

## Committee: **Healthier Communities and Older People Overview and Scrutiny Panel**

**Date: 10<sup>th</sup> January 2022**

Wards: All

### **Subject: Merton Safeguarding Annual Report**

Lead officer: Phil Howell, Assistant Director Adult Social Care, Community & Housing

Lead member: Councillor Rebecca Lanning, Cabinet Member for Adult Social Care, Health and the Environment

Contact officer: Claire Migale Head of Operations, Adult Social Care, and Community & Housing

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### **Recommendations:**

This report provides Scrutiny Committee Members with an overview of the Merton Safeguarding Adults Board (MSAB) Annual Report for 2020/21. The report summarises safeguarding activity undertaken in that period by the Council and its key partners and the performance data figures to date.

#### **1. EXECUTIVE SUMMARY**

The Safeguarding Adults Annual Report is published retrospectively and reflects on the work undertaken for a previous period. This is due to the process in which, the Department of Health and Social Care collate the national annual data returns. The data is collated and retrospectively published as a national document. As such, the data for the period 2020/21 has not yet been published and cannot be reported on. We are only now publishing the data for 2019/20.

#### **2. STATUTORY FRAMEWORK**

2.1 The Care Act 2014 sets out a clear legal framework for how local authorities and partners should work to support and protect adults at risk of abuse or neglect. The Safeguarding Adults at risk is a key corporate priority and is integral to all the relevant key plans for adult social care.

The Local Authorities statutory responsibilities amongst other duties include:

- Make enquiries, or request others to make them, when concerns have been raised or they think an adult with care and support needs may be at risk of abuse or neglect in order to need to find out what action may be needed

- Lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens
- Establish a Safeguarding Adults Boards, including the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy

### **3 MERTON SAFEGUARDING ADULTS BOARD (MSAB)**

- 3.1 The Merton Safeguarding Adults Board (MSAB) is a statutory function, under Section 43 of the Care Act 2014. The Board is responsible for writing and publishing the Annual Safeguarding Report.
- 3.2 The MSAB operates at a strategic level. Supporting and protecting adults in Merton from abuse and neglect, through co-ordinating and reviewing the multi-agency approach to safeguarding, across all member organisations. The approach that the MSAB takes, directly influences how frontline safeguarding operations are carried out in each member organisation.
- 3.3 The Local Authority and the Board has oversight on all adult safeguarding across the local area. Collaboration and co-operation are fundamental to gathering safeguarding intelligence across the whole borough and is key to the effectiveness of the MSAB. As such, the Board is made up of various local organisation's both statutory members (Local Authority, Clinical Commissioning Group and Police) and non-statutory members (provider health services, fire, probation, Healthwatch and the voluntary sector and other provider services).

### **4. MERTON ADULTS' SAFEGUARDING BOARD ANNUAL REPORT 2020/2021**

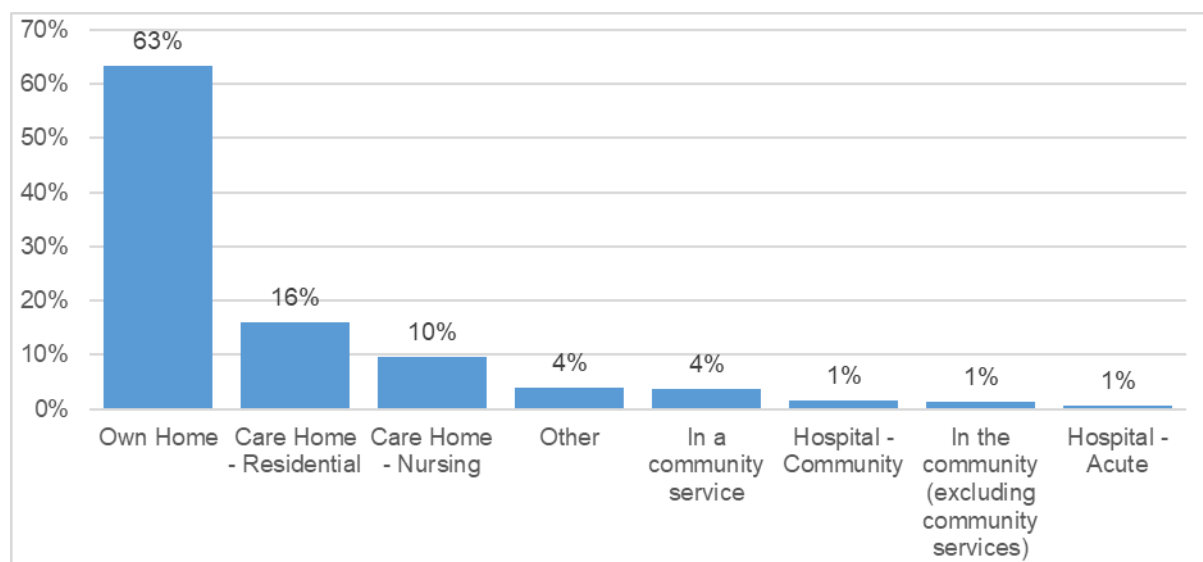
- 4.1 The MSAB Annual Report (attached Appendix 1) contains a forward by the Board's Independent Chair, Aileen Buckton MBE who started in this role in March 2020.
- 4.2 The Annual Report is an important function of the MSAB and provides an update on the multi-agency work undertaken to raise awareness in order to safeguard adults in Merton.
- 4.3 The annual report demonstrates that engagement with residents, the council and other agencies is improving and through the systems in place have provided feedback on the effectiveness of the Merton arrangements for safeguarding adults.

## 5. A PERSONALISED APPROACH TO SAFEGUARDING

5.1 The 'Making Safeguarding Personal (MSP)' principles continue to be at the centre of safeguarding adults work in Merton. It is about engaging with people about the outcomes they want at the beginning and middle of working with them, and then ascertaining the extent to which those outcomes were realised at the end. Furthermore, that we become involved only as much as the person states they need us to and that we take the least intrusive response appropriate to the risk presented. This has been a strength in Merton in previous years and in 2020/21 we have focused on further strengthening the recording of outcomes and managing risk, in order to demonstrate an accurate reflection of our safeguarding activity in the national data collection dashboard.

### 5.2 LOCATION OF RISK

**Location of Risk (Data source: concluded enquiries during 2020-21)**



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

## 6. HIGHLIGHTS FROM THE ANNUAL REPORT: SAFEGUARDING DATA, BENCHMARKING AND UPDATES FROM 2019/20

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

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

6.2 The data also shows a slight decrease for the numbers of Section 42 enquires (a response to indications of abuse or neglect in relation to an adult with care and support needs who are at risk and are unable to protect themselves because of those needs). This indicates a slight decrease in the overall conversion rate decreased from 50% to 46%. This figure is higher than the national average.

### 6.3 Making Safeguarding Personal - Completed Enquiries Outcomes 2020/21 %

Fully Achieved **61%**

Partially Achieved **36%**

Not Achieved **3%**

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

**66%** of people expressed a desired outcome compared to **64%** last year

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

## **Impact on Risk Adult**

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

### **Completed Enquiries where risks were identified No, %**

Risk removed or reduced **345, 93%**

Risk remains **26, 7%**

## **6.4 COVID 19 INSIGHT PROJECT**

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

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

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

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

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

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

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

## **7. ACTION TAKEN TO IMPROVE AND SUSTAIN PRACTICE**

- 7.1 As part of our continuous response to improve recording, feedback and updates for practitioners are shared and discussed at Team Meetings, reflective practice and workshops. Safeguarding Adult Audits are also well embedded and outcomes are used to identify improvements and best practice.

7.2 In 20/21 work to map the safeguarding pathways continues to ensure that the all relevant data is captured. Our involvement in the COVID 19 Insight Project has meant we regular scrutinise our response to the pandemic and identify possible interventions to improve our safeguarding activity.

7.3 The Safeguarding Adults Quality Assurance Tool is now fully embedded and has a focus on the following areas:

- Timescales
- Management oversight (Safeguarding Adults Manager oversight)
- Meeting of the six Safeguarding Principles
- Use of the Safeguarding Process
- Process/Systems
- Summary of Strengths
- Points for development

7.4 Work continues in the MSAB subgroups and with partners to raise awareness of safeguarding adult reporting processes and work on initiatives to improve our Responses to adults at risk in the community. We have four subgroups and each sub group has a work plan that is aligned to the MSAB Priorities.

The four sub groups are:

- **Safeguarding Adult Review (SAR) Sub Group;** Overseas the safeguarding adult review process when they meet the criteria. Ensures learning from reviews are identified and shared effectively.
- **Learning and Development Sub Group;** Oversees the learning and development strategy, including training across the partnership. Works alongside the SAR Sub Group to ensure learning from SAR's are included in training plans as required.
- **Performance & Quality Sub Group;** Has oversight of performance and quality of safeguarding activity, through developing robust mechanisms across the partnership, which assure good practice to safeguard adults at risk.
- **Communication and Engagement Sub Group;** Overseas communication and engagement to improve engagement with a wider range of stockholders, including service users and carers, on behalf of the Board.

## **8. SAFEGUARDING ADULT REVIEWS (SAR)**

**8.1** A Safeguarding Adults Review is a legal duty under the Care Act 2014. The purpose of a SAR is to learn from cases, on a multi- agency 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.

### **8.2 SAR Notifications in Merton**

The Board received and considered two new SAR Notifications during 2020-2021, which resulted in one new SAR commencing. Included in the two was one referral that had been reconsidered and recommissioned, and another where the decision to carry out a SAR had been reviewed and a single agency review had been agreed. In total five cases were considered and or monitored by the Sub-Group throughout the reporting period.

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

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

## **9. Appendices**

The Merton Safeguarding Adults Board (MSAB) Annual Report 2020/2021

## **10. BACKGROUND PAPERS**

None

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