Barnet Safeguarding Adults Board
Annual Report 2020-21

Foreword from the Independent Chair, Fiona Bateman

There is no way that I could do justice within this introduction to the remarkable effort that volunteers and colleagues across the partnership put in to reduce harm to adults with care and support needs during the pandemic. It was awe-inspiring.

I would, however, like to take the opportunity to remember all those who died, their families and friends who have suffered such loss and to those who remain unwell. I must also pay tribute to so many people who put themselves in harm's way to protect our vulnerable residents and to those who worked tirelessly to reduce risks, wherever possible, and provide care and comfort. This report was written as we were in the grip of a third wave in London so the threat remains, but so too does the remarkable response.

Throughout 2020-21 partners provided regular assurance reports to the Barnet Safeguarding Adults Board [hereafter referred to as 'BSAB' or 'Board'] about the work they were doing within their own organisation and collectively to:

- anticipate new risks that emerged as a consequence of Covid-19;
- mitigate the risks associated with the changing nature of how support was provided; and
- manage safeguarding duties as 'business as usual' given the exceptional pressures across the health, social care and criminal justice workforce.

As the data shows, staff involved in safeguarding enquiries continued to see an increase both in the number and complexity of the concerns being referred. This data isn't intended to capture activity that prevents harm before any safeguarding concerns arise. Such preventative, work has such a positive impact on the lives of our most vulnerable residents so we have therefore provided examples of this work done by partners in the voluntary, community and statutory sectors to demonstrate the breadth of activity. There is, of course, more that we hope to achieve in the coming year.

We have also heard a strong commitment from BSAB members to reflect on the innovation that we have seen this year and to use what we have learnt to ensure that systems work to address the inequalities that the pandemic emphasised.

Thank you for taking the time to read through this report. Please do take a few minutes to think about others within your circle of friends, colleagues or people you come into contact with through your work or volunteering activities that could also benefit from the information within the report or available on the BSAB website and share these with them. I hope you find much of interest within this report and that it provides reassurance that there is clear commitment to working together to keep our most vulnerable residents safe and supporting system wide practice improvement.

Best wishes,

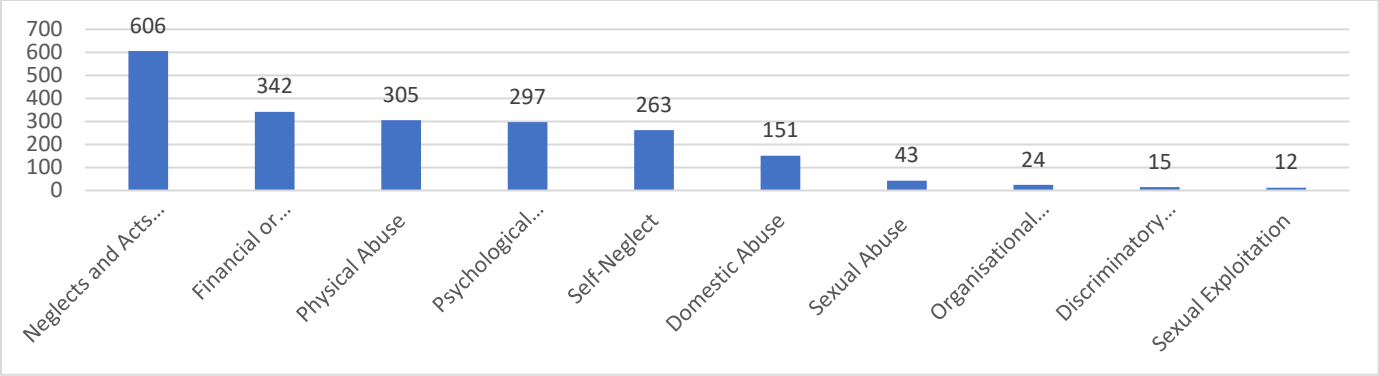
Fiona Bateman,
BSAB Independent Chair

Safeguarding activity in Barnet 2020-21

Between April 2020- March 2021 there were 1695 safeguarding concerns received by Barnet Council's adult social care service. This is a slight decrease from the number the previous year, but 1794 safeguarding concerns decisions were completed in the 2020-21 year, a 3% increase in activity. This is in line with reports nationally[1] that, despite an initial reduction in notifications during the first lockdown period in March 2020, safeguarding concerns rose steadily. Nationally, rates of safeguarding concerns were overall higher than in the previous year. National data also demonstrated a significant increase in the **complexity** of safeguarding enquiries.

Of the concerns received, 412 went on to require a full enquiry, a conversion rate of 23%. On first glance this may appear low, but it is worth noting that not all concerns raised will require a formal enquiry in line with s42 Care Act 2014. Staff within the Multi-Agency Safeguarding Hub [the 'MASH'] review referrals and, where there is a more appropriate mechanism for assessing and addressing risks they will direct the concern to those processes. For example, as noted below locally, in common with patterns nationally, there was a rise in domestic abuse concerns.[2] In response to this, the MASH team worked with partners to ensure that where adults did not have care and support needs, the domestic abuse risks were assessed in line with the Multi--Agency Risk Assessment Conference process ['MARAC'] overseen by the Barnet Council Community Safety Team. Similarly, where concerns relate to the provision of commissioned health or social care services, these would be addressed through NHS investigation procedures or the Provider Concerns Protocol, as agencies with regulatory and contractual obligations have established procedures in place to work together with providers to address operational concerns and respond at a strategic level.

Concerns by types of abuse of all Safeguarding Concerns



The largest number of safeguarding concerns by abuse type in 2020-21 was 'Neglect and Acts of Omission' (29% of the total). 'Financial or material' abuse was the second highest (17% of the total). This is similar to previous years and in line with national and regional comparators. In Barnet, in common with national data, there was a rise in concerns regarding domestic abuse, self-neglect and psychological abuse (compared with 2019). Partners responded to this change in the nature of abuse locally, by providing awareness campaigns for practitioners and members of the public to highlight new powers under the Domestic Abuse Act 2020 and inform the issues discussed in on-line community engagement events during Carers week in June and Safeguarding week in November 2020.

Source of Referral for Safeguarding Concerns

Traditionally we have always seen a much higher percentage of safeguarding concerns raised by partner agencies' staff than from other sources. This is because of the high level of safeguarding training across that workforce, but it also reflects professional practice standards that provide personal responsibility to recognise and report safeguarding concerns. What stands out this year is the rise in referrals from family, neighbours, friends and from those wishing to remain anonymous. The National Insight Report noted an increase

[1] National Insight Report 2021 available at: https://local.gov.uk/publications/covid-19-adult-safeguarding-insight-project-second-report-july-2021#part-1-safeguarding-concerns

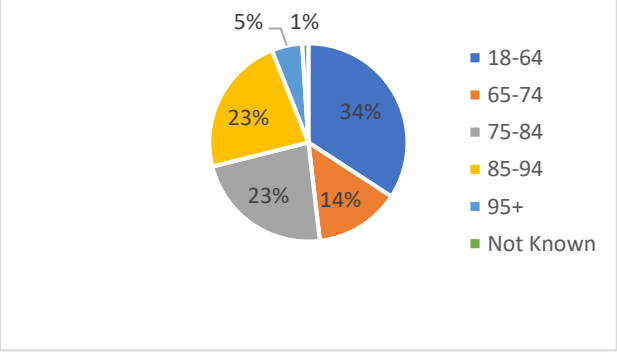
[2] This amounted to 7% of concerns reported to the local authority, though it is possible that this may not reflect the full picture as often concerns are attributed to the most obvious form of harm (e.g. physical or psychological). In fact, where abuse is suspected and people are or were in family or intimate relationships this should be categorised as domestic abuse.

nationally from emergency services and volunteers who were taking part in providing COVID-19 related support during the lockdown periods. That report identified that neighbours, the 'general public' and volunteers tended to raise safeguarding concerns because they were supporting people through the pandemic and were coming face-to-face with adults who may appear to be experiencing abuse and neglect, particularly regarding self-neglect, hoarding and residents living in poor conditions. The increase in community awareness during Covid of risks faced by adults with care and support needs is something all partners wish to build on in the future, so this data will be monitored closely over the coming year to ascertain where we may best target campaigns to improve early identification of harm.

Source of Referral	Total	%
Police Merlin reports	233	14%
Health partner agencies- CCG Acute hospital trusts GP and community health providers NHS Mental Health Trust	 9 336 112 21	28%
Social care agencies– Social work and Occupational Health Staff (LA) Providers (residential, domiciliary care and day centre) Personal Assistants (funded via direct payments)	 71 286 3	21%
Friend, Relative or neighbour	142	8.4%
Self-Referral	28	2%
Barnet Group, Housing and trading standards staff	63	4%
Emergency response services (LAS and LFB)	69	4%
CQC	13	0.8%
Advocacy services	8	0.5%
Anonymous	162	10%
Other (Charities, Education, Workplace, Hospice)	115	7%
Grand Total	**1695**	**100%**

Profile of Adults at risk in Barnet by age

Contrary to previous years, there was a more even split between those aged 75-95+ years old (51%) and those aged 18-74 (49%) who were the subject of a safeguarding concern in Barnet. Usually adults within the older age ranges have more contact with statutory agencies and, rightly, any concerns are reported by those agencies. The difference this year may reflect national trends, which noted a shift in concerns away from those raised from care and hospital settings to risks faced by younger adults residing in their own homes. Throughout the year partners reported on the steps taken to mitigate risks for those within care settings, for example CQC and Barnet Council reported on work done to protect against 'closed cultures' developing. In addition, we worked with the London SAB and key partner agencies to devise an action plan to improve consistency from partners in responding to allegations of organisational abuse that might arise following the easing of lockdown measures. CLCH also shared useful tools to identify when pressure ulcers or medication errors may constitute neglect and require a s42 enquiry or police investigation.

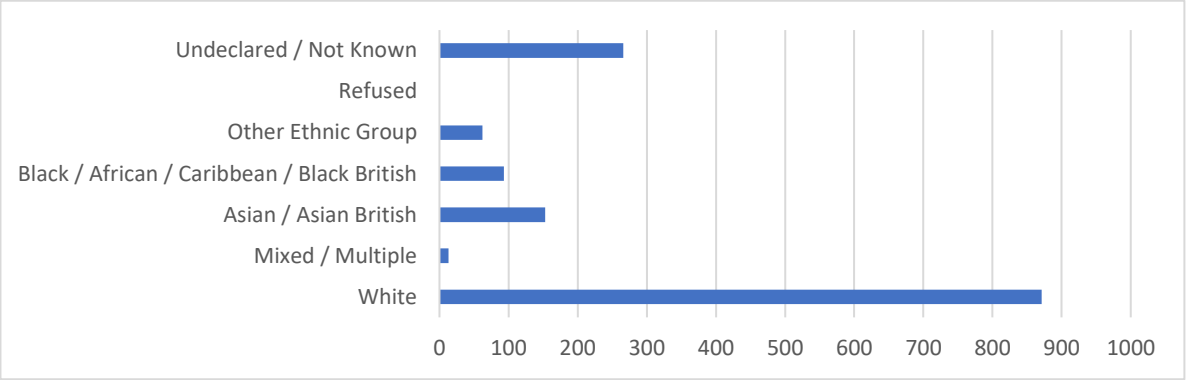


As lockdown measures continue to ease, this data will be carefully monitored to understand the long-term impact of this work.

Safeguarding concerns by Gender: 60% of concerns related to female adults at risk, 38% referred were male (2% gender was not recorded). This is a similar pattern to 2019-20 and is largely in line with national

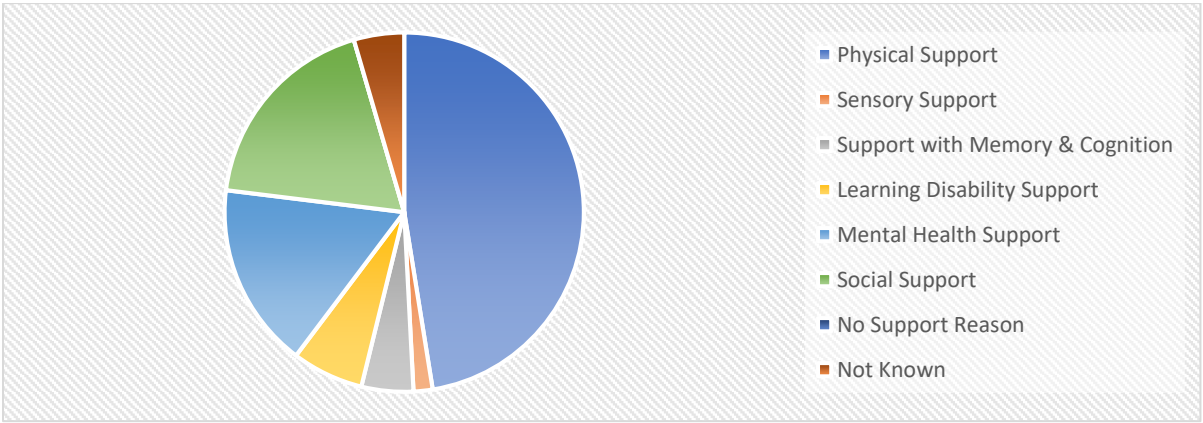
statistics.

Individuals involved in Safeguarding Concerns by ethnic origin: 59% of the people subject to a safeguarding concern in Barnet were described as 'White', lower than the national average of 79% but closely matching our population profile. The number of people described as Asian/Asian British (10%) was higher than the national average of 3%; as was those described as being Black /African/ Caribbean/ Black British (6%) where the national average is 3%. A high priority of the SAB in 2020-21 was to raise awareness within Barnet's diverse communities of the risks of abuse and encourage those communities to report abuse. The number of concerns submitted to the local authority where the person's ethnicity was not recorded rose from 158 (in 2019-20) to 266. This suggests we still need to do more to raise awareness across our partners and the public of the need to report this information into the local authority when raising a concern, so that from the beginning of discussions we are considering the adults needs in a culturally sensitive manner.



Safeguarding Concerns by Primary Support reason

In line with previous years and national data, a physical disability or personal care need was the primary support need for adults thought to be at risk or experiencing abuse or neglect (48%). 19% of concerns raised related to those who required social support, 17% of adults at risk were believed to have mental health needs. 6% of safeguarding concerns related to people with learning disabilities and a further 5% required support for memory or cognitive impairments.



Barnet Safeguarding Adults Board: Our vision and purpose

The 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.

Our vision is for all 'adults at risk',[3] 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. 2020-21 was the final year of our three-year strategic plan, within which we set out three key priority areas, namely:

- Establish consistent practice across partnership agencies which reflect the 'Making Safeguarding Personal' principles[4]
- 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'

BSAB meets as a whole group every three months

Throughout 2020-21 the BSAB moved to virtual meetings to ensure business could continue. The convenience of online meetings meant we saw increased attendance and engagement with the work of the BSAB. A key focus was emerging risks from the pandemic.

In May we held an extra meeting to explore likely issues and suspected hidden demand due to COVID. We also reviewed how practice had changed and what was being done to anticipate risks of abuse and mitigate these. The MASH team also spoke of the changing nature of risk and new ways of working with partner agencies to respond to concerns. They reported a reduction in concerns regarding self-neglect and a rise in complex and high value financial scams linked to Covid. BEH NHS Trust confirmed this was a key area of concern for their community based clients. MASH and Police colleagues also confirmed a rise in domestic abuse concerns during the first lockdown, confirming that within Barnet the prominent challenge was the significant increase in calls requiring police intervention, rather than an increase in serious harm. In response MARAC meetings were held more frequently (weekly). All partners reported good engagement in the virtual meetings. In addition, CCG colleagues reported on SOLACE webinars to GPs and primary health staff to support regarding identification and reporting of safeguarding concerns. Voluntary sector partners, the Police and MASH colleagues reported an increase in concerns involving people struggling with their mental health, particularly that a reduction in face to face support, necessary to prevent the spread of the virus, may increase risks for carers, family members and people the care for. BEH spoke of the steps staff had taken to check on their clients' wellbeing and Barnet Mencap reported on the introduction of Project 300, a joint venture between the Council's learning disability team and Mencap to provide welfare calls and support to access essential supplies or care for residents with learning disabilities and their families.

Our June meeting considered how, as a system, partners could support recovery from the first wave with a particular emphasis on supporting residents with their mental health. Mental Health practitioners reported they saw a huge impact of Covid-19 on their client population- necessitating the reconfiguration of services. They reported difficulty in managing infection control for those who had difficulty understanding the new risks and the significant rise in high levels of anxiety within in-patient groups resulting in a rise in safeguarding enquiries for their in-patients. They also reported a rise in safeguarding concerns linked to 'county lines' for community based clients. BSAB partners reviewed the assurance report provided to the Department for Health and Social Care ['DHSC'] on the support provided locally to care homes to reduce the risks they faced and agreed to amend our SAR protocol to ensure, if referrals were made in line with s44 Care Act for safeguarding adults reviews, we would be in a strong position to respond promptly in preparation for subsequent infection waves.

[3] 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

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

In September we explored the impact Covid-19 had on increasing the risks of abuse to our diverse communities. We also explored the steps taken by each agency and the BSAB collectively to reach out to our faith and BAME communities to build trust that responses to safeguarding concerns would be appropriate and culturally sensitive. As data above shows, there is still much to be done and the Board has set up a focus group to continue this work as a golden thread running through each of our actions and key priorities in the coming year.

In November the BAME Community Engagement Task and Finish group was set up and the group used Safeguarding Week as an opportunity to start to engage with the BAME community through local organisations, faith communities and professionals. This took place during safeguarding week 16th – 20th November. The events and activities covered the following topics;

- Serious Adult Violence,
- Safeguarding and Hate Crime Webinar,
- Recognising and raising concerns- what everyone needs to know about the safeguarding duty,
- Coping with Lockdown 2,
- Embedding Safeguarding practices in faith organisations,
- Taking a multi-faith approach to safeguarding
- Introduction to the Adults MASH.

In December, in response to concerns raised regarding financial abuse we reviewed the findings from a survey of residents with learning disabilities and their experiences of financial abuse. Work continues, led by BEH, Mencap and the police to improve awareness of these risks and enable practitioners to build into care plans preventative support to reduce risks. Partners were also appraised of the early findings of the 'Gabrielle' SAR (reported below). In addition, the Board agreed actions needed locally to raise awareness of risks within Barnet of Modern Slavery and exploitation in response to the concerns raised regarding risks associated with 'county lines' and to build on work started prior to the pandemic. This work has carried over to our current work plan and will be done in partnership with the Community Safety Partnership and neighbouring boroughs.

In March the BSAB reviewed our governance arrangements, including making provisions to appoint a joint co-chair (alongside a partner from the voluntary sector) who is an expert by experience, so that people who have lived experience of safeguarding process are at the heart of strategic decision making in Barnet. We also signed off the workplan for 2021-22. We received an update on joint work with Barnet Safeguarding Children Partnership to understand responses to transitional safeguarding risks and received the final report of the Gabrielle SAR. The fire safety task and finish group also reported on the completion of their work, in response to the Mr A SAR published in 2019 and two further fire deaths. A key task of the group was to commission an independent audit of case files to provide assurance that arrangements to meet statutory duties are effective and take into account the obligation to prevent needs escalating or reduce fire risk in the Barnet area. The auditor was able to confirm good practice, particularly that practitioners are correctly recognising fire risk and the circumstances that may trigger the duty under s42 Care Act 2014. The audit also confirmed evidence of good partnership working with the fire service, housing, health and care providers.

Throughout this period, despite unprecedented pressures across health, social care and wider partner agencies posed by the pandemic, partners worked within BSAB sub groups to complete our work programme. A summary of the work completed and the impact is given below.

THE CASE REVIEW GROUP ['CRG']:

The CRG undertakes the statutory duties set out under Section 44 of the Care Act, namely to review any case where an adult with care and support needs in Barnet has suffered serious harm or died as a result of abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult. The group considers all referrals to assess the opportunity for learning and reports quarterly to the BSAB with recommendations on the commissioning of reviews. The CRG also monitors the recommendations and action plans of partners where a review has taken place, and co-ordinates multi-agency responses.

Thematic Learning review: Supporting learning disabled adults at risk from hoarding behaviours

As reported within the last annual report in March 2020 BSAB agreed to carry out a discretionary learning review following the death of an adult with learning disabilities due to her poorly controlled diabetes. Although neglect or abuse had not contributed her death, practitioners agreed a review could assist partners better understand how to respond where there were concerns regarding self-neglect for adults with learning disabilities. This review was paused during the Coronavirus 'lockdown' in order to ensure that frontline officers, re-deployed in the first wave, could actively engage with the review process. During that period another case was referred involving a younger woman with learning disabilities who, despite numerous attempts by her GP and social care, had not had a review of her needs since leaving education. Professionals and neighbours had raised concerns regarding the family's living conditions and ability to meet her needs, but offers of support had been refused by her family. Sadly, both her parents became acutely unwell during the first lockdown, necessitating intervention by health and social care. She now has full support and is reported to be thriving, but CRG believed the poor state of her family home and lack of formal support likely had significant impacted on her development and wellbeing. The BSAB commissioned a thematic review of the two cases to explore opportunities for improved practice across safeguarding partners to prevent similar harm occurring in future cases.

The review was undertaken by an independent reviewer with expertise in learning disabilities. Attempts were made to contact family members involved, but unfortunately they did not wish or could not take part in the review. Practitioners involved in both cases did meet with the reviewer to share their experiences. In addition, the reviewer met with relevant designated safeguarding leads to discuss her findings and understand what steps had already been taken to improve practice. The reviewer presented her findings in June 2021 and a summary of her report and the recommendations is available on the BSAB website.

The reviewer found that in both cases risks associated with hoarding and neglect of health conditions were identified, but there was considerable drift as practitioners struggled with the complexity of both cases. All service providers and partner agencies are required to have clear safeguarding policies and staff are expected to recognise and report safeguarding concerns. In both cases practitioners did seek to offer support, but despite clear safeguarding policies and procedures, practitioners accepted their actions didn't reduce the risks and cases were not escalated in line with the multi-agency safeguarding policy. In one case, the provider raising concerns felt these were dismissed until they could justify a case for increasing the commissioned package with little regard had for the complex nature of the adult's needs or understanding as to why she had 'disengaged' from statutory support. Whilst housing maintenance staff and health professionals had identified that the housing conditions in both cases made it unsafe for them to complete their responsibilities, it was troubling that this did not trigger recognition that this would likely mean (in both cases) the adults were at risk.

Practitioners in both cases reported difficulties in assessing capacity, particularly someone's capacity to execute a decision and that this can make it harder for professionals to offer more support if earlier less invasive offers of support are refused or professional advice is not followed. Practitioners also spoke of conflict in values between different professionals, some prefer paternalistic and risk averse plans whilst others take a more liberal approach. This, coupled with a mixed grasp of legal options that might be available to address ongoing very high risks, can impact on the effectiveness of safety planning.

In both cases more timely, effective interventions would have prevented harm. For example, adopting a more proactive approach to enabling access to healthcare and ensuring take up of annual health checks.

The reviewer was concerned too that, in one case, the adult was discharged from specialist clinics due to non-attendance with seemingly no regard to her disability and how this might make it difficult for her to accept support or attend appointments. In the other, professionals accepted family members' refusal to attend for health checks. Given this was not in her best interests, this should have been actively challenged including, if necessary, through a s42 enquiry process.

Likewise, when s42 enquiry duties were triggered, these did not address the concerns through the lens of the 'family' unit. For example, in one case the adult had been prevented, due to financial abuse concerns, from contact with a close friend who helped manage her health. Whilst there was no criticism that action may have been required to reduce the risk of abuse, the reviewer did question if practitioners took sufficient account of the adult's wish or the impact that such action would have on the adult's ability to manage her own health. A s42 enquiry was also conducted in the second case, but because the subject of that enquiry was her mother it failed to consider risks to her daughter despite clear indications that her disability would

mean she was unable to protect herself. Neither safeguarding enquiry addressed the ongoing risk (incl. fire safety) of hoarding. In addition, the review found that efforts to refer for legal advice were frustrated as too little information as to the circumstances and previous involvement of services were provided to the legal department.

Practitioners were able to identify changes that have already been implemented in the intervening period. The BSAB Self-Neglect policy enables practitioners to explore cases from different perspectives- promoting creative approaches for family support. It requires that, if risk is not reduced, cases are escalated to the 'Multi-agency Risk panel'. Practitioners across all agencies were also aware of the Community Learning Disability Team's Complex Case Panel and spoke of the opportunities this provided to collectively consider needs and prevent safeguarding risks. Practitioners across all agencies reported that the new 'safeguarding champions' programme and more accessible training should improve implementation and use of the safeguarding policies and the application of equality and mental capacity legal obligations. Similarly, safeguarding leads from all agencies felt the new BSAB escalation protocol and guidance for third sector groups on 'Making Safeguarding Personal' would improve practice. They welcomed the suggestions that Environmental Health and Barnet Homes colleagues be encouraged to work with private landlords so they too are aware of BSAB's Hoarding policy and safeguarding duties.

SAR in Rapid Time: Gabrielle

Throughout the pandemic BSAB partners remained alert to new risk posed by the necessary changes to health and social care service delivery. During the initial lockdown safeguarding leads from the local authority and community health providers highlighted how many families had, understandably, requested a suspension of carer or district nursing services and the steps taken to mitigate risks to adults with care and support needs. In July 2020 the Board's Case Review Group were asked by our acute health provider to consider a Safeguarding Adults Review in the case of Gabrielle. The group concluded that, whilst partners had taken steps to mitigate known risks to her, a review would identify important learning for all agencies seeking to manage the ongoing complexities posed for adults with care and support needs, particularly those with clinical vulnerabilities advised to 'shield'. The BSAB board therefore agreed in October 2020 to commission a discretionary SAR. Given the ongoing risks associated with further rises in infections at that time, the BSAB sought the assistance of SCIE to complete this as a 'SAR in Rapid Time'. The report was completed by an independent safeguarding expert who heard directly from practitioners and senior safeguarding leads involved in the case. Due to ongoing proceedings, it was unfortunately not possible to involve Gabrielle's family, but very great care was taken to ensure her voice was represented. The report is published on our website.

The review identified issues with the recording of mental capacity assessments and verification of assertions by family members regarding their authority under a lasting power of attorney. It noted that whilst information was passed between professionals, the fact that this was done by way of email or formal referral resulted in a cautious approach to communicating low-level safeguarding concerns. When different agencies have co-located services, there can be a more natural flow of information as 'soft' intelligence is more likely to be shared verbally. The review acknowledged that practitioners need to feel confident that information they share will be used proportionately by other agencies, so that each agency has all of the pieces of the puzzle. They need to identify when safeguarding risks are escalating for an adult in need of care and support. The reviewer also found that overwhelming pressure on staffing levels during the pandemic reduced the efficacy of supervision processes, resulting in episodic analysis of information.

There was also evidence of professional over-optimism. In the context of the pandemic, professionals overlooked the rationale of having a refused visit policy, which is to ensure that there is a proportionate response to risk, even when there is a reasonable explanation for the refusal. Assertions by family members in respect of improved health were not considered in the context of the available evidence. An over-reliance on information from families without professional oversight from any agency greatly increases the risk of harm for adults who are wholly reliant on others for their care. Our partners accepted all the reviewer's recommendations and we are working together to implement an action plan to address these.

Finally, the CRG fulfil a vital BSAB function to monitor practice improvements. Partners report, both through their self-evaluation [the 'SAPAT'] and within our challenge and progress events, the steps they have taken to implement recommendations from both these reviews. Partners have complimented the BSAB team on the 7-step briefings and on training events held during Safeguarding week, relevant awareness days (e.g. in Carers week) and on publication of SAR reports as this eases the dissemination to their staff.

Partners have also provided more details on their own organisations actions to embed learning and monitor practice improvements, including:

1. The CCG Pharmacy team have changed their prescribing policy for emollients to prioritise non-petroleum based products. An automatic pop up has been implemented in the system for whenever emollients are prescribed so that the prescriber considers if there are other high-risk factors (smoking/ immobility) which may trigger a further offer of support or fire prevention support;
2. Training to GPs and providers (e.g. Jewish Care) re fire safety was provided by CCG and LFB;
3. CLCH reviewed their datix systems reports re pressure ulcers, reviewed their 'no access' policies and made adaptions to supervision policies to mitigate risks during high levels of staff redeployment or sickness associated with Covid-19;
4. Disseminating lessons from LEDER reviews and thematic review findings shared with the Learning Disability Steering group to change practice in relation to supporting and protecting people with learning disability or mental health needs;
5. Revising level 3 Safeguarding training to include learning from SARs and ensure local themes, trends and high risks cases emerging from Covid-19 are discussed;
6. Royal Free advised they had considered national SAR reports regarding homelessness and hospital discharge to improve staff confidence to use the 'duty to refer' powers, regularly audited mental capacity assessments regarding refusal of medical treatments to ensure good practice;
7. BEH trust reported their involvement in a London wide SAR prompted implementation of parental mental health training across the Trust. They have also updated their safeguarding supervision documentation and provided staff with targeted 'quick grab' guides as detailed later in this report.

The CRG will continue to monitor the implementation of the action plan arising from these reviews and report on the impact that those actions have had to improve practice and safeguard our residents.

Professional and Quality Assurance 'PQA' Group

Effective quality assurance drives continuous improvement and is recognised as a critical function of the BSAB. The group provides assurance that local safeguarding arrangements are in place and work effectively, and risks and concerns are escalated to the Independent Chair and BSAB. The Group meets quarterly to review safeguarding performance via an integrated monitoring report which reviews data and key performance indicators from across the partnership. The group also considered reports from partner agencies detailing their internal audits and those conducted to ensure multi-agency protocols were being used effectively. Partners have demonstrated improved client satisfaction and closer adherence to MSP principles and active engagement of service users in line with the BSAB's priorities.

Workforce development and safeguarding training: An important function of BSAB is to monitor the implementation and impact of safeguarding training. Our PQA subgroup receives regular reports (as part of the BSAB quarterly monitoring dataset) from partners of compliance with the National Competence Framework for Safeguarding Adults.

The Council's adult social care workforce development team provides a comprehensive range of multiagency training for staff from within the council and from partner agencies. This is led by the Principal Social Worker who plays an important role in ensuring that the programme improves the quality of safeguarding practice across the partnership. The programme includes a variety of courses, briefings and forums delivered within the London Multi-Agency Safeguarding Adults policy and procedures framework, based on levels 1-3 and in line with the National Competence Framework for Safeguarding Adults. Additionally, all staff have access to a suite of online learning:

- Safeguarding Adults - Level 1
- Safeguarding Adults - Level 2
- Mental Capacity Act 2005
- Deprivation of Liberty Safeguards

Safeguarding practitioners also have access to all the multi-agency training delivered by BSCP and Barnet Council's Family Services e.g.: Coercive Control, Domestic Abuse etc.

The BSAB has also ensured that a wide range of relevant training / workshops/ webinars and training material provided by professional bodies such as Research in Practice for Adults (RiPfA), Skills for Care, Social Care Institute for Excellence (SCIE) has been disseminated across the partnership.

Formal training programmes are also supplemented by a range of practice forums which provide reflective learning opportunities for staff to discuss real cases and learn from good practice examples. Practice forums are quarterly and focus on safeguarding, Mental Capacity and the role and function of Best Interest Assessors under the Deprivation of Liberty Safeguards. Safeguarding Adults face to face Training has also been provided to staff from across approximately 30 external providers.

THE ACCESS TO JUSTICE GROUP

This group was set up in response to concerns that adults with care and support needs may need agencies to proactively change practice so that, if they experience abuse or neglect, they can get redress through the civil or criminal legal system. The group have met every quarter and meetings have been well attended and the following areas have been explored.

A survey on the financial abuse of people with a learning disability was facilitated by the Access to Justice group because it was concerned to hear reports of the financial abuse of people with learning disabilities and the concern was that this could be so pervasive that many people with learning disabilities did not perceive that it was happening. The survey was sent to people with learning disabilities in July 2020. Barnet Mencap, Barnet's Learning Disability Team and LD service providers were involved in supporting the process. Most of the respondents had some paid support and one focus for further work is what more support workers can do around preventative work. The survey response showed 79% of the respondents did not think they had been financially abused. Following the report, there has been a lot of interest from LD organisations in their staff and the people they support, attending training and awareness raising workshops. Following this survey, the group have agreed to look at what more could be done following disclosure or discovery of financial abuse. It is important that support workers and families can recognise financial abuse, that they know how to report it to the police and to the MASH (Multi-Agency Safeguarding Hub), and for the CPS to consider ways to prosecute offenders.

Project 300 involved the Barnet Learning Disability Service working with Barnet Mencap, which has provided welfare checks for people with a learning disability and autism. By building relationships with people, it has been possible to respond quickly to any risks, and to coordinate the appropriate input from voluntary and statutory organisations. The intention is to further explore such models of support, introduced at the start of the pandemic, which have the potential to really develop the prevention duty and safeguarding.

The Zero Tolerance to Hate Crime Project has collaborated with "Why Me?" – an organisation which provides Restorative Justice Services to victims of crime. Victims of disability hate crime who report incidents through Barnet Mencap are offered restorative justice as a resolution. This is hoped to be particularly helpful in Neighbour Disputes, where the victim of hate crime knows the perpetrator.
In 2020 restorative justice was offered to 3 victims, in addition to support with reporting to the Police. In 2021 the Project will continue to offer Restorative Justice to victims. A short film is to be produced by Middlesex University and Restorative Justice Training is being offered to Barnet Council Adult Social Care Teams, to build on the Hate Crime Training Workshops which were delivered to staff in September and October 2020.

The Hate Crime Reporting Champion scheme has been running for three years now. This year, due to the pandemic, registration for the scheme moved online so that Barnet residents and visitors can register safely and remotely. This is accessed via a dedicated Hate Crime Awareness Week webpage, which will be kept updated with news and information about workshops and awareness raising events.

Data produced by the police, showed that **Appropriate Adults** are not always available in a timely way. The Access to Justice sub-group is exploring opportunities to fund a local scheme through the Mayor's Office for Policing and Crime (MOPAC).

BSAB partnership response to Covid-19 Pandemic

In addition to the assurance reports received at BSAB meetings, each year BSAB partner agencies are asked to complete a self-evaluation of the effectiveness of their own agencies safeguarding work and consider the impact of the BSAB through a London wide audit tool, namely the Safeguarding Adults Partnership Audit Tool or 'SAPAT'. This report draws from our BSAB meeting minutes and SAPATs completed by Barnet Carers Centre, Inclusion Barnet, Barnet Mencap, NCL CCG, BEH Mental Health NHS Trust, Royal Free NHS Trust, CLCH NHS Trust, Barnet Homes, LFB and Barnet Council adult social care.

The rapid way in which partners had worked together to respond to emerging risks during the pandemic was identified by all our partners as both key achievements and as posing ongoing challenges for the BSAB. Much of the rapid innovation we saw during this period has already been reported elsewhere, however, key innovations and improved safeguarding practice reported by partners were:

1. Swift move to communicating and providing services via online platforms enabled innovation, including:
    - The development of new operational meetings, e.g. weekly meetings between MASH and Designated Safeguarding Leads ['DSL'] within the CCG, Hospital, Community and Mental Health NHS Trusts to assess and review 'live' safeguarding concerns. These ensured continued focus on safeguarding and support to frontline staff working in very challenging conditions;
    - RFL's DSL were involved in designing technical innovations- resulting in positive and substantial impact in patient care (e.g. virtual consultations for patients with learning disabilities and Autistic patients).

2. Strength of existing partnership model enhances partners ability to reconfigure and problem solve during COVID-19, reducing siloed working and risks to vulnerable people. For example:
    - Barnet Carers spoke of "collaboration through crisis" and working together at a faster pace than might otherwise have been achieved. They commended the Adult MASH team, reporting improvements in how they received feedback and were involved in follow up work from safeguarding concerns. They felt there had been concerted effort by partners to involve carers in safeguarding.
    - Barnet homes reported many new initiatives to work jointly with colleagues, for example they offered increased floating support services to address housing related support issues. Staff (working with Your Choice Barnet) made daily contact calls to vulnerable residents to ensure support needs are met, get access to food and medication. They also worked with hospital and social care staff to facilitate hospital discharges and contacted GP when required.

3. A concerted effort to provide information to practitioners and the public highlighted emerging risks and guidance on reducing harmful impacts:
    - Council colleagues worked effectively to ensure PPE was available to care homes and, later, to aid the vaccine programme roll out;
    - BSAB provided information on legislative changes and DHSC expectations;
    - Barnet Council provided additional funding to support providers deliver safe care and essential supplies;
    - CCG raised awareness of the risks of domestic abuse, including ensuring that all GPs have posters on how to access support in Barnet visible behind them when conducting virtual consultations.
    - CLCH provided a single point of access for frontline staff and managers from which they could provide (7 days a week) safeguarding advice, they also developed risk assessment tools to assist with prioritising those needing face to face care and revised they supervision model to include restorative supervision- an audit of which demonstrated greater compliance and increased effectiveness;
    - BEH reported their fortnight comms programme with staff had seen improved compliance with higher levels of safeguarding training;

4. Evidence of local learning during the pandemic. Many partners wished to ensure that advances made to collaborative working during the pandemic remain within the system. For example;
    - Establishment of multi-agency practice forums (e.g. Safeguarding Adults Managers forum and Practice Interest Group, Safeguarding) to discuss and agree operational practice improvements.
    - Use of Lead Practitioners 'buddying' to enable cross fertilisation of best practice and robust information sharing between adults and children service areas.

- In response to the increased risks linked to heightened anxiety, BEH's DSL developed 'quick grab guides' for their workforce providing best practice guidance and links to local policies and support services in relation to financial abuse, sexual harm, self-neglect and executive decision making;
- MASH and partners increased frequency and membership of shared risk management forums such as the multi-agency risk panel, pressure ulcer forums, MARAC and partners welcomed the new forum being set up between mental health and social care, voluntary sector providers and police to tackle financial abuse.
- BSAB members used new ways to reach out to communities to offer reassurance and information throughout the pandemic. For example, working with Meridian wellbeing BSAB members recorded a number of podcasts looking at life in lockdown, mental health, adult safeguarding, peer support and tackling myths about the Covid-19 vaccine. These are available at: https://www.meridianwellbeing.com/resources.

What our partner said about safeguarding systems in Barnet and the BSAB's impact

Inclusion Barnet: *'Becoming part of the SAB has demonstrated the importance of skilling up the VCS sector in best practice around safeguarding. The pandemic has been extremely challenging for all sectors, yet the levels of active partnership working between VCS organisations themselves, and between the VCS and the local authority has increased exponentially during this time. The continued development of the Adult MASH has led to a step change in safeguarding*.'

Barnet Carers: '*Services have collectively addressed additional challenges faced due to COVID-19 and have shared strategies of best-practice for safeguarding. There has been a considerable improvement to follow up and response from safeguarding concerns raised over the past year as a result of the work of the Adult MASH.'*

Barnet Mencap *'Exploring the overlap between safeguarding and disability hate crime has been a key achievement this year. As has the work done by the BAME engagement group to advocate for improved uptake of the Covid-19 Vaccine.'*

Barnet (now NCL) CCG: *'The work across the partnership in quickly recognising the increased risk of domestic abuse, using early indicators from China and the Rapid Safeguarding Adult Review (SARs) organised by the Board demonstrates excellent partnership work. In this case the Royal Free hospital recognised hidden harm and referred to the BSAB who respond quickly and commissioning a rapid process so partners could make improvements to avoid similar harms occurring in subsequent lockdowns.'*

CLCH *'BSAB delivered multiagency training to improve practice and outcomes for adults at risk and their families. Use of virtual platforms to ensure work continued. MSP now influences risk management processes e.g. Section 42 enquiry, High Risk Panel and partnership working. Another key achievement was the continued emphasis on human rights approaches as evidenced by the work of our Access to Justice subgroup.*

Attendance at the Safeguarding Adults Board meetings 2020-21

Organisation	June 2020	September 2020	December 2020	March 2021
Local Authority – Adults & Health				
Local Authority – Community Safety				
Local Authority – Public Health				
Royal Free London NHS Trust				
North Central London CCG				
Central London Community Healthcare NHS Trust.				
Barnet Enfield Haringey Mental Health Trust				
Barnet Safeguarding Children Partnership				
Care Quality Commission London Region				
Barnet Group				
Barnet Mencap				
London Fire Brigade		[5]		
Inclusion Barnet				
CommUnity Barnet				
Barnet Carer Centre				
London Metropolitan Police Barnet				
Department for Work and Pensions				
London Community Rehabilitation Company				
Safeguarding Adult GP				

BSAB Partner financial contribution 2020-21

Statutory Partner	Contribution
London Borough of Barnet	£60,000
Barnet Clinical Commissioning Group	£20,000
Barnet Enfield Haringey Mental Health Trust	£5,000
Metropolitan Police	£5,000
Central London Community Health	£5,000
Non-statutory Partner	**Contribution**
London Fire Brigade	£500

[5] During the period September- December 2020 there was no permanent Commander in place

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.