Merton Safeguarding Adults Board

Annual Report 2022 - 23

Message from the Independent Chair

This report covers the work of the Merton Safeguarding Adults Board during the period March 2022 – 2023.

This year, the Board has continued to focus on how we develop our engagement with local communities and hear from people with lived experience of safeguarding, such as Sandra's Story. I am delighted to see the successful launch of Community Adult Safeguarding Champions Network this year, which is a significant development for the Board. Representatives from local organisations across Merton and members of the wider community have signed up as Champions and engaged in the network. This will be an important vehicle for reaching out to our local communities and raising awareness about safeguarding to residents across the borough.

As we look ahead to the next year, we are committed to working in partnership with the Merton Child Safeguarding Partnership to embed a Think Family and transitional safeguarding approach. As joint Chair for both partnerships, I can see how vital this work is and how it will make a difference for adults, children and young people across Merton.

I once again extend my sincere thanks to all partners in the Board and the business support team for their work over the year and look forward to continuing our ambitious programme of work. I would like to express my particular thanks to Nicola Brownjohn for covering the position of Independent Chair for part of this year.

Aileen Buckton

Independent Chair of the Merton Safeguarding Adults Board

Safeguarding Adults at Risk in Merton

Merton Safeguarding Adults Board (MSAB) is made up of a collection of local organisations both statutory members (Local Authority, Integrated Care Board (ICB) and Police) and non-statutory members (provider health services, fire, housing, probation, Healthwatch and the voluntary sector and other provider services).

We work together as a partnership to ensure adults at risk of abuse or neglect with care and support needs (whether or not those needs are being met by any agency) receive appropriate advice, support and guidance to keep themselves safe and ensure they are safeguarded in a proportionate, empowering and responsive manner.

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 and:

- 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 of whether the local authority are funding care or not.

Core Duties

The core duties of the Safeguarding Adults Board are to:

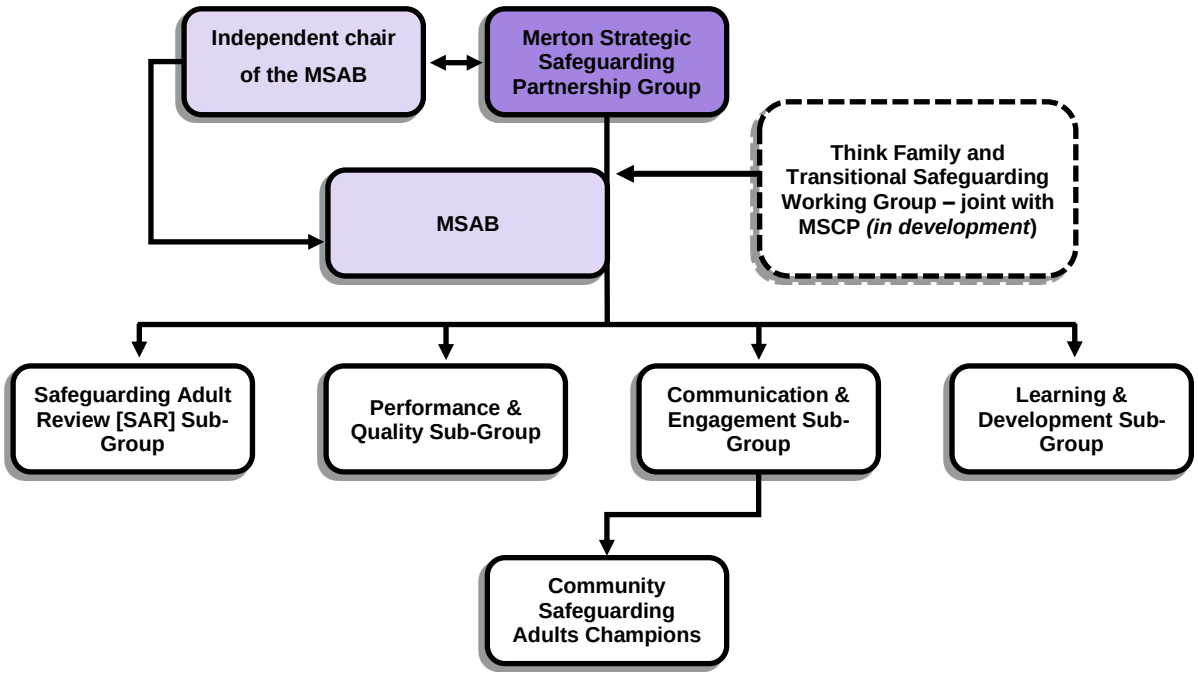
- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- publish an annual report detailing how effective their work has been.
- commission safeguarding adults' reviews (SARs) for any cases which meet the criteria for these. (See -Safeguarding Adults Review Section)

Governance Structure

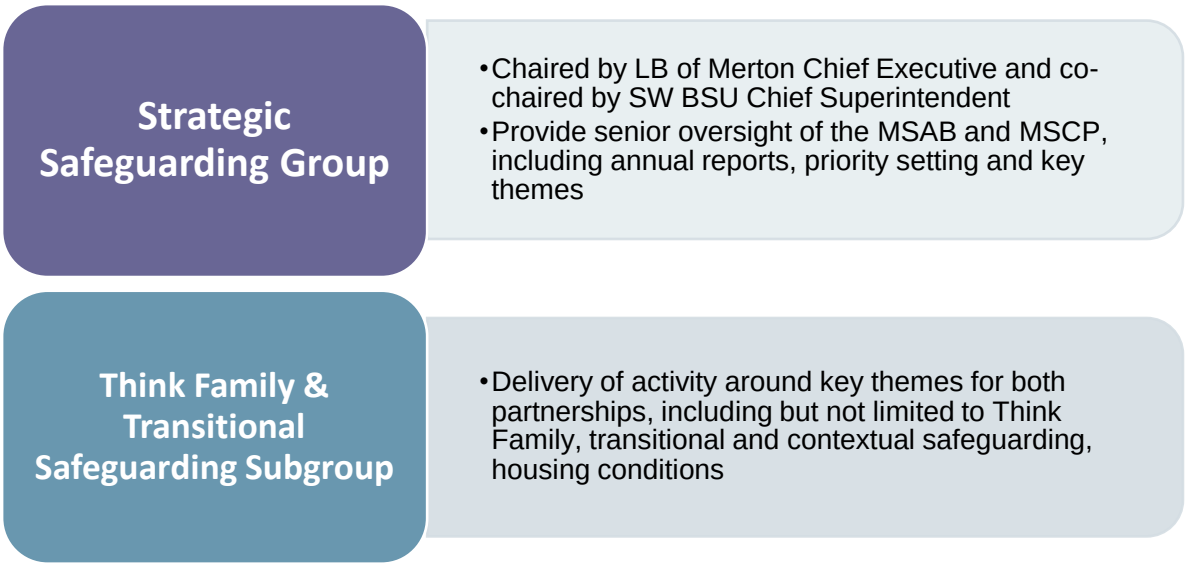
In 2022-23 the MSAB continued to work closely with the Merton Safeguarding Childrens Partnership (MSCP). This included activities delivered together and the attendance of key representatives to link the MSAB, the MSCP Executive and MSCP Full Partnership. The MSAB and MSCP continued to share an Independent Chair, including via interim cover, which has further supported this.

Additionally, a Think Family & Transitional Safeguarding Subgroup will also meet for the first time in in 2023-24. This new subgroup was initiated as an outcome from the March 2023 Joint Safeguarding Conference, to work on the delivery of important cross cutting themes, as well as building on already established links across the partnerships.

A new Strategic Safeguarding group is in the process of being set up with the first meeting in 2023-24. This new group will provide senior level strategic oversight of safeguarding for the MSAB and the MSCP.



Merton Safeguarding Adults Board



MSAB Strategic Plan 2021-2024

Priority 1 - Prevention and Early Detection

Our aim- Adults from all communities will feel supported to keep safe. Partners, service users, carers 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 aim- 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 improve outcomes and experience in the context of safeguarding adults at risk.
To learn from reviews, for example SAR's, Domestic Homicide Reviews (DHR) and Learning Disability Mortality Reviews (LeDeR) will be embedded, and mechanisms are in place to measure effectiveness.

In 2022-23 We Said, We Would

We set out specific commitments for action in the previous MSAB annual report 2021-22 on how we would work together in partnership to progress against the four strategic priorities in our Strategic Plan.

- Develop a program 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.

- Continue our work around learning from SAR's. To 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 Communication and Engagement Subgroup of the Board will work 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.

- Develop a data set and analyse meaningful information to support the Board with Prevention and Detection so that adults from all communities will feel supported to keep safe.

- 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.

What we did to achieve this

‘Sandra’s Story’ Working in Partnership with People with Lived Experience – Making Safeguarding Personal

Work has begun to engage people with lived experience to support the improvement of safeguarding work in Merton. One example of this work is how we have engaged with the daughters of Sandra. Following the SK Safeguarding Adults Review (SAR), now known as Sandra’s Story, we sought the views of Sandra’s daughters to share their experience. They have since spoken at the joint MSAB and MSCP conference well as **Epsom and St-Helier’s Hospital** Annual safeguarding conference to share their story and experience. The learning has been immense, and we thank them both for their contributions.

Plans are underway with the CLCH Patient Experience Team to produce a video which can be used on the MSAB website, for learning events and for wider SAR learning.

Comments and evaluations on ‘Sandra’s Story’ from the Joint Safeguarding conference:

“Sandra story - having people with lived experience brings so much more meaning and learning - with them bringing a perspective and details that professionals can't possibly bring.”

“Highlights the impact on the whole family and need to consider whole family needs.”

“Ensure we cross over with children and adults and understand children's experience as it will influence them in adult life, but also understanding adults’ experiences.”

“Commitment to change and hearing the voice of the child /think family.”

“Remembering the words of those who experienced our services and how we missed opportunities to support and safeguard them better and how we can remain curious and respectful and work alongside families in distress to create plans to bring about change.”

Learning from SARS and practice development – Prevention and Early Detection

Analysing themes from recent Safeguarding Adults Reviews has been a focus of the SAR Subgroup. This year the subgroup has looked at improving how agencies work collaboratively together on complex cases, particularly where there is a high level of risk and where the person with care and support needs declines support.

This work developed from a recent SAR 'Colin' and has resulted in a new framework to guide a multi-agency and coordinated approach to cases where there is a high level of risk. The 'Multi-Agency Risk Assessment Tool' is currently being used by the partnership to support their work with adults at risk and further work will continue in 2023/24 to embed this approach. Alongside this framework, the subgroup has been looking at self-neglect and supporting improved practice through a self-neglect and hoarding tool to help practitioners working on these cases.

Developing the Community Safeguarding Adults Champions Network – Building and Strengthening Connections

In 2022-23, the MSAB partners established the Community Safeguarding Adults Champions initiative. The launch took place in National Safeguarding Week November 2022 which successfully recruited representatives from the local community as well as some key organisations from the Voluntary Sector. The network has grown to 30 members since its launch. Forums have been well attended by Community Champions and key topics around adult safeguarding have been covered including a dedicated session on modern slavery and exploitation.

Meet the Champions!

"We work with vulnerable adults. By becoming Safeguarding Champions, we are making a public declaration as to the importance of safeguarding within our organisation, whilst also ensuring we are able to keep up to date and continue to cascade key messages to staff, volunteers and our beneficiaries."

Veronica Fleming and Daljinder Nagi, Imagine Independence

"Vestry Hall has hundreds of unique visitors pass through its doors every week. It is so important that we can all recognise potential safeguarding issues and know how and whom to report"

Julie Noel, Manager of Vestry Hall

I became a safeguarding champion because I want to be confident that I am doing the right thing when working with the public and the people who use our services".

Sabriti Ray, Project Manager Ethnic Minority Centre Merton

" We work to support vulnerable women and girls, safeguarding is always uppermost in our mind. It's imperative that we all can recognise signs of safety and confidently refer individuals when we have concerns".

Maureen Bailey and Camz Campbell, Inner Strength Network

Developing Data Collection - Quality Assurance & Embedding Learning

Collecting meaningful data to support the work of the Board has been a high priority for the Board over 2022-23. This includes a deep dive into ethnicity data relating to concerns and enquiries which is outlined further below in this report.

The MSAB has been working closely with partners over the course of this year to identify data by partners on key safeguarding areas and will continue to build on this work next year over 2023-24. Audits also continue to be undertaken of the safeguarding adults process and information to support quality assurance and provide learning to improve outcomes for people in Merton.

Progress on our Strategic Priorities – feedback from partners

1. Prevention and Early Detection

Partners have worked together to ensure staff and volunteers working in the community have a basic knowledge of awareness of Safeguarding Adults. The Safeguarding Adults Level 1 training which is accessible to all partner agencies, including the voluntary sector was launched in November 2022. A free E-learning package is available on the Merton Safeguarding Adults Board website training platform.

During National Safeguarding Week 2022 the **SW London Integrated Care System (ICS)** held a conference focusing on the National Themes for Safeguarding which are: "Responding to Contemporary Safeguarding Challenges". They looked at the challenges of dealing with abuse, exploitation, or neglect and how harm can have a devastating and long-lasting impact on victims, their families, and carers.

It was outlined that how safeguarding adults at risk remains a priority for Southwest London ICS and the aim of this conference was to increase awareness, so as a collective system, they can continue to keep vulnerable adults at risk safe, wherever people live and whenever they access services.

Responding effectively to domestic abuse is a priority that is woven throughout the work partners do to support adults at risk. Support from **Safer Merton** continues and in 2022-23 they funded an Independent Domestic Violence Advocate (IDVA) to join the Local Authority First Response Team initially for 12 months. This will assist with improving early identification of domestic abuse cases as well as improve staff's knowledge and understanding.

Safer Merton has also led on 'White Ribbon' accreditation and Merton Council achieved accredited status in November 2022, demonstrating the commitment in the borough to ending violence against women and girls by men and boys. Multi-Agency Risk Assessment Conference (MARAC) continues to be held regularly and has representation from the Safeguarding Adults Team as well as other partners, including statutory members of the MSAB.

Merton Housing colleagues have revised their domestic abuse processes to support improvements around prevention and early detection of domestic abuse. They are now using the Domestic Abuse, Stalking and Honour Based Violence (DASH) tool, bringing housing assessments in line with best practice.

Domestic Abuse Case Study

The example below shows how the expertise of specialist Independent Domestic Violence Advocates (IDVA) can support early intervention and prevention of further harm. In this case, effective professional expertise and partnership working ensured that the victim at risk was identified and action taken to safeguard her from further harm:

"A softly spoken male victim approached a female IDVA stating that he was being abused. His comments included "my partner hits me with an umbrella, she has mental health issues and one day she will hurt herself" as well as other comments that seemed strange. The IDVA in this case was not totally satisfied that the male was the victim and felt the female maybe the person at risk. Something did not sit right for the IDVA, so she decided to refer the case to the Multi-Agency Risk Assessment Conference (MARAC).

When MARAC discussed the case, there was not a lot of information about either from party agencies and after lengthy discussions all partners said that they felt that the female was the likely victim and were worried about her safety. Collectively we agreed to ask a male IDVA to talk with the male to help understand the dynamics of the relationship.

The male IDVA contacted the self-referred male and during that conversation he spoke completely differently to way he spoke to a female IDVA. He came across very bold, arrogant, and self-entitled and said that he would be the one to hurt the female and he was trained in martial arts and the female would not be able to defend herself. Following this disclosure, the male IDVA called 999 and the male was arrested and charged with several offences. The female partner was contacted by an IDVA, offered support and was now safe.

It is not always the case that a perpetrator presents as a victim but in this case, it showed how professional curiosity, partnership working to discuss the case, shared professional opinions and information helped to safeguard the female. It also demonstrates the effectiveness of MARAC and how agencies worked extremely quickly together to achieve an excellent outcome."

The London Fire Brigade (LFB) published its Community Risk Management Plan (CRMP) in January 2023 and includes a seven-year commitment and action plan for Londoners. There was considerable consultation with all communities in London to shape the plan and as a result it outlines how the LFB will engage with all communities going forward, including Community Forums. The Borough Commander in Merton is working closely with the Board and in particular the Subgroups to ensure the CRMP is communicated to all partners and community groups. In 2023-24 a program of learning events will be scheduled.

2. Building and Strengthening Connections

In 2022-23 **partners** have worked hard to get the Community Safeguarding Adults Champions network and quarterly forums off the ground. This was launched in National Safeguarding Week 2022 and Partners participated in the promotion of the network via their individual platforms as well as using the MSAB website to advertise forums and the Safeguarding Adults E-learning training, which is very much part of equipping Champions in their role.

Partners, including **Central London Community Health Care Trust (CLCH), Mental Health, St George's** as well as the Board and **Merton Childrens Safeguarding Partnership (MSCP)** have delivered safeguarding conferences in 2022-23. Focus has very much been around learning and particularly sharing learning from local and national Safeguarding Adult Reviews (SAR's).

Local Police continue to share information and intelligence with partners via systems already set up including MARAC. Working together to keep vulnerable children, young people, and vulnerable adults safe from harm, by safeguarding, initiative-taking and investigation is a priority and partners continue to improve practice in this area. A key improvement has been having the right representation at the right meetings to improve outcomes for people using safeguarding services.

Colleagues from the **MET SW Borough Command UNIT** delivered Road Shows in 2022/23 which were held virtually and in person. The events were shining a light on safeguarding during and post the COVID-19 pandemic. There was a particular focus on reaching the voluntary and community sectors who contribute towards public protection and keeping people safe during the current challenging times. Positive feedback came from the voluntary and community sectors in relation to the improved relationships between them and the police.

3. Making Safeguarding Personal

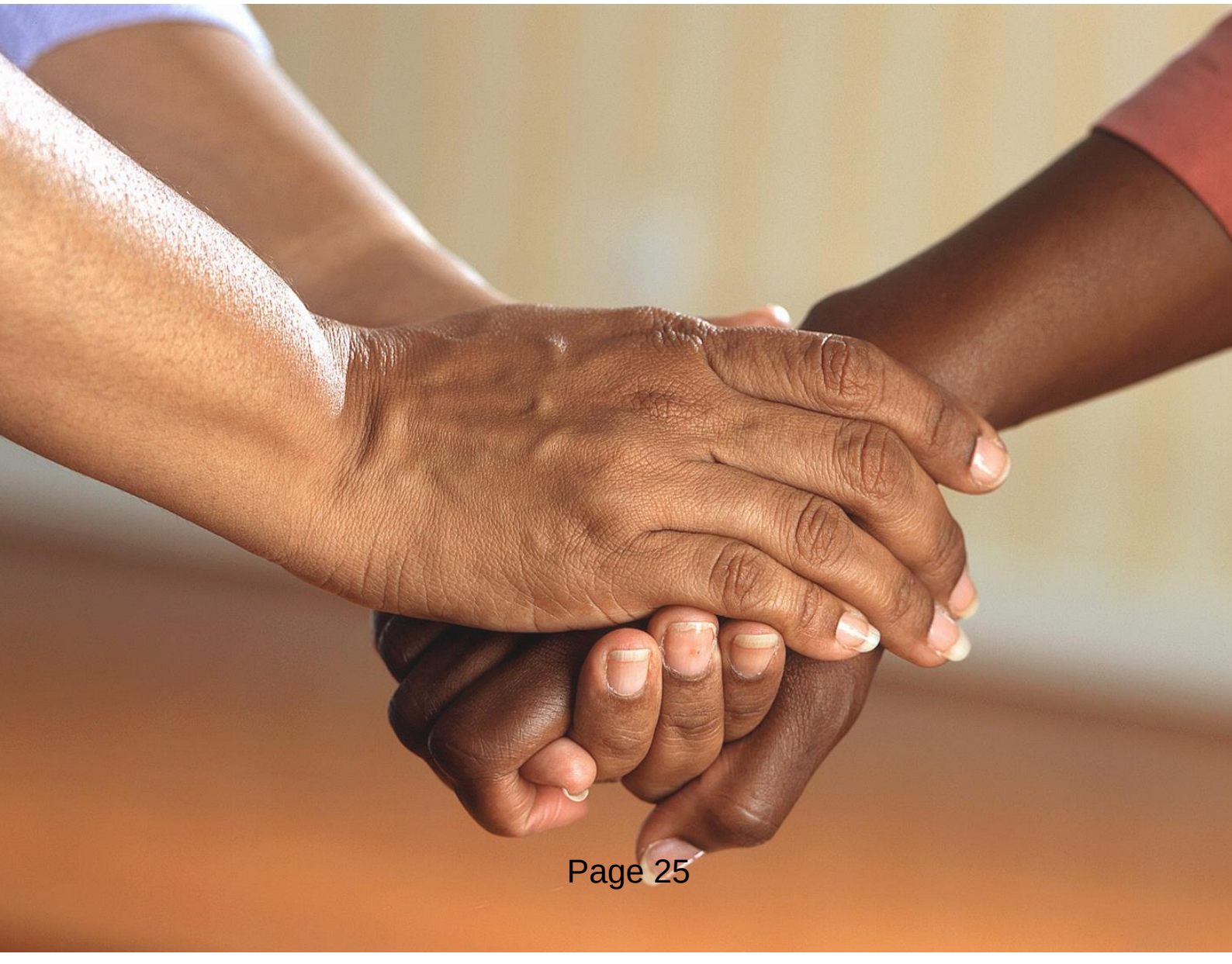
In 2022, **Merton Adult Social Care,** led on the introduction of a new process called 'Discovery Interviews' to support the gathering of feedback and gaining valuable insight, directly from people who had been through a Safeguarding Adult Enquiry.

Over the coming year, plans are in place to role this approach out further with the Safeguarding Adults Managers (SAM's) taking the lead. This will help strengthen the voice of people going through the safeguarding process, as well as to identify learning areas, make improvements to the systems used, and support people through what can be a difficult process.

Colleagues from the **SW BCU** have been trained in trauma informed practice and utilising this approach when working with individuals with complex needs. Officers have reported listening to adults at risk and respecting their views as well as working with them to achieve the desired outcomes. This includes considering alternative avenues for addressing behaviour and not unnecessarily criminalising adults at risk, where this is appropriate.

The **SWL ICB** have supported the introduction of new approach to patient safety incidents – PSIRF (Patient Safety Incident Response Framework) –which came into place this year. This new approach will change the way that the system learns from patient safety incidents and events. Compassionate engagement and involvement of those affected has been highlighted as an important aspect of the PSIRF framework.

The MSAB SAR Subgroup has been focusing on the voices of people with lived experience who have gone through the SAR process and continues to develop this work. Feedback from family and friends with lived experience remains a focus to inform how people using services are supported.



4. Quality Assurance and Embedding Learning

As done in previous years, Board partners completed the Safeguarding Adults Partnership Audit Tool (SAPAT), followed by a Challenge Event to look at the findings and to inform the annual priorities.

In 2022-23 we have seen good engagement and representation from diverse partners from all the MSAB Subgroups which has enhanced ownership of the MSAB priorities and contributed to improving practice for those at risk. Co-chairs, include partners from **CLCH, Integrated Care Board (ICB), Merton Connected and Adult Social Care (ASC).**

Achievements in 2023 have included the launch of a New Multi-Agency Risk Assessment Framework and Tool following the 'Colin' SAR as outlined above. This was signed off by the Board in December 2022. Further work around the implementation and review of the Framework will take place in 2023-24. The Board continues to undertake and learn from SAR's. Three SAR's have been completed in 2022-23 and one has been published (See Section on SAR's).

In February 2023 Michael Preston Shoot, who led the review of the SAR Analysis 2018-19, provided a workshop for Board members around the SAR process. It covered decision making, legal literacy, commissioning, Quality Markers and learning and service improvement. The Merton SAR Protocol was reviewed to incorporate this information as well as any learning from the review process in Merton and included the updated SCIE Quality Markers.

Following feedback from managers and staff regarding the SAR Process and challenges often faced in terms of the issues raised by staff and how they might be left feeling, the SAR Subgroup Co-Chair delivered a workshop on Compassion Fatigue. Also led by the SAR Subgroup, guidance to support managers and staff has been produced and is available on the MSAB website.

7-minute briefings have been developed to share the learning and they sit alongside published SARs on the website. Learning Events are also arranged to share SAR learning and further work is underway to measure the impact of learning on practice as well as for people using services, asking the key question 'What difference has this made?'.

The Work of the Subgroups

Safeguarding Adults Review (SAR)	Considered SAR referrals and commissioned reviews in line with the SAR Protocol	**Learning and Development**	Level 1 Safeguarding Adult Training available free and to the Voluntary Sector, Faith communities, volunteers and the wider community.
	Raised awareness of the contribution of people with lived experience in the SAR process at the Joint Conference 2022		Online training now available on the website to raise awareness of prevent, radicalisation and extremism
	Guidance for Managers and Staff to support them during the SAR Process.		Raising awareness of Fire Safety through promoting news, campains and engagement from the LFB
			Promoted the Think Family approach in collaboration with the MSCP
Performance and Quality	Continued to progress the work on gathering data for MSAB quality assurance	**Communication and Engagement**	Launched the Community Safeguarding Adults Champion Network November 2022
	Produced a Multi-Agency Risk Assessment Framework and Tool for complex and high risk cases		Arranged quarterly forums for the Champions with speakers on topics such as the work of the Board, Scams and Financial Abuse
	Developed and piloted 'Discovery Interviews' to hear the voices of people having experienced the safeguarding adult enquiry process.		Advertised events for National Safeguarding Week November 2022 as well as MSAB partner events
			Updated and maintained the MSAB Website as a resource for partners

Spotlight on: Merton Safeguarding Children Partnership (MSCP) and the Merton Safeguarding Adults Board (MSAB) Joint Conference – March 2023

On 15th March 2023, Nicky Brownjohn, the interim joint chair led the annual conference for Merton's Safeguarding Adults Board and Safeguarding Children's Partnership: ***Domestic Abuse Safeguarding: "Learning from the Lived Experience of Trauma from Child to Adult".***

Councillor Peter McCabe, Cabinet Member for Health and Social Care, and Councillor Brenda Fraser, Cabinet Member for Children's Services provided the opening addresses.

Hayley Tuffin delivered a keynote speech on trauma informed practice which set the scene for the afternoon, looking at the lifetime impact of childhood trauma.

CLCH followed with a session about Safeguarding Adult Reviews, taking us from an overview of the national learning from reviews to a Merton SAR. Lorel and Kerylyn were introduced as the daughters of SK and spoke from their lived experience of being hidden young carers, when they were children, to their parent who could not manage their own care and support needs.

This provided the conference with a vital picture of how services saw the adult at risk without seeing the children. Lorel and Kerylyn showed us how important it is for professionals to 'think family' to prevent harm. Lorel has since presented their story in video form that is accessible via the MSAB website.

Feedback has demonstrated the impact and learning gained from people with lived experience as well as giving an opportunity to people to describe how it was for them, which does not always happen.

For the final part of the conference, Safer Merton spoke about the impact of domestic abuse on children, and their lifelong trauma. They provided advice on how to approach individuals who disclose domestic abuse: '*Begin from a place of empathy'.*

The conference ended with break out room activities to consider the next steps in our learning. Key outputs were:

1. Continue strengthening relationship-based practice
2. Let's be bold, let's create a Think Family charter
3. Focus on children, don't just listen to the adult
4. Adult and children services working together
5. Consider the recurring themes: Relationships

This year the MSAB and MSCP Joint Chair and Statutory partners have been reflecting on the key outputs for the conference and are working together to develop the Strategic Safeguarding Partnership to support the safeguarding strategic

priorities and governance of both partnerships. This group will be jointly chaired by Merton Chief Executive and the Met Police.

A joint Think Family and Transitions working group will also be developed in 2023-24 to look at areas such as learning from reviews, transition from Children to adults and other agendas that impact on both adult and children's safeguarding.

Safeguarding Adult Reviews- 2022-23

The Board received three SAR notifications during 2022-23. One notification was approved for an in-depth review, and one other is awaiting further information and one did not meet the criteria for a review.

Three other reviews were concluded during the last year, two of which were not published. The Board considers the publication of each review on a case-by-case basis recognising that in some situations, there are factors which mean that is not appropriate to publish – such as the wishes of the family or where the individual has suffered serious harm or neglect.

SAR Notifications received	**3**
Reviews initiated	**1**
Reviews completed	**3**
Reviews published	**1**

SAR Annabel (published 31st March 2023)

Annabel was a mother to several children from different relationships. At the time of her death, she was still considered a permanent resident in LB Merton but had been living in temporary accommodation in Brighton & Hove since January 2021. In her short life, Annabel had experienced multiple trauma, through rape as a teenager, significant domestic violence and abuse in several relationships, multiple miscarriages and the separation from her children due to care proceedings.

Annabel and her family had been known to several agencies within and outside of Merton due to incidents of domestic abuse leading her to seek emergency accommodation outside of Merton. During the time period under review, Merton Children's Services escalated their involvement to child protection and subsequently issued care proceedings in relation to four of Annabel's children, which was an enormous shock to the whole family and devastating for Annabel.

Annabel experienced multiple crises of physical and mental ill health, including several attempts to take her life. In December 2020, a road traffic collision left Annabel temporarily paralysed and with care and support needs. The children's care proceedings concluded with the judge ordering for the children to live with extended family members and limited contact was granted to Annabel. Annabel sadly took her own life on 5th March 2021 by taking an overdose. She was 34 years old.

Key Learning Points

- Adequately managing risk for vulnerable mothers if the local authority proposes care arrangements for their children outside the family home.

- A think family approach is required to be fully embedded in circumstances where children's services are initiating court proceedings. Adequate input is required from a range of adult services who know the mother, to feed into planning at the stage of the child protection processes.

- Vital information must be shared about risks of self-harm or suicide linked to their despair, so support can be provided.

The MSAB and the MSCP are committed to the learning from the Annabel review and are working together to ensure system changes and improvements are made.

Learning from Life and Death Reviews (Previously 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 known 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.

All deaths notified to the programme are reviewed locally by trained reviewers. The focus of each review is to identify good practice and what has worked well, as well as where improvements to the provision of care could be made.

In 2022-23 there have been nine reviews carried out for Merton.

The figures show for completed reviews to date, out of the nine, one person had a Learning Disability and Autism, whilst eight recorded a Learning Disability. Five people had ethnicity classed as white British and one white Irish. Two were from a Black Asian Minority Ethnic community (one ethnicity was not recorded).

Over the year, three males and six females were reviewed. Four lived in care homes, two in supported/sheltered living, whilst three lived at home with family. All died in hospital except for one person who had good end of life care at home with services to support. The youngest was 18 and the oldest 73 (both females). There were no unavoidable deaths.

Concerns identified in Life and Death Reviews:

- Concerns were raised around neglect.
- Lack of appropriate weight management and dietary management in the community.
- Delay in accessing a timely mental health assessment.
- Non-attendance for health screening or appropriate age-related screening.
- Reported delays in specialist equipment being put in place.
- Transition handover, including communication from Children’s to Adults could have been improved.

Positive Practice identified in Life and Death Reviews

- One report showed good planning and end of life care at the care home (which were the persons wishes).
- Report of good care in hospital and another report of excellent end of life care provided in hospital.
- Two reports showed good GP involvement, with timely access to care and services with dignity, kindness, compassion, and respect.
- One report identified very good care and relationships between the carers and the person.
- Demonstration of comprehensive community assessments by dementia diagnostic team, and same person whilst in hospital a non-pharmaceutical approach via one-to-one support was used rather than medication. The day centre in this case were also able to refer directly to dysphagia team without having to go via GP.
- A review showed cultural awareness on death, hospice had open door policy and supported the person and family well at home.

Learning and Development

The Board has offered several learning and development opportunities for partners over the course of this year. The delivery of Blue Light training was a key action which emerged from the recommendations of the SK SAR review to improve how services work with people who are alcohol dependent.

Safeguarding Adults Level 1 E-training is now available on the MSAB website where it can be accessed by partners, voluntary sector and the wider community – including our Community Champions Network. 62 people have booked onto this training, with 24 completing and 34 ongoing.

Overview of learning events and training sessions	
Multi Agency Learning Events	**Compassion Fatigue 1st March 2023.**
	WDP Drug & Alcohol Treatment in Merton 8th July 2022.
	Bitesize training London Fire Brigade 30th June 2022.
SGA Champions Network,	**Safeguarding Community Awareness film**
	Financial abuse and Scam Awareness – Dec 22
Public Health-Blue Light Training,	**1 day training =79**
	2-day Train the Trainer =7
MSAB Learning Sessions	**February 2023 - Decision Making Regarding SARs (Michael Preston-Shoot).**
	December 2022 - Office Public Guardian

Merton Council Adult Safeguarding Training	
Safeguarding Adults Level 1	82
Safeguarding Adults Level 2 ASC Health 2020	**38**
Safeguarding Adults Level 3	**9**
Care Certificate - Standard 10: Safeguarding Adults	**1**
Modern Slavery and Human Trafficking	**17**
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS)	**58**
Safeguarding Adults	**47**
Mental Capacity Act Level 1	**2**
Mental Capacity Act Level 2	**36**
Safeguarding Adults - Basic Awareness	**1**
Safeguarding Adults Managers - Level 3	**15**

Safeguarding Adults Data 2022 - 23

During 2022-23 850 concerns were received by Merton Local Authority in total. This is an increase of 40 (5%) on the number of concerns raised in 2021-22 Section 42 enquiries were commenced in 392 cases and Other enquiries commenced in 64 cases, giving a total of 456 enquiries commenced. This is an increase of 9 (2%) on 2021-22 and represents a conversion rate (concerns raised to enquiries started) of 54%.

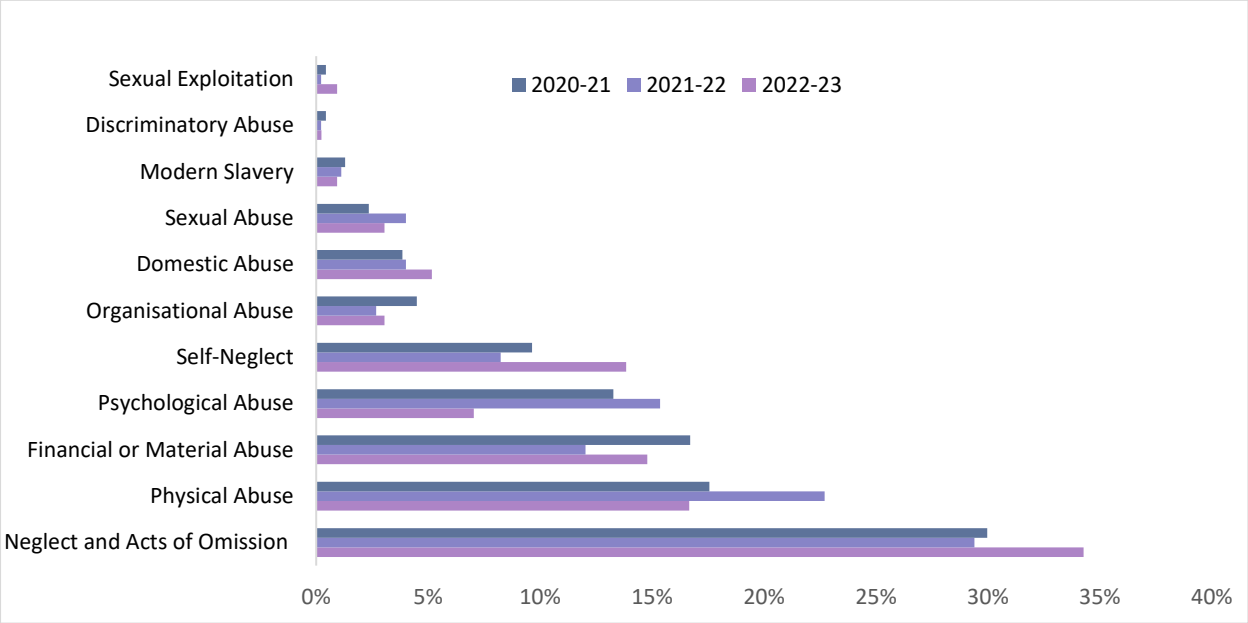
The percentage of the conversion rate is slightly lower this year and is attributed to improved understanding of the thresholds for safeguarding adults at risk. In 2023/24 further work is planned in the Safeguarding Adults and DoLS Team to address the conversion rate to ensure it reflects closer to the national and London average.

In terms of type and location of risk in enquiries, 61% were reported to be in people's own homes, in common with previous years, and there was a slight increase in percentage of 'Neglect and Acts of Omission' risks (4%). Safeguarding Adults data for all local authorities is published by the Department for Health and Social Care each year including all London boroughs and can be viewed here.

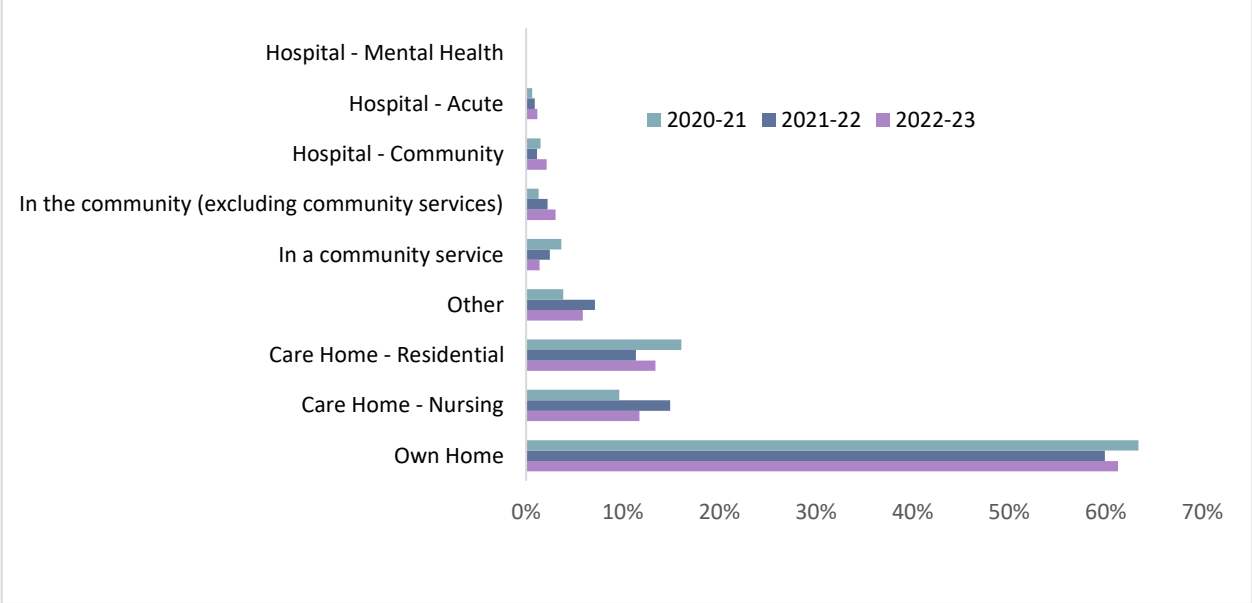
Year	2022-23	2021-22	2020-21	2019-20
Total number of Adult Safeguarding Concerns raised during the year	**850**	**810**	**830**	**732**
Total number of Adult Safeguarding Enquiries commenced during the year	**456**	**447**	**379**	**366**
Conversion Rate in Merton (Number of Section 42 Enquiries + Number of Other Enquiries) /Number of Concerns	**54%**	**55%**	**46%**	**50%**
Conversion Rate (England)	**33%**	**34%**	**34%**	**37%**
Conversion Rate (London)	**35%**	**33%**	**33%**	**41%**

Type and location of risk in enquiries 2022-23

Type of risk in concluded enquiries during the year 2022-23



Location of risk in concluded enquiries during the year 2022-23

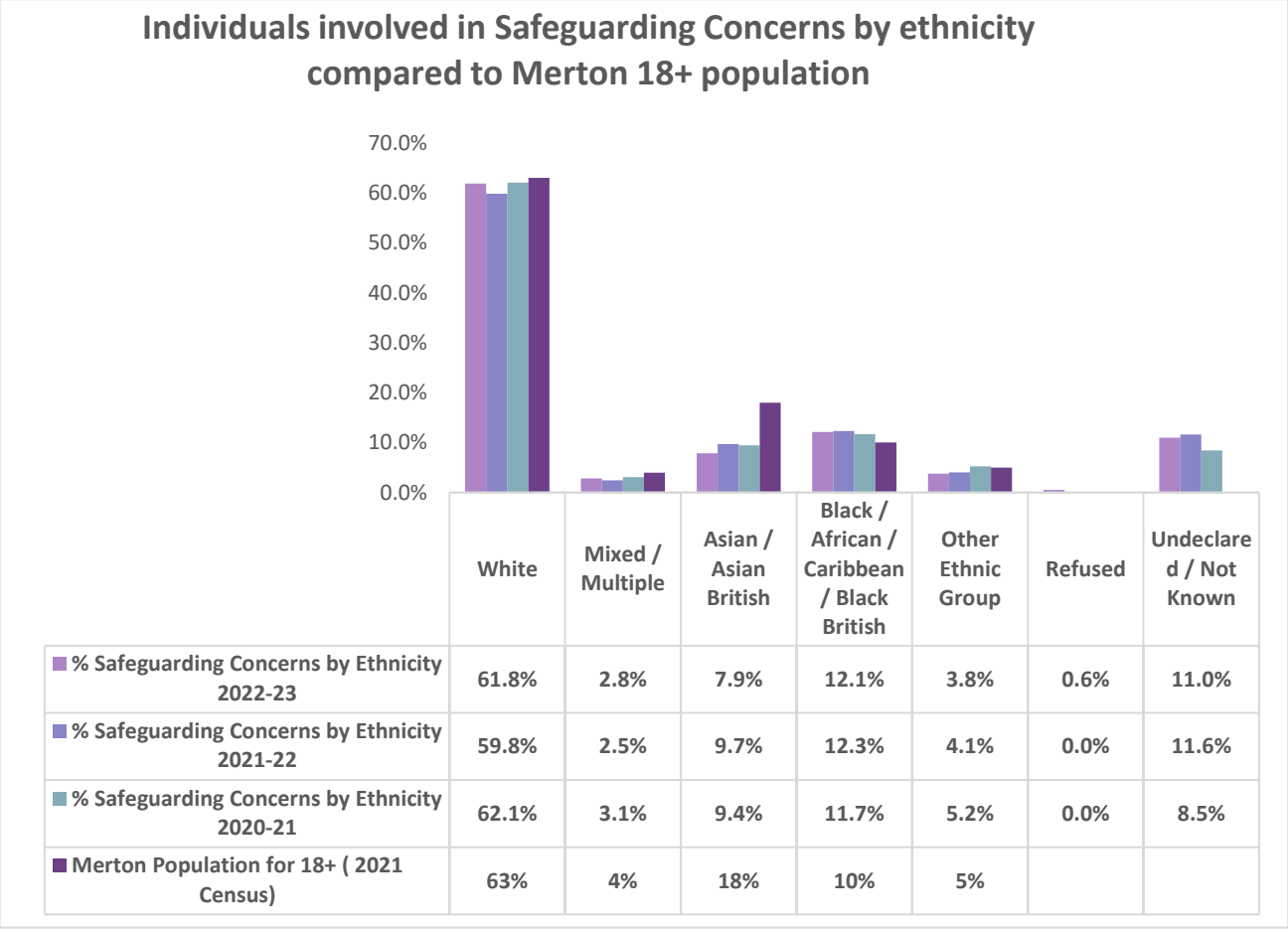


Safeguarding Ethnicity Data 2022-23

This year we have continued to analyse our data in relation to Ethnicity. This analysis helps us to understand inequalities but also identify where we need to focus our work to address where there are disparities. The Performance and Quality Assurance Group will continue to review this data.

During 2022/23 7.9.% of people from Asian/Asian British were involved in safeguarding concerns and 8.8% were involved in safeguarding enquiries. There is a decrease in the proportion involved in safeguarding concerns and safeguarding enquiries compared to 2021/22.

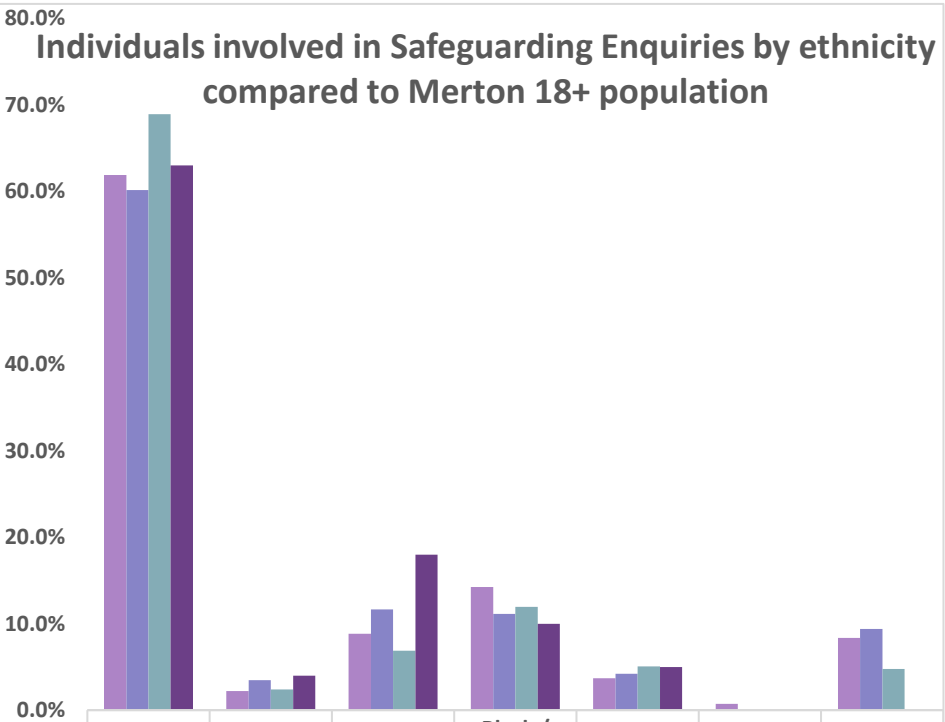
During 2022/23, 12.1% of people involved in safeguarding concerns and 14.3% of people involved in safeguarding enquiries were Black/ African/Caribbean/Black British. This compares to 10% of the Merton 18+ population who are Black/African/Caribbean/Black British. Work is underway in the Safeguarding Adult Review (SAR) Subgroup to consider why this is the case as we see a similar picture for this group of people involved in SARs in Merton.



	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	Refused	Undeclared / Not Known
% Safeguarding Concerns by Ethnicity 2022-23	61.8%	2.8%	7.9%	12.1%	3.8%	0.6%	11.0%
% 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%
Merton Population for 18+ (2021 Census)	63%	4%	18%	10%	5%		

In terms of action to address disparities, developing how we hear from people with lived experience will feed into this and our new Community Adult Safeguarding Champions Network will play a crucial role.

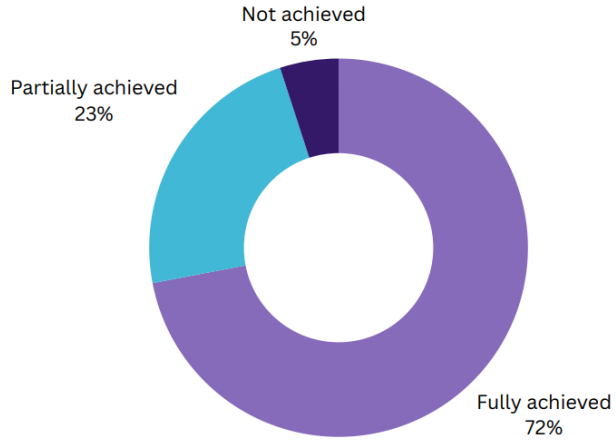
This network is comprised of a range of local voluntary sector organisations, including faith groups, so it is an important initiative for reaching the community and hard to reach groups and get key messages out. It is hoped that these Community Champions can help people across the community to recognise and report cases of suspected abuse and neglect but they will also be important in alerting and engaging the Board around potential safeguarding issues in the community.



	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	Refused	Undeclared / Not Known
% Safeguarding Enquiries by Ethnicity 2022-23	61.9%	2.2%	8.8%	14.3%	3.7%	0.7%	8.4%
% 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%
Merton Population for 18+ (2021 Census)	63%	4%	18%	10%	5%		

Making Safeguarding Personal

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 **95% of people's outcomes being fully or partially met.**



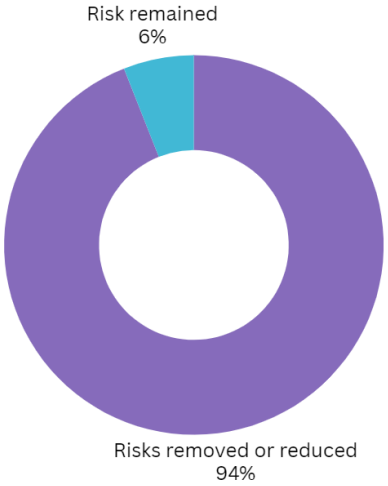
Percentage of enquiries concluded where outcomes were fully or partially met over 2022-23

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.

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.



Percentage of enquiries concluded where risk was removed or reduced over 2022-23

Making Safeguarding Personal Case Study- Robert

"*Robert was a 76-year-old man who grew up in Merton. He lived in a ground floor rental flat. He was a sociable person and enjoyed conversations and visiting the local pubs.*

He had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and was living with dementia. A few years prior he invited a friend to move into this home and he was helping with practical tasks. As well as this a care package was provided for one care call daily to assist with personal care.

This arrangement appeared to be going well, however, his GP contacted Merton Adult Social Care to raise a safeguarding adult referral after noticing at a visit by medical staff, that he had bruises to his face.

As part of the Safeguarding Enquiry a Team Manager and an Assistant Social Worker undertook an urgent visit. During the visit he disclosed that the person living with him was drunk and had hit him. At this time a place of safety was offered, however this was declined.

Early in 2022 a new concern was raised, and a subsequent safeguarding referral was received from the care agency. Robert had a bruise above his eye and a cut on his cheek. The team manager and a Senior Social Worker visited Robert, however, once again he refused a place of safety in a care home. Consent for a Safeguarding Enquiry to proceed was sought, however, Robert's mental capacity needed to be assessed. He could not remember what happened or when he sustained the bruise and cut. A referral was made for an Independent Mental Capacity Advocate (IMCA) to act on Robert's behalf to make certain decisions.

As part of the Safeguarding Enquiry the carer and the neighbour were interviewed. The neighbour disclosed that they had called the Police during the previous weekend as she could hear the friend shouting at Robert."

Outcome of the Safeguarding Adults Enquiry

- A referral was made for an Independent Mental Capacity Advocate (IMCA)
- Locks were changed for Robert's friend so he could no longer access his home.
- The friend agreed to present at Homeless Person Unit and was placed into B&B due to his homelessness.
- Robert's care package was increased to 2 care calls daily.

Making Safeguarding Personal

- **Empowerment –** Robert was supported and encouraged to make his own decisions via an Independent Mental Capacity Advocate (IMCA) support.
- **Prevention –** locks to the external doors were changed.
- **Proportionality –** using the least restrictive option i.e., Robert wished to stay in his home.
- **Partnership working –** with Police, GP, Social Services, Care Provider, Housing and IMCA
- **Protection Plan –** the friend could only access his belongings when escorted by a social worker after the locks were changed.
- **Accountability –** clearly defined roles/responsibility for each organisation.

Our priorities for 2023-24

- Improve the multi-agency approach to complex and high-risk cases by providing practitioners with new guidance and approaches to use in their work.

- Support the development of the Community Safeguarding Champions Network with a focus on hearing the voices from our communities, encouraging participation and raise awareness about safeguarding in the wider community.

- Develop an approach to working with people who have lived experience of safeguarding so that their voices are heard and make a difference, including through the SAR process.

- Strengthening our work across children and adult services by:
    - embedding a Think Family approach
    - improving how we support the transition of children and young people into adulthood

- Continue the work with all partners on bringing together key data on safeguarding to provide better quality assurance arrangements in Merton.

Merton Safeguarding Adults Board

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