Merton Safeguarding Adults Board

Annual Report 2021/22

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Message from Interim Chair

This report covers the work of the Merton Safeguarding Adults Board (MSAB) during the period April 21 to the end of March 22 and reflects on the work of the board as we recover from the Pandemic and look forward to brighter days. Our role has been to continue to ensure the systems, policies and procedures in Merton continue to be effective in keeping adults at risk safe.

The MSAB continues to focus its work on our Strategic Priorities 2021-2024 as well as the statutory duties that include, publication of an annual report; focused work based on a strategic plan; and the commissioning and completion of Safeguarding Adults reviews (SARs).

With our priorities in mind, partners have continued to build strong partnerships and develop new and innovative ways of connecting with people using services, residents of Merton and each other. They are committed to hearing the voices of people with lived experience as well as learning from feedback to improve on practice going forward.

This annual report includes details of SARs that have been completed during 2021-2022 and has demonstrated via the case study, how we are following through on learning from previously completed SARs.

One area of learning has been around how we better support people experiencing difficulties with alcohol and substance misuse. As well as working closely with Public Health colleagues and partners, workshops have been facilitated by Mike Ward from Alcohol Change UK to ensure the Blue Light Approach is embedded in the way we support people with these difficulties. The Blue Light approach means that, while we may not always be able to make someone change completely, we can help reduce harm and manage the risk they pose to themselves and others.

Work continues with raising awareness of safeguarding adults in the community and working with our partners. The MSAB are in the process of developing an initiative to recruit and work with 'Community Safeguarding Adults Champions' in the coming year. As well as awareness raising, this will provide links to our residents, the voluntary sector and faith communities around the safeguarding adults agenda.

I once again thank all our partners as well as those who manage and support the work of the MSAB for their contributions and commitment to keeping people safe in Merton.

John Morgan

John Morgan
Interim Director of Community and Housing (Interim MSAB Chair)

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. Further on in the report there is an update on the position in terms of SAR's.

Our Strategic Priorities 2021-2024

Priority 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.

Priority 2: 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.

Priority 3: Making Safeguarding Personal

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

Priority 4: Quality Assurance & Embedding Learning

Our aims: 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.

We Said, We Would

- MSAB partners would complete the annual Safeguarding Adults Partnership Audit and attend a Challenge Event to measure the effectiveness of safeguarding activity and establish what's working well and where improvements are needed.
- Review the Safeguarding Adults Review (SAR) Protocol and or processes around SAR's to ensure the recommendations from the National SAR Analysis Review April 17-March 2019 are embedded.
- Oversee the implementation of the Liberty Protection Safeguards, now due to be implemented in April 2023.The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) system.

  The Liberty Protection Safeguards will deliver improved outcomes for people who are or who need to be deprived of their liberty. They have been designed to put the rights and wishes of those people at the centre of all decision-making on deprivation of liberty.
- Continue to work with partners to develop a comprehensive MSAB data set using the National Data Framework Tool. This will assist with assessing 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.
- Agree and sign off the Learning & Development Strategy and Training Competency Framework and continue to look at ways of providing level 1 Safeguarding Adult's Training to our voluntary sector, service users and residents.
- Develop a programme of work to engage people with lived experience and to include their voices in the work of the Board as well as Safeguarding Adult Review Action Planning.

What We've Done So Far

- In May 2021 we held our annual Challenge Event'. We were able to agree a very ambitious Strategic Plan for 2021-2024 and the MSAB annual priorities for 2021-2022. There was recognition of the continued work undertaken in keeping people safe during the pandemic as well the recovery plan required going forward. Also highlighted was the need to harness and embrace some of our new ways of working brought about by the pandemic as well as reverting back to the responses that worked well before the outbreak.
- The Safeguarding Adults Review (SAR) Protocol was reviewed to ensure the recommendations from the National SAR Analysis Review April 17-March 2019 were embedded. Michael Preston-Shoot, the author of the review, presented the findings to the MSAB in December 2021 and an action plan for continuous learning from SAR's was produced. The refreshed SAR Quality Markers are due to be launched in April 2022 and will be added to the Protocol as an appendix. The SAR Quality Markers are a tool to support people involved in commissioning, undertaking and quality-assuring SARs to know what good looks like.
- In 2020/2021 the MSAB commissioned a Task and Finish Group to oversee the implementation of the Liberty Protection Safeguards (LPS) that will replace the Depravation of Liberty Safeguards (DoLS). This is being led by the London Borough of Merton and the Clinical Commissioning Group (CCG). The group have met regularly and completed a scoping exercise to determine resources and to ensure systems are in place for a smooth transition.
- A Learning & Development Strategy and Training Competency Framework has now been signed off by the Board. We are also pleased to confirm that a safeguarding adult's E-learning package has been agreed and in 2022/23 will be added to the MSAB Website. It will provide Level 1 Safeguarding Adult's training for our voluntary sector partners, volunteers, and the wider partnership.
- The Communication Strategy for the Board has been developed. The focus has been 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. Links with Black, Asian and Minority Ethnic people as well as the seldom heard have begun. Our Voluntary Sector lead and Board partners 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 2021/2022, they have developed a DASH (Domestic Abuse, Stalking and Harassment and Honour Based Violence) training focused on early risk identification, intervention and prevention delivered to Housing officers.

This year they have facilitated Bite Size training including, Domestic Abuse Awareness: Supporting those at risk of Domestic Abuse, which focused on the use of the DASH risk assessment referral form and was delivered by the Safer Merton Domestic Abuse & VAWG Lead. They also promoted the SafeLives Dash risk checklist for the identification of high-risk cases of domestic abuse, stalking and 'honour'-based violence.

A Multi -Agency Risk Assessment Conference (MARAC) Learning Day was facilitated, to bring together a wide range of MARAC partner agencies to build and strengthen the connections across the partnership. It allowed partners to reflect on practice, including prevention and early detection, seeking to continuously improve how the partnership recognise and respond to risk of domestic abuse.

South West London and St Georges MH Trust provides representation at the MSAB and continues to support the work of the Board and its subgroups.

Mental Health Teams review Merlin's received at their Multi-Disciplinary Team (MDT) meeting for multidisciplinary consideration of the issue and action as appropriate –this is ongoing. Going forward, further action in this area will be evidence of consistent contribution to the decision making. (Merlin is the police database that generates 'Adult Come to Notice' information).

Safeguarding incidents are reported within the Trust assurance process including at Executive level and local regular Safeguarding Meetings ensure staff remain focused on Safeguarding considerations. Staff are also encouraged to attend Safeguarding Adult Managers (SAM) and Enquiry Officer meetings with Adult Social Care colleagues.

The Trust has established and has embedded robust interventions around Domestic Abuse, which necessitates partnership working and actions to support families and adults at risk.

Below is an example of advice given by the Trust, Domestic Abuse Lead, regarding a case brought to her attention. It evidences there is routine consideration of partnership working and using national and local frameworks which support the reduction of domestic abuse.

"On reading the below detail can I clarify if this family are known to children's services and how old the children are now? (They may be adults).

Really glad to see her being referred to IDVA services and they will complete a DASH risk assessment – do you know if they have made contact yet? If there is a delay it would be best practice for you to complete the DASH as this lady may need a MARAC referral – could you explore any threats to kill made towards her or any harm to pets or use of weapons."

In response to learning from Safeguarding Adults Reviews (SAR's) the Trust is establishing robust responses to the complexities of Substance Alcohol misuse in the context of serious mental illness. This is evidenced in staff meeting notes and information disseminated across the Trust.

There is local embedding and Trust wide Learning from SARs, Domestic Homicide Reviews (DHR) and Learning Disability Mortality Reviews (LeDeR). Learning is evaluated and assured via auditing and quality assurance systems and fed back at the Learning and Development Subgroup.

The Metropolitan Police Borough Command Unit (Met's BCU) in the Southwest continue working on processes to improve adult safeguarding work. This includes an appointment of a dedicated Detective Inspector to lead on adult safeguarding. This has strengthened the Met's responses and engagement with partner agencies. It is beginning to raise the adult safeguarding agenda within policing locally, developing improved awareness around adult abuse safeguarding and embedding learning from Safeguarding Adults Reviews (SAR's).

In the previous year the police have been developing a cuckooing protocol with partners, which includes clear referral pathways for police and other professionals. The protocol is now being used and embedded to identify perpetrators and to support victims of cuckooing.

In 2021-2022 the police have made improvements to frontline Multi Agency Safeguarding Hub (MASH) referrals to allow for a smoother escalation process ensuring strategy discussions can be effectively run.

The SW BCU continues to be fully engaged with the work of the MSAB and subgroups as well as other multi-agency panels including Multi Agency Risk Assessment Conference (MARAC) and Community Multi Agency Risk Assessment Conferences (CMARAC). They also play a key role in embedding learning from SARs, as well as sharing 7-Minute learning briefings widely across the SW teams.

In 2021-2022 the **Clinical Commissioning Group's (CCG)** Designated Adults Safeguarding Professional for Merton, has contributed directly to the MSAB and its priorities by co-chairing the Communications and Engagement Subgroup and the Liberty Protection Safeguards Task and Finish Group, as well as being an active member and working closely with the MSAB through attending all other sub-groups

They also worked closely with the Violence Against Women and Girls (VAWG) for Merton as a member of the board as well as Counter-Terrorism, Channel Panel to provide expert advice and support to these groups.

Examples of feedback towards the MSAB Priorities include contributions towards the development of a Communications and Engagement strategy (including action plan) to support partners, service users, carers and residents to understand the work of the board and how to stay safe.

The Safeguarding Adults Leads Forum for Southwest London continued to meet six weekly with representation from safeguarding leads from all the major health provider services across SW London, the local authority leads and with private and voluntary sector representatives. During the pandemic these meetings provided assurance to the safeguarding adult designates that providers and partner organisations continued to work collaboratively to support adults at risk across South- West London. The aims of this group are to work jointly across SWL to provide support, advice, and guidance and to share information related to adult safeguarding between partners on the local and national safeguarding agenda. This group values a spirit and culture of partnership and collaboration with professional safeguarding leads across SWL.

In 2021/22 SWL CCG have been preparing to transition smoothly to become an Integrated Care Board (ICB) to establish an Integrated Care System (ICS) across South West London to empower better joined up health and care as set out in the Health and Care Bill 2021.

The four aims of an ICS are:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Integrated Care Boards (ICBs) will replace Clinical Commissioning Groups in the NHS in England from 1st July 2022.

The team also hosted an on-line Adults and Children Safeguarding Conference. The Safeguarding Designates recognised that safeguarding issues had increased during lockdown with the local tier restrictions and that it was increasingly important to understand the issues adults and children were facing and to support the most vulnerable. This conference was aimed at and attended by over one hundred front line health staff and safeguarding practitioners and was an accredited level 3 safeguarding event. The event was opened by the Director of Nursing for NHS England/ Improvement and Regional Safeguarding Lead for London and facilitated by a national Safeguarding Consultant.

Daily learning events were also arranged during the National Safeguarding Week in November 2021, the theme was based on “creating safer cultures”. Also in March 2022, SWL CCG hosted a webinar conference on the Liberty Protection Safeguards and Mental Capacity Act Amendment Bill (2019) which are currently under consultation with the Government.

Our **Central London Community Health (CLCH) NHS Trust** has continued to contribute to the MSAB and its subgroups: Contributions include

- L&D subgroup: The group has been co-chaired by Haidar Ramadan-Head of Adult Safeguarding to ensure Merton SAB has a clear learning and development strategy in place
- CLCH represented at all Merton SAB subgroups
- Merton Safeguarding Adults Partnership Audit Tool- submitted and engagement with the SAPAT challenge event to inform the MSAB objectives, priorities, and 3 Year Business Plan in 2022/23.
- Facilitated joint workshops and learning events with Richmond and Wandsworth SAB, part of the adult safeguarding week 2021

Examples that led to improvements in practice included the CLCH safeguarding business continuity plan in place to ensure increased reach and influence with frontline staff and managers during COVID and virtual training, safeguarding supervision and drop-in sessions in place. A well-established ‘duty’ system to support staff accessing timely advice and support.

They contributed to several panels including CMARAC, MARAC and MSAB sub-group as well as being fully engaged with safeguarding adult activity and safeguarding reviews.

Trust wide audits on quality of safeguarding referrals to social services continued and CLCH SAFER guidance was developed and promoted to assist when making a referral to local authority.

Two cohorts of safeguarding and MCA champions graduated, and network days for update and supervision with all champions were organised. Bespoke training was also developed for staff and partners re: MCA, DOLs and Making Safeguarding Personal (MSP).

There were revised safeguarding training packages virtual with interactive software linked to L2 booklet and a safeguarding training passport. Compliance for Level 3 adult safeguarding and MCA training compliance was 95% in Merton and Wandsworth

The annual CLCH safeguarding conference: What really matters in safeguarding? was attended by 520 delegates and received very positive feedback. CLCH also attended and contributed to the MSAB and CSP ‘Think Family’ Conference in March 2022 which had some focus on a SAR that had been undertaken. In Safeguarding Adults Week CLCH utilised their networks and reach to promote and share the weeks programme and ADASS conference. They also developed and cascaded a significant number of 7-minute briefings in response to internal investigations, S42 and learning from local and national inquiries or reviews. (Focus on Self-neglect, No Access, DHR).

As well as supporting the formulation of actions for implementation of the MSAB Communication Strategy, they used intelligence from already established local forums to share and understand current issues and learn from lived experiences of people in the wider community in relation to adult safeguarding. This is an area that will be progressed in the coming months to ensure the voices of people are heard and included in the safeguarding adults work of the board.

The London Fire Brigade (Merton) continues to support the partnership. They 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. The Safeguarding Adults and Deprivation of Liberty Safeguards (DoLS) Team Manager has also begun to deliver a bespoke Level One Safeguarding Adults Training session to Fire Service staff with a view of evaluation the impact on referrals in the coming months.

Merton Connected – Continue to cascade the message that **#safeguarding is everybody's business**.

Enhancing the knowledge and confidence amongst staff and volunteers across the local voluntary, community and faith sector, has been a key focus of our work with the Board this year. In pursuant of this they have co-hosted three Introduction to Safeguarding for Adults training workshops with Merton Local Authority. The workshops were well attended, with 54 individuals, representing 31 organisations in attendance.

Further work has been undertaken with regards to an ongoing training offer for the voluntary sector and next year we are hoping to launch an accredited level 1 and 2 E-learning module that voluntary sector staff and volunteers will be able to access and undertake via the MSAB website.

In addition, they are working on an initiative to develop a cohort of volunteer Community Safeguarding Adult Champions, who will be a valuable resource to help raise awareness and increase knowledge and confidence amongst local voluntary, community, and faith sector organisations, with regards to their role in safeguarding the adults who used or benefit from their services and activities. It will also provide a valuable link to the MSAB and support them to understand the issues and priorities with regards to the safeguarding adults in the community.

In June 2021 the National Probation Service and Community Rehabilitation Companies (CRC) unified to become one organisation. The Probation Service has experienced severe staffing challenges since this time, alongside managing the ongoing changes required to embed new processes and policies and ensuring appropriate training is undertaken by staff to deliver effective offender management services. Delivery of services are therefore modified in line with available resources in different boroughs, with Merton delivering under 'Amber'. Adult safeguarding processes remain unchanged as part of this model and remain a priority.
In relation to safeguarding, they continue to implement mandatory training and encourage staff to access all available safeguarding training opportunities from local authorities and other bodies. They also ensure adult safeguarding activity is addressed at all points of delivery, including Courts, custody and supervision in the community. Concerns about safeguarding are escalated for management through MAPPA where necessary.

Healthwatch Merton continues to support the work of the MSAB and the Communication & Engagement subgroup. Their Chief Executive has contributed to the formulation of actions for the Communication Strategy. They have used intelligence from already established local forums to share and understand current issues and learn from the lived experiences of people in the wider community in relation to safeguarding adults.

Next steps include seeking to develop something more robust and formalised to feed in local intelligence regarding safeguarding adults' activity on a more regular basis. They have begun supporting work on developing a way to test access by public and organisations in raising safeguarding issues. In March 2022 they attended the MSCP/MSAB Joint Conference - Integrated Safeguarding: Working Together to Safeguard Adults and Children as well as attending events in National Safeguarding Week, including the ADASS conference.

The Work of the Subgroups of the Board

The Safeguarding Adults Review (SAR) Subgroup

The SAR Sub-Group manages and oversees the Safeguarding Adults Review (SAR) process in Merton and meet six weekly with representation including the London Borough Merton, the Metropolitan Police, South West London Clinical Commissioning Group (CCG), St George's University Hospitals NHS Foundation Trust, Epsom & St Helier's University Hospital, London Fire Brigade and Central London Community Healthcare NHS Trust.

The group has been co-chaired by Trish Stewart, Associate Director for Adult Safeguarding and Phil Howell, Assistant Director Community & Housing in Merton. With clear leadership from the chairs and commitment to making a difference, the subgroup is focused on learning from SAR's as well as embedding learning from local and national reviews across all agencies in Merton.

During 2021-22 as part of the learning from SAR's and hearing the voices of people with lived experience, they met with family members and set up meetings to discuss how their experiences can be shared. This led to an arrangement for them to speak at the Epsom and St Heliers University Hospital Safeguarding Conference. As part of the groups work going forward, this will be an approach taken to ensure voices are included as part of the SARs process. SAR themes were also included in the Joint conference with the Merton Children Safeguarding Partnership, which focused on Think Family.

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 and has been co-chaired by Beau Fadahunsi, Head of Development and Volunteering at Merton Connected and Claire Migale, Head of Social Care Operations in Merton.

Its focus this year has been on the continuing development of the MSAB dashboard that includes data from agencies across the partnership.

The National Safeguarding Adults Board Managers Network have been working on the development of a National Data Toolkit Framework to support and inform the work of the Board and the Performance and Quality Sub-Group. The aim is to succeed in using data to improve services and prevent neglect and abuse in their area effectively and consistently. The MSAB has agreed to look at this and will shortly be launching a Task and Finish group to follow through on the work.

Learning and Development Subgroup

This group meets quarterly and has been co-chaired by Haidar Ramadan (HR), Head of Adult Safeguarding, Merton & Wandsworth CLCH and Lisa Hewitt- Principal Social Worker at Merton.

The aim of this subgroup is 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 continues to be the learning and findings from Safeguarding Adults Reviews (SAR's) and sharing key learning. Partners have shared Seven Minute Learning Briefings around themes from SAR's with their staff groups and they have also been added to the MSAB website to ensure a wide reach.

The subgroup members have also been involved in the planning and facilitating of the Joint Conference and promoted the 'Think Family' approach in its Learning and Development Strategy and wider work. They have continued their pursuit of a Safeguarding Adults Level One E- Learning programme for the voluntary sector and volunteers and are pleased to announce a package will be available in 2022-2023.This will be available to access via the MSAB website.

Communication and Engagement Subgroup

The Communication and Engagement Subgroup meets quarterly and has been co-chaired by Lorraine Henry, DoLs and Safeguarding Team Manager and Edwina Curtis, Designated Adult Safeguarding Professional (Merton). The aim of the group is to continue to raise the profile of the work of the board and promote awareness of safeguarding adults. This is done via partner engagement with people that use their services as well as through the MSAB website.

Some of initiatives are almost ready to get off the ground and some introduced. The implementation of Discovery Interviews for people who have gone through the safeguarding adults process and linked to Making Safeguarding Personal have begun. In the local authority they have been carried out by practitioners who haven't been involved in the case and information is then used to improve the process. A review is currently underway to ensure the approach is effective going forward.

As well as listening to the voices of people with lived experience, an initiative is underway to recruit Community Safeguarding Adults Champions, who will be a link between the Board, the voluntary sector and the residents of Merton

Merton Safeguarding Children Partnership (MSCP) and the Merton Safeguarding Adults Board (MSAB) Joint Conference – 21st March 2021

The joint conference was opened with addresses from Cllr Stringer, Joint Deputy Leader and Cabinet Member for Children and Education, and Cllr Lanning, Cabinet Member for Adult Social Care and Public Health, who expressed their pleasure to see colleagues from across partner agencies coming together to share in the event.

The first half of our joint conference focussed on family safeguarding and the **importance of adopting a 'Think Family' approach to safeguarding**. To open our conference we heard from Sue Williams, who developed the Family Safeguarding model as part of her work as Hertfordshire County Council's Director for Social Work.

Continuing the theme of holistic provision to families, we next heard from speakers Dr Benedicta Ogeah (Co-Chair of the MSCP Domestic Abuse & Think Family sub-group), Dheeraj Chibber, (Chair of the MSCP Quality Assurance sub-group) and Trish Stewart (Chair of the MSAB Safeguarding Adults Review (SAR) Subgroup), who spoke about the 'Think Family' model and approach in Merton.

In the afternoon there was a focus on the transition of young people moving into adulthood. It got underway with our second keynote speaker, Sarah Ashworth, Schools and Families Programme Director at The Charlie Waller Trust. In her presentation, she explored the difficulties, complex needs and pressures young people face in transition to adulthood, as well as some of the physical and psychological challenges faced through growing up. The statistics and figures for self-harm and mental health problems were deeply concerning, and particularly resonated with attendees.

Also highlighted was thinking on how to support resilience in transition and the importance for individuals to have: a 'secure base' of support from their family and wider community networks; an interesting and engaging education; quality, positive friendships; encouragement to pursue talents and interests, and support for developing positive social values and competencies.

The conference provided plenty of key learning points, with lots to talk about and learn in breakout group discussions. It was wonderful to see colleagues from across the children's and adult's partnerships sharing experiences and working together to improve our collective understanding and practice. We will be looking at what multi-agency practitioners shared and considering next steps on both these important topics for the MSCP and MSAB, also planning a Joint Conference for 2022-2023.

Pandemic Recovery

COVID-19 assurance, recovery, and learning continue to be a key priority for the MSAB. There has been a focus on continuing to ensure adults at risk are supported in ways that are flexible and meet individual's needs. Partners report that some of the ways of working during the pandemic that have worked well continue to be used, as well as returning to more traditional ways of working with people. Prevention and risk management continue to be key components in service delivery and Making Safeguarding Personal remains a priority.

Care Homes

"Over the past 12 months the Council, primarily through our Public Health and Contract Management teams have continued to provide significant support to all 38 care homes in the borough, particularly as we have moved into 'living with Covid'. Additional Infection Prevention and Control (IPC) capacity was maintained and continued to provide both on-site and remote advice, training and support to care home managers and staff.

In addition to this enhanced IPC support, very regular contact was maintained with all care home managers and proactive support provided in response to Covid outbreaks and other out of the ordinary events. There has been close and effective partnership working with the developing Care Home Support Team commissioned by the CCG; with specialist Community Pharmacists and with a range of other health colleagues to respond to safeguarding concerns as and when required. The Merton Joint Intelligence Group (MJIG) has continued to provide an effective means of identifying issues early and ensuring that the required support and, where necessary, challenge is provided to care homes.

As we continue the return to pre-pandemic ways of working routine on-site quality visits are restarting and these will add to our oversight of the care home market across the borough and further enhance our ability to provide support."

Learning from Lives and Deaths

(Previously known as, The Learning Disability Mortality Review (LeDeR)

The National programme aimed at making improvements to the lives of people with learning disabilities is known as “Learning from Lives and Deaths” People with a learning disability and autistic people, previously know as The Learning Disability Mortality Review (LeDeR). It requires that reviews are carried out following the death of anyone with a learning disability and those people who have a diagnosis of autism. 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. The LeDeR process and the way reviews are undertaken is currently being reviewed to ensure it is in line with the recommendations from the NHSE LeDeR Policy (2021).

Integrated Care Boards (ICBs) will replace Clinical Commissioning Groups in the NHS in England from 1st July 2022.

Learning from Lives and Deaths in Merton

In 2021/22 Merton CCG has received a total of 4 death notifications for the learning from death reviews (LeDeR) which are discussed at the Merton, Sutton, Wandsworth LeDeR steering group, which is held quarterly.

2 people died from pneumonia

1 person died from aspiration pneumonia

1 person died from sepsis of unknown aetiology

Across South West London, respiratory disease was the most common cause of death, in particular aspiration pneumonia which continues to be an urgent focus of attention in South West London, which is consistent with previous years.

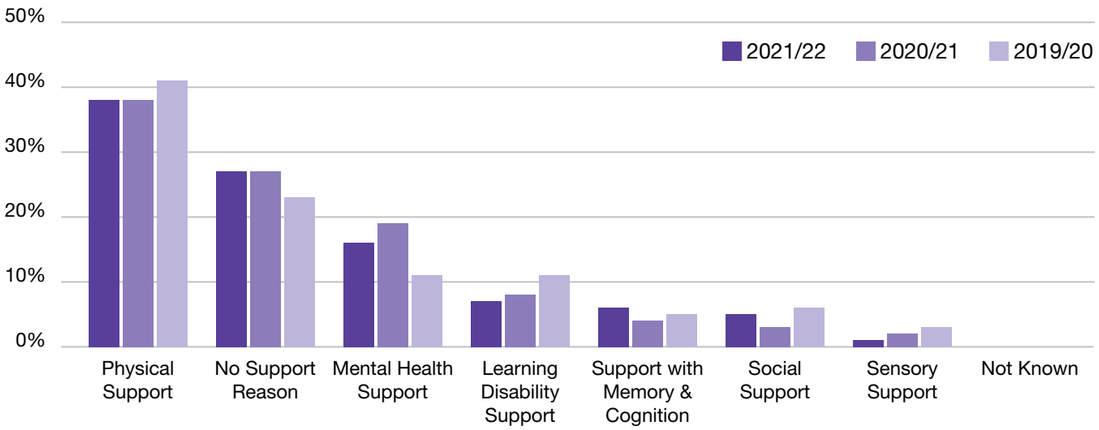
Whilst good practice is also identified and shared within the LeDeR steering group, key learning has also been identified across SWL which included;

- Annual health checks as a key means to improve and maintain health of people with learning disabilities
- DNACPR notice (Do Not Attempt Cardio-Pulmonary Resuscitation) as a feature of advance care planning, which attracted some notoriety during Covid-19 where there was widespread concern that orders were being issued to groups of people rather than for individuals based on their circumstances
- Application of the Mental Capacity Act and robust recording following assessment

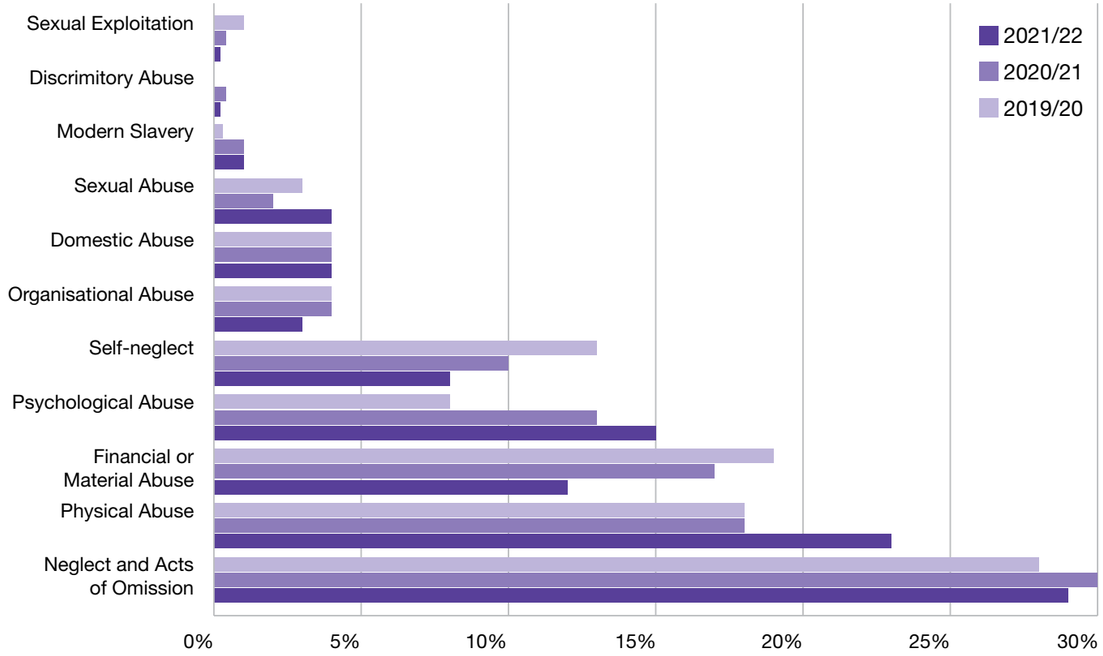
Safeguarding Adults Data

Year	2021/22	2020/21	2019/20	2018/19
Total number of Adult Safeguarding Concerns raised during the year	810	830	732	483
Total number of Adult Safeguarding Enquiries commenced during the year	447	379	366	98
Conversion Rate (Number of Section 42 Enquiries + Number of Other Enquiries / Number of Concerns)	**55%**	**46%**	**50%**	**20%**
Conversion Rate (England)	34%	34%	37%	39%
Conversion Rate (London)	**33%**	**33%**	41%	43%

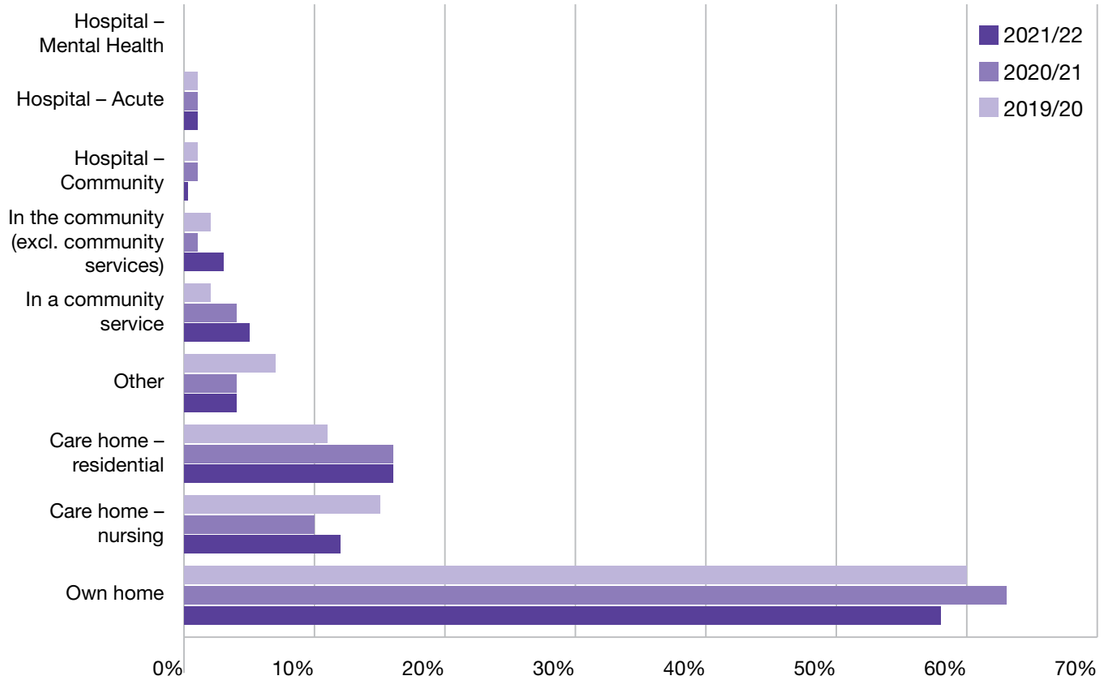
Individuals involved in Safeguarding Concerns during 2020/21 by Primary Support Reasons



Type of Risk (Data source: concluded enquiries during the year)



Location of Risk (Data source: concluded enquiries during the year)



During 2021-22 810 concerns were received by Merton Local Authority in total. This is a decrease of 20 (2.5%) on the number of concerns raised in 2020-21.

In terms of location of risk 60% were reported to be in people's own homes. Last year it was slightly higher at 63%, however it is broadly in line with the national picture.

Section 42 enquiries were commenced in 347 cases and Other enquiries commenced in 100 cases, giving a total of 447 enquiries commenced. This is an increase of 68 (18%) on 2020-21 and represents a conversion rate (concerns raised to enquiries started) of 55%.

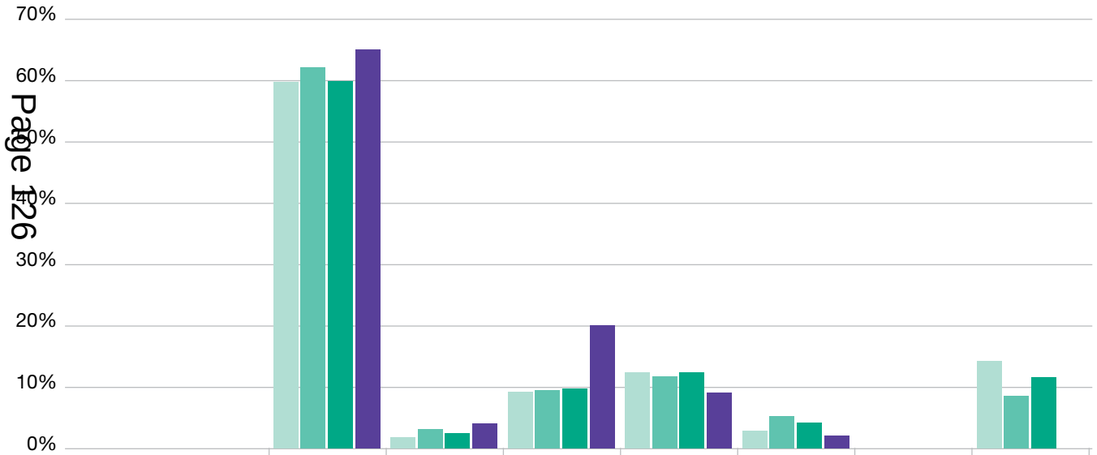
The percentage of the conversion rate is higher this year and is attributed to an improvement in the recording of safeguarding adult activity on the database and more importantly a greater understanding amongst practitioners regarding what constitutes a Safeguarding Adults Enquiry.

Last year we begun to analyse our data in relation to Ethnicity. Our aim was 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. The work on reviewing the current MSAB data set to include partner information, is one of our priorities and a Task and Finish Group is about to be set up.

As a result of what the data is telling us, we have begun focusing on raising awareness of safeguarding adults in the local community, voluntary sector, and faith groups. Our Safeguarding Adults Champions initiative came as result of this work and plans are in place to launch in 2022-2023.

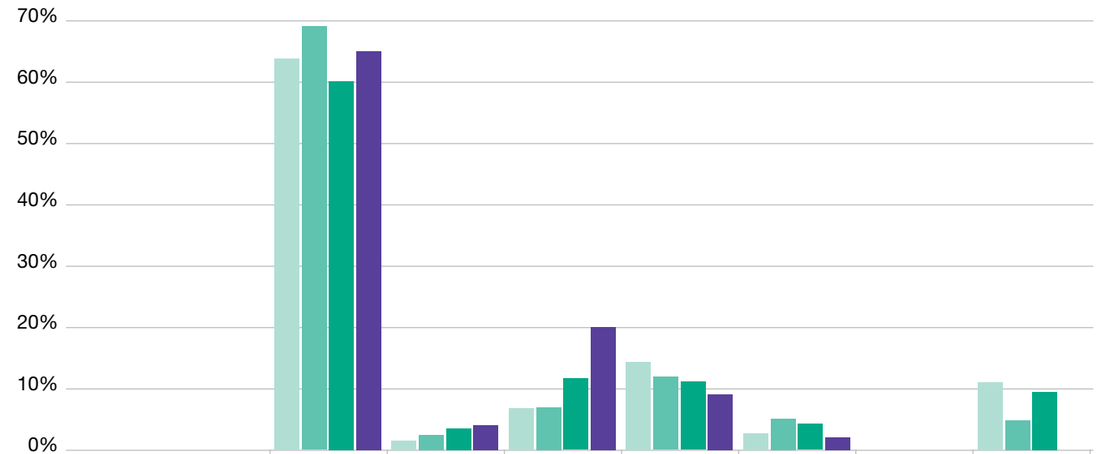
The charts below demonstrate individuals involved in Safeguarding Concerns and Enquiries by Ethnicity compared to the Merton 18+ population

Individuals involved in Safeguarding Concerns by ethnicity compared to Merton 18+ population



	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	Refused	Undeclared / Not Known
% Safeguarding Concerns by Ethnicity 2021/22	59.8%	2.5%	9.7%	12.3%	4.1%	0.0%	11.6%
% Safeguarding Concerns by Ethnicity 2020/21	62.1%	3.1%	9.4%	11.7%	5.2%	0.0%	8.5%
% Safeguarding Concerns by Ethnicity 2019/20	59.7%	1.8%	9.2%	12.3%	2.9%	0.0%	14.2%
Merton Population for 18+ (2021/22)	65%	4%	20%	9%	2%		

Individuals involved in Safeguarding Enquiries by ethnicity compared to Merton 18+ population



	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	Refused	Undeclared / Not Known
% Safeguarding Enquiries by Ethnicity 2021/22	60.1%	3.5%	11.6%	11.1%	4.2%	0.0%	9.4%
% Safeguarding Enquiries by Ethnicity 2020/21	69.0%	2.4%	6.9%	11.9%	5.1%	0.0%	4.8%
% Safeguarding Enquiries by Ethnicity 2019/20	63.7%	1.5%	6.8%	14.3%	2.7%	0.0%	11.0%
Merton Population for 18+ (2021/22)	65%	4%	20%	9%	2%		

In 2021/22 9.7% of people from Asian/Asian British were involved in safeguarding concerns and 11. 6% were involved in safeguarding enquiries. There is an increase in the proportion involved in safeguarding enquiries, moving closer to being comparable to the Merton 18+ population.' This has been attributed to the awareness raising around safeguarding adults, by our voluntary sector partners and lead representative from Merton Connected.

During 2021/22 12.3% of people involved in safeguarding concerns and 11.1% 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.

In 2021/22 the Communication and Engagement Subgroup, as well as the Learning and Development subgroup, developed programmes to raise awareness of safeguarding adults. Merton Connected have been working with groups to ensure appropriate safeguarding adults' policies are in place and generally raising awareness of how to report and record safeguarding concerns.

The Local Authority Safeguarding Adults and Deprivation of Liberty (DoLS) Team manager has also facilitated Safeguarding Adults Level 1 Training as well as bespoke workshops for the Voluntary Sector and volunteers.

We are still working in partnership and gathering information to see 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 2021/22 %

68%
Fully Achieved

29%
Partially Achieved

3%
Not Achieved

97%
of people's outcomes being fully or partially met.

71%
of people expressed a desired outcome
compared to
66%
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 a 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, %

324, 93%
Risk removed or reduced

23, 7%
Risk remains

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 three new SAR Notifications during 2021-2022, which resulted in two new SAR's 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 did not meet the Criteria. However, it was agreed at the SAR Subgroup that a Practitioners Event would be arranged to consider learning. The Practitioner Event was facilitated by Mike Ward from Alcohol Change UK.

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

Published SAR'S

RD Colin-SAR
Colin was found deceased at his home address by police after neighbours had raised concerns with police that they had not seen him for at least six weeks. It is believed that Colin had been dead some two weeks prior to being found by police.

Colin had been known to mental health services since at least 2006 and had a diagnosis of Paranoid Schizophrenia.

Actions for improvements
Mental Capacity Act training and the reviewing of guidance on triggers for cases where repeated unwise decisions have been made. This review has also recommended further changes in some of these areas, including, a review of:

- How Adult Social Care and Mental Health Services assess risks with regards self-neglect and non-engagement
- The Board's self-neglect policy will incorporate the learning from this review, including,
  - what constitutes self-neglect
  - risk assessment and risk panel and thresholds
  - case coordination
  - importance of relationship building
  - legal guidance and measures to protect others - advocacy

SK SAR
The MSAB received a referral for SK from Merton Centre for Independent Living (MCIL). The concerns raised by MCIL at this time centred around the long delays in getting support in place for SK, and the concerns raised regarding the discharge from hospital shortly before her death.

The SAR explored whether the views of SK reflected her complex situation and if her care may have been delayed due to a failure to recognise her needs and to work effectively with health and other agencies.

As a result of this specific review, the lessons learnt have led to improvements in how we work together to support people who are alcohol dependant and their families, namely:

Learning from SAR's
- The MSAB commissioned training for practitioners, from Alcohol Change UK, on the 'Blue Light Project' principles as well as the guidance they produced for 'Safeguarding Vulnerable Dependent Drinkers'. The training aimed to improve and innovate practice in working with people experiencing difficulty with alcohol use. The Board will evaluate the impact of this training going forward.
- We continue to develop tangible plans for improving our 'Think Family' approach. This is a priority for the Board and has been woven through our Business Plan for 2021-2024 and was one of the key themes of our Joint Safeguarding Conference in March 2022. Stronger strategic and working relationships have been forged with the Children's Safeguarding Partnership to support this work.
- Board partners have agreed to establish a Multi -Agency Risk Assessment Framework. This guidance will be developed in partnership with members of the Merton Safeguarding Adult Board and sit alongside the London Multi-agency Safeguarding Adults Policy and procedures. It will provide guidance on managing cases relating to adults where there is a high level of risk. The circumstances may sit outside the statutory adult safeguarding framework however a multi-agency approach would be beneficial.

  The MSAB continues their learning around Mental Capacity, and this learning has been at the forefront of the plans to introduce the Liberty Protection Safeguards (LPS).

Key messages and guidance coming from the MSAB LPA Task and finish Group include.

- LPS (formerly DoLS) is rooted firmly within the Mental Capacity Act 2005 (MCA) and all the key principles of the MCA fully apply.
- LPS will be about safeguarding the rights of people who are under high levels of care and supervision but lack the mental capacity to consent to those arrangements for their care.
- LPS will apply to people in care homes, hospitals, supported accommodation, Shared Lives accommodation and their own homes.
- LPS will apply to everyone from the age of 16 years.
- LPS will need to be authorised in advance where possible by what will be termed ‘the Responsible Body’ which now includes health authorities.

Alcohol Change UK Workshop and Practitioners Root Cause Analysis Event

In November 2021 MSAB commissioned a workshop for Board members and practitioners to assist with their work with dependant drinkers. The focus was on the guidance, safeguarding dependant drinkers and how to use legal powers. The guidance was produced by Alcohol Change and written by Professor Michael Preston-Shoot and Mike Ward.

The guidance aimed to help practitioners to improve the wellbeing and safety of adults who are highly vulnerable, chronic, dependent drinkers.

The Practitioners Event in February 2022 was arranged to review a specific alcohol death so that we could learn about what happened and think about what could have been done differently using the Blue Light Root Cause Analysis Approach.

The Blue Light approach involves bringing key agencies such as police, housing, mental health, hospital and others together with specialist alcohol services and challenges the belief that only drinkers who show clear motivation to change can be helped.

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.

As an outcome of a Safeguarding Adult Review (SAR) the Merton Safeguarding Adults Board commissioned training for practitioners, from Alcohol Change UK, on the 'Blue Light Project' approach. The training and Practitioners Event aimed to improve and innovate practice in working with people experiencing difficulty with alcohol use.

This case study demonstrates how practitioners have put learning into practice, using the Blue Light Project principles as well as Making Safeguarding Personal to support an adult at risk.

Case example

Situation:
This case example refers to an older person who was alcohol dependent and had been self-neglecting for many years. There had also been reports of drug misuse. Several safeguarding referrals, relating to self-neglect as well as possible sexual abuse, exploitation (Cuckooing) and financial abuse had been received by the Adult Social Care Team (ASC). Their general health was poor, and weight was reported to be around six stone. They lived alone and had a close family network who were generally supportive, however the children had experienced trauma growing up because of difficulties their parent faced, which made relationships tenuous at times.

The Blue Light Approach
Practitioners who had undertaken the 'Blue Light Project' training, worked closely with the person to develop a support plan with the aim of reducing the risk of self-neglect, and minimise the risk of harm and exploitation. The Blue Light initiative offers an innovative approach to supporting and motivating high impact dependent drinkers.

There were times when the person was sober and had mental capacity when the plan worked well, however as soon as they were intoxicated any interventions broke down quickly and the same behavior was perpetuated. Detoxification was tried but unfortunately could not be sustained for any length of time. A placement was also tried which broke down after about six weeks due to their continued dependency on alcohol.

An important breakthrough came after practitioners trailed through previous files and worked closely with other agencies, including the Westminster Drug Project (WDP) to discover the person had a diagnosis of Alcohol Related Brain Injury. After consultation with the person, their family and other agencies involved it was agreed that a specialist placement would be sought to allow for expertise in supporting the person.

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

What practitioners involved in the case noted was that if they hadn't properly understood the nature of a problem the individual was facing, they would risk proposing the wrong solutions. In this case, they sought to fully understand the issues including the diagnosis. They also worked closely with the family who remained very supportive of the person.

Joint working was also established with the Westminster Drug Project (WDP), police, and the Hospital Safeguarding Team, for a suitable specialist placement to be found that fully met the person's needs.

What was put in place to support the person?

- A specialist residential placement was commissioned to meet the person's individual needs in relation to their brain injury and substance misuse, including appropriate therapy.
- Regular accompanied and more recently unaccompanied community visits supported by the home to promote independence.
- Regular communication with family via telephone and plans for home visits.
- Regular telephone and face to face reviews by practitioners.

Outcomes achieved
The person settled well at the placement that provided personalised support as well as therapy to support recovery. It was also important to minimise further risk of harm from alcohol misuse to enable them to have a better quality of life.

Feedback regarding person putting on weight, spending time looking after their personal appearance and being involved in activities demonstrated that their, health, wellbeing and quality of life had considerably improved.

Practitioners have undertaken regular telephone and face to face reviews and heard from the person about how happy and fulfilled they were and the improvements in their life they were now living, thanks to the intervention.

Annual Priorities 2022/23

- Develop a programme of work to engage people with lived experience and to include their voices in the work of the Board as well as the Safeguarding Adult Review (SAR) action planning process. Public Health partners have agreed to work with the MSAB on an approach, which will then inform the service model and specification for commissioning substance misuse services. A bid for funding has been submitted.
- Work will continue around learning from SAR's. There will also be a focus on what SAR's are telling us in terms of themes we might be seeing and how as a partnership we can improve our practice for those at risk.
- The MASB strategic priority around Prevention and Early detection focuses on enabling people to recognise risk, includes developing links with residents and the local community, particularly those who are seldom heard. The Communication and Engagement Subgroup of the Board are working with Merton Connected on developing a model of Community Safeguarding Adults Champions. They will be the vehicle for raising awareness of safeguarding adults in the community and amongst its residents, as well as informing the board of what's needed to support the community and to identify any emerging issues.
- After consultation and discussions at the Board on how best to go forward with gathering meaningful data to support their work, partners have agreed to develop a comprehensive data set for the Board. This will be linked to the National Data Framework Tool, recently produced by the National Safeguarding Adults Board Managers Network.
- Social Care departments will be inspected by the Care Quality Commission from as a result of the Health and Care Act 2022 coming into force, which will include a focus on adult safeguarding. The same legislation will see Clinical Commissioning Groups replaced by Integrated Care Boards. Safeguarding will continue to feature prominently in these new arrangements across South West London.

  The MSAB will be kept updated and prepare for the implementation of the Care Quality Commission's framework on Oversight for Local Authorities and Integrated Care Systems, due to be introduced in April 2023.

Summary

This report seeks to provide assurances to our stakeholders, including the residents of Merton, that the Merton Safeguarding Adults Board (MSAB) are fulfilling their statutory responsibilities in terms of safeguarding adults at risk.

It demonstrates a strong commitment to working in partnership to keep people safe throughout the report.

There has been a huge amount of work and development to improve practice, build on existing systems and processes, as well as work with the local community, to achieve further improvement and embed good practice.

A robust evolving work plan has been created for the safeguarding Strategic Priorities 2021/2024, to translate the plan into tangible actions.

Reporting a Safeguarding Concern

Phone:
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

Out of Hours and Bank Holidays:
020 8770 5000

Email:
safeguarding.adults@merton.gov.uk

Emergency:
Call the Police or emergency services - 999

Merton
Safeguarding
Adults Board

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