Barnet Safeguarding Adults Board
Annual Report 2023-24

Foreword from the Independent Chair, Fiona Bateman

Sadly, this will be my final annual report as I am stepping down after 7 years of chairing this dynamic, supportive and energetic group of people. You will see from the report that the partnership has continued to work extremely hard over the year to offer strategic leadership across statutory, voluntary and community organisations and to work with our residents and experts by experience to provide assurance that partners take their responsibilities to safeguarding adults very seriously.

I am stepping down as I feel it is time for fresh eyes to support the onward development of the safeguarding practice in Barnet. I have always enjoyed my time as Chair of this SAB and feel extremely proud of the achievements of the partnership. I leave the group in a strong position. One where parity across the workforce is genuinely valued, expertise is understood and differing opinions respected.

Please take time to review the activity of the SAB over this period, our partners have worked hard to establish consistent ways in which to explore our responses to recurring forms of abuse, as well as championing innovation to support the development of safe systems. You will see the impact of awareness raising work has led to further increases in concerns reported. This is to be welcomed as it means more support for adults at risk of abuse. However, there is also examples throughout the report of steps taken by partners to prevent abuse and support frontline staff (including within Barnet's multi-agency safeguarding hub or high-risk panel) to respond as a team around the adult to problem solve with the adult and their support networks, hold perpetrators to account and inform best practice and policy development locally, regionally and nationally.

I want to take this opportunity to thank everyone involved in the SAB, our partners and contributors who work quietly behind the scenes to ensure delivery of strategic priorities, I am particularly grateful to Joyce Mbewe our Board manager for keeping us all on track. Her enthusiasm for community engagement and broad reach has enabled us to progress important work in understanding how we can more effectively reach all our diverse communities so every adult at risk can be confident to raise concerns and secure support to protect them from abuse or neglect.

I know the Board will be in safe hands with the new Chair, Lesley Hutchinson. She has a wealth of relevant experience and knowledge to guide the delivery of the 2024-26 strategic plan. I wish the BSAB partners, practitioners and (above all) our residents all the very best for the future.

Best wishes,

Fiona Bateman
BSAB Independent Chair

Safeguarding activity in Barnet 2022-23

Summary

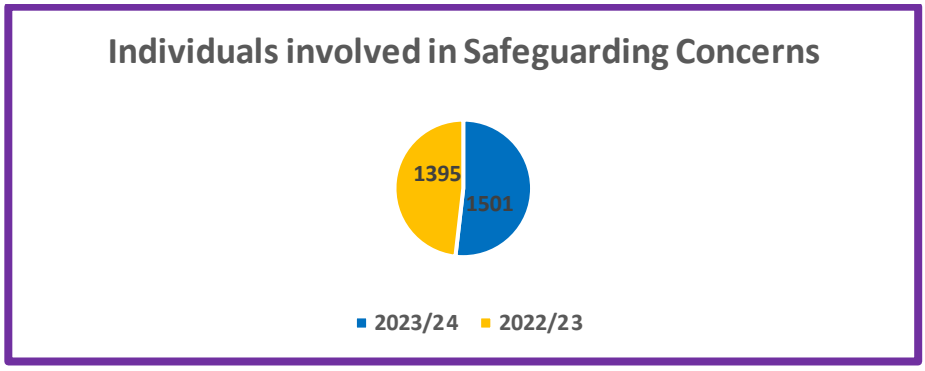
The following data comes from the Council's 2022-23 Safeguarding Adults Collection (SAC) which records details about safeguarding activity for adults aged 18 and over in England, reported to, or identified by, Councils with Adult Social Services Responsibilities.

In common with national trends, we observed increases in people referring their safeguarding concerns into the local authority and an increase in the number of enquiries undertaken. This was in part due to the change in reporting processes initially introduced in April 2022 to ensure our data is more representative of the actual safeguarding activity within the department. This is positive, it suggests our residents and practitioners feel confident to report their concerns. We have also seen positive improvements reflected in our local data, for example:

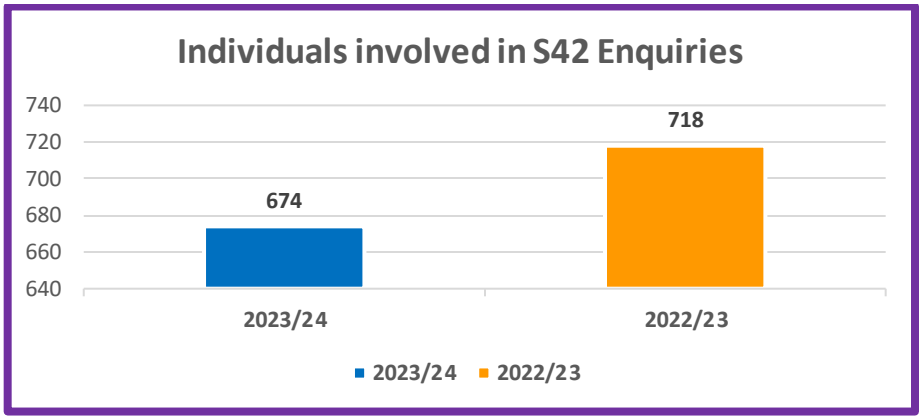
- Although the location of abuse order has not changed significantly the proportions have, with own home location accounting for 57% of referred concerns this year compared to 55.6% in 2022-23. Care Homes for both residential and nursing equated to 24.9% of all enquiry locations compared to 27.8% in 2022-23. This demonstrates improved practice within these settings as, proportionately, fewer concerns regarding abuse or neglect within our registered care settings are meeting the threshold for investigation.
- Recorded desired outcomes the proportion fully or partially achieving these outcomes increased to 94.6% up from 2022-23 performance of 89.8%
- In 97.5% of completed s42 enquiries the risks were reduced or removed, compared to 93.2% in 2022-23. Comparing nationally 2022-23 benchmarking, Barnet is 5th
- Our local data dashboard reported the median time for reviewing a concern was 3 working days, meaning the majority of service users experienced a timely decision. However, we know overall there is still work to do to improve timeliness across the partnership as on average decisions whether to start an enquiry took 7.4 (up from 5.3 working days in 2022-23). This is, in part, due to increased demand on the MASH team but also due to pressure on resources across the partnership. We have identified this will be subject to further scrutiny in 2023-24.
- Our local data dashboard also reports on our shared ambition to complete safeguarding enquiries within 30 days. We know this is not a 'target' that all cases can achieve as it is much more important that enquiries work at the adult at risk's pace and enable partners to actively contribute at every stage of the process. However, it is pleasing to see that enquiries are progressing faster than in previous years. They are now taking an average of 47.3 working days, rather than 48.7 in 2022-23. The median time in 2023-24 was 19 working days meaning the majority of service users experienced a timely conclusion to their safeguarding enquiry.

Safeguarding Collection data.

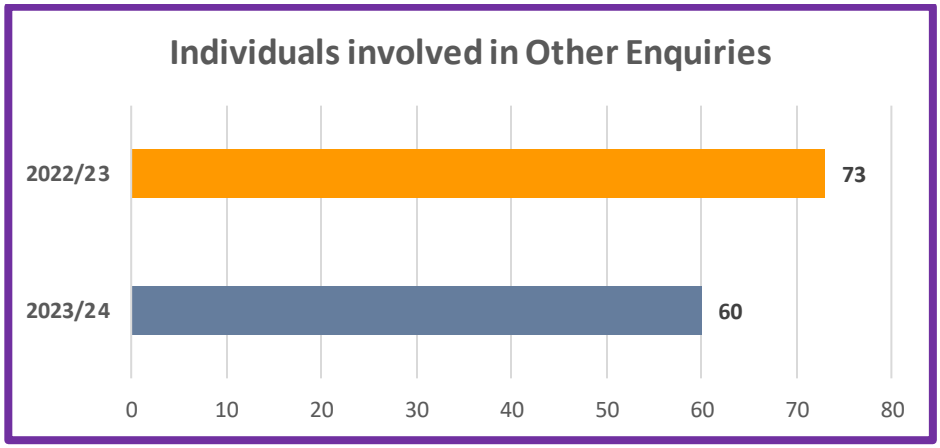
Individuals



⬆ A total of **1,501** individuals were involved in safeguarding concerns during 2023-24, an increase from **1,395** in 2022-23 (7.6% increase equivalent to 106 more individuals).

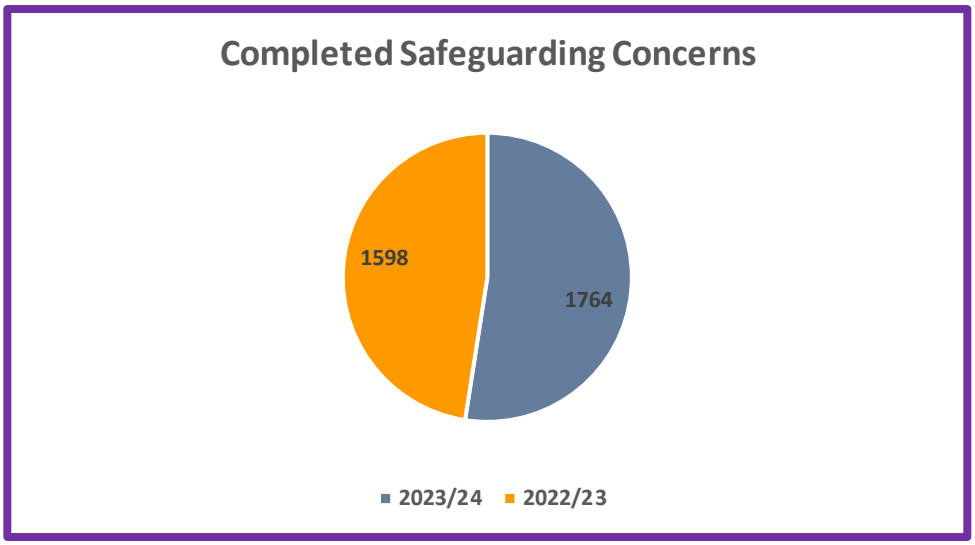


⬇ A total of **674** individuals were involved in Section 42 Safeguarding Enquiries during 2023-24, a decrease from **718** in 2022-23 (6.1% decrease equivalent to 44 fewer individuals).

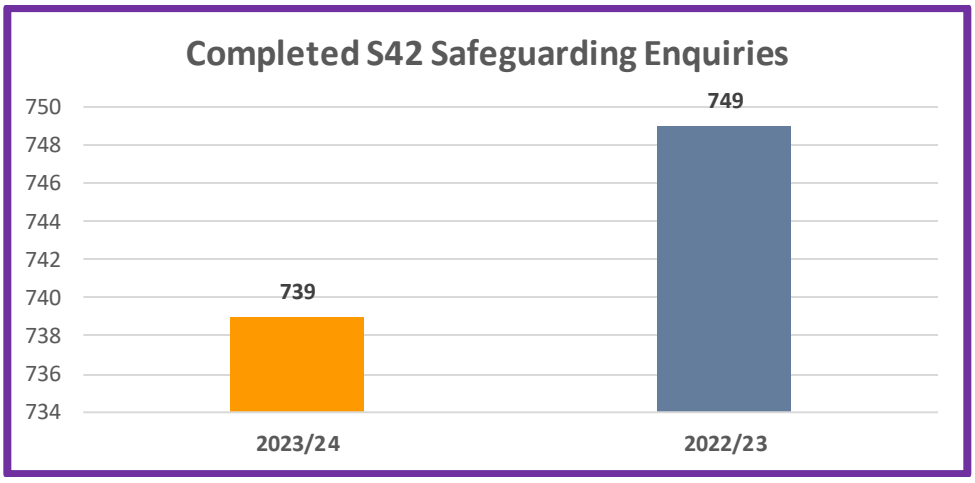


⬇ A total of **60** individuals were involved in other Safeguarding Enquiries during 2023-24, a decrease from **73** in 2022-23 (17.8% decrease equivalent to 13 fewer individuals).

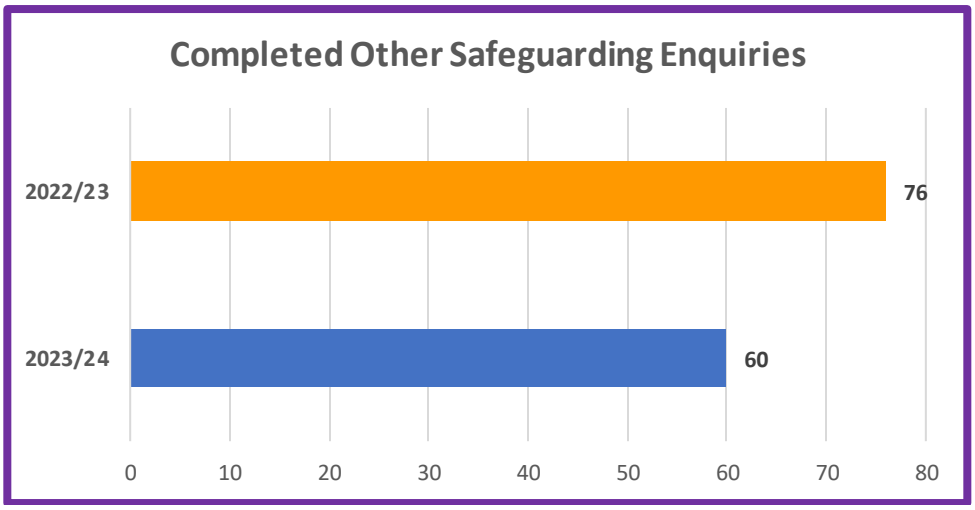
Activity



- ⬆ **1,764** Safeguarding Concerns were completed during 2023-24, up from 1,598 in 2022-23 (10.4% increase equivalent to 166 more Safeguarding Concerns).



- ⬇ **739** S42 Safeguarding Enquiries were completed during 2023-24, down from 749 in 2022-23 (1.3% decrease equivalent to 10 fewer S42 Safeguarding Enquiries).



- ⬇ **60** Other Safeguarding Enquiries were completed during 2023-24, down from 76 in 2022-23 (21.1% decrease equivalent to 16 fewer 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 31.7% (⬇ down from 35% last year) of all the source of risk types.
- Financial or Material Abuse continues to be the second highest proportion of source of risk accounting for 17.1 (⬆ up from 16.7% last year) of all the source of risk types.
- Physical Abuse continues to be the third highest proportion of source of risk accounting for 16% (⬆ up from 14.6% last year) of all the source of risk types.
- Self-Neglect moved up 1 place to be the fourth highest proportion of source of risk accounting for 10.1% (⬆ up from 9.5% last year) of all the source of risk types.
- Psychological Abuse moved down 1 place to be the fifth highest proportion of source of risk accounting for 9.7% (⬇ down from 13.1% last year) of all the source of risk types.
- Domestic Abuse continues to be the sixth highest proportion of source of risk accounting for 6.3% (⬆ up from 5.4% last year) of all the source of risk types.
- Sexual Abuse continues to be the seventh highest proportion of source of risk accounting for 4.3% (⬆ up from 3.7% last year) of all the source of risk types.
- Organisational abuse continues to be the eighth highest proportion of source of risk accounting for 2.2% (⬆ up from 1.2% last year) of all the source of risk types.
- Sexual exploitation moved up 1 position this year to be the ninth highest proportion of source of risk accounting for 1.5% (⬆ up from 0.4% last year) of all the source of risk types.
- Modern Slavery continues to be the tenth highest proportion of source of risk accounting for 0.6% (⬆ up from 0.3% last year) of all the source of risk types.
- Discriminatory abuse continues to be the eleventh highest proportion of risk (0.5% ⬆ up from 0.1% 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 (57.0% up from 55.6% in 2022-23).
- ⬇ Care Home – Residential continues to be the second highest proportion of location of abuse in safeguarding enquiries (13.3% down from 18.7% in 2022-23).
- ⬆ Care Home – Nursing continues to be the third highest proportion of location of abuse in safeguarding enquiries (11.6% up from 9.1% in 2022-23).
- ⬆ In the community (excluding community services) continues to be the fourth highest proportion of location of abuse in safeguarding enquiries (7.2% up from 5.7% in 2022-23).
- ⬆ Other continues to be the fifth highest proportion of location of abuse in safeguarding enquiries (4.6% up from 4% in 2022-23).
- ⬆ In a community service continues to be the sixth highest proportion of location of abuse in safeguarding enquiries (3.8% up from 2.9% in 2022-23).
- ⬇ Hospital – Acute continues to be the seventh highest proportion of location of abuse in safeguarding enquiries (0.9% down from 2.0% in 2022-23).
- ⬇ Hospital – Community moved up 1 place to be joint seventh highest proportion of location of abuse in safeguarding enquiries (0.9% down from 1.6% in 2022-23).
- ⬆ Hospital – Mental Health continues to be the ninth highest proportion of location of abuse in safeguarding enquiries (0.7% up from 0.5% in 2022-23).

Risk Assessment Outcomes

- Risk Identified and **action taken** continues to be the highest proportion of outcomes with 77.8% (up from 73.1% last year) of risk outcomes falling into this category.
- No risk identified and **no action taken** continues to be the 2nd highest proportion of outcomes with 7.3% (down from 7.8% last year) of risk outcomes falling into this category.
- No risk identified and **action taken** continues to be the 3rd highest proportion of outcomes with 3.8% (down from 7.0% last year) of risk outcomes falling into this category.
- Risk – Assessment inconclusive and **action taken** continues to be the 4th highest proportion of outcomes with 3.4% (down from 4.3% last year) of risk outcomes falling into this category.
- Enquiry ceased at individual's request and **no action taken** moved up from last place to be the 5th highest proportion of outcomes with 3.1% (up from 2% last year) of risk outcomes falling into this category.

- Risk identified and **no action taken** moved down one place to be the 6th highest proportion of outcomes (was 5th last year) with 2.6% (down from 3.7% last year) of risk outcomes falling into this category.
- Risk – Assessment inconclusive and **no action taken** continues to be the seventh highest proportion of outcomes with 2.0% (down from 2.1% 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 58.8% of the time (down slightly from 59.0% last year)
- ⬆ Risk Removed in 38.7% of the time (up from 34.1% last year)
- ⬇ Risk Remained in 2.5% of the time (down from 6.9% last year)

Mental Capacity for concluded S42 Safeguarding Enquiries

- ⬇ 55.1% of concluded S42 Safeguarding Enquiries did not lack capacity (down from 58.8% last year)
- ⬆ 34.0% of concluded S42 Safeguarding Enquiries lacked capacity (up from 27.8% last year)
- ⬆ 10.7% (79 recorded as 'Don't know') of concluded S42 Safeguarding Enquiries it was not known what their mental capacity was (up from 9.4% last year)
- ⬇ 0.3% (2 not recorded) of concluded S42 Safeguarding Enquiries their mental capacity was not recorded (down from 4% last year)
- ⬇ 94.0% of people who were identified as lacking capacity were provided support by an advocate, family, or friend (down from 96.6% in 2022-23).

Making Safeguarding Personal

- ⬇ 72.9% of concluded S42 Safeguarding Enquiries (539) the individual or individual's representative **were asked, and outcomes were expressed** (down from 78.7% last year).
- ⬆ 15.3% of concluded S42 Safeguarding Enquiries (113) the individual or individual's representative **were asked, but no outcomes were expressed** (up from 10.6% last year).
- ⬇ 7.3% of concluded S42 Safeguarding Enquiries (54) the individual or individual's representative **were not asked about desired outcomes** (down from 8.4% last year).
- ⬆ 2.4% of concluded S42 Safeguarding Enquiries (18) the individual or individual's representative **did not know about desired outcomes** (up from 2.1% last year).
- ⬆ 2.0% of concluded S42 Safeguarding Enquiries (15) it was **not recorded** that the individual or individual's representative were asked about desired outcomes (up from 0.1% last year).

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

- ⬇ Fully achieved – 57.9% down from to 59.6% last year.
- ⬆ Partially achieved – 36.7% up from 30.2% last year.
- ⬆ Not achieved – 5.4% up from 10.2% last year.
- ⬆ 94.6% of cases where desired outcomes were recorded were fully or partially achieved up from 89.8% last year.

SARS

0 SARS were recorded in 2023-24. In 2022-23 2 SARS were recorded.

Barnet Safeguarding Adults Board: Our vision and purpose.

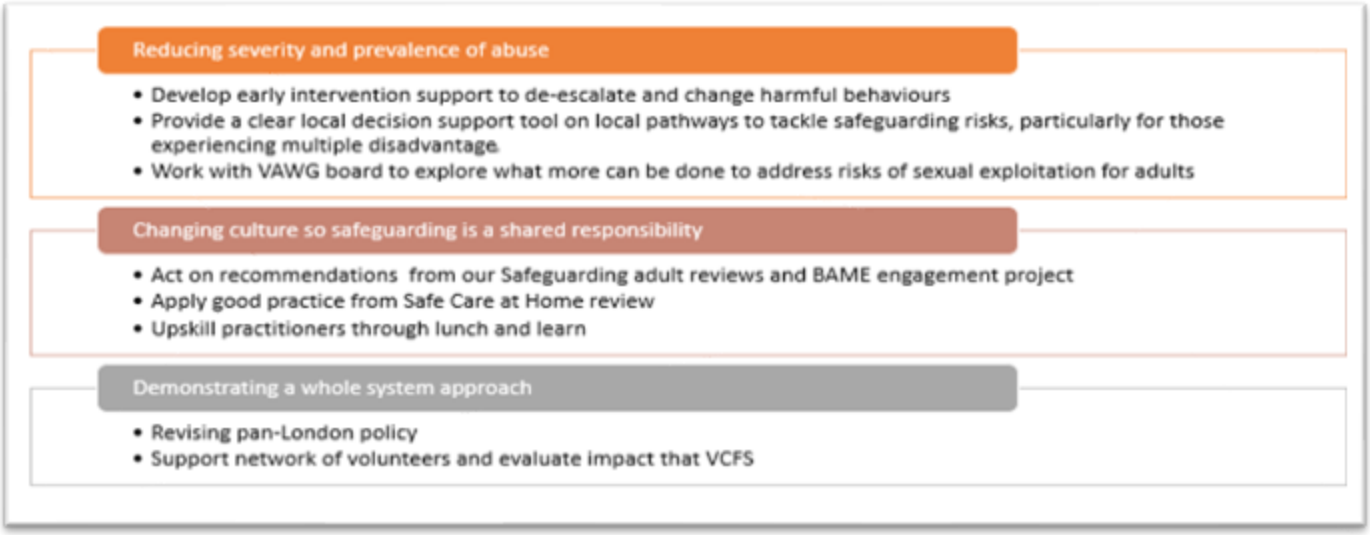
BSAB is a partnership, it includes the local authority, NCL ICB and NHS providers, police, fire service, housing, voluntary organisations and experts by experience. We are required to 'help and protect adults in its area by co-ordinating and ensuring the effectiveness of what each of its members does.'
The board provides opportunities to review practice and offer cross-agency challenges. This enables accountability and strengthens the culture of continuous improvement.

Our Statutory responsibilities are:

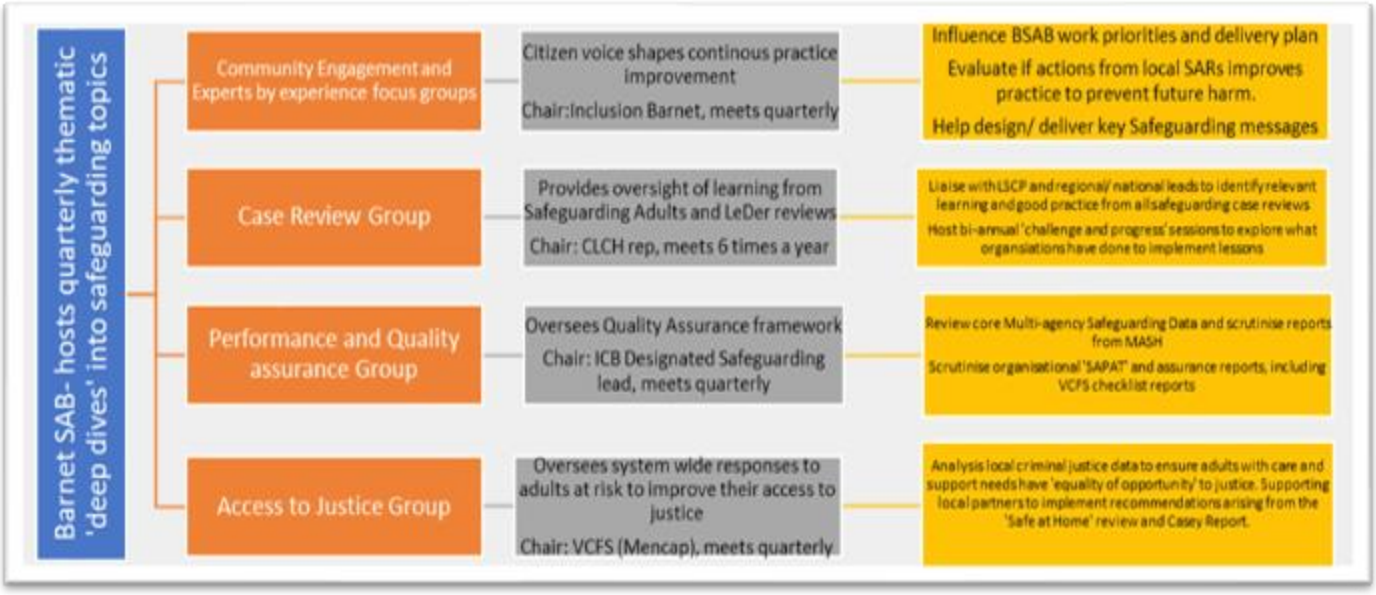
- to publish a strategic plan and report on the work each member organisation does (individually and collectively as the BSAB) to enact that plan
- commission safeguarding adult reviews and report on actions taken to shape practice to prevent future harm.

Our challenge is creating a system approach that embodies the principle that safeguarding is everyone's business, (responsive to individual needs/risks and aspirations so that we make safeguarding personal).

Our values are to work with Experts by experience, local residents and our workforce to embed the 6 safeguarding principles. In 2023 BSAB partners adopted a three-year plan setting out 3 key priorities for 2023-26, namely:



The Board also added a VCFS and MASH safeguarding leads sub-group to enable practitioners across the statutory, voluntary and community sectors come together to build on the innovation and existing strong partnership collaboration.



BSAB 2024-25 Workplan

In March 2023 partners agreed the Strategic plan for 2023-26, adopting 3 key priorities, namely:

- Reducing the severity and prevalence of abuse,
- Securing a change in culture so responding to abuse is a shared responsibility and
- Demonstrating a whole system approach to safeguarding.

We agreed that to realise this plan we would devise a dynamic work plan to take forward actions and develop mechanisms to evidence those actions have resulted in measurable improvements. More detail is available at: BSAB Strategic Operations Plan 2023-26

The BSAB team and sub-group chairs identified safeguarding topics for the main meeting's focus, chosen because of national and local learning from safeguarding adults reviews or to take forward local strategic plans.

SAB meets as a whole group every three months.

Across the year, BSAB partners wanted to enhance ways in which we could secure assurance of 'safe systems' thinking. We used dedicated time within each quarterly meeting to explore safeguarding practice across our workforce and community groups in respect of issues or learning from national and local audits and case reviews.

In June 2023: At the main board meeting in June partners came together to explore how each agencies had taken forward the learning from the Colin and Phil SARs. These reviews were commissioned in 2022 following the deaths of two men, both with care and support needs, who had died while sleeping rough in the borough. The circumstances that led up to their deaths and the learning from those cases were discussed. BSAB partners accepted the recommendations and reported on the actions taken to address the SAR author's recommendation for practice improvement. A comprehensive BSAB response the SARs was published. In addition to those actions, BSAB partners retain strong links with the Homeless Health Steering group through our committed members (including ICB and public health leads), with the VCFS homeless support organisations to continue to champion for the rights of people facing homelessness to have access to necessary support so they can live free from abuse and neglect. We have also shared our learning at regional and national safeguarding networks.

In September 2023: The BSAB discussed the new 'Right Care Right Person' (RCRP) policy approach which was due to be introduced in November 2023 by the Metropolitan Police in respect of mental health attendances and welfare checks and represented a significant change in practice across partner agencies. The Met Police confirmed they would continue to protect communities and frontline colleagues in health and social care and would attend a call if the public or officers were in danger. The police explained the changes would be about how MPS call centres respond to health-related incidents, applying new guidance but that this also included a mechanism for partners to request real time escalation if they disagreed with the call handler's decision not to deploy officers. The policy was supported nationally through a partnership agreement between ADASS, NHS England and Government partners.
Within our discussions, partners considered how they could ensure support was available for anyone in mental health crisis, including those within acute health settings. We explored the likely training needs for frontline staff and whether current local provision/ protocols for checking welfare for those at high risk would protect against avoidable harm. Partners agreed to expand Herbert Protocol until such a time as regional policies could be agreed and implemented. The Board also agreed to set up a working group on RCRP across NW BCU to explore how local implementation was working.

In December 2023: The BSAB continued to explore Police, community safety and probation involvement in safeguarding enquiries and protection planning. Frontline police officers submitted 3800 notifications (known as 'Merlins') in 2023- 24, but MASH reported significant spikes in referrals from police officers between June- September 2023. Police colleagues reported on changes to the MPS reporting system with the introduction of Connect, which they believed could address concerns raised by partners regarding low level issues that didn't meet the s42 criteria but still required significant time from MASH staff to triage.
We also received assurance the LBB's Public Health department would continue to lead on a co-occurring condition working group (people experiencing homelessness, mental health challenges and / or substance

use). That working group was reported to have wide, committed membership from relevant partners and was proving to be a useful forum for tackling operational challenges and joint working. Across NCL there is a new workstream to look at a 'core offer' for homeless health, with mental health as one of the top 3 priorities. The NCL ICB homeless health team explained they were completing a gap analysis and identified Barnet as an area for additional coordination, support and potential investment. They were also developing an assertive outreach model, working across Mental Health Trust, LBB and other partners.

In March 2024: The BSAB met and explored how local partners work together in response to Adult Exploitation. The second national SAR analysis identified 11% of all SARs involve exploitation and raises questions about where the current list of types of abuse is sufficiently nuanced to support the public and professionals recognise different forms of exploitation. That analysis recommended the DHSC should seek to address this with better national guidance, however locally we had previously identified two specific areas to explore in more detail, namely system responses to Modern Slavery and Sexual abuse. We heard from partners regarding the work of the Modern Slavery Board and agreed BSAB representation at that meeting. In response to concerns regarding responses to sexual abuse and exploitation, partners confirmed the actions available (including through People in Position of Trust policies) to disrupt and pursue perpetrators of harm, the support locally to victim/survivors including through dedicated, specially trained police teams to enable access to justice for victims. Our VCFS colleagues spoke of the preventative work they had completed with young neurodivergent people and those with learning disabilities to ensure they understood healthy relationships and knew how to access support if they felt unsafe.

How BSAB and partners respond to safeguarding risks

The SAB Development Day Report - The Day was attended by 11 out of 29 members of the BSAB attend the day presenting Inclusion Barnet, Royal Free Hospital, Barnet Council Communities, Adults & Health, North Central London Integrated Care Board, London Fire Brigade, LBB Barnet Children Strategic Partnership, CB Plus, and Central London Community Healthcare NHS Trust. It was facilitated by an independent safeguarding lead who also works closely with LBB to provide independent quality assurance reports through case audits. Following presentation and discussion the BSAB:

1. agreed to develop policy and practice guidance for partner organisations' staff, to support multi-agency safeguarding decision making and guidance on how practitioners can refer for MDTs before abuse/neglect occurs in high-risk cases and support frontline practitioners to 'manage low level or emerging risks'
2. received some relevant data to assist members evaluate responses by MASH to concerns and completed enquiries. Over the next year we want to expand our data dashboard to demonstrate safeguarding adults' activity of partner organisations and enable BSAB and member organisations to better understand wider partnership training needs.
3. Agreed BSAB would benefit from brief quarterly reports from MA risk panels/ forum on any notable improvements to practice and issues raised, particularly if any gaps in public awareness or partner training needs are identified.

Reframing Safeguarding Project: This project started in 2022/23 and was funded through the Public Health prevention fund.

What did the project do?

The project aimed to promote understanding about safeguarding amongst Barnet's diverse communities. Led by a task group sitting under the Barnet Safeguarding Adults Board, the project delivered an initial engagement programme consisting of focus groups, face-to-face conversations, social media campaign, survey to scope understanding. This focussed on working with residents and community groups working with protected and/or at-risk users to deliver a community safeguarding information for people and organisations on how to effectively safeguard adults

Why is this important?

- Barnet communities have become more diverse over time (Source: Barnet JSNA)

- The Performance & Quality Assurance subgroup of the Safeguarding Adults Board regularly reviews performance information from organisations on safeguarding and had identified there was a gap around community knowledge and confidence in this area, which this project would provide.

What have we learnt?

Through the focus groups and survey, we have learnt:

- The term safeguarding did not always have an equivalent in other languages or cultures
- Differing attitudes as to whether people feel comfortable in reporting safeguarding issues
- Barnet Mencap group identified that they wanted more information about preventing financial abuse
- Suggestion on develop a codeword which could be used in local shops which could be used to alert people that an individual needed help

What was its impact?

57 participants took part in the focus groups undertaken by CB Plus, plus 30 individuals/organisations filled in the online survey. The programme was promoted through several community events including Hub Connections, Mental Health Awareness Day, Purple Tuesday, and Black History Month. Approximately 800 people attended the events held at Brent Cross, Meritage Centre, and Burnt Oak Leisure Centre, and 500+ organisations have been reached via outreach events.
An online video has been produced for use in future events Safeguarding Video
Next steps identified in the research have been included in the BSAB work plan and assigned to two sub-groups for action. To read the full report BSAB Community Engagement Reframing Safeguarding

BSAB is also active in other strategic partnerships and activities:

1. Throughout 2023-24, the SAB Business Manager and Independent Chair represented SAB at the Barnet's Safer Communities Partnership's quarterly meeting, VAWG forum and delivery board meetings and Health and Wellbeing Board's quarterly meeting, the NCL SAB sub-regional group, National and London Board Manager's & Chairs meetings and the London SAB.
2. We jointly hosted the BVCS Forum with the Prevention & Wellbeing Development Officer on 15th September at the West Hendon Community Centre, the focus of the discussion was managing Risk in the community and the support systems available for the Voluntary sector organisations. Challenges they face were discussed. Safeguarding training offer by the Local Authority for providers was shared. Pohwer the Advocacy commissioned provider in Barnet were invited to join the Access to Justice subgroup following this engagement meeting.
3. We also hosted a webinar during safeguarding week to explore multiple and severe disadvantage, homelessness and safeguarding- following on from the findings and recommendations in the Phil and Colin SARs. This was attended by 55 practitioners and senior managers across the partnership.
4. We met regularly with BSCP team to explore how both adults and children safeguarding partnerships could apply emerging learning from reviews involving transgender young people and adults at risk.

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 & Children's 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.

Multiple exclusion homelessness assurance reports

As detailed above, during this year BSAB completed SAR reports into the deaths of two men (known by pseudonym of 'Phil' and Colin'). In July 2023 BSAB members received the reports, accepted the findings and agreed to action the recommendations. In September 2023 relevant partners came together to explore what actions each agency had already taken or would take to progress the actions and implement change. A summary of this is detailed below. In addition, in September 2023 Barnet's Health and Wellbeing Board completed a deep dive into local responses to homelessness, reporting how the work to improve responses

to multiple exclusion homelessness was being taken forward in Barnet and how the impact of actions taken would be monitored both locally and by the Pan- London Health, Homelessness and Safeguarding Practice Development Group.

In respect of the procedural issues that arose in the completion of these reviews, BSAB reviewed and agreed revisions to our Safeguarding Adults Review guidance. This was signed off by BSAB partners in July 2023. We have also inducted new members into the Board, including a strategic housing lead and set up a rolling programme to ensure board members have opportunities to meet with the Chair and SAB manager to evaluate contributions and ensure our work plan remains on-track and relevant to individual organisations and our shared priorities. In symmetry, the ICB are working with health partners to introduce the new Patient Safety Incident Reporting Framework in line with NHSE's expectations for full implementation by 2024. North London Mental Health Partnership have committed to provide confirmation at BSAB's next challenge and progress event of how they are managing to meet demand for specialist safeguarding oversight into SAR or SI processes and how they have socialised the new expectations across their operational services.

BSAB also drew common learning themes emerging from other local reviews to highlight what enables good safeguarding practice and enables safe systems approach, namely:

1. Understanding the legal duties to refer for multi-agency enquiry and protection plan, even without consent, where there is a persistent/ high risk or wider risk to the public e.g. fire safety or self-neglect (Fire safety thematic review).

   Example of Fire Safety safeguarding from CLCH
   Frontline staff and managers engaged with CLCH webinars regarding fire risk and SAEB webinars CLCH audits of risk re: fire safety /risk. They facilitated a Safeguarding conference in September 2023 included learning from SARs and fire deaths. This included a nurse talking about her experience of attending a coroner's inquest in relation to a fire death and what she learned. There are now examples of frontline practitioners recalling the nurse's story and influencing their practice to make referrals in relation to fire risk. A Fire risk audit was completed in 2023 and repeated in 2024 to assure risk is recorded and referral to London Fire and Rescue completed. Belief that if a person refuses a referral to London Fire and Rescue that we consider the public interest /executive function of the person to make that decision /accept the risk. Webinars for staff re fire risk were held.

2. Access to advocacy or IDVA support for the adult at risk to enable a trusted relationship to develop. Advocacy should be available in a timely manner and clear guidance on how/ when to refer. (LD thematic review, Gabrielle)

3. Ensuring carers have clear information about how to care safely for their loved one and that their ability to provide this and manage treatment plans/ meds is properly assessed. (Ms A, Gabrielle, LD thematic review)
   Example of safe system approach between Barnet Council's MASH and CLCH
   In January 2024 the Government issued new guidance on responding to people at risk of developing pressure ulcers. To enact the revised protocol, CLCH explored how they could review pressure ulcer concerns raised whenever someone received care in hospital or community settings using their clinical expertise to ensure that only unavoidable pressure ulcers where referred under s42 Care Act for the local authority to investigate. Partners undertaking enquiries are now better informed by clinical expertise at point of referral, enabling immediate preventative support to the adult. MASH report this has significantly improved outcomes for adults and enhanced our system response to identifying patterns of poor practice so support can be offered to providers and family carers at the earliest opportunity.

4. Partners should have managerial overview of risks in out of area placements and support information gathering and the delivery of protection plans, including civil legal powers (West Berks- MR A)

5. Be open to challenge regarding assumptions of a person's capacity to recognise risk or to protect themselves from harm arising from abuse, exploitation, neglect or self-neglect esp. where the adult at risk has co-occurring conditions. (MEH thematic review)

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. To progress the BSAB 3 strategic aims for 2023-24, the PQA reported they had reviewed the data dashboard each quarter, reporting to the main BSAB meeting any notable changes in trends or issues arising from qualitative or quantitative audits.

Safeguarding Adults Partnership Audit Tool Report (SAPAT) 2023-24

The SAPAT was completed by 14 partners. The PQA subgroup had a Challenge and Progress event for partners to discuss the submitted SAPAT returns.

Achievement: Partners feedback that the work of the Board embraces and values input from VCFS colleagues within the board and subgroups which is exceptional. There is networking, information sharing and positive working relationships with critical friends & strong consistent membership. Partners involvement and contributions at the SAB through the SAB Review Day demonstrated the buy-in from partner agencies and the value placed in coming together to tackle adult safeguarding risk collectively. Partners reported they felt the new SAB strategy 2023-26 has a good focus. The commitment to partnership working continues to be a strength of the SAB and the standard of work was high and they felt this '*sets the bar across London*'.

Challenges: All partners felt operational pressures as a result of increased demand as duties to keep adults with care needs safe is better understood across agencies and the public in Barnet. They felt this reflects the wider system pressures on resourcing and capacity. The impact of the cost-of-living crisis for residents and organisational restructuring/ to engage in SAB work will require the partnership to be innovative and to set efficient and effective timescales for delivering outcomes

Our partners were asked to comment on what they felt were the key achievements and challenges with adult safeguarding practice.

Probation have utilised MAPPA and attended BSAB Access to Justice meetings. All staff have completed mandatory Adult Safeguarding training. Probation find difficulty where consent is not obtained, or if they have not met the threshold but concerns exist. Probation use MAPPA, professionals' meetings, referrals to support staff with high-risk cases. A significant proportion of the Probation caseload is high risk and complex. Staff have support from the Offender Personality Disorder (OPD) Pathway.

Met Police: Implementation of RCRP. MASH referral training rolled out across frontline policing Pan London. Ongoing Stop and Search charter work is ongoing across PAN London. The challenge is the vacancies, recruitment and retention issues *within their workforce* and working with an inexperienced cohort of investigators. As part of the MASH Review police are co-creating a term of reference between ASC and the MPS re how they should be working together.

London Fire Brigade have allowed for greater and a more responsive process.

The Local Authority (Communities, Adults & Health) had a safeguarding external Audit which confirmed safe, proportionate safeguarding practice with evidence of good legal literacy in practitioners' responses. The adult's voice is heard and recorded clearly. Achieving timely responses from partner organisations is a challenge for practitioners. To manage high risk case a significant incident tracker is held locally for all high risk/complex cases. The safeguarding team are informed of high risk/ complex cases and have oversight of any issues and Multi-Agency Risk panels/ complex case discussions / supervisions/ Safeguarding practice forums and senior management escalation. In response to the findings in Phil and Colin SARs, the local authority also reviewed their Deprivation of Liberty Safeguards [DoLS] triage process.

Barnet Mencap provided MSP training and sharing new developments with Trustees and staff. Participated in community engagement with minoritized communities. There is still a lack of trust, between social workers and VCS staff where small adjustment are suggested to safeguard the person receiving support. High risk cases are managed through individual supervision, regular Team meetings, and the internal Safeguarding group. They also provided training to staff which focused on fire safety and reinforcing the lessons from the thematic review in 2021 about additional risks for people with learning disabilities.

Inclusion Barnet led on setting up the VCSF MASH Forum subgroup. Delays in feedback and progressing safeguarding issues for our clients though MASH but this has improved a great deal.

North Central London Integrated Care Board despite organisational restructure they maintain safeguarding business as usual obligations. ICB funded safeguarding supervision training via Bond Solon for the health safeguarding workforce across NCL. The ICB has experienced some disruption due to restructure and there has been a gap within named GP roles. The designates offer support to senior safeguarding staff from provider trusts, operational continuing healthcare staff from within the ICB for professional's meetings/strategy meetings where cases are contentious and/or sensitive.

CB Plus reviewed their safeguarding processes and protocols; DBS status of status and implemented the six areas of safeguarding in their corporate register. Challenge is the types of safeguarding concerns coming to their attention have grown in complexity. Supported by the Safeguarding lead and team manager with debriefs.

Barnet Enfield Haringey Mental Health Trust introduction of safeguarding surgeries, amalgamation of various policies to streamline documents. Safeguarding Team now involved in new starter induction. Staff turnover results in a constant need to train new staff around safeguarding. BEHMTH Safeguarding Team Leads provide case consultation for front line staff and teams who are working directly with high-risk/complex cases. This includes support at MDT's and Professionals Meetings. The Trust also developed 7-minute briefings and cascaded learning to staff regarding local and regional SARs. What is learnt in one borough is disseminated across NLMHP to ensure learning is wider than the Division involved

Central London Community Healthcare significant work carried to highlight areas of concern, raise awareness and make necessary changes. Practitioner safeguarding training compliance, safe hospital discharge processes reviewed, Pressure Ulcer risk assessment reviews for improvement with audits to evidence this. CLCH SPOC services provide support to staff who are concerned about high risk and complex cases. This is also monitored through the online datix system, ad hoc and planned supervision and MDT meetings. Throughout the year, the safeguarding team provided webinars for Staff and hosted Safeguarding conference.

Royal Free Hospital - Face to face training has been delivered to staff to increase knowledge and practice of the Mental Capacity Act. There has been a focus on Professional curiosity

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 2023-24, the Access to Justice group reported:

The Access to Justice group were required to explore how changes introduced through the Domestic Abuse Act 2021 and the findings and recommendations from the **Safe Care at Home Review** may assist partners to recognise and respond more effectively to protect adults feel safe in their home.
The group invited the Police to give the group an update on their response to the Casey Report and Turn Around, specifically the police response to working with adults at risk and also as much of this was about how the Met can build the trust of the community.

Community activity engagement has a much-reduced programme for Hate Crime Week. Staff had a stall at LB Barnet's offices in Colindale. But the situation in Gaza and Israel, and anxiety about community relations in Barnet, led to the cancellation of the street stall that are usually staffed jointly with the police. The Access to Justice Group members see the link between framing of safeguarding narratives in Black and Minority communities with work on the Safe at Home agenda.

The group have been monitoring the new Carers 'Strategy which will have action plans to support its implementation, and this is the opportunity to address safeguarding and carers' issues in more detail. The group are working closely with the Barnet Carer Centre and Barnet's Carer lead to get assurance on support carers get when involved in a safeguarding investigation.

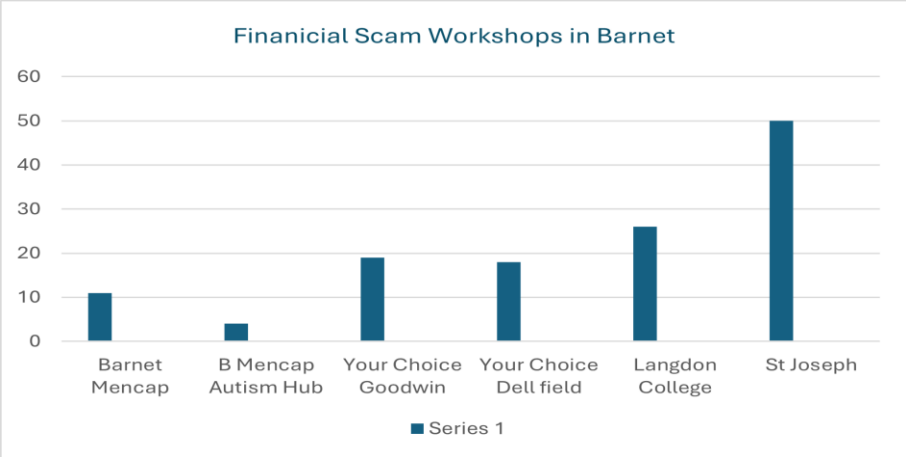
There has been work to develop the CJS/autism priority, including contact with Met Detention, Training Officers for the police, for the BCU and Neighbourhood Teams, and in making the referral pathways more effective, especially with the Probation Service.

Emerging issues identified by the group include the availability of appropriate Adults and Autism and the Criminal Justice system. Autism Training for the police will be arranged and this should be delivered in the autumn.

The Barnet Victim Care Hub has been set-up for victims of reported and unreported crime, providing them with information on their rights and services available to them based on their individual needs following an incident. The Hub can provide information and local signposting options to those who may have also experienced crime indirectly, their friends and family.

The Hate Crime Project have continued to report to the group. Hate Crime Figures and Disability Hate Crime Review with the Police of incidents to find out whether victims were referred/signposted to support organisations was completed. Staff training workshops continue to take place and awareness raising is also taking place. Working with the Community Safety Team jointly on cases that involve antisocial behaviour and people with learning disability. They joint working encouraged the Council to give better recognition for the needs of residents with learning disabilities. Awareness Raising Workshop focused on Scams and Fraud Workshop had 9 attendees with learning disabilities and/autism. This covered Doorstep Scams, Phone and Text Scams, Online Scams including e-mail and Social Media platforms, Postal Scams.

NCL Financial Abuse Workshop: BSAB progressed this work started in 2022-23 by funding Barnet Mencap to deliver 10 X 2.5-hour sessions for People with Learning Disability in Barnet in 2023/24. The project involved conducting financial scam workshops across the borough from mid-January 2024 to mid-July 2024. They reached out to 15 organizations, presented the project, and successfully organized 7 financial scam workshops in Barnet, with 128 attendees



The workshops were conducted in collaboration with two police officers and included: Easy-Read PowerPoint presentations, Videos, Role-play activities and shared examples from officers. The presence of police officers was highly beneficial to the attendees, as they were able to ask questions and clarify doubts. The workshops were conducted in various settings, including schools and care homes, and the participants' ages ranged from 18 to 89. Feedback from the attendees was positive, with many emphasizing the importance of the topic, as financial scams can affect anyone. Attendees shared personal examples of themselves or relatives being victims of financial scams, underscoring the need for ongoing awareness and education on the topic. Attendees expressed a desire for more workshops with specific focuses, such as IT scams and hate crime scams.

BSAB partnership achievements

Cross sector learning opportunities or community engagement events

Through 2023-24 BSAB delivered regular 'lunch and learn' webinars which provided the BSAB with a means to communicate directly with frontline practitioners from across partner organisations to discuss emerging risks and raise awareness of good practice briefings or new guidance published by national bodies. This year we covered a range of safeguarding topics including:

- Carers and Safeguarding,
- Medication non – compliance,
- Safeguarding and Right Care Right Person,
- Addiction and safeguarding,
- Safeguarding Adults at risk of Multiple exclusion homelessness learning from the Colin and Phil SARs,
- Combatting Drug Awareness
- Public Health and 'High Risk Cases, Tools Techniques and processes and High-Risk Panel.

Training for Multiagency Staff and Volunteers

The Communities, Adults & Health Service's new training system: The Place of Development known as 'The POD', provides staff and volunteers the opportunity to self-register for access to eLearning, online and face2face training. The following four eLearning modules is available:

- ➢ Safeguarding Adults - Level 1
- ➢ Safeguarding Adults - Level 2
- ➢ The Mental Capacity Act
- ➢ The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS)

Attendance from 1st April 2023 – 31st March 2024.

Safeguarding - External Policies & Procedures 42 attended
Safeguarding Adults - Provider Led Enquires 33 attended
The Safeguarding Adults Partnership Audit Tool Report (SAPAT) 2023-24 is available here BSAB SAPAT REPORT 2024

Attendance at the Safeguarding Adults Board meetings 2023 -2024

Organisation	June 2023	September 2023	December 2023	March 2024
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 2023-24

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

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, always call 999.