



Barnet Safeguarding Adults Board Annual Report 2021-22

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Barnet Clinical Commissioning Group 



Royal Free London 
NHS Foundation Trust



Barnet, Enfield and Haringey 
Mental Health NHS Trust



Central London Community Healthcare 
NHS Trust

Barnet | Hammersmith and Fulham | Kensington and Chelsea | Westminster



Foreword from the Independent Chair, Fiona Bateman

I paid tribute in last year's annual report to the remarkable energy, compassion and fortitude shown by volunteers and colleagues across the partnership during the Pandemic. Again, you will see from this report, that despite ongoing challenges the Pandemic presented throughout 2021-22, there is no questioning the strong commitment to public service demonstrated by all partners. Throughout the year we saw countless examples of practitioners working together and alongside our communities to address risks posed by rising levels of infections, new variants, and risks posed by old harms (such domestic abuse, hate crime and scamming) which continued to be cruelly dispensed throughout the period.

Time and time again I saw examples where partners, practitioners and members of the public also openly embraced additional responsibilities, new tasks or new methods of delivery for services in order to ensure we could better protect our most vulnerable residents. The most celebrated example of this was the amazingly effective vaccine rollout, but throughout this report there are many other examples. I remain extremely proud to work with so many people so committed to safeguarding and so focused on continually seeking to improve care for those people reliant on health, social care and public services for protection.

Thank you for taking the time to read through this report. I know I am lucky to chair a group of energetic people who, despite significant pressures on public services, provide 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 keep adults with care and support needs safe.

Best wishes,



Fiona Bateman,
BSAB Independent Chair

1. Safeguarding activity in Barnet 2021-22

Summary

The following data comes from the Council's 2021-22 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 Barnet in 2021-22 there were fewer safeguarding concerns reported and enquiries investigated than during 2020-21. This has followed concerted efforts by the adults MASH to work with frequent referrers to educate on what is best reported as a safeguarding concern and what should be addressed through an alternative pathway. The outcomes for residents involved in the safeguarding process were improved, with risks reduced and removed in 93.1% of the cases compared to 91.7% in 2020-21.

Although the location of abuse order has not changed significantly the proportions have, with own home location accounting for fewer than during the height of the pandemic and Care Homes for both residential and nursing both increasing. The reduction in care home visiting restrictions as the pandemic eased has meant greater ability for professionals and family members to identify and report concerns.

The most common type of risk in Section 42 enquiries that concluded in the year for Barnet and nationally was Neglect and Acts of Omission, which accounted for 39% of risks (this was 31% nationally and up from 38.1% in 2020/21).

National picture

Safeguarding concerns¹:

- Nationally there were an estimated 541,535 concerns of abuse raised during 2021-22, an increase of 9% on the previous year, this is slightly above the average annual growth rate per year for the previous four years (8% per year on average between 2016-17 and 2020-21).

Section 42 enquiries²:

- The number of enquiries that commenced under Section 42 of the Care Act 2014 during the year increased by 6% to an estimated 161,925, following a similar decrease the previous year, and involved 129,685 individuals.

Type and location of risk:


- The most common type of risk in Section 42 enquiries that concluded in the year was Neglect and Acts of Omission, which accounted for 31% of risks, and the most common location of the risk was the person's own home at 48%

Outcomes:

- In 91% of concluded Section 42 enquiries where a risk was identified, the reported outcome was that the risk was reduced or removed.

Safeguarding in Barnet

Individuals:

-  A total of **1,265** individuals were involved in safeguarding concerns during 2021-22, down from **1,458** in 2020-21 (13.2% decrease equivalent to 193 fewer individuals).

¹An adult safeguarding concern is any worry about an adult who has or appears to have care and support needs, that they may be subject to, or may be at risk of, abuse and neglect and may be unable to protect themselves against this.

² A safeguarding enquiry is initiated when the initial concern has been assessed and meets the threshold for a Section 42 enquiry within the [Care Act 2014](#), which requires the local authority to make enquiries (or cause others to do so) if it believes an adult is experiencing, or is at risk of, abuse or neglect. When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened.

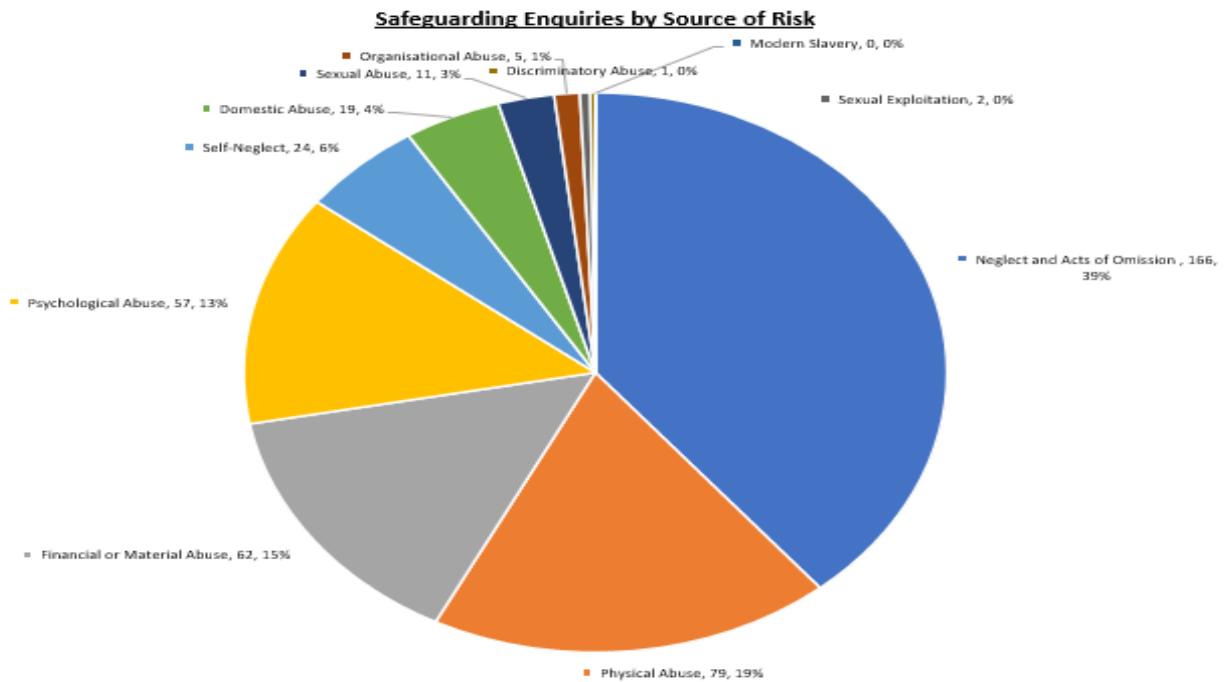
- **↓** A total of **303** individuals were involved in Section 42 Safeguarding Enquiries, down from **367** in 2020-21 (17.4% decrease equivalent to 64 fewer individuals).

Activity:

- **↓** 1,463 Safeguarding Concerns were completed during 2021-22, down from 1,695 in 2020-21 (13.7% decrease equivalent to 232 fewer Safeguarding Concerns).
- **↓** 318 s42 Safeguarding Enquiries were completed during 2021-22, down from 384 in 2020-21 (17.2% decrease equivalent to 66 fewer s42 Safeguarding Enquiries).
- **↓** 11 Other Safeguarding Enquiries were completed during 2021-22, down from 28 in 2020-21 (60.7% decrease equivalent to 17 fewer individuals).

Safeguarding Enquiries by Source of Risk

- The top five sources of risk have remained the same this year and are:
 1. Neglect and Acts of Omission - 39% (**↑** up from 38.1% last year).
 2. Physical Abuse - 18.5% (**↓** down from 19% last year)
 3. Financial or Material Abuse - 14.6% (**↓** down from 15.4% last year)
 4. Psychological Abuse - 13.4% (**↑** up from 12.7% last year)
 5. Self-Neglect - 5.6% (**↓** down from 6.1% last year)
- There were no recorded Safeguarding Enquiries for Modern Slavery in both 2020-21 and 2021-22.



Safeguarding Enquiries by Location

- **↓** Own home continues to be the highest proportion of location of abuse in safeguarding enquiries (46.2% down from 54% in 2020-21).
- **↑** Care Home – Residential continues to be the second highest proportion of location of abuse in safeguarding enquiries (18.6% up from 14.5% in 2020-21).
- **↑** Care Home – Nursing is the third highest proportion of location of abuse in safeguarding enquiries (was joint 2nd last year) (17.4% up from 14.5% in 2020-21).
- **↑** Other accounted for the fourth highest proportion of location of abuse in safeguarding enquiries (was joint 5th last year) (6.4% up from 3.1% in 2020-21).
- **↓** In the community (excluding community services) was the fifth highest proportion of location of abuse in safeguarding enquiries (was 4th last year) (4.1% down from 7.5% in 2020-21).
- **→** There were no recorded Safeguarding Enquiries in Hospital – Mental Health in both 2020-21 and 2021-22.

Risk Assessment Outcomes

- **↑** Risk Identified and **action taken** continues to be the highest proportion of outcomes with 75.1% (up from 64.9% last year) of risk outcomes falling into this category.
- **↑** Risk – Assessment inconclusive and **action taken** continues to be the second highest proportion of outcomes with 9% (down from 11% last year) of risk outcomes falling into this category.
- **↑** No risk identified and **no action taken** continues to be the third highest proportion of outcomes with 6% (down from 4.8% last year) of risk outcomes falling into this category.
- **↑** No risk identified and **action taken** was the fourth highest proportion of outcomes (was 7th last year) with 5.7% (up from 2.7% last year) of risk outcomes falling into this category.
- **↑** Risk identified and **no action taken** was the fifth highest proportion of outcomes (was 6th last year) with 2.7% (down from 4.1% 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 60.4% of the time (up from 58.6% last year)
- **↓** Risk Removed in 32.7% of the time (slightly down from 33.1% last year)
- **↑** Risk Remained in 6.9% of the time (down from 8.3% last year)

Mental Capacity for concluded S42 Safeguarding Enquiries

- **↑** 46.1% of concluded S42 Safeguarding Enquiries pertained to individuals assessed as lacking capacity to make decisions as to how they were kept safe (up from 38.4% last year)
- **↓** 41.3% of concluded S42 Safeguarding Enquiries pertained to individuals assessed as having capacity (down from 49.7% last year)
- **↑** 6.8% of concluded S42 Safeguarding Enquiries pertained to individuals assessed whose mental capacity was not recorded (slightly up from 5.1% last year)
- **↓** 5.8% of concluded S42 Safeguarding Enquiries pertained to individuals assessed for whom it was not known what their mental capacity was (slightly down from 6.7% last year)
- **↑** 95.8% of people who were identified as lacking capacity were provided support by an advocate, family, or friend (up from 94.4% in 2020-21).

Making Safeguarding Personal

- **➔** 74.2% of concluded S42 Safeguarding Enquiries the individual or individual's representative were asked, and outcomes were expressed (slightly down from 74.7% last year).
- **↑** 20% of concluded S42 Safeguarding Enquiries the individual or individual's representative were asked, but no outcomes were expressed (up from 15.1% last year).
- **↓** 3.5% of concluded S42 Safeguarding Enquiries the individual or individual's representative were not asked about desired outcomes (down from 6.2% last year).
- **➔** 1.6% of concluded S42 Safeguarding Enquiries it was not recorded that the individual or individual's representative were asked about desired outcomes (slightly down from 1.9% last year).
- **↑** 0.6% of concluded S42 Safeguarding Enquiries the individual or individual's representative did not know about desired outcomes (down from 2.2% last year).

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

- **➔** Fully achieved - 47.8% (was 48.9% last year).
- **➔** Partially achieved – 40% (was 41% last year).
- **↑** Not achieved - 12.2% (was 10.1% last year).
- **➔** 87.8% of cases where desired outcomes were recorded were fully or partially achieved (was 89.9% last year).

1. Barnet Safeguarding Adults Board: Our vision and purpose

The Barnet Safeguarding Adults Board ['BSAB'] is a partnership of voluntary, statutory and community organisations. The BSAB's purpose is to enable partner agencies to review adult safeguarding practice across the borough's health, 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, in which we set out three key priority areas:

- Establish consistent practice across partnership agencies which reflect the 'Making Safeguarding Personal' principles⁴
- 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'

2. BSAB quarterly meetings

In March 2021 the BSAB Constitution was revised to streamline the subgroup structure, to reflect how we operate, and to consider issues raised regionally and nationally, for example by the LGA/ADASS Analysis of Safeguarding Adults Reviews⁵. The Board's original Quality Assurance Framework (QAF) was updated to reflect changes in the Care and Support Guidance 2016, our own priorities, learning from the National SAR analysis and local SARs. Key policies and protocols, such as the Self-neglect and Hoarding policy, and the BSAB escalation protocol were also reviewed.

In June 2021 the BSAB focused on issues highlighted in both local and national safeguarding reviews around young people transitioning from different services, education providers and locations and the need for bespoke safeguarding provision for young people transitioning into adulthood. The Board and Barnet Safeguarding Children's Partnership (BSCP) came together to review how effectively we identify those young people at risk, and what support we currently offer. BSCP and BSAB agreed to continue to work closely together to bridge the gap for young people facing potential safeguarding issues when transitioning to adulthood. Progress will also be monitored through the Vulnerable Adolescent Strategy Group.

The Board also approved a 'Making Safeguarding Personal (MSP) - Steps to success for VCFS' leaflet, which explains how to incorporate MSP principles into business as usual for all practitioners, including those working across our voluntary, community and faith organisations. This work was co-produced with VCFS organisations, was launched in June (during carers week) and was also featured at a lunch and learn event in December.

In September 2021 the BSAB focussed on recruiting members with lived experience of safeguarding to join the Board and successfully recruited three experts by experience. These three Board members have also been invited to be our delegates at the London Voices group for adults with lived experience of care and support. The Vice Chair role has also been revised and this role is now held by a person with lived experience. All of these developments support our vision that Adults at risk are heard and understood and their experiences and views shape continuous improvement.

The Board also reviewed qualitative and quantitative data on safeguarding concerns mapped against Barnet's demographics to ascertain why there is under reporting from certain communities. Discussions with the Voluntary, Charities and Faith Sector group highlighted cultural barriers that exist and prevent our ambitions to ensure all of our communities are confident to seek support from partner agencies in relation to safeguarding. We produced a [Safeguarding checklist](#) to support the Voluntary, Charities and Faith Sector, designed for smaller organisations so they can demonstrate good safeguarding practice. This supplements the many links and support for organisations to understand their role and what is expected of them, to support

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>

⁵ Available at: <https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf>

safer service delivery. We also agreed to deliver actions which improve identification and reporting of safeguarding concerns from communities where there is under reporting.

In December 2021 the BSAB sought assurance from partners that we were effectively addressing identified needs in respect of Carers and Safeguarding. Locally we have seen increasingly complex challenges to supporting unpaid carers to provide safe care during and following the Pandemic. This correlates to national research by Carers UK in 2021. Barnet Carers Centre support over 2500 adult carers and 700 young carers. It is estimated that there are up to 40,000 unpaid carers in Barnet providing care for individual with physical, mental health, sensory or cognitive impairments and learning disabilities and substance misuse. The findings from BSAB 'Gabrielle' SAR [Report & Recommendations](#) from a previous year and earlier audit activity in medical treatments demonstrated more needs to be done to support Carers to understand their rights to information, including the right to information about care and treatment plans for those they care for.

In response to this, BSAB's [Unpaid Carer's Leaflet](#) sets out their rights and responsibilities when taking on an unpaid caring role for dissemination by partner agency staff. We also hosted a 'lunch and learn' for partners, staff, volunteers and carers on 'Carers and Safeguarding'. This included a focus on the support offered by the Carers Centre, and covered numerous practical courses to support carers meet key standards in care specifically in respect of common safeguarding issues such as pressure care and manual handling.

In March 2022 the BSAB reviewed how effectively partner agencies were working together to holistically respond when adults with care and support need are at risk of domestic abuse. Nationally, the level of domestic abuse rose during the pandemic. There is still a considerable gap in our knowledge nationally and locally into the risk of domestic abuse faced by adults with care and support needs. We know we need to improve this and ensure easier access to support to safeguarding adults. In response to this BSAB and partners hosted awareness sessions and published a [7-minute briefing on Domestic Abuse](#).

For 2022-23 the BSAB has asked each partner agency to provide assurance on the steps it takes to support staff to recognise signs of domestic abuse; how to report domestic abuse and how to support carers in relation to domestic abuse. The partnership will consider what local data is available to demonstrate improvements to multi-agency practice when responding to domestic abuse against adults with care and support needs.

Throughout this period, despite pressures across health, social care and wider partner agencies posed by the pandemic, partners worked within BSAB subgroups to complete our work programme. A summary of the work completed by the Board and it's Sub Groups, and the impact this had, is given below.

3. 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 safeguarding adults reviews (SARs). The CRG also monitors the recommendations and action plans of partners where a review has taken place, and co-ordinates multi-agency responses.

There were no SARs undertaken by the Board in 2021-22.

In last year's annual report we reported on the key findings of BSAB's thematic review in response to two cases involving adults with learning disabilities who experienced harm associated with hoarding and neglect. This was undertaken to explore opportunities for improved practice across safeguarding partners to prevent similar harm occurring in future. Through our bi-annual progress and challenge events, partner agencies were able to update the CRG on steps taken to implement recommendations from the review. The review of BSAB's Self-Neglect policy now enables practitioners to explore cases from different perspectives, promoting creative approaches for family support. If risk is not reduced, cases are escalated to the 'Multi-agency Risk panel'.

The new 'safeguarding champions' programme and more accessible training should also improve implementation and use of the safeguarding policies and the application of equality and mental capacity legal obligations. Similarly, safeguarding leads from all agencies are supportive of the impact the new BSAB escalation protocol and guidance for third sector groups on 'Making Safeguarding Personal' in practice. BSAB also ran lunch and learn sessions on the findings from the review for practitioners and published learning briefings with key messages for managers and practitioners.

During the year, partners were invited to take part in two 'challenge and progress' meetings to advise the BSAB on the steps they have taken to implement recommendations from SARs carried out in Barnet and reported in previous BSAB annual reports. Partners were asked to set out their key actions.

Barnet Carers reported:

- they have ensured carers have access to information relating to fire safety, including how to receive a LFB's Home safety fire visit and assessment.
- they ensure that carers are provided with information around emergency planning and that they issue emergency support cards [Barnet Carers](#), so that if a carer is taken into hospital or otherwise unable to provide necessary care, agencies are made aware and know what support is needed for their loved one.
- that carer needs are clearly identified within support plans and that any specific needs are supported and followed up.

Barnet Mencap reported:

- support staff have received training to ensure they recognise the fire risks, especially the increased risk from the use of emollient creams.
- fire risk assessments will be renewed for all tenants.
- a staff checklist and escalation policy will be used.

The Barnet Group (TBG) reported:

- all front-line staff and managers received a London Fire Brigade Vulnerable Adults training presentation.
- a Fire safety lead officer is in place and they have contributed to LBB's Hoarding strategy.
- there is a newly updated Safeguarding policy and procedure with designated safeguarding leads for both Barnet Homes and Your Choice Barnet, including dedicated safeguarding email inboxes.
- staff receive safeguarding training as part of induction and every two years after.
- fire safety works have been completed to all high-risk buildings under TBGs portfolio all people supported by TBG who have a support plan will have a risk assessment that reflects risks around fire safety.
- PEEPs are in place for all people who may need assistance to evacuate their homes or our buildings in the event of an emergency.
- all people with LD will be encouraged to uptake annual health checks, and attend pre-planned appointments with health professionals to help a greater uptake of annual health checks.

CLCH reported:

- that there has been improved practice that implementing a No Access, Not seen, and disengagement Policy has had on supporting adults with a learning disability to access healthcare and work with their carers or family to ensure reasonable adjustments are made.
- this policy has also been revised and formulated to provide CLCH staff a step-by-step guidance how to deal with no access to patient homes, disengagement and was not brought (face to face, virtual, phone).
- delivery of bespoke 'No access' training which was delivered to community nursing services, No access training is also delivered at Level 3 Safeguarding Adults at Risks training and has been added to the statutory mandatory training booklet.
- ran a campaign to launch revised No access Policy.

Royal Free Hospital reported:

- an individualised risk assessment is in place for every adult and proportionate escalation/mitigation plan for patients who did not attend or was not brought by monitoring via safeguarding process, supervision, and internal incident reporting system.
- power of attorneys/ deputyship is reviewed as part of any best interest meeting.

London Fire Brigade reported:

- an Adult Safeguarding Policy is available to all front-line staff and is the part of initial and ongoing maintenance of skills training.
- recent review of the policy has improved automated Safeguarding and Welfare concern reporting, with a new pathway created.
- a dedicated SAR Champion works across London to support local practice. They also manage the LFB's SAR library and provides support to officers who attend SABs.

Barnet Enfield Haringey Mental Health Trust reported:

- policies have been reviewed for adults who 'did not attend' and adjustments have been made to discharge practices if the adult is dependent on others to access medical treatment or necessary support services.
- Risk to self and others is on their standard risk assessment forms.
- The fire referral form is on the intranet, fire safety is now part of the induction and fire Safety Training is also covered in the level 3 safeguarding training for all professionals (BEH report 90 % compliant levels for staff against NHSE/I training targets).
- BEH safeguarding team audits 'making safeguarding personal' quarterly to ensure the adult at risk's voice is being heard.
- there is an expectation for all health care professionals to provide contingency plans to ensure an adult's care and treatment is provided without interruption.

4. Professional and Quality Assurance 'PQA' Group

Effective quality assurance drives continuous improvement and is recognised as a critical function of the BSAB. The PQA group provides assurance that local safeguarding arrangements are in place and work effectively, with risks and concerns 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 considers reports from partner agencies detailing their internal audits or in respect of audits 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.

During the course of 2021-22, the group reviewed the data collected and agreed it was necessary to scale back data collected to ensure we could focus on what is priority for partners. People with expertise from partner agencies were asked to join the group. The Terms of Reference of the group and membership was reviewed and a New Chair and Vice Chair were appointed, the vice chair was drawn from VCFS organisations to reflect the parity of esteem and underline the crucial role such groups have in our partnership.

As a result of their quality assurance activity, the PQA subgroup is also well placed to identify gaps in workforce learning across the partnership or areas which requires increased public awareness. This information feeds directly into the Board's workplan by assisting us to identify topics to cover within our monthly 'Lunch and Learn' sessions.

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 following safeguarding training has been offered the BSAB partnership workforce mainly online.

1. Deprivation of Liberty Safeguards (DoLS)
2. Mental Capacity Act 2005
3. Safeguarding Adults - Level 1
4. Safeguarding Adults - Level 2

Attendance breakdown for 2021-22

| Course Name | | Total |
|---|--|--------------|
| Fire Safety Internal (delivered by LFB) | | 69 |
| Fire Safety External | | 68 |
| Safeguarding Courses | Safeguarding Adults - Legal Literacy | 7 |
| | Safeguarding Adults- Working With Unpaid Carers | 16 |
| | Liberty Protection Safeguards | 56 |
| | Safeguarding Adults - Conducting Enquiries | 31 |
| | Safeguarding Adults - Policy and Procedures | 25 |
| | Safeguarding Adults - Legal Literacy | 24 |
| | Collating & Recording a Safeguarding Plan | 23 |
| | Safeguarding Adults - Enquiry Report Writing | 35 |
| | Managing and Chairing Safeguarding Meetings for Managers | 17 |
| | Safeguarding Adults - Live Themes | 13 |
| | Safeguarding Adults - Working with Outcomes: From Concern to Closure | 8 |
| Total | | 392 |

The Board also runs monthly lunch and learn sessions, which are bitesize webinars for practitioners across our partnership workforce, held on the last Tuesday of each month. Throughout the year, these sessions were well attended by 20 to 50 participants per session with at least 420 people engaging over the year. The following topics were covered in 2021-22:

- **April 2021:** The lessons arising from BSAB's published Safeguarding Adults Review in respect of 'Gabrielle'
- **May 2021:** The 'making safeguarding personal principles'
- **June 2021:** Professional curiosity and embedding the 'making safeguarding personal/ principles'
- **July 2021:** Impact of anti-Semitic and anti-Islamic abuse on those in our community with care and support needs
- **August 2021:** The lessons from a thematic review - responses when concerns are raised in respect of adults with learning disabilities
- **September 2021:** Principles of risk assessment and risk management tools
- **November 2021:** Financial abuse

This remains a key priority for the BSAB and further work is being undertaken in 2022-23 to improve our detection rates and responses to protect adults with care and support needs from financial abuse and economic coercion.

- **December 2021:** Safeguarding and Carers
- **January 2022:** ‘Think family’ and domestic abuse run jointly with the Barnet Safeguarding Children’s Partnership (BSCP)
- **February 2022:** Adult with care needs and equal access to justice
- **March 2022:** Domestic abuse

5. The Access to Justice Group [‘AtJ’]

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 Access to Justice Sub-group met every quarter and enjoys representation from some of the key stakeholders in Barnet. The group in 2021-22 were committed to identifying the barriers 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 criminal justice system, and reports its findings and proposals to the Barnet Safeguarding Adults Board and Barnet’s Community Safety Partnership.

Hate Crime Reporting Project

- A Hate Crime Strategy for Barnet was approved by the Barnet Safeguarding Board and the Safer Communities Partnership Board. This has helped to coordinate the efforts to tackle hate crime and encourage residents to report it.
- There has been a record number of disability hate crimes reported this year (see table below), building on the training and workshops provided for professionals and people with lived experience across the borough. The Project reached two hundred residents at events during Hate Crime Week and signed up 50 Champions who will support residents in the community to report Hate Crime.
- The Hate Crime Reporting Coordinator has also developed the Safe Places scheme for adults with learning disabilities. The Project focuses on the interface between safeguarding, disability hate crime and, increasingly, violence against women and girls, to increase the understanding of what this means when keeping people safe.
- The table below sets out hate crime incidents recorded by the Metropolitan Police for the borough of Barnet

| Category of Hate Crime | Apr 2020 – Mar 2021 | Apr 2021 – Mar 2022 |
|------------------------|---------------------|---------------------|
| Race and Religion | 787 | 826 |
| Anti-Semitism | 128 | 154 |
| Islamophobic | 11 | 33 |
| Disability | 14 | 23 |
| Homophobic | 72 | 67 |
| Transgender | 5 | 13 |

Autism and Access to Justice

- The national Autism Strategy has been updated and highlights the importance of improving the support for autistic people in the youth and criminal justice system. The AtJ group has invited commissioners and Autism leads in the borough to explore how this can be done locally.
- Work is needed to identify autistic people who encounter the criminal justice system, to increase the understanding and acceptance of autism by criminal justice staff through training and briefings, to explore how to adapt custody procedures, alternatives to prosecution, and support for victims and witnesses. This work is also incorporated into Barnet’s multi agency Autism Action Plan.

Restorative Justice

- Work to increase awareness of restorative justice models, how it can benefit people who have been abused, has increased this year.

- Four short films were made by Middlesex University and Why Me, these were launched in Barnet and won at the national Learning on Screen awards.

6. What partners said about the work of BSAB

North Central London Integrated Care Board:

- Partners collaborated and responded very quickly to the pandemic. For example, the VAWG partnership started weekly meetings to assure that steps were taken to support people at risk of an escalation in DVA; MARAC meetings also moved to weekly; MASH started weekly meetings with health partners to triage and respond to new referrals to the Prevent Channel.
- The team worked together to support some individuals who could have been negatively affected by the restrictions. The partners reported into the SAB via the subgroup reports.

Barnet Enfield Haringey Mental Health Trust:

- An example of where learning from SARs in other boroughs has driven change in BEH MH trust is the implementation of a sexual safety and domestic abuse coordinator. One of the main themes running through the SARs that we have been involved with, is the presence of domestic abuse and family violence.
- In a bid to improve our response and preventative measures in this area, we have created an additional role in the safeguarding team - Domestic abuse and sexual safety coordinator.
- As a mental health trust, we have also found that we work with a proportion of perpetrators and we need to push forward the agenda around this.

London Fire Brigade:

- Whilst some LFB community safety work was suspended or restricted during the pandemic the benefit of relationships developed via the SAB assisted in prioritising cases.
- Collaboration was still affected with the use of IT systems, however due to a change in LFB Borough management previous face to face relationships had not been made, which may have reduced the efficiency slightly.
- The total LFB adult safeguarding referrals for years 2018/19 (pre-covid) were 2,093 as opposed to 2021/22 which was 3,385.

Central London Community Health NHS Trust:

- BSAB has welcomed research by Michael Preston Shoot to influence the board's work and priorities. BSAB has utilised the SAR in Rapid Time model to support a more efficient and effective approach to identifying learning, improving information sharing and utilising legal options to protect vulnerable people.
- A number of multi-agency audits completed and themed approach to work (Adult A and Adult B) in progress to review how the system works to protect and represent learning disabled.
- Policies and procedures have been amended in light of the Board's work.
- BSAB Case Review group actively led by CLCH was well attended and includes feedback from local (neighbouring boroughs) and national SARs and research.

Barnet Mencap:

- The introduction of a new checklist should help the organisation to collect and reflect on what individuals say at the beginning of safeguarding enquires.
- Regarding the learning from SARS the BSAB has introduced training/briefing sessions and improved the website. However, more could be done to promote these two initiatives. People still don't always know what information is available or how to find it.
- The main learning from the SLIP Review has been the need to escalate concerns in an appropriate and timely way between statutory social work teams and the VCS.
- Safeguarding was specifically the focus of the MASH/VCS group and that needs to continue.
- It is a great forum for discussing case dilemmas, sharing lessons from reviews and providing updates on changes or new innovations relevant to safeguarding.

7. Attendance at the Safeguarding Adults Board meetings 2021-22

| Organisation | June 2021 | September 2021 | December 2021 | March 2022 |
|---|-----------|----------------|---------------|------------|
| Local Authority – Adults & Health | | | | |
| Local Authority – Community Safety | | | | |
| Local Authority – Public Health | | | | |
| Royal Free London NHS Trust | | | | |
| North Central London CCG | | | | |
| Central London Community Health NHS Trust. | | | | |
| Barnet Enfield Haringey Mental Health Trust | | | | |
| Barnet Safeguarding Children Partnership | | | | |
| London Fire Brigade | | | | |
| Barnet Group | | | | |
| Barnet Mencap | | | | |
| London Probation Service | | | | |
| Inclusion Barnet | | | | |
| CommUnity Barnet | | | | |
| Barnet Carer Centre | | | | |
| London Metropolitan Police Barnet | | | | |
| | | | | |

8. BSAB Partner financial contribution 2021-22

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

9. 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: socialcaresdirect@barnet.gov.uk

Or call the police on 101. In an emergency call 999.