



Merton
Safeguarding
Adults Board

Annual Report

2020/21



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It required all agencies to work together in partnership and I would like to thank all our partners for doing just that in such a committed and productive way.

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Message from Chair

This report covers the work of the Merton Safeguarding Adults Board (MSAB) during the period April 2020 to March 2021 and reflects on probably the most challenging time that public services have ever faced. Our job was to continue to ensure that policies and actions were in place to prevent harm, abuse and neglect wherever possible. The demands and impact of the pandemic made this challenging and meant adapting to new ways of working and finding new ways to ensure that residents were protected. It required all agencies to work together in partnership and I would like to thank all our partners for doing just that in such a committed and productive way. You will see examples of the partnership working throughout the report. In a period of lockdown it was inevitable that safeguarding concerns would rise and we have developed new ways of responding and increased training to keep safeguarding at the forefront of public service.

The challenges posed by the pandemic were not only felt by front line staff. All residents and their families faced both economic and social challenges of their own; particularly those caring for vulnerable family members or dealing with the loss of a loved one. I would like to thank our voluntary sector partners who together with many volunteers worked to support families in their local communities and to keep them safe.

Residents themselves also told us when they were concerned about a neighbour, friend or family member. We appreciate this as it helps us as a Board to continue to be vigilant and responsive to the concerns of local communities.

Looking back over the year 2020/21 has given us as a board a chance to reflect on what has gone well and what needs to change and this has helped to shape our work programme for the current year.

We look forward to continuing to work across agencies and with local residents to make Merton a safer place.

Aileen Buckton
Independent Chair –
Merton Safeguarding Adults Board



Safeguarding Adults in Merton

The Merton Safeguarding Adults Board (MSAB) work together as a partnership to prevent abuse and neglect.

When someone has experienced abuse or neglect, we are committed to responding in a way that supports their choices and promotes their well-being. This is known as Making Safeguarding Personal.

What we do and how we do it

The role of the MSAB is to assure itself that local safeguarding arrangements are in place to help and protect adults in Merton.

Our main objective is to assure itself that local safeguarding arrangements and partner organisations act to help and protect people aged 18 and over in the area who:

- have needs for care and support are experiencing, or at risk of, abuse or neglect (as a result of their care and support needs) are unable to protect themselves from either the risk of, or experience of, abuse or neglect regardless if the local authority are funding care or not

Core Duties

We develop a strategic plan and publish an annual report of the work of the board. We also commission Safeguarding Adults Reviews (SAR) for any cases that meet the SAR criteria.

The Merton Story

What is the Merton story?

- ✓ Summary of the Joint Strategic Needs Assessment (JSNA)
- ✓ High-level health profile of Merton's population
- ✓ Statutory requirement of the Health and Wellbeing Board

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✗ Not a review of services or series of recommendations

Merton Story 2021 - Special considerations

Focus on COVID-19 impact and inequalities in Merton

Limited 2020 data available at local level

Resident 'Voice' incorporated throughout, including engagement work from BAME voice, MenCap, AgeUK and Young Inspectors.

Useful Resources



Merton Joint Strategic Needs Assessment (JSNA) is available online and gives an overview of the health and wellbeing of Merton residents.

The Merton Story provides a snapshot of local needs through the JSNA

Health Profiles by ward and comparing east and west Merton

Health Needs Assessments e.g. CYP SEND JSNA Profile 2020

Merton data provides an overview of Merton level demographics

Annual Public Health Reports including Tackling Childhood Obesity Together; Tackling Health Inequalities - Closing the Gap; Diabetes Whole System Approach

Merton Health and Wellbeing Strategy

Merton Local Health and Care Plan

Public Health England - PHE Fingertips

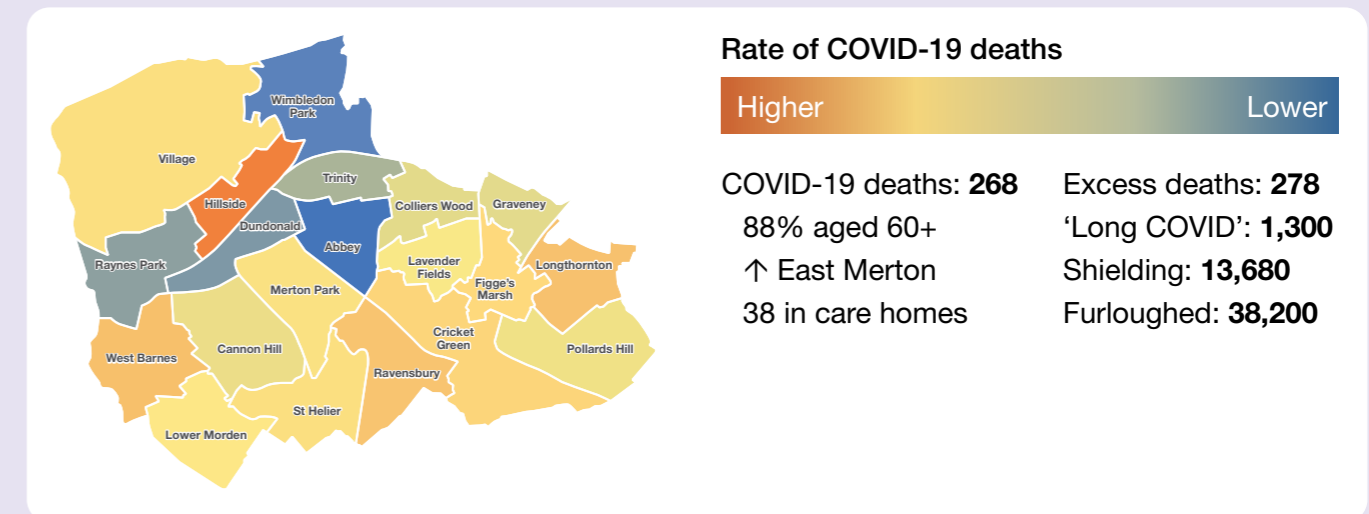
Merton's population

COVID-19 impact: expected total population fall for 2020



COVID-19 direct impacts (Jan – Dec 2020)

Existing health and social inequalities amplified by COVID-19

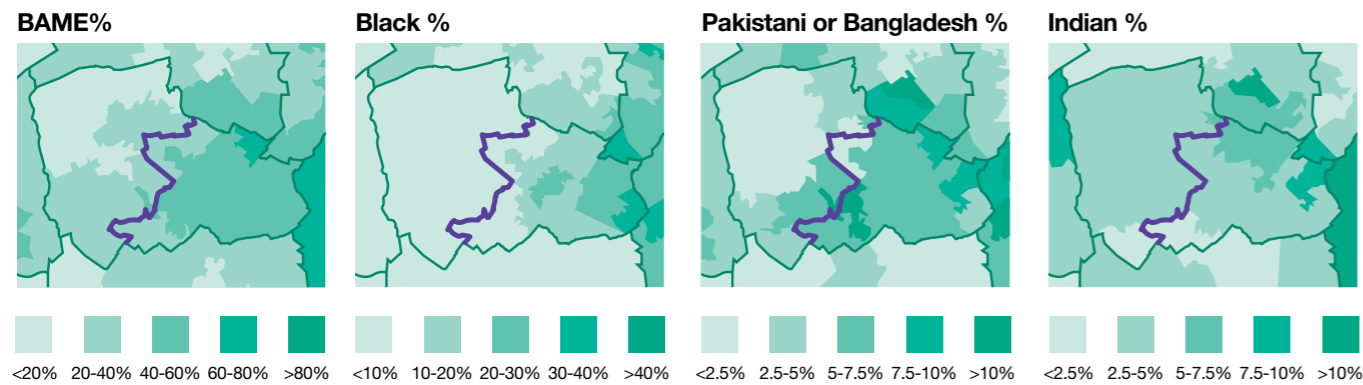


Population Breakdown

	White	BAME	White British	White Other	Asian	Black	Mixed	Other
Merton	63.1%	37.0%	41.3%	21.7%	20.5%	9.2%	5.4%	1.9%
London	56.3%	43.7%	38.3%	18.1%	20.5%	13.4%	5.8%	4.1%

Proportion of the 2021 Merton and London population broken down by ethnic groups.

The geographic distribution of ethnic groups in Merton is not uniform. A larger proportion of Black and Asian Minority Ethnicity (BAME) groups live in the Eastern half of Merton, while a larger proportion of White ethnic groups live in the West of the Borough.



Ethnic minority groups in Merton by MSOA – 2011 UK Census. Please note figure legend thresholds may not align.



Wellbeing in Merton

Before the pandemic, 22.2% of Merton residents reported a high anxiety score compared with 22.4% London and 21.9% England (2019/2020). The average anxiety score reported by residents in this period was 6.9 (out of 10). However, early in the pandemic (April 2020 – September 2020) this score increased to 3.3.

In Merton there has been a slight increase in alcohol related deaths in hospital in 2020/21, when compared to 2017–2020 (an average of 17 deaths in 2020/2021 compared with 15 deaths per year in 2017–2020). This is keeping with national trends. There has also been an overall increase of 8% in alcohol related hospital admissions for the same time-period

In relation to safeguarding adults at risk, partners have developed and continue to develop innovative ways of reaching people, particularly during lockdowns. Along with volunteers, they have been working hard to provide information, advice and support to residents of Merton.

Our Priorities for 2020/21

Priority 1:

We will ensure that partner agencies work together to prevent abuse and protect adults at risk of abuse and neglect.

Priority 2:

We will strengthen our communication and engagement across groups and communities in Merton to increase public awareness of safeguarding adults and to ensure that our plans and actions are informed by the experience of the widest range of local people.

Priority 3:

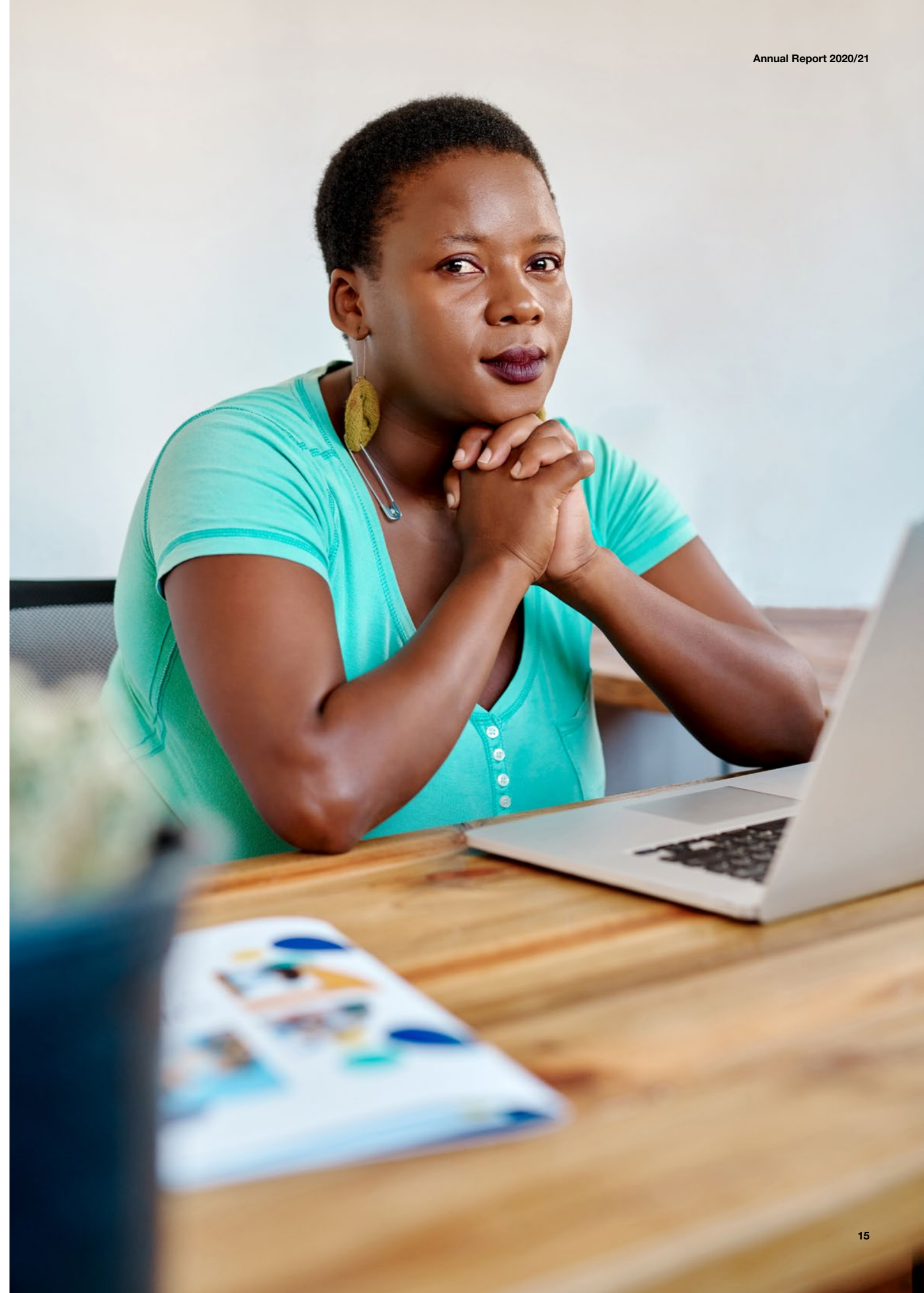
Together we will learn from experience and support both paid and unpaid staff across the partnership to continually build confidence and the effectiveness of everyone's safeguarding practice.

Priority 4:

We will understand how effective adult safeguarding is across Merton to ensure that we identify emerging risks and take action accordingly.

In 2020/21 we said we would

- Hold a 'Challenge Event', focusing on the MSAB partnership and the effectiveness of partnership working. It will concentrate on what we do in partnership, rather than what we are doing within our own organisation. It is envisaged that it will enable the MSAB to demonstrate more clearly what contributors have achieved and where there are strengths and challenges in how partners work together.
- Aim to develop robust systems for the SAR process, as well as gaining assurance around multi-agency learning from SAR's. Learning will be shared via the Learning and Development subgroup, before the Quality and Performance subgroup seek assurance from partners that learning has been embedded in their organisation.
- Aim to develop a multi-agency learning and development strategy, based on a competency framework and capturing safeguarding adult related training undertaken by all partners. Also, we will promote access to E-Learning training to the private and voluntary sectors.
- Aim to develop the MSAB data set and quality assurance framework. This will assist with measuring the impact of our work as well as identifying the need for improvements. We want to know that what we do is making a difference.
- Aim to develop our communication strategy to focus on building links with service users, carers and the local community. We will also reach out to Black, Asian and Minority Ethnic communities as well as people who are seldom heard to ensure their voices count.



What we've done so far

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- Due to the pandemic pressures we had to push back the 'Challenge Event' to May 2021. We will update on this in the next Annual Report. However we did receive lots of useful contributions from partners demonstrating the effectiveness of the board partnership and indeed how we work to keep adults at risk safe. If the pandemic has taught us anything, it's that we need each other more than ever to be assured that adults at risk in Merton are kept safe.
 - In 2020/2021 we reviewed our Safeguarding Adults Review (SAR) Protocol and the board agreed a new protocol to assist us with the SAR process. Our Decision Tree has allowed us to be more focused around how we consider each SAR referral, as well as how we make decisions regarding our recommendations for a SAR. Learning from SAR's has generated at least one extremely well attended multi agency learning event and a number of changes to policies and procedures. Learning is being shared via the Learning and Development Subgroup, before the Performance and Quality Subgroup develop ways of seeking assurance from all partners that learning has been embedded in all organisations.
 - The Learning and Development Subgroup have produced a draft Learning & Development Strategy as well as a Training Competency Framework. It will shortly go to the board for sign off. They have also been working on securing safeguarding training for the voluntary sector and the wider partnership. This year, during the National Safeguarding Adults Week, members of the MSAB hosted a number of workshops for staff across the partnership. Areas covered included cuckooing, self-neglect and hoarding, scams, and safeguarding adults in the community. Professor Keith Brown also provided a very useful presentation to the Board on Scams titled The Persuasive Power of Language.
 - In 2019/2020 we started the process of building systems to collect meaningful data from our partners. This is to assure the Board that we have valuable insights into safeguarding activity across the partnership. It's essential that we understand what is happening in Merton, in terms of safeguarding but more importantly understanding where we need to raise awareness and provide support. We have been working closely with our leads in the voluntary sector to understand how best we can do this and for the Board to be able to support this very important area of our work. A workshop was held with leads and our independent Chair to discuss a plan going forward. We also surveyed partners to better understand what further work needs to be done.
 - The implementation of a quality assurance framework for the MSAB is being worked on for 2021/2022
 - Our Communication Strategy for the Board has been developed. The focus is on the COVID-19 recovery as well as strengthening links with service users, carers and the local community. We have begun developing mechanisms to enable this to happen. Our links with Black, Asian and Minority Ethnic people as well as the seldom heard have begun. Our Voluntary Sector lead and Commissioning lead are providing a bridge to those communities. Work is progressing well.

Our Priorities – Feedback from Partners

Safer Merton is a key member of Merton Safeguarding Adults Board. They ensure a coordinated partnership approach in response to Violence Against Women and Girls (VAWG).

In 2020/21 they continued to raise awareness of Domestic Violence and Abuse (DVA) and VAWG across the council, partnership and community, as well as fulfilling policy and statutory requirements, specifically conducting Domestic Homicide Reviews. At present there are two active reviews ongoing. Work has also been carried out in relation to co-ordinating the forthcoming implementation of the Domestic Abuse Act 2021.

During the lockdown there were a number of initiatives developed focusing on safety and the increased prevalence of domestic abuse. In terms of cases we saw up to a 70% increase in cases to our community Independent Domestic Violence Advocacy Services (IDVA's) and complex needs IDVA's. There was also a 20% increase to our Multi Agency Risk Assessment Conference (MARAC).

An application was made to the COVID-19 Recovery Fund Pot and there has been subsequent funding for a community Independent Domestic Violence Advocacy Service (IDVA) for 12 months to help with the increase in cases. Social media campaigns were made available to let victims know that they could leave their house despite lockdown if people were fleeing domestic abuse. Also information regarding support services were

advertised informing them that services were still open and supporting victims and survivors.

Safer Merton established a task group to consider how to develop safe and confidential opportunities for women and girls to share their experience with the Council and partners. This provides insight, which informs the work on reducing VAWG, as well as addressing male behaviour and exploring the use of restorative justice as part of our response to VAWG.

Commissioning and managing the delivery of front-line services for victims of Domestic Abuse continued.

During 2020/21 staff at **South West London & St Georges Mental Health Trust** worked under exceptionally difficult circumstances and continued to adapt the way they delivered services and the way they worked with stakeholders in response to guidance on COVID-19. Working arrangements for each service were led by the needs of that specific service and ensuring they delivered the best care to patients.

The Trust has remained fully open for business to look after the people who use their services, carers, friends and family. They have made sure that staff at all levels have been supported with the often complex challenges of safeguarding adults at risk of abuse and neglect.

Throughout the year, there were important quality improvement initiatives. They included,

embedding the principles of Trauma Informed Care (TIC) across services; providing overarching support for key policy initiatives to promote service user's wellbeing, including policies on Restrictive Practice, Domestic Violence & Abuse, and Sexual Safety.

In Merton, focus has been on agreeing a consistent approach across services to the way Merlin's are received. Also embedding the consistency of reporting Safeguarding within the Trust Incident System and the smooth transfer and actioning within Local Authority data system. To ensure community staff are kept updated, they receive information coming from the Merton Safeguarding Adults Board and the Trust Executive Safeguarding Meeting.

In December 2020, the Trusts Domestic Violence & Abuse working group were commended for its work at the second Annual Conference. They also secured a new part-time post on a six-month contract to provide support to staff, service users and carers to manage the concerning increase of local and national reports of domestic abuse.

The Trust re-launched its policy requiring inpatient services to better manage staff and service user's sexual safety. All inpatient services are being supported to meet the National Sexual Safety Standards.

The Metropolitan Police Borough Command Unit (Met's BCU) in the South West begun working on processes to improve adult safeguarding work. This includes appointing

a dedicated Detective Inspector to lead on adult safeguarding. By doing this they aim to strengthen the Met's responses and engagement, raise the adult safeguarding agenda within policing locally, develop a network of subject matter experts around adult abuse and embed learning from Safeguarding Adults Reviews (SAR's). In 2020/21 the police co-chaired the SAR subgroup, a subgroup of the Board.

In line with the priorities, a cuckooing protocol was developed with partners, which includes clear referral pathways for police and other professionals. It also includes tactical options for officers, to better identify and support victims of cuckooing and target perpetrators.

The SW BCU continues to be fully engaged with the MSAB and sub group meetings as well as other multi agency panels including Multi Agency Risk Assessment Conference and Community Multi Agency Risk Assessment Conference.

Colleagues in the **South West London Clinical Commissioning Group** continue to ensure commissioned providers across SWL and including Merton are using the Safeguarding Adults Monitoring Framework. They report their safeguarding adults Key Performance Indicators to the CCG to demonstrate that they are discharging their statutory safeguarding adults' duties. They acknowledge that since the appointment of a new Independent Chair in March 2020, ongoing development of the strategic direction and planning of the MSAB has been the priority focus for them as well as the Boards partners.

Key initiatives to establish and embed effective multi agency subgroups to support and inform the ongoing direction of the MSAB were highlighted in 2020 as a matter of priority. Also a focus has been on the development of the engagement strategy for partners to the Board and included strengthening links with the voluntary sector, provider services and wider stakeholders.

Our Central London Community Health (CLCH) NHS Trust partners have continued to operate a Safeguarding Team 'duty' system seven days a week at the height of the first lockdown (April – June 2020) to support staff accessing timely advice and support.

They continued their Robust COVID-19 response with enhanced safeguarding provision including virtual drop-in session for safeguarding supervision for staff in both children and adult services.

Adult safeguarding one to one and group supervision sessions within CLCH included combined sessions with safeguarding children practitioners to promote and embed a 'Think Family' approach to care and support. The 'Think Family' approach is something we are encouraging all Board partners to consider as a way of supporting adult and children's safeguarding.

A workshop on self-neglect was delivered to all complex case management teams and specialist nursing teams. As well as this the adult safeguarding team in Merton hosted a 7 minute

Learning workshop which touched on self – neglect and hoarding. As a result the Hoarding Policy was updated and work on developing a multi-agency risk panel begun.

Two cohorts of safeguarding and Mental Capacity Act champions graduated in 2020/21, also two network days were organised for update and supervision with all champions.

Strong partnerships working continues and CLCH are represented at the Board as well as the subgroups. The CLCH Associate Director of Safeguarding co-chairs the SAR subgroup. Also the CLCH safeguarding adults lead also co-chairs the Learning & Development Subgroup.

Age UK continue to work in partnership with other agencies to improve outcomes for service users. This ensures that the people receive the best support possible and their needs are person-centred.

Increased capacity across services has helped the organisation to meet an exponential increase in demand, particularly during the pandemic. The resources to conduct home visits have been invaluable during this time for identifying safeguarding concerns that may otherwise have gone unchecked.

The London Fire Brigade (Merton) have introduced a new electronic and interactive Safeguarding Adults Referral form for all staff that has been very well received. The new referral system has provided another opportunity to highlight the importance of safeguarding to staff,

and has also encouraged staff to make referrals through the ease of using the new form. Talks have begun with the Safeguarding Adults and Deprivation of Liberty Safeguards (DoLS) Team Manager and the Borough Commander regarding a training programme for Fire Service staff.

Merton Connected set out to review the safeguarding policies and procedures across the local voluntary, community and faith sector, with a view to developing, in partnership with Board, a training offer that will ensure consistency in knowledge base and the implementation of good practice. This work sits with the Learning and Development Subgroup of the Board.

They continue to promote the importance of safeguarding as well as organisations safeguarding responsibilities by, ensuring it becomes an integral part of the Merton Connected grant giving application due diligence process. All applicants now have to provide a copy of their safeguarding policy and procedures as part of application. These are routinely reviewed and in instances where they do not meet current good practice standards, one to one assistance and support is offered from the team to help them develop a policy that is fit for purpose.

In response to feedback from the Voluntary Sector Forum organisations, discussions are underway regarding the establishing of a safeguarding officer forum for the Voluntary Sector. A quarterly meeting is currently held for representatives from organisations commissioned by Adult Social Care. They

discuss issues and emerging themes often around safeguarding adults. Suggestions are being considered for invitations to this meeting to be extended to include a wider cohort of organisations, also that Action Learning Sets are incorporated within these meetings.

Priorities for the coming year include developing and implementing a local 'Volunteer Passport' which will include safeguarding as one of the core training modules. Also to develop and implement a local quality assurance standard for VCF sector organisations.

HealthWatch Merton's success in 2020/21 has been measured in how they have been able to share local intelligence and influence local safeguarding improvements. Over the last year they have been able to develop a closer relationship and greater shared understanding of their role in adult safeguarding. This has led to them to be able to support the Board with improving communication and engagement for local people.

The Communication and Engagement Sub Group of the Board, has created a space to review the experience and journey for people going through the safeguarding process locally. This has enabled Healthwatch Merton to provide a greater sharing of their insight and perspective, with the aim of enhancing a person's understanding and support needs. Plans are in place for continued work around the voice of people with lived experience in the coming year.

The Work of the Subgroups of the Board

The SAR Review Sub-Group

The SAR Sub-Group manages and oversees the Safeguarding Adults Review (SAR) process in Merton and is led by the Assistant Director of Housing & Community and the Met Police. The group met six weekly and representation included the London Borough Merton, the Metropolitan Police, South West London Clinical Commissioning Group (CCG), St George's University Hospitals NHS Foundation Trust, London Fire Brigade and Central London Community Healthcare NHS Trust.

Safeguarding Adults Reviews as well as other non-statutory reviews and reports were considered and monitored. This included the local annual reports for The Learning Disability Mortality Review Programme (LeDeR), Domestic Homicide Reviews and Drug and Alcohol Related Deaths. Reviews are reported on separately in this report. The group have continued to improve the processes for considering reviews as well as identifying themes for learning from reviews. In 2020/21 there has been an emphasis on looking at the way we consider drug and alcohol deaths and work continues with Public Health colleagues to improve our reporting mechanisms and systems.

Performance and Quality Subgroup

This group aims to oversee the collective performance of partner agencies in Merton in relation to protecting adults at risk of abuse and neglect. The group meets quarterly. Its main focus this year has been to develop a dashboard that includes data from agencies across the partnership. We have surveyed partners in order to establish what data is currently being collected and how we can develop a dashboard that includes meaningful data from all agencies. There is also a focus on ethnicity data and an analysis of what this tells us about the work needed in the Black, Asian and Ethnic Minority communities in terms of engagement and awareness raising.

Learning and Development Subgroup

This group aims to develop robust mechanisms to assure the Board of good practice regarding safeguarding adults in workforce development, quality of training and monitoring training standards across agencies. A key focus is on emerging learning and findings from Safeguarding Adults Reviews and how it is shared effectively. This year there has been a revamp of this group to include key partners becoming members. Also an assessment of the training and development happening across the partnership has been achieved. A draft learning and development strategy has been developed, as well as a training competency framework and a training plan. Moving forward, the group is working on ensuring a safeguarding adult's E-Learning programme is available for partners, particularly those in the Voluntary Sector to access.

Communication and Engagement Subgroup

The Communication and Engagement subgroup has continued to raise the profile of the work of the board and promote awareness of safeguarding adults via the Merton Safeguarding Adults Website. During the pandemic the website has been used to convey important messages relating to COVID-19 and the lockdown. The group have developed a communications strategy, setting out pathways for awareness raising and engagement with a wide range of stakeholders, service users, carers and the public. An area of focus in the coming year is on Making Safeguarding Personal and listening to the lived experience of people involved in the safeguarding process.

COVID-19

Impact

As well as working on the priorities for the Board this year in Merton, COVID-19 assurance, recovery and learning has been a key priority. There has been a focus on gaining understanding of key vulnerability factors and risks being experienced during the pandemic impacting on wellbeing and safety of individuals. What we have tried to do is develop systems and processes that assist us with the minimising of the risks identified as well as providing appropriate support during this difficult time. Our partners in Merton have worked together to ensure safeguarding adults continues to be a priority.

COVID-19 and Black Lives Matter

The Board and its partners responded to the concerns of Black, Asian and Minority Ethnic staff (BAME), including anxiety caused by the disproportionate impact of COVID-19 on the BAME communities, coupled with the killing of George Floyd.

In Merton Council the senior leadership team set up, in conjunction with senior managers in Adult Social Care, a series of four workshops for staff. It provided a safe space for staff to come together to share how they were left feeling following the awful events.

From these workshops it became evident that staff wanted a regular forum to discuss matters pertinent to them. As such the Race Equality Network (REN) forum was set up. This was timely as head lines were frequently referencing the disproportionate impact that COVID-19 was having in those communities.

Merton Council were selected to be a pilot site for the Workforce Race Equality Standard and are committed to sharing datasets on the nine standards. The data gathered is for all staff and not just for social care staff. The REN looks forward to reviewing the data set to examine what it tells us.

South West London & St Georges Mental Health Trust organised a webinar with members of the Evolve (BAME) Network and the CEO. The main questions were related to risks assessments, PPE and challenges in the workplace. Five additional webinars were arranged with the BAME Network. Managers were asked to encourage BAME staff and those in high risk categories to have conversations with them about their experience and any health and wellbeing concerns using the risk assessment process.

Care Homes

Throughout the pandemic safeguarding adults has remained a statutory duty and duties have not been 'eased'. The Care Act Easements guidance 2020 points out that it is vital that local authorities continue to offer the same oversight and application of Care Act 2014 Section 42 duties as before, but that responses are **proportionate, and are mindful of pressures on Social Care providers**.

Care homes across Merton have faced many challenges throughout the COVID-19 pandemic; managers and staff have worked tirelessly to help protect and champion the wellbeing of both their residents and staff. The Public Health and Adult Social Care teams at Merton Council have provided additional 'wrap-around' support, which we explore below.

From the outset of the pandemic the Council invested significant time, effort and funding in sourcing and securing PPE for onward distribution to care homes across the Borough at no cost to the homes. During 2021/22 some 1.25million items of PPE were delivered by Council staff to care homes in Merton.

Throughout the pandemic, Merton Council staff have been answering questions from care homes and helping to interpret government guidance and to support care homes to maintain the safest care they can for residents and staff. Council staff have worked in partnership with care homes to troubleshoot challenges such as signposting to COVID-19 testing portals, supported ordering PPE once the National portal went live, providing advice and guidance around testing, management of COVID-19 outbreaks and supporting care homes to reintroduce visiting in a COVID-19 secure way. This has also provided a great opportunity to strengthen the relationships and communication between the Council and care homes.

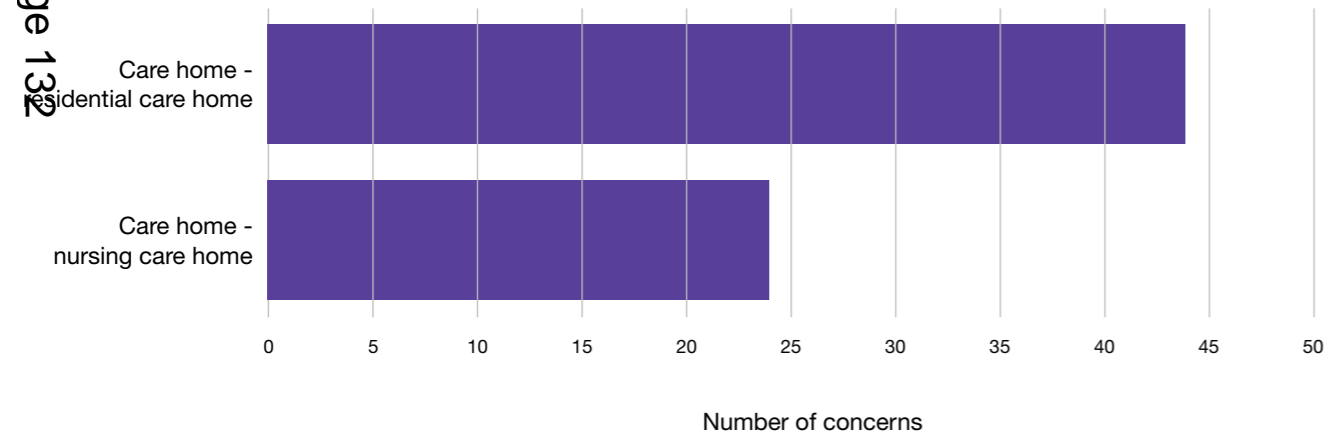
Merton staff have worked with care homes to develop care home IPC (infection prevention and control) champions, who support and promote the importance of IPC in everyone's daily working life and to build resilience and sustainability in IPC practices across Merton.

Each safeguarding team member acted as a care home link officer and were allocated a cluster of care homes. The remit of the link officer was to make telephone contact and digital/online contact with each registered Manager and deputy fortnightly. They forged close relationships with the Managers of the home whilst familiarising themselves with the issues within the home and supporting the home to mitigate and reduce the risks for the residents.

This partnership working has provided an opportunity to promote wider public health messages to care homes, including information on dementia. The Public Health and Adult Social Care team have also helped signpost training opportunities for care home Managers and staff.

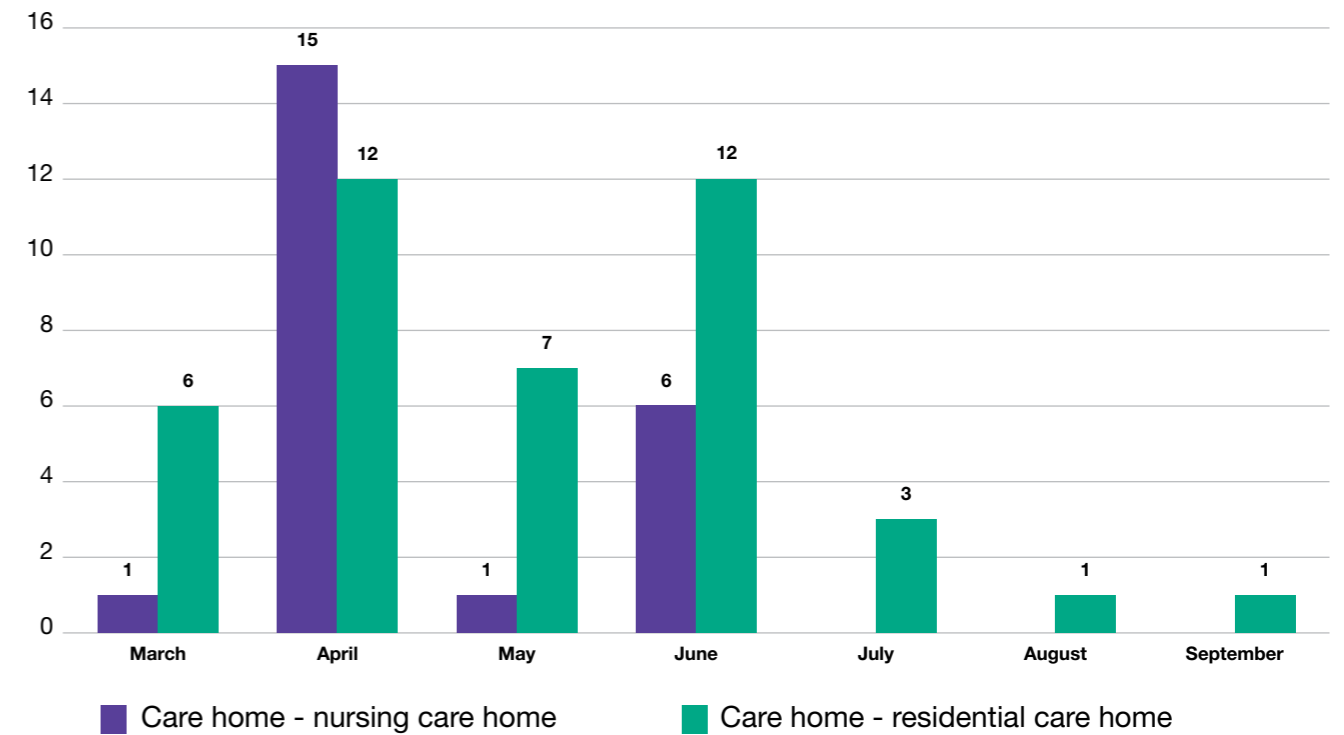
See a snapshot of safeguarding adults concerns for March 1st 2020-September 8th 2020

Number of concerns raised March 1st - September 8th 2020



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Total Number of Safeguarding Enquiries started in a period by Location of Risk



Themes

The data showed that the greatest areas of concerns for both residential and nursing homes were Neglect and Acts of Omission in this period, followed by physical and organisational abuse. The main referrer was the Care Homes themselves.

Learning identified going forward

The team were initially working with 21 of the 37 homes in the Borough. The initial homes were selected based on the prevalence of previous safeguarding concerns. From October 2020 the support was expanded to reach the remaining homes sharing the learning gathered whilst developing stronger partnerships. Safeguarding team members used the intelligence gathered in Phase one, to specifically target support given to the homes.

Homes were encouraged to ensure they had robust risk assessments in place to prevent avoidable risk to residents. They were also asked to identify the support they wanted and worked in partnership to achieve this.

Merton 2020/2021 Mortality Review (LeDeR)

The National programme aimed at making improvements to the lives of people with learning disabilities is known as Learning Disability Mortality Reviews (LeDeR). It requires that reviews are carried out following the death of anyone with a learning disability. The purpose of the review is to identify whether there are any concerns or areas of learning to improve the health and quality of care for people with learning disabilities. These reviews are conducted by South West London Clinical Commissioning Group (CCG) and the findings are reported to NHS England. South West London is high performing in terms of the timeliness of completion of these reviews and delivered 99% on time, which is higher than both the London and National average.

The LeDeR reviews undertaken in the past year in the context of the COVID-19 pandemic, showed an overall increase in the death rate for people with Learning Disabilities, specifically during the first phase (March 2020-May 2020). In Merton, 38% of the deaths of people with

Learning Disabilities recorded COVID-19 as the cause of death. Respiratory disease remained the most common cause of death for people with Learning Disabilities. This is distinct from the general population where respiratory disease is the third most common cause. A key area of national concern during the COVID-19 pandemic was the promotion of 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) directives. Assurance was obtained that this was not a feature locally in Merton for people with Learning Disabilities. It is encouraging to note that family members reported positively on their experiences of interacting with acute hospitals during the COVID-19 pandemic. They stated that they were kept informed, were involved in decision making and were accommodated regarding hospital visits. After targeted awareness raising and training for GPs and their staff, there was an improved take-up of annual health checks of people with Learning Disabilities across South-West London. More details on LeDeR and programme reports, can be found on the SWL CCG website. <https://swlondonccg.nhs.uk/>

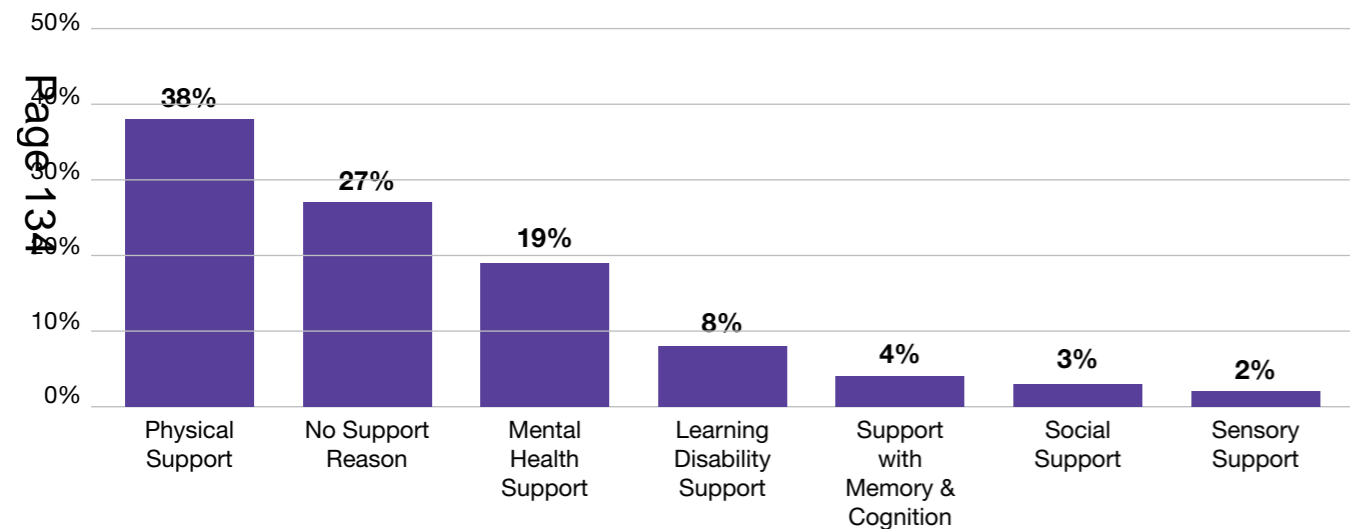
LeDeR	COVID-19 recorded as cause of Death	Other cause of death recorded	Total deaths for people with LD in 2020/21	% COVID-19 as cause of death
Merton	3	5	8	38%



Safeguarding Adults Data

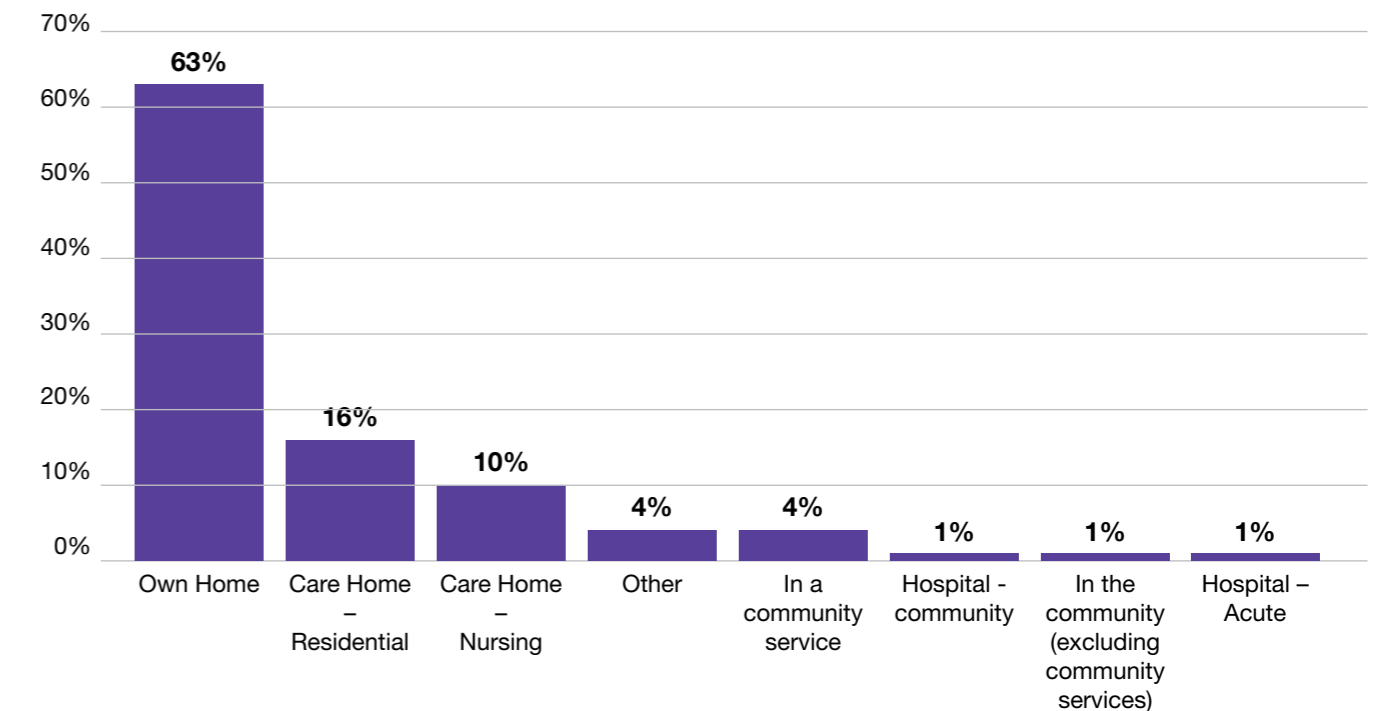
Year	2020/21	2019/20	2018/19
Total number of Adult Safeguarding Concerns raised during the year	830	732	483
Total number of Adult Safeguarding Enquiries commenced during the year	379	366	98
Conversion Rate (Number of Section 42 Enquiries + Number of Other Enquiries / Number of Concerns)	46%	50%	20%

Individuals involved in Safeguarding Concerns during 2020/21 by Primary Support Reasons



Type of Risk (Data source: concluded enquiries during 2020/21)	
Neglect and Acts of Omission	30%
Physical Abuse	18%
Financial or Material Abuse	17%
Psychological Abuse	13%
Self-Neglect	10%
Organisational Abuse	4%
Domestic Abuse	4%
Sexual Abuse	2%
Modern Slavery	1%
Discriminatory Abuse	0%
Sexual Exploitation	0%

Location of Risk (Data source: Total number of concluded enquiries during 2019/20)



During 2020/21 830 concerns were received by Merton Local Authority in total. This is an increase of 98 (13%) on the number of concerns raised in 2019/20. This could be attributed to the pandemic and also awareness raising of adult safeguarding.

In terms of location of risk 63% were reported to be in people’s own homes. Last year it was lower at 58%. This could be attributed to pandemic lockdowns and lack of contact. Action to minimise risk is being addressed by all partners through various initiatives to improve ways of communication.

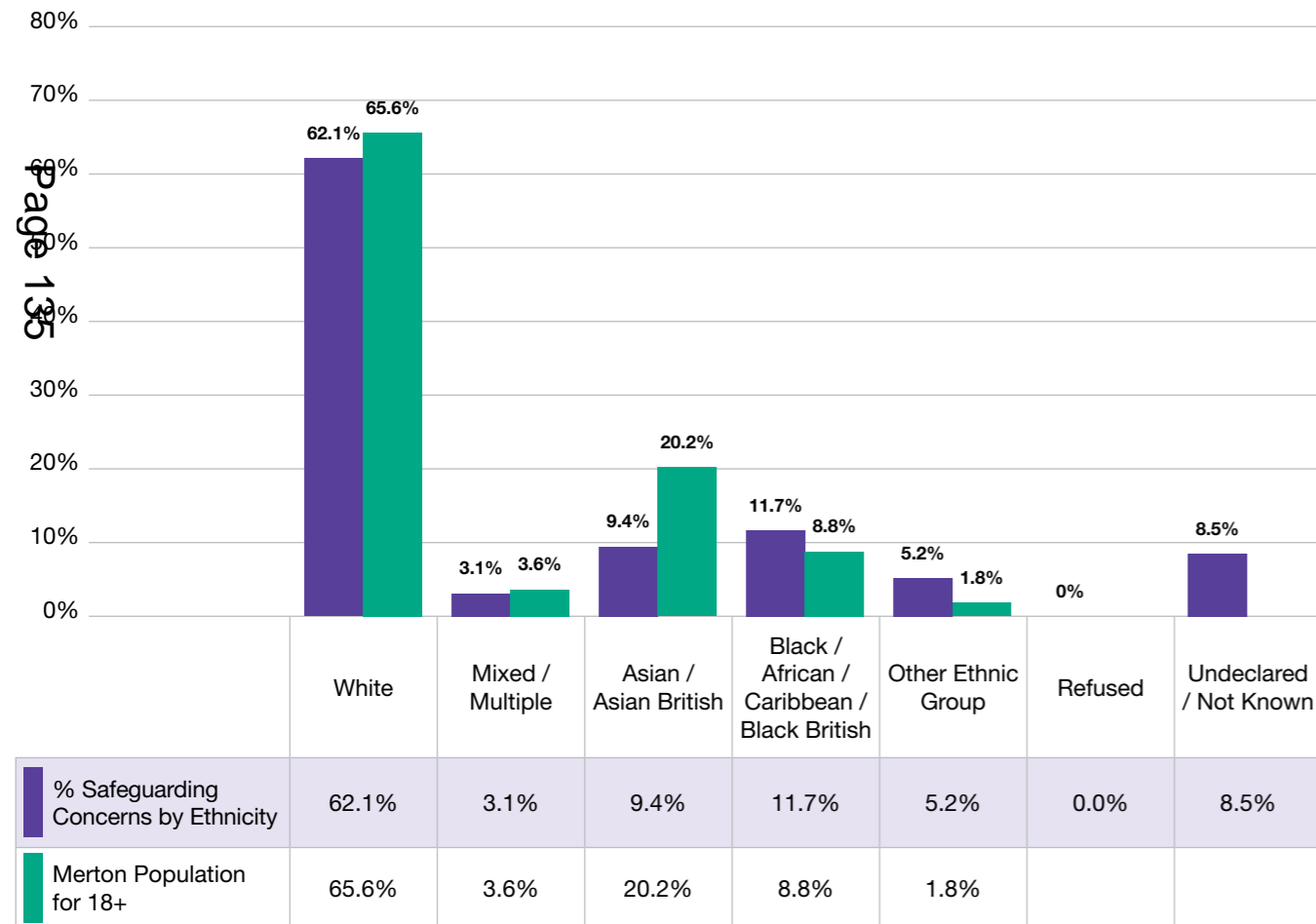
Section 42 enquiries were commenced in 313 cases and Other enquiries commenced in 66 cases, giving a total of 379 enquiries commenced. This is an increase of 13 (4%) on 2019/20, and represents a conversion rate (concerns raised to enquiries started) of 46%.

Work has begun to analyse our data in relation to Ethnicity. In February 2021 we undertook an in depth deep dive in order to better understand the complex information relating to this area and to inform our decisions and plan of action for the Board going forward. This dataset piece of work is ambitious and still in development.

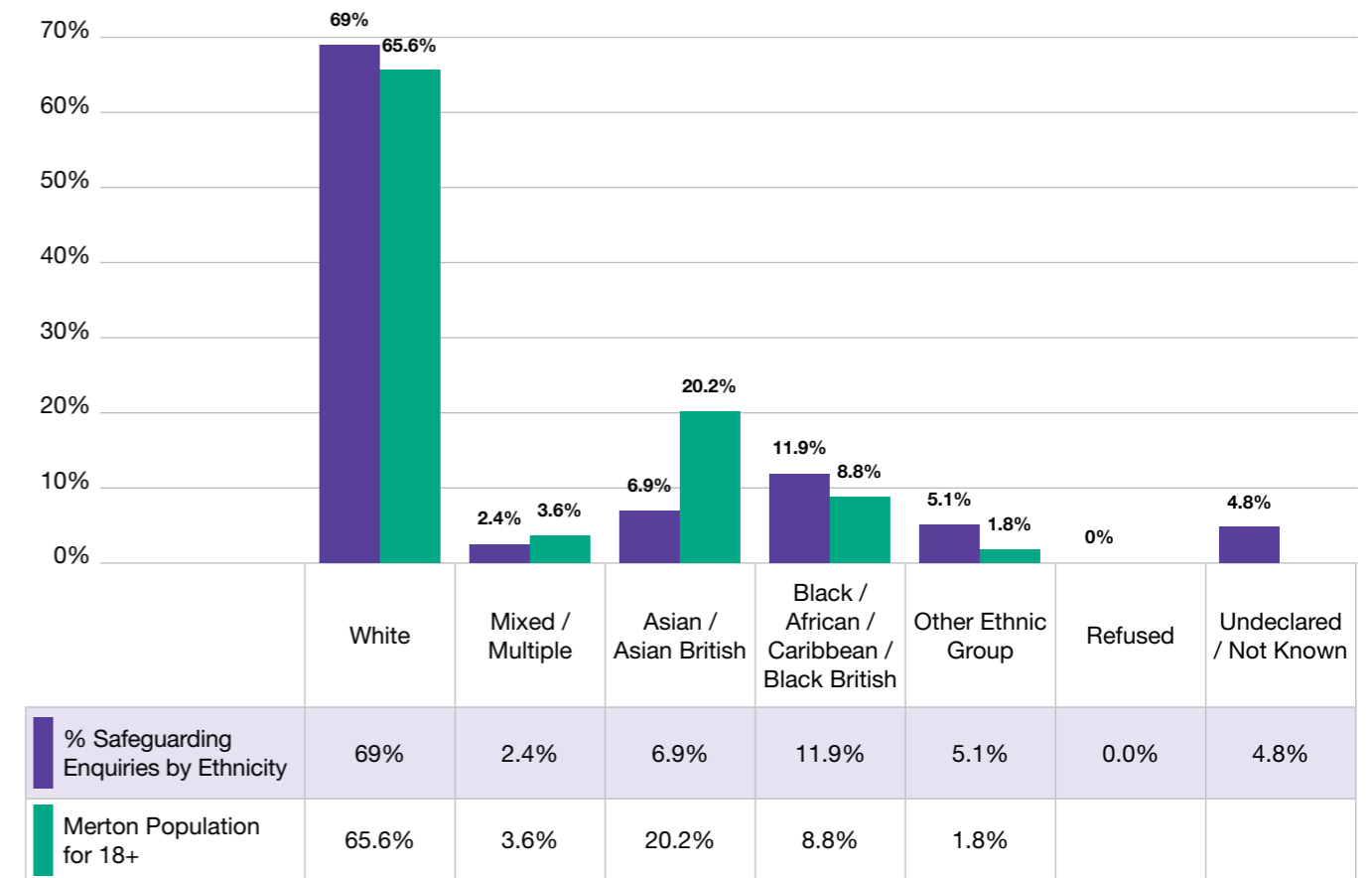
Our aim is to paint a picture across the protected characteristics so that it can be used in the context of inequalities and diversity. This couples with the intention to get much broader data from our partners, as currently any analysis is based on what the London Borough of Merton holds and not the whole partnership.

The following charts demonstrate individuals involved in Safeguarding Concerns and Enquiries by Ethnicity compared to the Merton 18+ population.

2020/21: Individuals involved in Safeguarding Concerns by ethnicity compared to Merton 18+ population



2020/21: Individuals involved in Safeguarding Enquiries by ethnicity compared to Merton 18+ population



During 2020/21 a smaller proportion of people from Asian/Asian British were involved in safeguarding concerns and enquiries when compared to the Merton 18+ population.

During 2020/21 12% of people involved in safeguarding concerns and 12% of people involved in safeguarding enquiries were Black/African/Caribbean/Black British. This compares to 9% of the Merton 18+ population who are Black/African/Caribbean/Black British.

The Performance and Quality Sub Group of the Board have been tasked to lead on this important

work around Ethnicity and will formulate a plan of action going forward. This may include awareness raising for some communities as well as identifying particular safeguarding concerns for other communities and addressing them accordingly.

We do not know at the moment if the difference in concerns compared with the % of the population is due to a difference in the level of safeguarding issues present in these communities or due to over or under reporting of safeguarding concerns.

Making Safeguarding Personal

Completed Enquiries Outcomes 2020/21 %

61%

Fully Achieved

36%

Partially Achieved

3%

Not Achieved

97%

of people's outcomes being fully or partially met.

66%

of people expressed a desired outcome compared to

64%

last year

An important success measure of 'Making Safeguarding Personal' is the extent to which the person's desired outcomes are met. Locally, Making Safeguarding Personal is well embedded in practice, with 97% of people's outcomes being fully or partially met. Where outcomes were not met, this is usually due to the person not engaging with the process or being unable to articulate if they consider that their outcomes were met. There was slight increase in the number of people who expressed a desired outcome compared to last year.

Impact on Risk Adult

Safeguarding aims to remove or reduce the risk to the adult. It is not always possible to completely remove risk and the risk will remain in cases where adults with capacity make a decision to continue living with an elevated level of risk. The impact of Safeguarding on risk is good with the risk removed or reduced in over 93% of cases. Where the risk remains, this is usually the result of people choosing to live with risk and understanding the implications of it.

Completed Enquiries where risks were identified No, %

345, 93%

Risk removed or reduced

26, 7%

Risk remains

COVID-19 Insight Project

The insight project was developed to create a national picture regarding safeguarding adults' activity during the COVID-19 pandemic.

A request was made for local insight and data on safeguarding activity on a voluntary basis, in order to develop an understanding about this impact at a National level, both during lockdown and as the restrictions were eased.

The December 20 reports showed nationally, safeguarding concerns dropped during the initial period of COVID-19, with the lowest point being in April 2020, before increasing again in May and June.

Merton experienced a similar drop, but with the lowest point being a month earlier, in March 2020.

Section 42 safeguarding enquiries also dropped nationally during the same period, but less steeply than concerns.

Merton followed the same pattern as nationally with the lowest point being in April 2020, before increasing again in May and June.

Full report can be seen in this link: <https://www.local.gov.uk/publications/covid-19-adult-safeguarding-insight-project-findings-and-discussion>

Working in Partnership and Making Safeguarding Personal Case Studies

Making Safeguarding Personal in its simplest form means putting the person at the centre of everything we do during the safeguarding process, from the very beginning to the very end.

The Making Safeguarding Personal (MSP) programme has been running since 2010. The Care Act 2014 guidance required adult safeguarding practice to be person led and outcome focused, aiming towards resolution or recovery. This embodies the MSP approach.

Case 1 example

Situation:

This case example refers to a middle aged person who was alcohol dependent and subject to a domestic abuse partnership for many years. The person had been known to social services in the past due to being a survivor of domestic abuse. They were experiencing multiple assaults that required numerous hospital admissions to treat the injuries. They were known to the hospital and on each admission safeguarding concerns were raised with local authority by the hospital. These included concerns that when the person returned home, they would be at high risk of assaults again. Their partner was known to the police and had broken bail conditions and absconded to avoid arrest and a potential prison sentence.

The concerns were, how to keep the person safe from further domestic violence as well as reducing alcohol intake which were causing self-neglect and high risk of death.

Making Safeguarding Personal:

By speaking with the person, their wishes and feelings were established as well as what outcomes they wanted to achieve.

They wanted to return home regardless of the risk to safety and wellbeing and wanted to have support to reduce alcohol intake, personal care, shopping and food preparation, plus ensuring their utilities were in working order to provide heat and electricity.

What was put in place to support the person?

- Partnership working with the hospital Safeguarding Team
- Planning meeting established each other's agencies role pertaining to health and social care.
- A warning would be sent to social care each time customer was admitted into hospital, due to either alcohol abuse or domestic abuse assault.
- Fire safety check completed by the London Fire Brigade.
- Mascot emergency service pendant provided.
- Care and support provided in the form of direct payments to ease procedural time slots, which would have constricted freedoms and choices of the customer.
- Budget managed by local authority.
- Welfare benefits were calculated and put in place.
- Package of care was commissioned to visit and support customer x 2 daily Monday-Sunday

Joint working was established with the Westminster Drug Project to support the customer to look at ways to reduce or cease alcohol intake. Partnership working with the police and ambulance services to ensure awareness of any incidents.

Arrangements were put in place with the Police to be aware of possible attacks by ex-partner that may result in their swift and concise intervention if the mascot button was pressed for help.

Ambulance Service were given reassurances that social care were aware of risk to the person and that they had devised a protection plan with the customers consent to establish actions that would help to protect them in the event of an emergency.

They were involved and reassured throughout their safeguarding journey and expressed satisfaction at the level of choice and control they had received. The plan put in place was regularly reviewed to take into account any changes in circumstances and the wishes of the customer.

Case 2 example

Situation:

This case example refers to a young man, who lived in a supported living complex and required full support with personal care, food preparation, medication and social interaction. He regularly visited his grandparents at the weekend.

Over time the person began to gain significant amounts of weight, and this was more prevalent when they were staying with their family at weekends. Supported living staff had been given a diet regime by their dietician which helped to ensure proper dietary needs were being met to avoid other health complications that may have occurred due to a high BMI.

During the pandemic home visits were halted due to shielding. This meant support staff in the supported living home were responsible for meal plans and monitoring of his dietary needs and this proved to be a success in terms of the weight loss that had taken place.

A safeguarding referral was sent to the Local Authority when it became clear that visits back to the family at the weekend were likely to begin again. Also the dietician had concerns about how the family would prepare meals for the young man and that the meals they had been providing him were likely to cause weight gain that had happened previously.

Making Safeguarding Personal:

Making Safeguarding Personal could not be fully met due to their inability to communicate and the lack of mental capacity to make informed decisions about what they wanted to achieve as part of their nutritional needs. However the MSP principles were upheld and a best interest decision was deemed to be the way forward.

What was put in place to support the person?

A safeguarding meeting was arranged to include the Safeguarding Adult Manager (SAM), social worker, dietician, family, key worker, and manager from the supported living complex.

The initial meeting was to find out from the professionals what they felt needed to be achieved with the family to help them develop a better way of meeting their loved one's nutritional needs. Also to reduce the risk of him putting on weight, and to maintain a healthy diet on a permanent basis.

The family felt they had not been provided enough evidence of how the weight had been gained, despite weight charts being provided to support the claim. They wanted to discuss medical issues, which they felt had caused the weight gain.

Due to the unsatisfactory outcome of the meeting a second safeguarding meeting was arranged and an action plan put in place.

A second meeting was held, and it resulted in the care home staff along with the family coming to an agreement that involved the family's input and actions they would take moving forward. This involved ensuring that when he visited them at the weekend a healthy diet could be provided using traditional cultural foods. Also how the supported living staff could support the family to provide appropriate dishes during his weekend visits. The GP (General Practitioner) had also contacted the family on the social workers request and arranged for medical investigations to rule out health reasons for weight gain other than diet.

The outcome for the young man meant that his dietary and health needs were being met appropriately and that he was still able to visit his family on a regular basis, which was important to him and his family.



Safeguarding Adult Reviews

A Safeguarding Adults Review (SAR) is a legal duty under the Care Act 2014. The purpose of a SAR is to learn from cases, on a multiagency level, to prevent similar incidents occurring. The aim is not to apportion blame on an organisation or individuals for any failings that may be discovered.

The criteria for a SAR states that we should consider a SAR if:

An adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

SAR Notifications in Merton

The Board received and considered two new SAR Notifications during 2020-2021, which resulted in one new SAR commencing. Included in the two was one referral that had been reconsidered and recommissioned, and another where the decision to carry out a SAR had been reviewed and a single agency review had been agreed.

In total five cases were considered and or monitored by the Sub-Group throughout the reporting period.

Learning from SAR's

What we have learnt from SAR's

There were a number of key areas identified early on in the SAR process, one being the understanding of Mental Capacity. This has reinforced the ongoing need for professional development in relation to Mental Capacity, which is also a very common feature in many SARs across the country.

We have responded to this in a number of ways. Regular training and learning sets for practitioners are on-going in relation to the Mental Capacity Act (MCA). Reflective practice also focuses on the MCA and recording to ensure important information and responses are captured. Professor Keith Brown (Founding Director, National Centre for Post Qualifying Social Work and Professional Practice) has been invited to present to the Board in June 2021 on the Mental Capacity and Best Interest Decisions.

A Multi-Agency Learning Event for a SAR was arranged and took place in October 2020. A robust Lessons Learned presentation was developed to allow all practitioners and Managers to participate via an online platform. Feedback from the Lessons Learnt event were subsequently fed back to the Safeguarding Adults Board and this feedback incorporated into the final Action Plan. The final report for this SAR will be published in 2021/22.

Our Strategic Plan 2021-2024

The impact of COVID-19:

Reviewing our priorities

Since 2020 COVID-19 has had a huge impact on us all. Though the Coronavirus Act 2020 does not affect the duties to safeguard adults at risk as laid out in the Care Act 2014, we have all had to change the way in which we work and this has created new challenges in safeguarding adults at risk. In reviewing our priorities and objectives, we have considered the challenges as well as our recovery plan from the pandemic. In reviewing previously identified objectives, we also thought about specific issues which may now need to be a focus. We felt that it was important to explicitly state our intention to seek to learn from the experiences of COVID-19 in order to improve future responses. The Board will also have an important role to play in seeking assurance about local arrangements and risk assessments.

How the strategy will be delivered

A new work-plan will be developed each year, where Board Members will agree on exactly what they need to do to achieve each of the agreed strategic priorities. Our targeted aims for 2021/22 will be complemented by a more detailed action plan which will be monitored regularly by the Board and its subgroups. This will also consider our responses to specific and thematic issues, such as modern slavery, domestic abuse, self-neglect, transitional safeguarding and adult safeguarding in the context of COVID-19. The subgroups of the Board are pivotal in supporting the MSAB to achieve its objectives and continue to deliver on campaigns and develop tools to support professionals and residents in understanding and responding to adult safeguarding concerns. Each subgroup has their own set of priorities and specific targets which complement the overarching priorities of the Board.

1. Prevention and Early Detection

Our Aim

- Adults from all communities will feel supported to keep safe. Partners, service users and residents will recognise risk and be confident in their response.

Building and strengthening connections

Our Aim

- Partners, service users and residents from all communities are engaged and working together to ensure an inclusive safeguarding framework.

3. Making Safeguarding Personal

Our Aim

- People will feel listened to and have real choice and control in shaping their safeguarding journey.

4. Quality Assurance & Embedding Learning

Our Aim

- To establish a Quality Assurance & Performance Framework to provide assurance that the Board and its partner agencies have effective systems, structures, processes and practice in place.
- To learn from reviews, for example SAR's, Domestic Homicide Reviews (DHR's) and Learning Disability Mortality Reviews (LeDeR) and ensure mechanisms are in place to measure effectiveness.

Reporting a Safeguarding Concern

Phone First Response Team:

020 8545 4388
9:00am-1:30pm excluding Bank Holidays

Crisis Line:

After 1.30pm, 07903 235 382 which is available from 1.30pm to 5.00pm Monday to Friday

Adult Emergency Duty Team - Out of Hours and Bank Holidays:

020 8770 5000 / 0345 618 9762

Email:

safeguarding.adults@merton.gov.uk

Emergency:

Call the Police or emergency services - 999



Merton
Safeguarding
Adults Board

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