Committee: Health and Wellbeing Board

Date: 24th January 2023

Agenda item:

Wards:

Subject:

Lead officer: Jane McSherry, Director of Children, Lifelong Learning and Families

Lead officer: Graham Terry, Interim Assistant Director Adult Social Care.

Lead member: Cllr Brenda Fraser, Cabinet Member Children's Services

Lead Member: Cllr Peter McCabe, Cabinet Member for Adult for Health and Social

Forward Plan reference number:

Contact officer for Children's: Maisie Davies, Head of Service, Performance, Improvement and Partnerships

Contact Officer for Adults: Janet Miller, Merton Safeguarding Board Business Manager, Adult Social Care, Community & Housing

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Recommendations:

A To consider and note the Merton Safeguarding Adults Board (MSAB) and the Merton Safeguarding Children Partnership (MSCP) Annual Report for the period 2021-2022.

B This year it has been agreed that the MSCP and MSAB Safeguarding Annual Reports will be presented at the same HWB meeting in order for the members to give consideration to the interface and joint work of MCSP and MSAB. Areas of learning, such as the local child safeguarding practice reviews (LCSPRs), Safeguarding Adult Reviews (SAR's), Think Family, Transitional Safeguarding and Domestic Abuse are highlighted for specific focus.

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. To provide information and account of the Safeguarding Children Partnership and the Safeguarding Adults Board's activity for the year period in line with its Business Plans and set objectives for that year prior to the report's publication.

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2 BACKGROUND

2.1. The Children's Social Work Act 2017 and Working Together to Safeguard Children 2018 requires each Local Authority area to establish arrangements for safeguarding and promoting the welfare of children. The Merton Safeguarding Children

Partnership fulfils this role for the London Borough of Merton. More detail on our local arrangements can be found in our Partnership Agreement[1].

2.2. Annually, the MSCP are required to produce and publish a report on actions taken by statutory partners and relevant agencies for the local authority area to safeguard children and promote their welfare and outline how effective those arrangements have been in practice. The 2021-22 annual report has been shared widely across the local partnership and is published on the MSCP website[2].

2.3. The MSAB has three core duties to:

1. Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute

2. Publish an annual report detailing how effective their work has been

3. Commission safeguarding adults reviews (SARs) for any cases, which meet the criteria for these

The Care Act 2014 states that the Safeguarding Adults Board Annual Report must be sent to:

- the Chief Executive and Leader of the local authority which established the SAB
- any local policing body that is required to sit on the Safeguarding Adults Board
- the local Healthwatch organisation
- the Chair of the local Health and Wellbeing Board. As soon as is feasible after the end of each financial year, a SAB must publish a report on:
- what it has done during that year to achieve its objective,
- what it has done during that year to implement its strategy,
- what each member has done during that year to implement the strategy,
- the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),
- the reviews arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),
- what it has done during that year to implement the findings of reviews arranged by it under that section, and

[1] https://www.mertonscp.org.uk/documents/partnership-agreement-december-2021/
[2] https://www.mertonscp.org.uk/documents/mscp-annual-report-2020-21/

- where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

3 DETAILS (MCSP AND MSAB 3.5- 3.7)

3.1. The Merton Safeguarding Children Partnership (MSCP) report covers the period April 22 to the end of March 22. Whilst there remained continued pressures on safeguarding systems as a result of the pandemic, safeguarding partners in Merton have worked together to continuously improve our safeguarding systems and strengthen the voice of the child in our Partnership. During the reporting period, the partnership welcomed on board our Young Scrutineer, who works in partnership with our Independent Scrutineer. We appointed an interim Independent Person, Aileen Buckton, who also chairs Merton Adults Safeguarding Board (MSAB). We also welcomed Justin Roper, Director of Quality, who represents South West London ICB (previously CCG), and Andrew Wadey, Detective Superintendent, who represents the Police, on the MSCP Executive Board.

3.2. During 2021/22 work was progressed against our three thematic priorities; Early Help and Neglect, Domestic Abuse and Think Family, and Contextual Safeguarding. The appended report provides further details about work in these areas and the difference this has made to safeguarding practice locally. The MSCP also further developed our training and audit programmes, including the completion of a Section 11 safeguarding audit.

3.3. During the business year 2021-22, the partnership oversaw the publication of three local child safeguarding practice reviews (LCSPRs (Jason, Baby Grace and Ananthi). During the business year, the MSCP also published our partnership review on Eddie and undertook a local learning review on Sudden Unexpected Death in Infancy (SUDI). There were no further notifications to the Department for Education (DfE) of significant incidents during 21/22. The MSCP annual reports sets out some of the steps the partnership has taken to respond to these reviews and how learning has been embedded across the Partnership.

3.4. Members of the Health and Wellbeing Board may be particularly interested in exploring the learning from the MSCP's local child safeguarding practice reviews, partnership reviews, and audits, which are all available on the MSCP's website. 7 minute briefings are available to be widely disseminated among all professionals working to safeguard children and young people in Merton.

3.5. The Merton Safeguarding Adults Board (MSAB) report covers the period April 21 to the end of March 22 and reflects on the work of the board as we recover from the Pandemic. 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. We also welcomed new members Justin Roper, Director of Quality, who represents South West London ICB (previously CCG), and Andrew Wadey, Detective Superintendent, who represents the Police on the Board. The MSAB continues to focus its work on its

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).

3.6. The MSAB received and considered three new SAR Notifications during 21-22, which resulted in two new SARs 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 (SARs). Published SAR's include RD Colin and SK. In line with the Boards strategic priorities, action plans developed in response to findings from the reviews is clearly set out in the report.

3.7. As mentioned in the MSCP details, members may be particularly interested in the learning from SAR's and the themes in relation to Domestic Abuse and young carers support. We continue to develop tangible plans for improving our 'Think Family' approach and are working closely with our Children's colleagues to embed systems and processes to enable this to happen. This is a priority for the Board and has been woven through our Business Plans for 2021-2024 as well as the annual subgroup work plans. Think Family and Transitional Safeguarding were key themes for our Joint Safeguarding Conference in March 2022.

3.8. In summary stronger strategic and working relationships have been forged with the Children's and Adults Services to support partnership working going forward. This includes the establishment of an annual Joint Safeguarding Conference, representation at Board and Partnership meetings and its subgroups. We continue to learn from reviews and seek out opportunities to improve safeguarding for children and adults in Merton.

4 ALTERNATIVE OPTIONS

N/A

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. The MSCP annual report has had input from all statutory partners as well as local agencies and the MSCP sub-group chairs. It received formal sign off from the MSCP Exec partners and the MSCP Full Partnership in October 2022. The MSCP's Independent Scrutineer and Young Scrutineer have had the opportunity to review and comment.

5.2. Individual partner agencies of the MSAB have submitted their accounts, which have informed the collective report. (Individual agency reports can be accessed via the Annual Report). The report has been accepted /signed off by members of the

Safeguarding Adults Board and presented to the Healthier Communities and Older People Overview and Scrutiny Panel.

6 TIMETABLE

N/A

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. None.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. As outlined in the report.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. As outlined in the report.

10 CRIME AND DISORDER IMPLICATIONS

10.1. As outlined in the report.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. As outlined in the report and the MSCP's Business Plan 21-23, available on the MSCP website. Also outlined in the MSAB Business Plan Strategic Priorities 22-24 which are available in the report and on the MSAB website.

12 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix 1 – Merton Safeguarding Children Partnership Annual Report 2021-22.

Appendix 2 – Merton Safeguarding Adults Board Annual Report 2021-22.

13 BACKGROUND PAPERS

MERTON SAFEGUARDING CHILDREN PARTNERSHIP

Annual Report 2021-2022

Contents

Foreword

This report covers the work of the Merton Safeguarding Children Partnership (MSCP) during the period April 2021 to March 2022, a year which saw continued pressures on safeguarding systems as a result of the Covid-19 pandemic. In this year, the tragic deaths of Arthur Labinjo-Hughes and Star Hobson shed a light nationally on the continued challenges in safeguarding children. The upsetting case of Child Q also highlighted the serious consequences for children and families when agencies do not take a safeguarding first approach or engage in robust, professional challenge.

During 2021-22 there were some significant changes locally for the MSCP. We were delighted to welcome on board our Young Scrutineer, Halima Mehmood, who has enabled us to start to scrutinise in depth how well we meet our ambitions to put children and young people's voices at the heart of what we do. Halima has worked closely with our Independent Scrutineer, Sarah Lawrence during the year to provide holistic and child-focused scrutiny on some key topics. The appointment of our interim Independent Person during 21-22 (Aileen Buckton), who also chairs the Adults Safeguarding Board, has helped us forge stronger connections with our Adults counterparts and progress our work around supporting a 'Think Family' approach and ensuring effective transition.

With the appointment of a new permanent team to support the Partnership from April 2021, the MSCP has been able to deliver significant progress against the priorities set out in the MSCP Business Plan. New data sets and dashboards were developed to help the Partnership monitor the impact of its work with families, supported by a multi-agency data lead.

The Partnership's Executive Board saw some changes with NHS representation, with Julie Hesketh Director of Quality, SWLCCG being replaced by Gloria Rowland, Chief Nurse, SWL CCG who is

represented by Justin Roper, Director of Quality. In addition the responsibilities of the SWL CCG transferred to SWL ICB (Integrated Care Board) on its establishment in July 2022. The ICB has responsibility for the development of the Integrated Care System (ICS), which will support improvements in health and wellbeing across SWL. Owain Richards, Superintendent, was also replaced on the Board by Detective Superintendent Andrew Wadey in July 2021.

In what has been another challenging year, safeguarding partners in Merton have worked together to continuously improve our safeguarding systems and strengthen the voice of the child in our Partnership. We welcomed the recognition from Ofsted in their inspection of the Local Authority's Children's Services that in Merton *'strong and respectful safeguarding partnerships act to protect children from harm'* and that locally excellent services are *'making a positive difference to enrich the daily lived experiences of children, while making them safer*[1]*'*. The inspection found that Children's Services in Merton are Outstanding.

We are proud of the work of all our partners who work tirelessly with families to keep them safe and promote their welfare and wellbeing. We also remain highly ambitious for our children and families and hope the year ahead will bring further opportunities to improve how children and families experience our services.

Justin Roper
Director of Quality, SWL ICB on behalf of Gloria Rowland

Andrew Wadey
Head of Safeguarding, Public Protection, Southwest BCU

Jane McSherry
Director of Children, Schools and Families, London Borough of Merton

[1] 50182669 (ofsted.gov.uk)

Introduction

The Children's Social Work Act 2017 and Working Together to Safeguard Children 2018 requires each Local Authority area to establish arrangements for safeguarding and promoting the welfare of children. The Merton Safeguarding Children Partnership fulfills this role for the London Borough of Merton. More detail on our local arrangements can be found in our Partnership Agreement.

Every 12 months the safeguarding partners must prepare and publish a report on what the safeguarding partners and relevant agencies for the local authority area have done as a result of the local safeguarding arrangements and outline how effective those arrangements have been in practice.

This report provides an overview of the impact of the MSCP's work on the safety and wellbeing of Merton's children and families, as well as an update against the Partnership's key priority areas outlined in the partnership's business plan. These priorities are:

- Strong Leadership and Strong Partnership
- Early Help and Neglect
- Domestic Abuse and Think Family
- Contextual Safeguarding

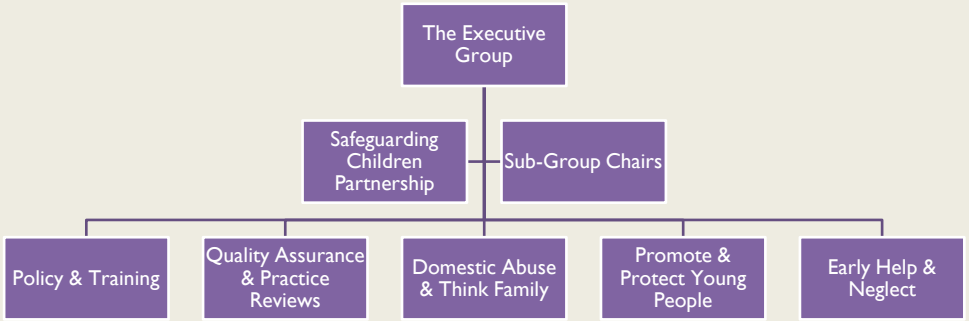
Under the first priority area, the report will also include how the Partnership learns from scrutiny, audits and learning reviews (local child safeguarding practice reviews) to embed a culture of continuous improvement in our local safeguarding arrangements.

Strong Leadership and Strong Partnership

Governance and Oversight

In May 2019, the MSCP formally adopted changes ushered in by the Social Work Act 2017. These are outlined in the MSCP's Partnership Agreement, which we refreshed in December 2021 following consultation with partners. Changes include an additional Full Partnership meeting, holding them termly to have more regular engagement with our wider partners (especially schools). Executive meetings would include the three statutory partners as core members and be held monthly to enable more agile decision making.

Business is prioritised and organised in the Biannual Business Plan and functions delivered through Sub-Groups which meet quarterly. Agency engagement with sub-group meetings has been strong overall, and strong multi-agency engagement in the delivery of statutory and non-statutory processes demonstrate continued commitment from partners. Sub-group chairs also meet monthly to ensure that the work of sub-groups is coordinated and effective and support with leading strategic updates to the Executive.



The Partnership also has three independent posts to support with our core duty to promote the welfare of children and monitor the strength of partnership working.

- An Independent Person, to act as chair
- An Independent Scrutineer, and
- A Young Scrutineer

Following the departure of the MSCP's Independent Person during 20-21, an interim Independent Person, Aileen Buckton was recruited. Aileen also chairs the Merton Safeguarding Adults Board and has provided challenge to our Partnership when chairing the Executive and the Full Partnership. She has also facilitated closer, more joined up working with the Merton Safeguarding Adults Board. This has enabled the MSCP to work more closely with the Merton Safeguarding Adults Board, for example in delivering a joint conference on Think Family and Transition. It has also supported closer working together in preparation for new requirements around the Mental Capacity Act and Deprivation of Liberty Safeguards.

Sarah Lawrence has been our Independent Scrutineer since February 2020, and during this year the MSCP prioritised appointing to the Young Scrutineer post. The MSCP was delighted to see this post filled by Halima Mehmood, a young Merton resident, who also worked as a Young Inspector for the London Borough of Merton.

Scrutiny Activity

The MSCP's Independent Scrutineer and Young Scrutineer work to a jointly owned workplan and report regularly to the Executive. The workplan uses best practice models for Independent Scrutiny including the 'Six Steps to Independent Scrutiny'.

At the MSCP's Full Partnership meeting in February 2022, our Young Scrutineer, Halima, presented the findings of the Merton Young Residents Survey, a survey of over 2,000 children and young people living and learning in Merton, with particular reference to

'Staying Safe'. She highlighted how young people still turn to informal support from family and friends in favour of professional support, and that many young people do not think they have a say in decision making.

"Young people want to feel safe locally, with a better relationship with the police"

"If there were more people to help… young people when getting sexually harassed because when it does happen it makes young people feel uncomfortable, scared, and panicked"

In follow-up to this session, Halima attended all of the MSCP's sub-groups to look at how we can better engage children and young people in the day-to-day work of the MSCP. It is hoped that we start to feel the impact of this work in 2022-23 as the Partnership's workplans are reviewed to reflect our Young Scrutineer's feedback.

During 21-22, the Scrutineers also undertook a thematic review on sexual harassment in schools, following concerns raised by the Everyone's Invited testimonials and the subsequent Ofsted report, which recommended safeguarding partnerships improve their working with schools and colleges. The review included interviews with headteachers and designated safeguarding leads in a variety of education settings, as well as wider partners (Children, Schools and Families, Community Safety and the Police). Importantly, they also spoke to young people living and learning in Merton to understand their lived experience of sexual harassment and how they experience the Partnership's response to the issue.

"School makes our feelings feel valid, e.g., they say 'banter' is not an excuse."

"We have to trust the people before we'd tell them or report SH. If we have a bad experience before it puts us off telling them something so personal."

Recommendations from the scrutiny work have been incorporated into the Partnership's ongoing workplans. Some examples of these are (this is not an exhaustive list):

- Refreshing Harmful Sexual Behaviour Policy with schools and college representatives, including special schools
- Develop and promote innovative ways that children can report sexual harassment and abuse
- Supporting all schools, including primary and early years, on this topic, and to share good practice

Other scrutiny activity undertaken by the scrutineers on behalf of the Partnership during 21-22, include:

- Scrutiny of the 20-21 MSCP Annual Report
- Scrutiny of the Section 11 audit submissions
- Engaging the Full Partnership and sub-groups on the voice of the child
- Feedback and challenge around nationally important issues such as Arthur Labinjo-Hughes, Star Hobson and Child Q

Reflections from Independent Scrutineer & Young Scrutineer

"We have worked together, with children, practitioners and with the MSCP during this year to assess how well the partners work together to protect children. We have carried out scrutiny work as this report describes which has enabled us to assess the level of success and impact that MSCP has had in doing this.

We have been very privileged to be able to speak directly to children in the Borough gaining their views about safeguarding and what they would like to see happen to support them to stay safe. We are also grateful to the practitioners and system leaders that have contributed to our work.

Our reflections fed by our work this year are, on the whole, very positive and while we have identified learning and improvements that can be made in some key areas, we feel confident that the MSCP is a mature and developed safeguarding partnership that can continue to respond to ever present challenges that face children and families at this time. We feel the feedback given by Ofsted reflects the strength of the MSCP accurately. They said:

"Partnership working is strong, both at strategic and operational levels…a culture of professional accountability, respectful challenge and mutual support [exists] across the partnership. Consequently, almost every child in Merton has access to good or outstanding support'.

The need for safeguarding services that respond to the needs of children and families is ever evolving and demand is growing. Learning from Merton and national safeguarding practice reviews of tragic cases this year have highlighted this starkly. It is evident to us that the high level of trust and cooperation between safeguarding partners in the borough will enable services to adapt in response.

Nevertheless, stubborn challenges on some key safeguarding topics remain for the partnership, some of which were reflected in feedback to MSCP from our scrutiny work. We feel confident that MSCP is able to act on such issues and has prioritised them in future planning for multi agency work. For example, children have clearly vocalised ways that partners can improve the level of trust they have in reporting abuse and harassment and we will continue to monitor and evaluate responses to these concerns through our scrutiny work in the coming year, while supporting MSCP with its priorities.

Sarah Lawrence
Independent Scrutineer MSCP

Halima Mehmood
Young Scrutineer MSCP

Learning Reviews and Audit

Learning Reviews

During 21/22, the partnership oversaw the publication of three local child safeguarding practice reviews (*Jason, Baby Grace,* and *Ananth*i). We also published our partnership review on Eddie and undertook a local learning review on Sudden Unexpected Death in Infancy (SUDI), following the death of two babies in SUDI circumstances. There were no serious incident notifications during 2021/22. All our learning review full reports and 7 minute learning briefings can be found on our website at the relevant webpages.

Child F / 'Jason' – LCSPR

The events surrounding '*Jason*' led the MSCP to commission a Local Child Safeguarding Practice Review (LCSPR). Jason had been missing for the first two weeks of April 2019, during which time he was involved in selling drugs (county lines) in a large town many miles from his home. On his return he presented as traumatised and disclosed that he had been assaulted and threatened that he would lose his life by those organising the drug-selling. He was highly anxious about his safety. The day after, Jason was taken to hospital after being stabbed in his leg and back.

The final report and a 7-minute learning briefing were published in June 2021and lunch and learn events held to share findings with the MSCP.

Baby Grace – LCSPR

Grace died in 2017, aged four weeks. Post-mortem forensic evidence showed that she had been shaken on three separate occasions and had 27 fractures. In November 2020, both her parents were found not guilty of murder, but both were convicted of causing, or allowing the death of a child. After the parents were charged with murder in Spring 2019 the MSCP agreed to commission a review to

learn lessons and to ascertain if any changes to local systems were required as a result.

The final report and a 7-minute learning briefing were published in August 2021 and lunch and learn event held to share findings with the MSCP.

Child H / 'Ananthi' – LCSPR

On 30 June 2020, emergency services were called to an address where a woman and 5-year-old child were found with serious injuries, stab wounds. They were both admitted to hospital. The child was in cardiac arrest when found and was pronounced dead at the scene, but the woman underwent surgery for her injuries. Ananthi was described by her father as *'a lovely child. She was very confident at cycling, and you were going to remove the stabilisers on her bike. She was good at school and liked learning spellings and doing well in spelling tests.*'

The final report and a 7-minute learning briefing were published in November 2021 and lunch and learn event held to share findings with the MSCP.

Child E / 'Eddie' – Partnership Review

In May 2019, a child, referred to in this review as 'Eddie', took an overdose of 9 Ibuprofen following an argument with a friend on the phone and following negative comments from his father. Following a Critical Incident Notification from the Youth Offending Team, this was escalated to the MSCP Quality Assurance Sub-Group and then to Statutory Partners to consider whether the incident met the criteria for a Local Child Safeguarding Practice Review under Working Together 2018. At an Extraordinary Meeting of the MSCP in June 2019, it was agreed that the case did not meet the criteria for a LSCPR but did warrant further investigation through a Partnership Review.

The final report and a 7-minute learning briefing were published in November 2021and lunch and learn events (jointly with the Jason review) were held to share learning with the MSCP.

SUDI Review

The MSCP received a recommendation from a Joint Agency Response (JAR) meeting to undertake a Partnership Review on two cases of Sudden Unexpected Death in Infancy (SUDI). Although neither of the SUDI cases met the criteria for a Serious Incident Notification, the JAR identified that there could be learning for multi-agency partners. The review took the form of two learning events, chaired by an independent lead reviewer using an appreciative inquiry approach.

The review found good practice of agencies providing information to families around risk factors for SUDI, including safe sleeping, addressing smoking and drinking alcohol, and monitoring birth weights. Following learning from Baby Grace, it was also positive to find that routine enquiries had been made for both babies. There was good information sharing and evidence of timely decision making.

The review identified some areas for improvement, which included strengthening the relationship between Children, Schools and Families and Merton Housing Services to ensure early, proactive support for families at risk of experiencing homelessness or overcrowding. The review also identified learning around how Early help services, midwifery, health visiting and the Children and Families Hub work together, the importance of undertaking agency checks and use of professional curiosity by agencies. Several recommendations were made and will be implemented by the MSCP.

The report was published in February 2022 and lunch and learn was held to share the findings of the report with the MSCP in March

2022, along with a Safer Sleep event to raise awareness in coordination with the Lullaby Trust.

What we did in response to the reviews

Sharing Learning

The MSCP took a range of actions in response to the reviews outlined above. In addition to final reports for each review, the chair and lead author for each review helped develop learning materials for dissemination across the partnership, which are published alongside the full reports on the MSCP website. We also launched 'Lunch and Learn' events to share the learning from our reviews and audits. These provided an opportunity for report writers and practitioners to explore the themes and recommendations from the reviews and embed the learning into their future work and practice. The MSCP also worked with agencies to embed learning from reviews into multi-agency and single agency training and events such as delivering presentations at the Early Help Summit and Children Schools and Families Practice Week.

The MSCP's Section 11 audit 2021/22 identified that disseminating and embedding learning from reviews was a particular strength for the Partnership, demonstrating the impact of this work.

Informing our Strategy and Practice

Learning from the practice reviews has directly impacted on the strategic work of the MSCP and its training programme.

- During 21-22, the MSCP continued to implement its contextual safeguarding strategy and action plan, as highlighted in the below contextual safeguarding section to respond to issues raised in the Jason and Eddie reviews.
- The practice reviews highlighted the importance of addressing trauma, and recommendations around trauma-informed approaches were made in both the Eddie and Jason reports. As a result, the CCG (now Integrated Care System ICB) funded CAMHS to deliver trauma-informed training to the MSCP to help embed trauma-informed approaches. Partners are also delivering trauma-informed practice across Merton. Asked what difference delegates thought the training would make to their work with children, young people and families, comments included:
    - *"Reinforce the importance in foster carers to be trauma informed; to better serve the needs of our children in care."*
    - *"I would feel confident with supporting families/teachers with the approach to managing trauma."*
    - *"Allows greater knowledge of how trauma has affected the person and its impact on younger sibling members."*
- To respond to concerns around disproportionality, the multi-agency Youth Crime Prevention Executive Board has focused on disproportionality as a priority, particularly in relation to young people open to the Youth Justice Service. Given learning around use of stop and search in Jason's story, a local stop and search pilot in Merton has been in place to identify where further interventions can be made to support young people who are stopped and searched. 66 young people were referred for further interventions to a range of partners offering support as a result.
- Following the 'stop and search' pilot and the national learning from Child Q, the BCU has adopted a policy whereby all children who are stopped and searched

receive a Merlin[2] which will then be followed up through appropriate pathways, e.g., MASH checks and Liaison and Diversion Panel. A Stop and Search workshop was also held to support better relationships between young people and the police, and to support better awareness raising of young people's rights. One young person said as a result of the workshop:

> *'I feel like I will definitely complain in the future now if the police treat me badly, I think I would have more understanding now.'*

- In response to Baby Grace, the MSCP has commissioned the ICON programme to ensure it can be embedded systemically across the Partnership. Further work on implementation will continue into 2022-23. Health partners have shared learning from the Baby Grace report widely, for example, at the GP leads safeguarding forum in March 2021 and delivering targeted training on issues arising from the review, for example, having difficult conversations and routine enquiry.
- The MSCP has commissioned Inner Strength Network (ISN)to speak to the Full Partnership about difficult conversations in the context of Baby Grace. ISN will also be delivering training sessions on this area during 2022-23. Although our Non-Accidental Injury (NAI) audit found good evidence of routine enquiry, our audit on the lived experience of Domestic Abuse undertaken in November 2021 found there is still some further work to do on these themes.
- With 'Think Family' being a feature of several of our learning reviews in children and adults practice (including the MSCP Ananthi and Eddie reviews), the Partnership focused on 'Think Family' as a priority at the Joint Conference with the Adults Board. The Domestic Abuse and Think Family sub-group will be following up further actions in 22-23. The MSCP are also planning some follow up scrutiny work on family networks to support with this further in 22-23.
- Several areas of learning from the local child safeguarding practice reviews were followed up with reassurances in our Section 11 audit for 21-22.

Learning from national reviews

During 2021-22 there was also considerable learning for safeguarding partnerships nationally, with the publication of the Child Protection in England report following the tragic deaths of Arthur Labinjo-Hughes and Star Hobson.

The Merton Safeguarding Children Partnership undertook reassurance with partners to ensure that the learning from these reviews were embedded. Responses were sought from across the Partnership and reported to the Executive. Several areas of improvement were already underway. For example, the MSCP are in the process of reviewing the local bruising policy to ensure it is up to date and includes risks to older children. Bruising was considered as a topic at the Full Partnership in February 2022, and some additional training and awareness raising sessions are being developed for 2022-23.

[2] The Merlin system was created as a vehicle for police officers to deal with vulnerability. This allowed the recording and sharing of concerns with partners in order to effectively safeguard members of the public. An MPS employee records their findings in a Merlin which is then processed according to the type of report written.

In March 2022, the sad case of Child Q in Hackney reminded us of the ongoing concerns around the adultification of Black children and the importance of professional challenge across partnerships. The MSCP published our statement on Child Q to help reassure professionals, children and families. As a Partnership we reviewed partners' processes and practice with reports to the Executive and the Full Partnership. Given the importance of this topic and the feedback locally that adultification of Black children can be less well understood among professionals especially outside of safeguarding roles, the MSCP has commissioned training from Listen Up to be delivered during 2022-23. We have also asked our Scrutineers to undertake thematic scrutiny on this topic during 2022-23.

Child Death Overview Panel (Summary of Caseload 2021-22)

The Merton Safeguarding Children Partnership works alongside the Child Death Overview Panel, which reviews all child deaths in Merton. A full report of activity of the Child Death Overview Panel can be found in the CDOP annual report.

A national consultation concluded that for CDOPs to be effective, reviews need to cover a sufficiently wide geographical area to produce meaningful data on the cause and demographics of child deaths. South West London (SWL) Child Death Review partners implemented this guidance and started regional operations in September 2019. The amalgamation of panels provides a larger cohort of information to enable better detection of themes, analysis of trends and learning to prevent future child deaths in line with national trends. Therefore the data provided is on a SWL level.

In 2021-22 there were 64 new notifications of child deaths for SWL, which is a reduction of 16 deaths from last year's 80 notifications of child deaths (2020-21). Nationally there were 3,068 notifications of child deaths for 2020-21 which is 361 fewer deaths than the previous year. One identified trend was a marked reduction over the winter months, which may have been due to social distancing and other public health measures put in place in response to the Covid-19 pandemic. This trend is also reflected in SWL.

In terms of the management of the CDOP process, as of 1 April 2022, there were 64 open cases, with 81 Child death reviews in 2021-22 being completed and closed. This is similar to the previous year of 78 completed child death reviews being closed and 61 open cases. Each case is kept open until all investigations are complete and then the case is reviewed by the CDOP Panel for closure. This means that some cases may remain open for an extended period of time until coroners inquests, serious incidents etc. have been completed.

Learning from audit

During 21-22, the MSCP launched a new audit programme to further embed its commitment to continuous improvement, and to ensure it meets expectations set out in Working Together 2018 to learn from multi-agency audits.

Section 11

The MSCP undertook a Section 11 audit during 21-22 (one of the recommendations/requirements of Working Together) to help organisations in Merton undertake their own quality assurance processes to safeguard and promote the welfare of children. 16 organisations submitted an online audit tool response and attended a peer review session with our Scrutineer and Young Scrutineer.

The Section 11 found that there were significant strengths in Merton with regards to safeguarding children and young people. This included clearly stated organisational safeguarding responsibilities, clear accountability frameworks, awareness of

information sharing procedures, and Safer Recruitment practice and LADO[3] processes.

The audit found less confidence from partners in embedding a culture of listening to children and taking into account their wishes and feelings. There were also other areas where agencies felt there could be further development, including: assurance in addressing issues of Equality and Diversity; practitioners' confidence in engaging with professional healthy challenge; and analysing and reporting the impact of training on practice and outcomes for children and young people.

During the Section 11 process, several multi-agency and single agency actions were identified, and these will be followed up in a further peer review meeting with the scrutineers in 22-23. More information can be found in our Section 11 learning summary.

Multi-agency audits

During 2021-22, the MSCP also developed a modest audit programme, with a rotating chair to share ownership across partners, and overseen by the QA sub-group. All audit briefings are published on our website to support dissemination of learning.

The first pilot audit was held in August 2021 on Non-Accidental Injury[4] and followed on from learning from the Baby Grace review and our Scrutineer's thematic scrutiny on NAI earlier in the year.

The pilot audit concluded that agencies had

- acted promptly to safeguard children
- worked collaboratively with the family
- provided an enhanced offer of support
- and that there was appropriate use of routine enquiry.

However, the audit identified some possible areas for improvement, including the need for senior managers to be available in the Out of Hours (OOH) service, which was followed up with this service.

The second audit on Domestic Abuse and the lived experience of young people was held in November 2021. The audit found several areas of good practice, including agencies acting promptly to make referrals, resulting in timely interventions to protect children. It also identified strong communication and information sharing between agencies, including with neighbouring boroughs. There was also evidence of additional needs being proactively identified and acted upon.

Learning for the Partnership included reviewing how robust interventions are in addressing domestic abuse and to ensure there is proactive engagement with parents. The audit also identified that there is more we can do as a Partnership to ensure the voice of the child is recorded. The recommendations from the audit are being overseen by the QA sub-group, and relevant actions have been added to the workplan for the Domestic Abuse and Think Family sub-group.

Due to the Children's ILACS inspection in March 2022, the third audit on contextual safeguarding has been rescheduled to July 2022.

[3] Local Authority Designated Officer (LADO) – for more information see the MSCP website: Managing allegations against adults who work with children (LADO) - Merton Safeguarding Children Partnership (mertonscp.org.uk)

[4] Non-Accidental Injury is **a term that is used to describe a number of different physical injuries or abuse to a child**. The term describes any injury that is said to have been inflicted. This means that it cannot simply be an injury that occurred unintentionally or unexpectedly.

Learning and Development

Training Programme 2021/22

The MSCP training programme continued to be overseen by the Policy and Training sub-group. Following a disruptive year in 2019-20, which impacted the delivery of training in that year.

With ongoing uncertainty around Covid advice to stay at home, the MSCP continued to deliver the majority of its training programme for 2021 virtually. The MSCP was able to deliver more events and attendance at events was considerably higher than the previous year. Feedback from partners indicated that the option to access training remotely enabled more partners to participate in the training.

The training programme is mostly delivered in house, by a range of partners across the MSCP. Courses and training themes are derived from sub-group work plans and recommendations (via Policy & Training Sub-Group), as well as from learning from case reviews. The training programme for 21/22 included training modules on our three thematic priorities, as well as a range of core safeguarding training. It included new courses to respond to emerging concerns, for example Understanding Eating Disorders course and targeted safeguarding training for local Madrassahs.

During 21/22, the MSCP also introduced 'Lunch and Learns' to share bitesize learning from emerging themes from our learning reviews, which have been successful in engaging higher numbers of delegates from a wider range of partners.

In 2021, the MSCP also delivered an Early Help Summit to formally launch the new Early Help Strategy and Effective Support Model, alongside the Effective Support for Families training (highlighted below in Early Help and Neglect).

The MSCP also delivered a joint conference with the Merton Safeguarding Adults Board on the themes of 'Think Family' and 'Transitional Safeguarding'. These themes were jointly agreed by representatives from the MSCP Policy and Training sub-group and the MSAB Learning and Development sub-group.

In addition, during 21-22, the MSCP also oversaw delivery of the Reducing Parental conflict e-learning training and are working with the provider to identify impact. This work will be further developed under the Domestic Abuse and Think Family sub-group during 22-23, with further training courses on reducing parental conflict to be delivered via a train-the-trainer approach.

Impact of our Training Programme

During the 2021/22 period, the MSCP offered 51 occurrences of 34 separate events. We offered a total of 1,399 training places; we had 1,032 bookings and 760 attended, an attendance rate of 74%. This brings the MSCP back in line with pre-pandemic training delivery (in 2019-20 there had been 77 occurrences, attended by 601 people).

The services with the highest number of attendees at MSCP training events during 2021/22 were London Borough of Merton Children Schools and Families (Education and Children's Social Services), Central London Community Healthcare Trust (CLCH), the Voluntary and Community and Faith group sector (VCS) and Education (schools, colleges and nurseries). The Policy and Training sub-group monitors attendance at training by agencies regularly and follows up with agencies where take up is lower.

Evaluation

The Policy and Training sub-group continues to use its Training Evaluation and Impact Analysis Framework, as endorsed by the London Safeguarding Board as good practice. Improving the rate of return for evaluation forms was a priority during 21-22. To date, 56

evaluation forms were returned via the Learning Management System. To help improve the return rate, completion of the evaluation form is now a mandatory requirement for receiving certification but work to encourage completion of evaluations will continue into 22-23. The MSCP ensures continuous improvement by providing summaries of evaluation feedback to trainers, so it can inform the development of the training programme.

Feedback from participants indicated that courses met their needs and participation was encouraged. Of the 56 evaluations returned through the Learning Management System, 98% of participants stated that trainers were well informed and encouraged participation. 95% agreed or strongly agreed that the training course met its aims and 87% agreed or strongly agreed that the course gave them a better understanding of the subject. The majority of participants strongly agreed that the course would help inform future practice. Below are some extracts from comments received.

"I work within sexual health and everything I learnt can be applied to my day-to-day role". (Key Principles in Responding to Young People's lived experiences of Sexual Violence)

"I know of services Merton has to offer. I feel I can recommend and refer to services now. I feel more comfortable if I need to speak to a victim. (Domestic Violence and Abuse)

"Greater knowledge and understanding of contextual factors that children and young people experience in their lives" (Contextual Harm)

I highly recommend this course because it equips you with the knowledge on how to deal with certain situations. These situation are nerve wrecking at the start but you gain confidence once you learn the process and realise there is support. (LADO)

The joint conference with the multi-agency safeguarding children partnership and adults board was attended by over 100 people. It provided an opportunity to share practice between children and adults' practitioners, particularly on Think Family and transitional safeguarding. Some of the feedback from delegates about how it would support their practice are as follows:

"By thinking about how MDT models around families really help and how the teenage brain develops in neurotypical as well as atypical young people. Another excellent course, thank you." (Integrated Safeguarding: Working Together to Safeguard Adults and Children)

"Having a greater awareness of how my organisation can work with partners to enable effective adult safeguarding." (Integrated Safeguarding: Working Together to Safeguard Adults and Children)

"I have a better understanding of The Think Family Model and how to work with young people acknowledging their brain development and the impact it has on their decision making." – (Integrated Safeguarding: Working Together to Safeguard Adults and Children)

The themes, content and scope of the MSCP training programme, and the sub-group workplans, is developed with a close association to the multi-agency data and its analysis. It is also informed from multi-agency practice from audits and learning reviews. From the 2021-22 year, each of the sub-groups conduct performance monitoring as standing items on their agenda in a move to ensure that trends and themes identified are better developed, understood and responded to. Where training gaps are identified the Business Support Unit will work with the Policy and Training sub-group towards finding suitable training.

Improving Dissemination of Learning

During 21-22, the MSCP also reviewed and developed ways in which we can share learning with the wider Partnership. This included a review of the MSCP website to ensure content for professionals is up to date, accurate and reflects best practice. The MSCP also launched a new bi-monthly news bulletin to help share local, regional and national safeguarding news and best practice with partners. Partners have fed back that they find this helpful and use it to keep up to date with the MSCP's training offer and to understand learning from learning reviews and audits.

Early Help and Neglect

One of the MSCP's priorities for 2021-22 was Early Help and Neglect. A dedicated sub-group, comprising a range of partnership agencies progressed actions to improve our early help offer and response to neglect.

What have we achieved this year?

We launched our Early Help Strategy and Effective Support for Families Model guidance and documents in 20-21 and focused on embedding the approach with partners during 21-22. Our Early Help strategy was informed by stakeholder engagement and feedback from children, families and practitioners.

The new integrated 'Children and Families Hub' went live in October 2021, integrating the way in which the Council responds to children and family needs at targeted Early Help and statutory levels. To support the new arrangements the MSCP held an Early Help Summit in November 2021, chaired by our Independent Person. It was attended by over 70 delegates from across our partnership and provided partners, stakeholders and practitioners an opportunity to reflect on the strategy and early help priorities and how to embed these in practice.

We also used evidence and information from local and national data to develop our vision. As part of our Early Help strategy, we are focusing on three priority outcome areas:

1. Fewer children and families require support from specialist services (and reduction in number of children in need).
2. More babies/children meet the expected stage of development for their age
3. More children/young people attend school regularly and fewer are excluded

During 21-22, we developed our early help performance dashboard to ensure we are able to monitor our progress against our three priority outcome areas and the impact on children and families. Our Early Help Performance Dashboard reports to every Early Help and Neglect Sub-group, using predictive 'turning the curve' modelling.

Multi-agency partners also reviewed the MSCP's Neglect Strategy and toolkit, which supports partners to identify and recognize neglect of children and young people. It included engagement with practitioners specifically on adolescent neglect, as this is recognized as a less well understood area. The Partnership launched the new Neglect Strategy and Toolkit at the February 2022 Full Partnership. The Neglect Toolkit aims to support practitioners in the early identification and assessment of neglect and in recognizing the impact of the cumulative harm caused by neglectful experiences on children and young people.

What difference have we made?

With our focus on embedding our "Effective Support for Families in Merton" model and guidance we delivered a comprehensive training programme during 2021-22. We delivered 9 sessions to the Partnership, with over 100 attendees from a wide range of partners. Feedback from this training has been positive and encouraging, with the majority of attendees saying that the training was either very or extremely relevant to their role (80%) and would recommend the training to their colleagues (93%).

Participants told us how it had made a difference to their work with children and families:

"It has helped me think more deeply about the trauma and patterns families have and how this can impact the young people we work with"

"My team are now more aware of what support for families is in the borough."

"A family is now being given the right support due to myself and the school understanding the procedures and who to refer to"

"Having the training has helped me to empower families to access the extra support they may need."

In February and March 2022, Merton's Children's Services were inspected by Ofsted under the Inspecting Local Authority Children's Services (ILACS) framework. The findings evidenced the impact of the MSCP's early help strategy and effective support model.

"Children and their families benefit from responsive well-coordinated universal and targeted early help services, helping to reduce harm. A recently updated coherent multi-agency strategy underpins the delivery of these services. This supports a system-wide relationship-based professional practice approach that is aligned to the social work model. Skilled and specifically trained early help practitioners use a variety of tools to build relationships with children and help them to express their wishes and concerns."

What will we do next?

Priorities for the Early Help and Neglect sub-group in 22-23 will be:

- To continue to embed and promote the Effective Support for Families Model. We will also review the impact of the Early Help strategy and Neglect Toolkit, and refresh the strategy and guidance as required.
- Develop our multi-agency early help approach further, using resource secured through grant funding, e.g. Supporting Families, Reducing Parental Conflict and Family Hubs.
- Continue to develop our Data Maturity work through the Insights to Intervention Project
- Develop further our work with partners to improve school attendance as part of our Early Help key priorities
- Embed the ICON programme across Merton's safeguarding system
- Strengthen our governance arrangements and alignment with key strategic work across our Partnership

Domestic Abuse & Think Family

What have we achieved this year?

The MSCP's Domestic Abuse and Think Family sub-group has oversight of work on domestic abuse from across the Partnership. This has included regular reporting from representatives from the Multi-Aaency Risk Assessment Conference (MARAC) and Violence Against Women and Girls (VAWG) Boards. The group has also overseen and driven forward actions from the MSCP's 'Baby Grace' LCSPR, which featured learning for the Partnership on identifying and addressing risk of domestic abuse and promotion of Clare's Law.

April 2021 saw the Domestic Abuse Act 2021 receive Royal Assent, which brings in some significant changes. The Act provides a statutory definition of domestic abuse for the first time and explicitly recognises children as victims of domestic abuse. The MSCP has worked with Safer Merton, who are leading a dedicated group overseeing the implementation of the Act locally with a dedicated Domestic Abuse Act Officer and working with Housing colleagues on progressing the Housing Duty.

Merton's multi-agency MARAC panel coordinates the partnership's response to the most complex/high risk domestic abuse cases using a range of statutory and non-statutory agencies.

The sub-group have developed a dedicated multi-agency performance dashboard to help monitor outcomes in this area, including regularly reviewing MARAC data.

What difference have we made?

In 2021/22 the MARAC considered 636 high risk and complex cases involving domestic abuse, 639 children were identified as part of these discussions.

There has been a continued increase in the number of cases discussed at MARAC since 2020 to date, an increase of 35% since 2019-2020. The rise in repeat cases being seen by MARAC across the three reporting years has also continued and we believe this was due to COVID lockdowns and DA increasing during this period. The number of children identified as in the household for 2021-22 is also the highest when compared to 2018-19 and 2019-20.

Figure 1: An overview of MARAC cases 2019/20 – 2021/22

Year	Number of Cases Discussed	Number of Repeat cases	% repeat cases	Number of children in the household
2019-20	410	162	39%	376
2020-21	576	234	41%	557
2021-22	636	301	47%	639

Multi-agency partners continue to deliver a strong response to domestic violence over the period, initiatives have included:

Independent Domestic Violence Advocates [IDVA's]

The work of Merton's IDVAs continued throughout 2021-22. Having introduced a case worker within the Multi-Agency Safeguarding Hub (MASH - now Children and Families Hub) the three IDVAs and Complex Needs IDVA in the community have seen an increase in case referrals. This arrangement remains under review and reports regularly to the Domestic Abuse and Think Family sub-group.

The IDVAs role includes sourcing safe/emergency accommodation, referrals to Safeguarding and/or MARAC, accompanying service users to court, information provision around criminal justice system, signposting for legal advice including clients with no recourse to public funds, and emotional support. It is

recognised that the IDVA role plays a pivotal role in supporting and managing domestic violence issues.

As a result of the pandemic, the One Stop Shop confidential weekly drop-in service for people experiencing domestic abuse was forced to close due to social distancing rules. However, it did manage to operate on a virtual basis during the pandemic and has reopened in November 2021.

The IDVA service received 769 referrals between April 2021 and March 2022 (compared to 691 the previous year), of which 283 were high risk. 93 of the total referrals came from Social Care services. In addition:

- Intensive support to 5 clients by the MASH DV caseworker during April 2021 to March 2022, representing 6 or more significant contacts, e.g., appointments, joint appointments, telephone-based RIC and ISSP completion.
- Medium support the MASH DV caseworker provided 63 clients with 2-5 significant contacts
- Single contact and advice provision was provided to 7 clients by the MASH DV caseworker
- 3 clients were uncontactable and 1 client declined support

Domestic Abuse Disclosure Scheme – Clare's Law

The overall aim of Clare's Law is to help people to make a more informed decision on whether to continue a relationship and provide help and support when making that choice; or have recently separated. Learning from Merton's Baby Grace Review suggested that Merton would benefit from increased promotion of Clare's Law locally. As a result, the MSCP has worked with other partners to deliver awareness raising activity, promoting the law in our newsbulletin as well as raising awareness of local training coordinated by the Police. 280 professionals attended the Police-led training and, since the training, 43 Clare's Law requests have been made in Merton.

Operation Encompass

Has been implemented successfully at many schools in Merton and informs school settings of incidents of domestic abuse involving children on roll in order that Designated Safeguarding Leads and key staff are aware of this context when supporting and working with their children.

Training

Over the course of 2021-22, the MSCP Training programme also delivered two Domestic Violence and Abuse virtual training courses, attended by 14 participants. This is slightly lower than the previous year. However, the MSCP plans to return to quarterly delivery of training in 22-23, which should see numbers increase again. For those who attended the training sessions, the feedback was very positive, with all delegates saying they would recommend the course to a colleague.

> *"I know of the services Merton has to offer. I feel I can recommend and refer to services now. I feel more comfortable if I need to speak to a victim."*

The Domestic Abuse and Think Family sub-group also supported the planning of a Joint Conference with the Merton Safeguarding Adults Board. One of its themes was 'Think Family'. The first half of the conference focused on family safeguarding and the importance of adopting a 'Think Family' approach to safeguarding. The MSCP heard from Sue Williams from Hertfordshire County Council, and Programme Director for The Centre for Family Safeguarding Practice, on the family safeguarding model. It also provided an opportunity to consider the Think Family themes that have arisen from local reviews such as Eddie, Ananthi and Basita (Domestic Homocide Review, DHR).

There has been some highly positive feedback and partners have told us they would welcome further resources to work with their staff on developing think family approaches. As such, the Domestic Abuse and Think Family sub-group are developing further training resources that can be shared across the Partnership.

Ofsted's inspection of Merton's Children's Services highlighted the positive impact 'Think Family' work is having for Merton's families. Following the findings from our learning reviews, we acknowledge that there is still further work to be done locally, and we will continue to progress with our plans during 2022-2023:

"Assessments using Merton's strengths-based social work model help identify the impact of parental mental illness, domestic abuse, substance misuse and the neglect of children.

Thoughtful and sensitive work with children during the assessment is supporting them to cope with and navigate entrenched parental difficulties. Trauma-informed therapeutic practice that assists professional thinking and approaches through systemic reflection and evaluation is augmented effectively by good-quality management direction and specialist consultants.

Exceptional examples were seen of social workers sensitively using bespoke direct work tools to evaluate the impact of parental vulnerabilities, while keeping a clear focus on children's need to remain safe. Social workers act to routinely involve fathers in assessments and plans. Care is taken to understand parental and family histories, cultural heritage and each child's unique and diverse needs."

What will we do next?

In 2022-23, the Domestic Abuse and Think Family sub-group will be further developing and embedding our work around 'Think Family'; working with Safer Merton in the preparation for and implementation of the Domestic Abuse Act locally; and taking forward actions from our recent domestic abuse audit.

Contextual Safeguarding

What have we achieved this year?

The Promote and Protect Young People (PPYP) sub-group has led on the Partnership's work to support a coordinated, embedded approach to contextual safeguarding. In addition to operational innovations, the partnership oversaw the development and monitoring of a multi-agency Contextual Safeguarding Strategy and Action Plan. This has led to several positive developments locally including:

- Clarifying referral pathways for adolescents via promotion of Merton's thresholds and referral routes through a comprehensive training programme (Effective Support Model).
- Delivery of regular training on contextual harm to safeguarding partners through 2021-22.
- Continuing to develop and promote our work on online safety, through regular training and refresh of our policy and resources.
- Identifying and training four contextual harm champions
- Developing and establishing the new Multi-Agency Child Exploitation (MACE) panel to replace MARVE, as outlined in the Pan-London Child Exploitation Operating Protocol (2021). The MACE Panel went live in November 2021 and helps to ensure swift identification of children at risk using screening tools. It is also supporting leaders locally to understand trends in the borough, which are regularly reported to the PPYP for oversight. Ofsted recognised that these multi-agency meetings were '*used constructively to share information*' and that '*management decisions are clear about next steps*'.
- Contextual Safeguarding working group for Designated Safeguarding Leads in schools and rolling out St. Giles Trust workers in schools to support relationship building and confidence.
- Delivery of child sexual exploitation day event with over 50 attendees, who heard directly from a Merton Young Resident about her lived experience of CSE.
- Development and publication of a refreshed parents pack, in conjunction with other Southwest London boroughs to support parents whose children have experienced exploitation.

Multi-agency panels to support children and young people at risk of contextual harm (MACE, pre-MACE and Missing Panel) have retained strong multi-agency membership, engagement, partnership and attendance. The focus continues to consider the needs of young people, not just the criminal and protection elements. As a partnership, we identified patterns and peer networks through mapping and intelligence sharing, which underpins joint interventions.

As a partnership, we consider the young person's journey and support networks, which informs our wrap around plans and support for families. For high-risk young people, we explored emerging themes, locations and trends. Further development is taking place to strengthen the voice of young people, how this might reflect their concerns compared to professionals, demonstrate where they lead contextual harm plans.

During 2021-22, the PPYP worked with Performance colleagues to develop a comprehensive performance dashboard, which regularly reports to the sub-group. This helps the PPYP understand the contextual risks to children and young people in Merton, including child sexual exploitation and child criminal exploitation, children missing education and also missing (from home or placement) among others. The improvements in multi-agency data collection and

performance reporting have also supported our multi-agency panels such as MACE.

While there have been lower numbers of referrals/young people discussed at MACE, it is expected that the Pre-MACE and MACE panel arrangements will enable the most high-risk young people to be presented. The highest category theme for MACE referrals continues to be child criminal exploitation. Referrals for child sexual exploitation have recently decreased, which may not be due to risk decreasing but issues of understanding and identification of CSE. As a result, training and consultation sessions have increased to address this.

Merton's Children Social Care service continues to develop its contextual safeguarding approach, having previously been successful in its bid to the London Scale Up project. An approach which develops safety planning has been developed and is in consultation with partners, which will be a priority into 2022/23. New assessments and tools are continuing to be embedded and this is supported by MSCP delivered training on contextual harm.

Following the abduction and murder of Sarah Everard and the establishment of the 'Everyone's invited' online platform for testimonies of sexual harassment, abuse and misogyny in schools, the MSCP continued to proactively respond to safeguarding concerns regarding sexual violence and harassment.

In June 2021, Alison Jerrard, Headteacher at Ricards Lodge High School, spoke to multi-agency partners at the Full Partnership about the challenges faced by schools. The MSCP's Scrutineer and Young Scrutineer undertook thematic scrutiny activity on sexual harassment in schools during 2021, which identified strong practice in schools in Merton, and identified some recommendations for improving practice. The findings are due to be finalised and fed back to the MSCP in 2022-23 and the partnership will then take forward any recommendations.

What difference have we made?

The new multi-agency MACE has enabled partners to better understand practice and risk for young people. We have identified:

- Emerging evidence of good information sharing across boroughs and between partners. Evidence that professionals can confidently tell the child's story, identify exploitation and risk and strengthen interventions with families.
- Consistent lead professional attendance at pre-MACE and improved communication with partners via contextual harm newsletters and better systems for updating screening tools.
- For a small number of young people open to Pre-MACE for extended periods, this reflects changing patterns of risk and the need for more time for these young people to build relationships and embed plans.
- The need for some reviews of strategic boards to reduce duplication, which will take place in 22-23.
- Case studies showing significant positive change – for example, one young person who was at significant risk of exploitation and involvement with Police. Following a strong partnership approach, and integrated, wraparound support for the young person, he was stepped down following positive outcomes.

Merton Safeguarding Children Partnership were pleased to see the work of Children's Social Care, alongside its partners, recognised by Ofsted in their inspection of Children's Services:

"Work with vulnerable adolescents and those at risk of exploitation is helping to keep them safer. Emerging risks to

young people are identified early using screening tools. Effective multi-agency arrangements ensure that there is swift identification of children at risk. Evidence of individualised skilful direct work is helping children understand risks posed to them, helping them develop strategies to exit harmful situations. Established professional partnerships and good management support strengthen the response to risk across communities and are helping practitioners engage young people in danger of extra-familial sexual and criminal exploitation. While contextual risks remain very real for young people, there is evidence of professionals persistently making an impact with their work."

What will we do next?

The Partnership will continue to develop and embed its approach to contextual safeguarding in 22-23, with a refreshed strategy focusing on making improvements in the following areas:

- Our practice
- Our data and systems
- Our partnership and risk management forums
- Our quality assurance

Looked After Children and Care Leavers

When a child comes into care, the council becomes their 'Corporate Parent', the term means the collective responsibility for providing the best possible care and safeguarding for the children in our care.

Children in Merton are less likely to be in care when compared to other boroughs. In 2020/21, 30 out of every 10,000 children in Merton are in care, compared to 47 in London and 67 Nationally.

Merton continues to buck the trend in increases of the number of children entering care nationally. The children-in-care population in Merton has been declining over the last four years. The number of unaccompanied asylum-seeking children in our care, has also declined, but at a lower rate to Merton residents.

Provisional data shows more boys are in care than girls (55.7% v 44.3%). We also know that proportionally more Merton children enter care at a later age when compared to London and national averages. Provisional data for 2021/22 also shows Black/Mixed children are over-represented in our care population. On 31st March 2022, the percentage of black/mixed-race is 43%; this compares to one in ten under-18s in Merton's general population. By contrast, only 6% of our children in our care are from an Asian background. This compares to just under 20% of Merton's under-18 population.

There are many reasons why a child may become looked after, in Merton for 2021/22, the main reasons for entering care are abuse or neglect. This has remained static for the last 6 years. Absent parenting is the second biggest reason why a child became looked after in 2021/22.

For care leavers, provisional data shows, as at 31st March 2022, 96% of our care experienced young people between the ages of 19 and 21 were 'in touch' with the Local Authority; this compares with 91% nationally as of 31st March 2021. The percentage of young people in suitable accommodation increased substantially from 66% in 2015 to 89% in 2021, faring better than London and national comparators. Provisional calculations show performance remains in line with last year.

74% of our care experienced young people, according to provisional reports, were in education, employment or training during 2021/22. This is an increase from 61% at the end of last year.

Merton's Corporate Parenting Strategy 2019-22 offers an overview of strategic multi-agency priorities.

In their recent inspection of Merton's services for children in need of help and protection, Ofsted said of children in care and care leavers:

"Children in care and young people leaving care in Merton receive outstanding care and support. Teams of highly committed, ambitious and determined professionals work extremely well together to help children to remain safe and achieve in life."

Annex 1: MSCP Budget and Spend 2021/22

MSCP Budget 2021-22 – Contributions by agency

London Borough of Merton	84,750
Merton CCG	55,000
Metropolitan Police	5,000
Total	**144,750**

MSCP Spend 2021-22

	Spend	Budget	Variance
Staffing:			
Salaries	89,882.57	88,970	912.57
Independent Posts	17,420.31	20,000	-2,579.69
Training	6,445	13,710	-7,265
Learning Reviews	3,889.28	3,890	-0.72
Supplies and Services (Office costs)	15,173.18	18,180	-3,006.82
Total	**132,810.34**	**144,750**	**-11,939.66**

Merton Safeguarding Adults Board

Annual Report 2021/22

Contents

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.

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.

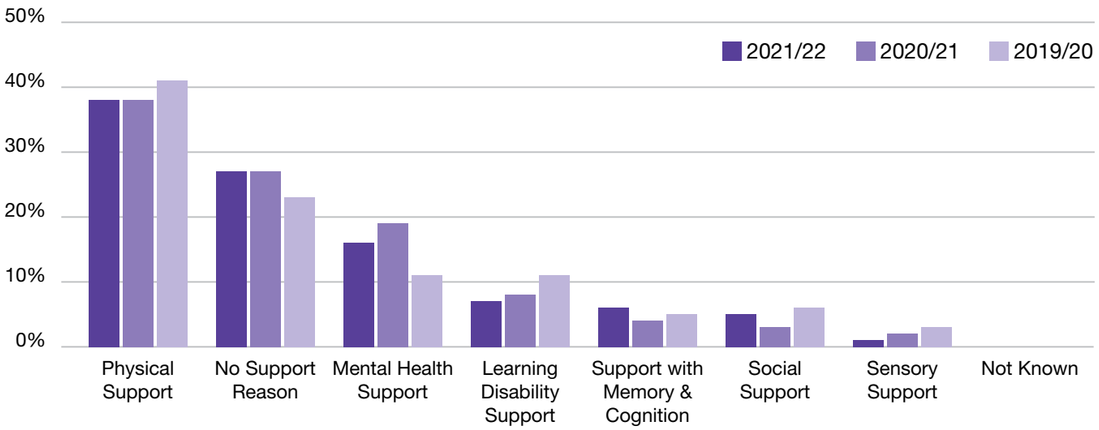
Whilst good practice is also identified and shared within the LeDeR steering group, key learning has also been identified across SWL which included;

- 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

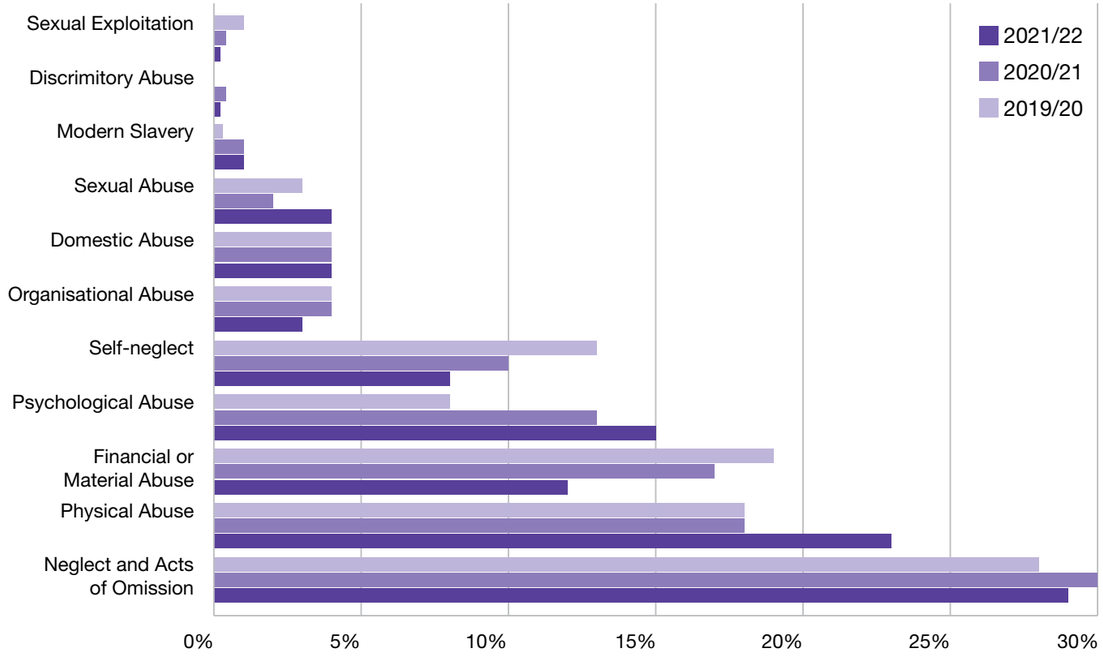
Safeguarding Adults Data

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%

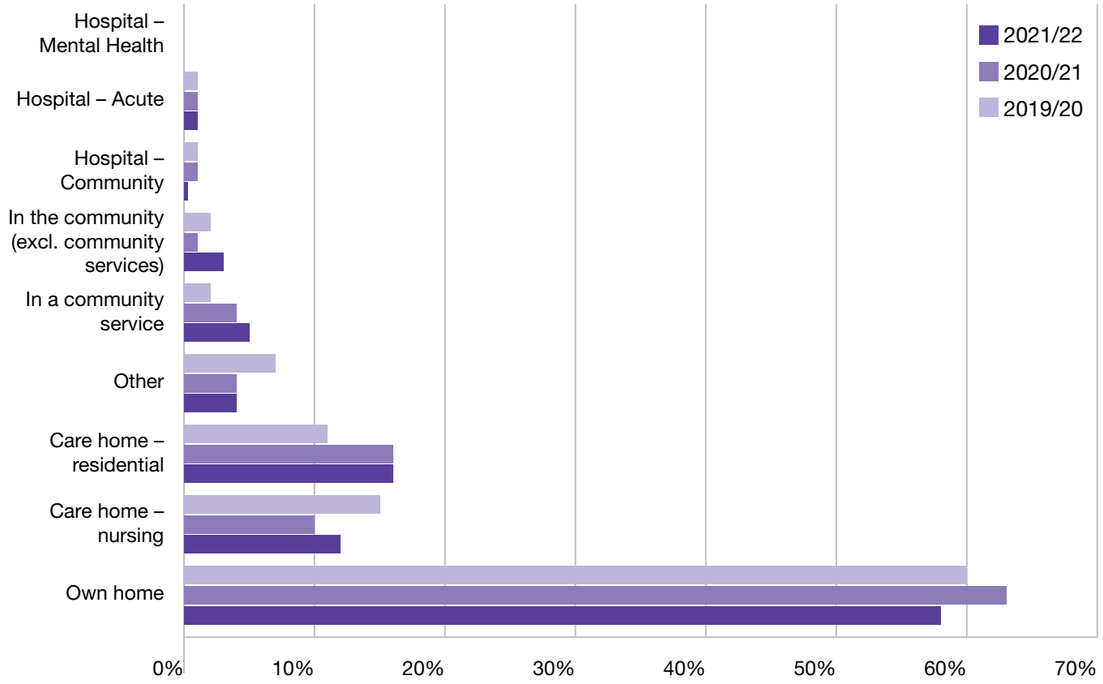
Individuals involved in Safeguarding Concerns during 2020/21 by Primary Support Reasons



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%.

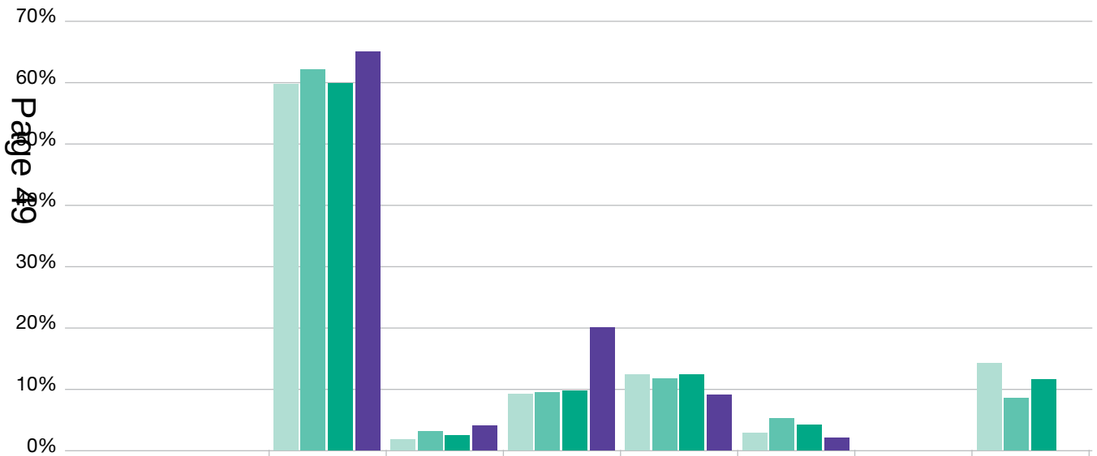
The percentage of the conversion rate is higher this year and is attributed to an improvement in the recording of safeguarding adult activity on the database and more importantly a greater understanding amongst practitioners regarding what constitutes a Safeguarding Adults Enquiry.

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.

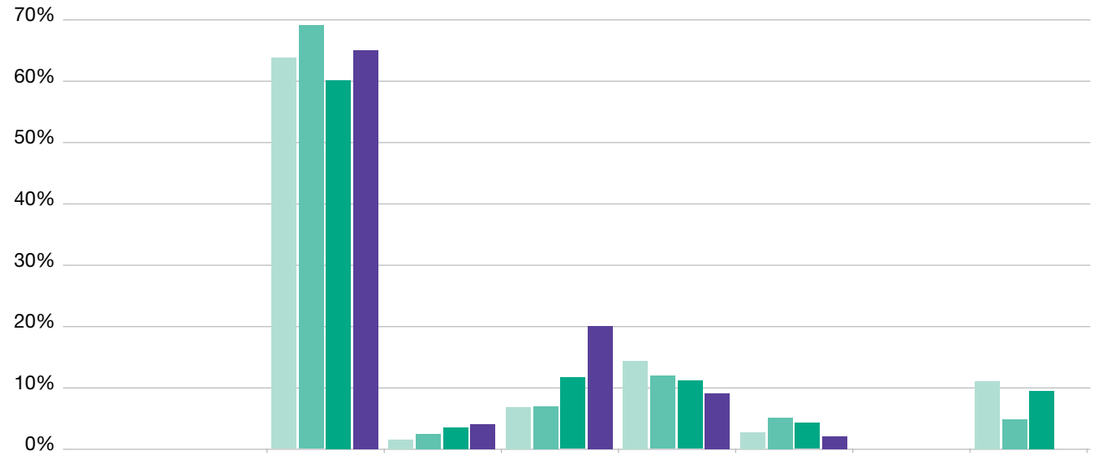
The charts below demonstrate individuals involved in Safeguarding Concerns and Enquiries by Ethnicity compared to the Merton 18+ population

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