurance in the following priority areas.

Autism and the Criminal Justice System [CJS]: looking at the Autism alert card, the Youth Justice service regarding prevalence of young autistic people in contact with the CJS. They also heard from practitioners involved in the 'Why Me' and Restorative justice programmes. Click here for more Information on these programmes and how they can support access to justice.

Carers: working with the Carers Centre and Social Care to gain understanding of carers in the safeguarding process and how to ensure that they are offered appropriate support. This work will continue to be a priority with the Safe Care at Home review.

Financial Abuse - Following last year's report on the financial abuse of people with learning disabilities and work by mental health services and the NCL Financial Abuse workshop, a new project will focus on upskilling staff to recognise the risks and improve the quality of investigations of financial abuse across North Central London. Scams awareness and financial abuse workshops for people with learning disabilities are planned, to complement the programme carried out by Age UK Barnet..

BSAB partnership achievements

Adults at risk are heard and understood, their experiences and views shape continuous improvement

What did we do?

- Our constitution and operational plan considers how we can facilitate participation from carers, advocacy groups and experts by experience ['EbE'] for each activity. We worked with the London Safeguarding Voices and Barnet Council's Involvement Board (a group of people with lived

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experience & carers)to ensure we hear from citizens, but we know we need to do better, particularly to reach under-represented communities.

- In 2022-23 BSAB secured funding to establish a project with a VCSF partner (CommUNITY Barnet) to ascertain with BAME communities how we can work more closely to keep adults safe.
- SAPAT, audit tools and data reports actively review partners' activity to embed participation, as well as adherence to MSP principles and SAR recommendations coming from representations from EbE, family, carers for system change.
- Research shows the importance of positive case studies within regular workforce development opportunities. This features heavily in our monthly lunch and learn sessions. Important to provide context for policy development through people's stories of what worked well.
- BSAB and partners offer practical support to safeguarding champions to shape practice improvement, e.g. supervision standards, examples of safeguarding appraisal aspirations etc.

Providing support on legislative change or topics relevant to adults at risk

What did we do?

- Working with our Experts by experience, partners and national leaders, we responded to the government consultation highlighting significant risks re safeguarding practice of the proposed reforms to the Human Rights Act and Mental Health Act reforms.
- Liberty Protection Safeguards: Prior to the announcement of further delay to the implementation of the new reforms, BSAB continued to receive regular reports to ascertain how partners are preparing for the implementation of legislation and provide updates to partners, residents and family carers in monthly webinars.
- In 2022-23 BSAB's members contributed to new strategies to address health inequalities and needs assessments, carers, dementia, autism and suicide prevention among others. Presently, our input is heavily reliant on 'finding out' through our networks about new developments. This means we are too often reactive. The work we do (including SARs/ audits and engagement with communities and residents) should help shape strategies at the earliest opportunities.

Case studies

Every year, staff across the partnership work together to enable people to safeguard themselves and to provide support & intervention when a person may not be able to. The following are recent examples of practice in Barnet.

Case Study 1: Alice

The DWP internal alert system picked up that Alice had made 5 separate Universal Credit ['UC'] claims, each of which had a different male attached. Her DWP's Disability Employment Advisor ['DEA'] was aware that due to Alice's vulnerability these were likely indicators of exploitation. So, rather than process these applications as fraudulent activity, the DEA considered their duties under safeguarding and modern slavery guidance.
Her advisor put an immediate freeze on her account to prevent her fellow applicants having access to her money and made contact through her Job Centre 'journal' to ensure she was seen face-to-face. The advisor also made contact with professionals and Alice's family network to understand better the risk for Alice. Throughout the interview Alice sought to provide assurances that she was not experiencing domestic abuse or financial exploitation by the men named on the applications. She was highly distressed, but consistently explained she had named the men as she had difficulties in managing her monies and they were supporting her. Staff interviewing her were concerned she had learning difficulties, poor mental health and given her past trauma of domestic abuse, felt she may have normalised the level of harm so wouldn't recognise her

risk of exploitation. She had a history of homelessness and reported she relied on the support from each of the men of the claims. DWP staff were aware they could not prevent her returning to the relationships as this was beyond their legal powers. Equally, they were satisfied that she remained at high risk of financial exploitation. She reported reluctance to approach the local authority to secure support, despite DWP staff explaining that such help might reduce her dependency on the men she believed were friends. She refused consent for the DWP staff to refer for housing or social care support, however, aware of the wider safety duties, DWP staff raised a safeguarding concern with the local authority.
Her DEA was clear with Alice that her reliance on others to manage her finances put her at increased risk of exploitation and triggered their duties to investigate. They resolved with her to open a new bank account and UC claim so that no other person would be able to access her money. The DEA explained, if this were to happen again it would be immediately flagged and investigated and that the DWP would have to stop any payments. The DEA supported Alice to open new bank account and the bank agreed to flag if any individuals try to take money out of the account.

Practitioners from the DWP explained they are trained to identify patterns of behaviour. However, usually they are reliant on information from the claimant when they're applying for benefits and have developed systems to prompt enquiries/ professional curiosity though there is flexibility to allow for cases to be considered on the specific facts. Throughout the enquiry Alice's voice was heard, and care taken to explain the risks of exploitation to her. DWP staff commented they took a proportionate, pragmatic decision in this case to refer to the local authority against Alice's wishes, due to the long-term risks of exploitation.

Case Study 2: Anna

Anna is in her late 30s and has a history of mental health, drug use and rough sleeping. She has a history of absconding from both her accommodation and from hospitals during active treatment; and of not engaging with services. She lives in a supported accommodation in Barnet funded by another LA. In April she was admitted to the hospital with pneumonia and sepsis. The hospital medical team raised a safeguarding referral for self-neglect and deteriorating physical and mental health. The medical team which oversees Anna's treatment raised concerns over her erratic behaviour, non-compliance with medication and high risk of death if she continues not to engage with medical treatment.

MASH team coordinated initial professionals meeting including health, the funding LA and St. Mungo's rough sleepers' team. A joint risk management plan was developed which included undertaking a MHA assessment, a psychiatry review, a mental capacity assessment and a review of Anna's care and support needs. All professionals continue to work together to promote Anna's wellbeing.

Following the recent MCA assessment, Anna has been deemed to lack capacity around her accommodation and finances. Whilst a DoLs application is being progressed, the rough sleeper team continue to support Anna to return to her accommodation when she is seen on the streets. Anna now tends to remain at the accommodation overnight and leaves it during the day. The funding LA is also taking Anna's case to its risk panel for further consideration.
The MASH officers involved in this case received the following from colleagues in the NHS:

"I really want to thank you for your expertise, input and guidance, leadership and your understanding of this complex case. (And so much more!). …. Really the words don't do [it] justice"

Since MASH involvement, Anna's compliance with medical treatment has slightly improved although it is still at variable level due to her past experiences. Professionals involved continue to explore all possible options to promote Anna's welfare and have engaged Anna's friend whom she trusts, in safeguarding plans hoping it will increase Anna's engagement too.

The case is ongoing, and the MASH team continues to coordinate a partnership response before this case can be handed over to the funding authority.

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Attendance at the Safeguarding Adults Board meetings 2022-23

Organisation	June 2022	September 2022	December 2022	March 2023
London Borough of Barnet (LBB) – Communities, Adults & Health	■	■	■	■
LBB – Community Safety				
LBB – Public Health			■	■
Royal Free London NHS Trust	■	■		
North Central London ICB	■	■	■	■
Central London Community Healthcare NHS Trust.		■	■	■
Barnet Enfield & Haringey Mental Health Trust	■	■	■	
Barnet Safeguarding Children Partnership		■		■
London Fire Brigade		■	■	■
The Barnet Group	■	■		
Barnet Mencap	■	■	■	■
London Probation Service	■		■	
Inclusion Barnet	■	■	■	■
CommUnity Barnet	■	■	■	■
Barnet Carers Centre	■		■	■
Metropolitan Police Barnet		■	■	
Department of Work & Pensions		■		

BSAB Partner financial contribution 2022-23

Statutory Partner	**Contribution**
London Borough of Barnet	£60,000
North Central London ICB	£20,000
Barnet Enfield & Haringey Mental Health Trust	£5,000
Metropolitan Police Barnet	£5,000
Central London Community Healthcare NHS Trust	£5,000
Non-statutory Partner	**Contribution**
London Fire Brigade	£500

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What should you do if you think someone is being abused?

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

If you or someone you know is being harmed in any way by another person, please do not ignore it.

Any information you provide to us will be treated in the strictest confidence.

Contact the Barnet Adult Multi Agency Safeguarding Hub (MASH)
Tel: 020 8359 5000 (9am- 5pm, Mon to Fri),
Or 020 8359 2000 (out of hours – emergency duty service)
Email: socialcaredirect@barnet.gov.uk
Or call the police on 101. In an emergency call 999.

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