Safeguarding Annual Report

2014

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Foreword

To meet the challenges faced by public sector services, in particular how we continue to meet the growing demand of Health and Social Care services whilst improving the customer experience, two major government initiatives were introduced in 2013/14. First, The Better Care Fund which has created a pooled fund for Health and Social Care and has amongst its priorities protection of social care with a health benefit, as well as integration of health and social care to make best use of the resources and better outcomes for customers. Secondly, The Care Act which amongst other things, reforms how care and support is to be paid for, sets a new eligibility criteria and has a strong focus on prevention and support for carers. Both will radically change how services are delivered in future.

The Care Act also for the first time puts Adult Safeguarding Boards on a statutory footing and creates a duty to appoint an independent chair, putting adult safeguarding on the same footing as for children and families. As a result, membership of the Portsmouth Board has been reviewed and we are pleased to welcome David Cooper as our new Independent Chair.

In 2014 we also saw Portsmouth engaged in a peer review of safeguarding services across the city. The review focussed on how well the health and social care system works together and how the safeguarding process can become more person centred, it provided an opportunity to reflect upon the effectiveness of current systems and areas for development. With a greater awareness in the general population about safeguarding matters there comes an increase in the number of alerts we receive. The review will help us to determine how everyone can work better to improve how the whole system responds to safeguarding concerns.

Robert Watt, Head of Adult Social Care, Portsmouth City Council

Introduction from the Independent Chair

Looking ahead to 2014/15

I am delighted to have been appointed as the Independent Chair of the Portsmouth Safeguarding Adults Board. Having met with Board members, I have been impressed with the commitment of all partner agencies represented on the Board to safeguarding adults and the strong partnership approach of this Board. It is a testimony to Robert Watts' leadership that the Board is ready to take on new challenges and opportunities with energy, and significant collective knowledge and experience.

In 2014/15 the Board will need to work closely with the Health and Wellbeing Board to align responsibilities and to ensure that learning from national and local reviews are understood and acted on by both partnership boards.

The Francis report into Mid Staffordshire Hospitals enquiry found a whole systems failure in protecting patients from unacceptable harm. A lack of openness, secrecy and a failure to put patients first, contributed to a negative culture where poor practice went unchallenged.

The recent review of the Francis report "One Year On" showed that whilst there has been significant progress, there is still much to do. Changing the culture was never going to be easy or a short one off task.

It is important that the Portsmouth Safeguarding Adults Board is therefore able to demonstrate cultural leadership through an approach of candour, openness and transparency.

It is for this reason that the Board will be looking closely at how it identifies risk, accountability and seeks assurance that appropriate actions are being taken. An on-going audit of the Safeguarding Adult Board will be taking place in 2014/15 involving all the key agencies represented on the Board.

Another way of measuring effectiveness will be looking at whether a person's outcomes have been met as a result of adult safeguarding interventions. Putting people at the centre of safeguarding, so that they feel in control and achieve the outcomes that they want, is an important priority for the Board. We are therefore looking forward to the planned peer review of safeguarding as an opportunity to develop our learning, and help shape our approach to improve the experience of people who have been the subject of safeguarding investigations or concerns.

The Board is well placed to respond to the statutory changes which will place adult safeguarding on a statutory footing over the coming year. Improvements in governance will further strengthen our state of readiness.

Other priorities for 2014/15 are highlighted in the report, they include:

- Ensuring the Board is ready for the changes in the Care Act 2014
- Understanding the external environment implications, including public sector fund and wider government initiatives such as a move to integrated services in-line with the Better Care Fund
- Aligning operation process across organisational boundaries, acknowledging differing statutory roles and responsibilities.
- Ensuring an effective workforce strategy that ensures staff working within health, social care and other partner agencies receive effective training relevant to their role to ensure safeguarding is fully understood and imbedded in practice.
- Working across geographical as well as organisational boundaries where appropriate, particularly in the establishment of sub-groups to make best use of limited resources.

I am greatly looking forward to working with the Board over the coming year and will report on progress in next year's annual report.

David Cooper - Independent Chair of Portsmouth Safeguarding Adults Board

Executive Summary

This report provides a background to safeguarding work within Portsmouth and a summary of work undertaken by the Portsmouth Safeguarding Adults Board between April 2013 and summer 2014.

During the last year, there have been changes to the structure and governance arrangements in terms of Board membership. The decision and appointment of an Independent Chair will enable the Board to move forward and ensure that all statutory partners are held to account in their duty to cooperate when dealing with safeguarding situations.

There have been changes with the establishment of Clinical Commissioning Groups (CCG's), and within Portsmouth the creation of a Safeguarding Lead Nurse has assisted in providing assurance to the CCG, as to the effectiveness of safeguarding in the area. The role is also key within the wider whole system approach to safeguarding.

2014/15 will prove to be a challenging year as there is a continued move towards integrating health and social care services, against a backdrop of significant financial pressures. Lessons learnt from Mid Staffordshire Hospitals as highlighted in the Francis Report and more recently The Francis Report "One Year On" still indicates that there is a greater need for transparency and joint working in ensuring the safety of people accessing health services.

Following on from the Winterbourne View enquiry there was a requirement to develop a joint strategic plan focusing on how locally we will support those with a learning disability who exhibit challenging behaviour. This strategic plan has been submitted to NHS England via the integrated commissioning unit who led on this work. The existing commitment at all levels working across statutory agencies, means that Portsmouth is well placed to make the necessary changes required during the current transition phase enabling the board to review its membership and consolidate its existing relationship with partner agencies.

National Developments

Government Policy

In May 2011 the Government issued a statement of policy for safeguarding vulnerable adults. It included principles for use by Local Authority Social Services and Housing, Health, the Police and other agencies for both developing and assessing the effectiveness of their local safeguarding arrangements. The policy objective is stated as to prevent and reduce the risk of significant harm to vulnerable adults from abuse or other types of exploitation, whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion.

The Government believes that safeguarding is everybody's business with communities playing a part in preventing, detecting and reporting neglect and abuse. Measures need to be in place locally to protect those least able to protect themselves. Safeguards against poor practice, harm and abuse need to be an integral part of care and support and should be achieved through partnerships between local organisations, communities and individuals.

The key Principles are:

Empowerment - presumption of person led decisions and informed consent

Protection - support and representation for those in greatest need

Prevention - it is better to take action before harm occurs

Proportionality – proportionate and least intrusive response appropriate to the risk Presented

Partnership - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse

Accountability - accountability and transparency in delivering safeguarding

The Government's Policy document suggests a range of measures that might indicate the outcomes for people using safeguarding adults' services and these have been incorporated by the LSAB into the Strategic Plan actions being developed with partner agencies.

Care Act 2014

As part of the Care Act the government has legislated for there to be Safeguarding Adults Boards (SABs).

Key changes of this new legislation which affect Safeguarding are :-
(i) Local Authorities confirmed as the lead agency; (ii) mandatory participation by Local Authority, NHS Clinical Commissioning Groups and the Police in Safeguarding Boards; (iii) Safeguarding Boards will have a high level of local discretion as to their

focus and role, with a primary function being to protect adults from abuse or neglect by providing leadership, ownership and coordination of multiagency working at local level; and (iv) Boards will be required to publish an annual strategic plan, and an annual report.

In the place of Serious Case Reviews, Boards will be required to commission 'safeguarding adults reviews' –

- where an adult experiencing abuse or neglect dies,
- or there is reasonable cause for concern about how the Board, or one of its members, or someone else involved in the case had acted

There will be a statutory duty on Local Authorities to enquire (or cause an enquiry) into allegations of abuse , although there will be no regulations defining the nature or details of such enquires .
To be the subject of an inquiry someone must need care or support (whether or not met by the local authority), be experiencing or be at risk of abuse or neglect, and be unable to protect themselves because of their care or support needs.

There will be no definition of a 'vulnerable adult' or 'adult at risk', but instead adult safeguarding will focus on abuse and neglect i.e. where adults in vulnerable situations are hurt because of the actions (or inactions) of others.

Self-harm will not be included, as the intention of safeguarding will be to address situations caused by the actions or inactions of others (but Safeguarding Boards may locally decide to include self-harm if they wish). In Portsmouth a separate multi-agency protocol "Working With Difficult to Engage Vulnerable Adults (including chronic hoarders) will be developed as part of our revised governance arrangements.

"No Secrets" Review

The review of "*No secrets - g*uidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse" was carried out by four government departments: the Department of Health (DH), the Home Office (HO), the Ministry of Justice (MoJ) and the Attorney General's Office (AGO) and ran from 16th October 2008 to 31st January 2009. The consultation involved 12,000 participants, including 3,000 members of the public (many of whom were adults to whom the guidance applied or their carers) and 9,000 professionals from this area of work.

Key messages from the participation of older people, adults with learning or other disabilities and people with mental health needs included:

- safeguarding must be built on empowerment – or listening to the victim's voice. Without this, safeguarding is experienced as safety at the expense of other qualities of life, such as self determination and the right to family life

- everyone must help to empower individuals, but safeguarding decisions should be taken by the individual concerned. People wanted help with

options, information and support. However, they wanted to retain control and make their own choices

- safeguarding adults is not like child protection. Adults do not want to be treated like children and do not want a system that was designed for children

- the participation/representation of people who lack capacity is also important

Disclosure and Barring Service (DBS)

The Home Office's Disclosure and Barring Service was created with the merger of the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority. It was established under the Protection of Freedoms Act 2012 and its primary role is to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups including children.

The DBS searches police records and, in relevant cases, barred list information and then issues a DBS certificate to the applicant and employer to help them make an informed recruitment decision.

DBS checks are only available where an employer is entitled to ask exempted questions under the Exceptions Order to the Rehabilitation of Offenders Act (ROA) 1974.

The Exceptions Order acts as the gateway for access to the DBS checking service and lists those occupations, professions and positions considered to be exempt from the ROA.

The checking service currently offers two levels of DBS check; standard and enhanced. The order allows for applications to be submitted to a standard level. To be eligible for an enhanced level DBS check, the position **must** be included in both the ROA Exceptions Order **and** in Police Act Regulations.

The range of groups that are required or empowered to make referrals are: regulated activity providers (employers and volunteer managers); personnel suppliers; local authorities; education and library boards; health and social care trusts; keepers of registers (e.g. General Medical Council, Nursing and Midwifery Council) and supervisory authorities (e.g. Care Quality Commission, Ofsted)

Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS)

Under the Mental Capacity Act 2005 a person is assumed to have capacity to make a decision unless proven otherwise. 'All practicable steps' must be taken to give them information in a way they understand and support them to make such decisions. People may be able to make some decisions and not others and capacity may fluctuate. No one can 'give consent' on behalf of an adult.

Where a person is unable to make a particular decision about a safeguarding issue it may be necessary for the investigating officer to consult with the person and those who know them best and make a 'best interests' decision. Carers or significant

others have a vital contribution to make to this. Ill-treatment or neglect of a person who lacks capacity is a crime.

People with limited capacity may benefit from access to advocacy - there is a legal right to this if an important decision has to be made and a person without capacity to make it has no family or friend to support them – the Independent Mental Capacity Advocate (IMCA) Service.

The LSAB has identified a need to further embed use of the Mental Capacity Act in safeguarding adults at risk work. This will be addressed through the training programme and ongoing briefing sessions/Best Practice Forums.

In April 2013, the Supervisory Body responsibility for Deprivation of Liberty Safeguards (DOLS) relating to NHS facilities/funded services transferred from the NHS to the Local Authority. Actions for the effective and smooth transition of these arrangements had been prioritised.

In March 2014, as a result of a Supreme Court judgement the definition of what constituted a Deprivation of Liberty was amended. A person was now considered to be deprived of their liberty, if they were:

1. Subject to continuous supervision

2. Not free to leave.

The person's compliance, or lack of objection, the relative normality of the placement and/or the reason or purpose behind the placement, were no longer considered to be relevant. This change in the definition of what constitutes a deprivation has led to a significant increase in referrals into all local authorities. In Portsmouth this has meant an increase in requests for assessments from approximately 6-8 referrals per month in 2013/14 to between 75 and 90 per month.

This increase in work has placed significant pressure on the current arrangements in place to undertake this work as they were made based on a significantly lower rate of referrals. An action plan has been developed and implementation will be monitored through steering group which will be up and running at the beginning of 2015. In addition there will be an increased workload will bring cost pressures to Adult Social Care.

Safeguarding and the Prevention of Abuse

In Section 7 of the “No Secrets” guidance, the Department of Health outlines a number of suggested approaches which will be effective in contributing to preventing the abuse of adults at risk. These alongside the recommendations from research taken from other documents will form the basis of a Portsmouth” Safeguarding and Prevention strategy”, which will be drafted as part of the Board Strategic Plan for 2015.

Equality, Diversity and Human Rights Impact Assessment

Portsmouth City Council wants to ensure that equality considerations are imbedded in our decision-making process and applied to everything we do, from the services we design and deliver, the policies we design, the way we carry our public functions, the way we commission and buy from others to the way we treat our staff.

So we have a corporate system of equality impact assessments that we carry out on all major council services, functions, projects and policies to assess any potential adverse implications.

Public equality duty

The public equality duty requires us to have due regard to the need to:

- eliminate discrimination
- promote equality of opportunity
- foster good relation between different communities.

This means that, in the formative stages of our services or policies, we need to take into account what impact our decisions will have on people who are protected under the Equality Act 2010 (people who share a protected characteristic of age, sex, race, disability, sexual orientation, gender reassignment, pregnancy and maternity, and religion or belief). These considerations must genuinely influence the decision-making and not just be a tick-box exercise.

Although Equality impact assessments (EIAs) in their written form are not a legal requirement under the Equality Law, the Equality and Human Rights Commission advises that written records of how Equality Duty is considered by public authorities in their decision-making process would provide evidence of compliance with that Duty.

Why we use equality impact assessments

We have decided to continue with the EIA process as it helps us to:

- Develop a better understanding of the community we serve;
- Make better decisions, based on principles of fairness and equality;
- Ensure our services and policies are inclusive and accessible to everyone;
- Ensure we use our resources efficiently based on the identified needs of our residents;
- Identify any potential disadvantage to certain community groups in our city with an aim of eliminating or mitigating it by seeking alternative non-discriminatory solutions;
- Identify positive action initiatives, wherever possible and permitted by the law, in order to meet specific needs of the vulnerable and disadvantaged members of our community;

- Identify improvements to our services, policies or the way we perform our functions;
- Identify ways of promoting cohesion and social inclusion in the city.

Winterbourne View

The final report of the Department of Health's review into the events at Winterbourne View was published in December 2012.[1] The report sets out a clear programme of national and local actions to ensure that better care is provided for people with a learning disability and challenging behaviour. An action plan was presented to the Safeguarding Adults Board by partner agencies in summer 2013, and as required by NHS England a self-assessment was completed and submitted indicating the city's position in respect of the recommendations which came out of the Winterbourne View report.

The report also recommended the establishment of a new NHS and local government-led joint improvement programme to support the transformation that will be necessary to achieve the required improvements.

The requirement, ensuring Clinical Commissioning Groups (CCGs) work with local authorities to ensure vulnerable people, particularly those with learning disabilities and autism receive appropriate, safe, high quality care.

As previously indicated, work is currently underway in delivering a Joint Strategy for supporting individuals with a learning disability and challenging behaviour . This needs to be completed and published in summer 2014.

Who is a Vulnerable Adult?

A vulnerable adult is defined in 'No Secrets'[2] as

"A person aged 18 years or over, who is in receipt of or may be in need of community care services by reason of mental or other disability, age or illness and who is unable to take care of him or herself or unable to protect him or herself from significant harm or exploitation" (Department of Health 2000)

The Safeguarding Vulnerable Groups Act (2006) recognises that any adult receiving any form of healthcare is vulnerable.

There is no formal definition of vulnerability within health care although some people receiving health care may be at greater risk from harm than others, which may be due to a complication of their presenting condition or individual circumstances.

Abuse can be physical, emotional, sexual, financial or a hate crime and can occur in

[1] Transforming Care: A National Response to Winterbourne View Hospital Department of Health Report December 2012

[2] No Secrets - Department of Health 2000

the person's own home, institutional settings or public places. The increasing awareness of Disability Hate Crime, where people with physical or learning disabilities are victimised for appearing to be different and unable to protect themselves and Mate Crime, where people are victimised by people they believed to be their friends, has added a new dimension to the traditional abuse suffered by vulnerable people.

Adult Social Care Safeguarding Team

Within Adult Social Care, a specialist safeguarding team was established in 2009 to provide arrangements to triage safeguarding referrals and lead on investigations relating to institutional abuse, and concerns raised, involving a potential crime. Part of the team's remit was also to raise awareness of safeguarding, and to work proactively with providers, alongside health colleagues, to promote best practice and reduce the likelihood and instances of institutional abuse. The team have now worked in this way for 5 years. During June this year the local safeguarding arrangements were the subject of a Peer Review. Overall the review was positive, noting the specialist expertise sitting within the safeguarding team and that partnership working was good. However the review highlighted the need to re-examine our current arrangements, in particular the way we record our work and the role of the community teams. The Care Act is also a driver for change.

There is a move locally to work towards developing a Multi- Agency Safeguarding Hub (MASH) which could see a multi-agency team to include the police, adult social care and health colleagues triaging safeguarding referrals and acting as first point of contact for any safeguarding queries. In 2014 Portsmouth City Council signed up to the Making Safeguarding Personal work programme led by the Local Government Association (LGA) in partnership with the Department of Health (DOH). The programme is one of the ways in which sector led improvement is being championed within adult social care. The Safeguarding Team, alongside colleagues within Health and Social ,), will be undertaking some project work which will focus on ensuring that everything we do is person centred and that we involve vulnerable adults in recognising and managing risk and to identify with the outcomes they wish to achieve.

Over the years there has been a steady increase in the number of alerts received by the team. An Alert *is a concern that a person is at risk or may be a victim of abuse, neglect or exploitation. An alert may be the result of a disclosure, an incident, or other signs or indications.*

For 2012/13 the number of alerts received by the team was 710, an increase of 17.9%% on the 2011/12 figure (602). Of the alerts received during 2012/13 186 became referrals. A Referral - *"an alert becomes a referral when it is passed on to a safeguarding adults referral point and accepted as a safeguarding adults referral"*

In 2013/14 the number of alerts received was 1300. Of the 1300 alerts received in 2013/14, 403 became referrals. These were investigated under the safeguarding pan Hampshire procedure.

The conversion rate of alerts to referrals in 2013/14 is 31%. In 2012/13 the rate was 30%. The increase in alerts received in 2013/14, indicates greater awareness of concerns about vulnerable people. This has had a significant impact on the workload

of the team. Alerts that are not taken into safeguarding may be picked up by other social work teams, information and advice given or just noted depending on the case.

Abuse by neglect rose by nearly 10% and again the largest client abuse groups were Older Persons and Learning Disabilities.

Primary/Secondary and Community Health staff was the largest reporting group when alerting the team too abuse-over 35% of referrals came from them.

The largest age group for reported abuse was between 40 to 60 years of age and 48% of abuse was reported to have happened in the clients own home

Where enquiries were conducted by the safeguarding team 44% of cases were either partially or fully substantiated. 32% were not substantiated and 24% were inconclusive.

Please see appendix 1 for a copy of the Safeguarding Yearly Report 2013/14.

Current Governance Arrangements

Prior to the appointment of an independent chair of the Portsmouth Safeguarding Executive Board in March 2014, the Board was chaired by the Head of Adult Social Care, and comprised senior managers from Health, the Police and the Council. The Board was supported by an operational Safeguarding Adults Board, with representatives of local agencies. While safeguarding operates within the context of the Pan Hampshire multi agency Policy (2013).

Sitting outside of the local Board arrangements is an Inter-Agency Management Committee, which comprises the local authority Board Chairs, and Safeguarding Leads across Portsmouth, Southampton, Hampshire, and the Isle of Wight, and senior representatives from the Police and Health. The committee overseas changes in Policies and Procedures, provides a forum for monitoring emerging issues/themes, and supports the Serious Case Review arrangements across the Safeguarding Adult Boards.

In preparation for the implementation of the Care Act in 2015, the Executive Board undertook a brief review of local multi agency arrangements. There was concern that the separation between an Executive and an Operational Board was not the most efficient use of resources, and there was universal support for the proposal to move to a single Board, henceforward titled The Portsmouth Safeguarding Adults Board (PSAB) and supported by a number of subgroups.

On the 18th June 2014 The Portsmouth Safeguarding Adults Board held a Development Day for existing Executive and Operational Board members, and other local strategic partners. The purpose of the day was to consider and prioritise major challenges faced by Local Strategic Partners over the next 3 years, discuss the proposed changes to the Board membership and to determine how they (LSP) would respond to these and ensure the PSAB provides the kind of leadership and direction expected of a successful Adult Safeguarding Board.

The Development Day reviewed current working arrangements within the PSAB, and identified some key priorities to take forward the work of the Board over the next 3 years. These have subsequently been reviewed by key senior managers to ensure that they can be supported by all the major statutory agencies, and that there is capacity to deliver them within the resources available.

Vision

“Portsmouth is a city where adults at risk of harm are safe and empowered to make their own decisions and where safeguarding is everyone's business”

Key Principles

The PSAB partners will safeguard the welfare of adults at risk by working together in the six key areas of the Governments statement of policy on safeguarding. These are; empowerment, protection, prevention, proportionality, partnership and accountability

The six key areas will ensure that:

- there is a culture that does not tolerate abuse (protection)
- dignity and respect are promoted so that abuse is prevented wherever possible (prevention)
- there is active engagement with all sections of the local community so that they are well informed about safeguarding issues (partnership)
- adults at risk are supported to safeguard themselves from harm and can report any concerns they have (empowerment)
- quality commissioned, regulated and accredited services are provided by staff with the appropriate level of training (accountability)
- there is a robust outcome focused process and performance framework so that everyone is undergoing safeguarding procedures receives a consistent high quality service which is underpinned by multiagency cooperation and continuous learning (accountability)
- victims are supported to stop the abuse continuing, access the services they need, including advocacy and victim support (proportionality)
- there is improved access to justice (empowerment)

Functions of the Board

“Providing good governance across the partnership agencies that work with adults at risk of harm”.

The functions of the Board are therefore:

Strategic planning - by agreeing shared priorities for improving outcomes for people at risk of harm

Setting standards and guidance - through agreed policies and procedures and protocols

Assuring quality - through activity reporting, data analysis, and learning lessons from case audit and case review, including Serious Case Review

Promoting participation - of people who receive services, their carers, and advocates and agencies such as Healthwatch

Raising Awareness - particularly public awareness of how to recognise vulnerability and abuse, and how to report it

Building capacity and training - ensuring staff and volunteers working with people at risk have appropriate values and skills to assess and meet their needs

Relationship management - developing partnerships that respond in a joined up, person centred way to ensure good outcomes for each person who has experienced harm

Inter Agency Working

The PSAB plan 2013- 2016 will set out the directions of travel for partnership working, building on the progress to date and looking forward to both national requirements and locally agreed priorities. The actions take over the period of the plan aim to achieve continuous improvements in the effectiveness of the PSAB.

Key Priorities and Action Plans

At its annual Development Day 2014, Local strategic partners agreed the following Four key work streams/subgroups over the next 3 years:

- Effective Governance (including strategy, and roles and responsibilities)
- Communication and Promotion of safeguarding
- Making Safeguarding Personal
- Quality Assurance and Performance

And endorsed a number of cross Regional and Inter-Board work streams:

- training, development and learning
- Safeguarding Adult Review coordination
- joint working between the LSAB and the LSCB
- fire and safety
- MAPPA SCR subgroup
- Communication and media

The actions in this section of the report will be taken forward by themed subgroups, led by senior strategic partners, that will report progress to the PSAB at its meetings and at the end of the year in the Boards Annual Report.

Resource Implications

At the Safeguarding Adults Board meeting in March 2014 the Independent Chair presented a paper which outlined the challenges facing the Board, and areas for development. It was agreed that to minimise risk and to support the delivery of the key objectives of the Board, there needed to be good professional and business support to the Board (which was lacking). This was also required to prepare the Board for undertaking its new statutory functions from April 2015.It was recognised that this would have resource implications for all partner agencies; reflecting the shared responsibilities for safeguarding.

The Independent Chair was therefore asked to give consideration to the possible interim funding implications for 2014/15.

Title	**Salary**	**Days**
Independent chair	£10,000	17-20 days per annum
Board Manager/coordinator	£30,000 (£45,000)	3 days per week
Board Administrator	£15,000 (£18,000)	2.5 days per week
Support Serious Case Reviews	£5,000	2-3 cases per annum
Board events, support lay member	£5,000	
TOTAL	**£65,000**	

At the Board meeting some partner agencies commented that funding should be provided by key statutory partners, including PCC, CCG (in there commissioning capacity) and Police and that other partner agencies (Providers) would provide support in kind.

The Independent Chair subsequently met with key statutory partners and proposed funding on a shared basis, and PCC and CCG agreed to funding of a Third (£22k x 2). However the Police have only agreed to funding of 11% (£7,150), and suggested that PCC and CCG meet the balance of the budget.

The chair has also met with the chairs of the local SAB's (Southampton, Hampshire and IoW), and we have explored a number of opportunities to develop closer working, and shared efficiencies, whilst maintaining a local focus.

We have appointed a part time Business Manager and Administrator.

Whilst this funding is most welcome, it will not be sufficient to meet the demands on the Board to address the current challenges, and take on the new statutory functions from April 2015. The independent chair will be tabling a further funding report to the Board in December, once the Business Plan is finalised, and future work pressures on the Board are clarified.

Partnership Profiles

Portsmouth Hospitals NHS Trust: Adult Safeguarding 2013/14

Key developments

The Trust has declared full compliance with Care Quality Commission Outcome 7. This was supported by the most recent full inspection in March 2013.

- Establishment of an overarching Trust Safeguarding Committee in January 2013 to ensure that the Trust is fulfilling its responsibilities for the safeguarding of adults and children.
- As of 31/03/2014 Adult Safeguarding training compliance was 96.5% (target >85%).
- Departmental Safeguarding Leads continue a programme of attendance at multiagency training:
    - Adult safeguarding training which includes a module on domestic abuse
    - Mental Capacity Act And Deprivation of Liberty Safeguards (DoLS)
- The Trust continues to have a healthy reporting culture and numbers of safeguarding alerts continues to rise year on year, with the majority of concerns (approximately 75%) relating to pre-admission or community provided care.
- The number of applications for DoLS Authorisations is also increasing each year. This will be further impacted by the Supreme Court ruling in March 2013 giving an 'Acid Test' which effectively lowers the threshold for determining if someone is deprived of their liberty whilst in hospital or a care home.
- In October 2013 the Trust held its first organisational Adult Safeguarding Awareness Week. This was aimed at professionals and patients / general public attending the hospital with the intention of raising general awareness about adult safeguarding, to provide resources and useful tips for clinical staff / areas. It is anticipated this will be an annual event.
- Trust sign-up to the Department of Health Responsibility Deal, pledge HO9: Domestic Violence.
- In conjunction with external partners, an updated domestic abuse and violence training programme has been developed. Key staff groups such as the Emergency Department have been the initial focus.

NHS Portsmouth Clinical Commissioning Group

NHS Portsmouth Clinical Commissioning Group (CCG) became a statutory body of the National Health Service in April 2013 following the re-organisation of Primary Care Trusts (PCTs) to CCGs. The CCG is responsible for commissioning a variety of health services for the population of Portsmouth in conjunction with NHS England and its City Council partners.

The CCG puts patient safety, safeguarding and quality at the heart of all its business and is committed to promoting the welfare of adults, with care and support needs experiencing or at risk of abuse or neglect. The CCG ensures that adult safeguarding is embedded within the CCG governance structure and all our commissioning activity, including quality contracts.

The CCG looks forward to the enactment of the Care Bill 2014 and for Safeguarding Adults Boards being put on a statutory footing. The CCG remains committed to the Board and its work in ensuring adults at risk receive the best possible service from all its partners.

During 2013/2014, we have:

- Recruited to a Designated Nurse for Safeguarding Adults, which has allowed for greater partnership working and enhanced integrated adult safeguarding arrangements to be developed and embedded into practice
- Developed a CCG combined safeguarding adult and children policy
- Developed a CCG combined safeguarding adult and children strategy
- Developed a dedicated safeguarding page on the CCG's website
- Commissioned an internal audit which reviewed the CCG safeguarding Arrangements which demonstrated that we had appropriate systems in place for safeguarding

In 2014/2015, our priorities will be:

- Continue to develop, expand and embed safeguarding practice into the work of the CCG
- Further develop partnership working with the City Council, local health providers, the Care Quality Commission and NHS England
- Continue the community wide pressure ulcer prevention work that was commenced in 2014
- Continue regular attendance and participation at the Portsmouth Safeguarding Adults Board
- Ensure that the consideration of mental capacity/consent is embedded into clinical practice across the health economy
- Ensure that the new Supreme Court ruling for DoLS is understood by providers so that patients are not unlawfully deprived of their liberty

Hampshire Constabulary

Throughout 2014 Hampshire Constabulary has continued to work to a demanding and comprehensive Organisational Change Programme that will be delivered well into 2015 to meet the needs of Portsmouth partners and communities.

This has involved:

- The restructure of departments, including the Public Protection Department to meet the demands across the different unitary authorities it works with.
- The identification of the relevant senior leaders for the respective LSAB and equivalent Boards for effective leadership.
- the placement of senior leaders for the local neighbourhoods and LSPs
- To adequately resource and be prepared for the Care Act and its implementation with partners through Safeguarding work.
- To continue to work towards and establish a MASH (Multi-Agency Safeguarding Hub) in each area so as to give consistent, excellent and efficient service.

By delivering further training to investigators and Neighbourhood officers into 2015, the awareness of the Care Act and partnership working will continue to be taken further forward with victims and witnesses at the centre of policing. Scrutiny of our work is undertaken by both the Crime Standards Team and the Serious Case Review Team who also maintain oversight of continuous learning from the national picture over what can be seen as complex business -whilst following the objectives of No Secrets.

Peer Review

Self-evaluation is becoming an increasingly popular and a critical element of local government's performance improvement agenda. The Carer Review recommended a move towards more outcome focused self-assessment, and this will support the ongoing development of outcome and performance driven Single Outcome Agreements.

With the principles of self-evaluation at its core, the Peer Review Framework is one tool which will help councils drive forward change and continuous improvement in the delivery of their services. Peer Reviews will identify both where a service is doing well and areas where improvements could be made.

One of the key strengths of the Peer Review Framework is the inclusion of officers from other local authorities, and potentially other public organisations, in the Peer Review Team which undertakes the review of the service. These officers will bring to the review their excellent working knowledge of the legislative and policy context within which the service being reviewed operates, giving the findings and recommendations of the Peer Review Team a high degree of legitimacy.
The Peer Review Framework provides an effective process by which the service being reviewed can drive forward change, achieve Best Value and improve its efficiency. It will also contribute to the promotion of a culture of excellence in Scotland's public services, through the sharing of best practice amongst organisations participating in a Peer Review.

What is a Peer Review?
Peer review processes have become an established part of the public sector improvement agenda in recent years. The peer review model supports the improvement process within a local authority by:

- providing a 'critical friend' assessment of a service;
- identifying areas for improvement within the service;
- supporting change and improvement within the service; and
- facilitating the exchange of ideas and good practice.

A peer review is not an inspection or audit of a service - it is a supportive review process designed to help identify areas for improvement and to aid a service's capacity to change.

What are the objectives of a Peer Review?

A peer review assesses a service against four key areas: leadership and governance, stakeholder management, performance management and organisational development.

Peer review of Adult Social Care in Portsmouth

Scope

Theme 1: Working together - interagency contact and partnership working at the investigation stages, consequent safeguarding meetings and case conclusion. Co-operation and feedback between, public, private and third sector groups and internal (PCC) departments and teams.

Theme 2: Outcomes for those who experience safeguarding interventions - To look at the experiences of those who have been the subject of safeguarding investigations and/or safeguarding concerns and if a person led approach is employed by those involved and that the outcomes achieved were those identified at the outset of the intervention.

Main outcomes to take forward

Portsmouth City Council Adult Social Care:

- Performance, quality data and key indicators –improvements to data entry/co-ordination of information
- Auditing of SVA
- Awareness and understanding of roles and responsibilities within PCC ASC:
    - Safeguarding team and some ASC community teams (push/pull);
    - Commissioning/contracting
- Impact of Care Act; BCF and DOLS needs to be factored in to future debate. Perception from outside of ASC that resources are 'thin' which was perceived to have reduced communication from ASC

Partners:

- Pushing at an open door - all partners want to make things better " (PCC and SVA) are looking to improve…I feel a lot of hope…things will change.."
- Governance structure that includes performance, quality data and key indicators
- Ensuring that the whole system is not overly reliant on individuals/relationship

Next steps

The way forward with the peer review will result in a separate full report and action plan that will follow and be shared .

Progress on priorities for previous year

2013/14 Priorities - Progress to date , below is an in indication of where the priorities of the last year have been met , where the items have been partially met then these will be carried over into the PSAB for the next year as actions .

Priority Issue	Progress to Date
Finalise Citywide Safeguarding Strategy	This has been developed and the plan sets out the vision for safeguarding adults in Portsmouth as well as the citywide commitment to safeguarding adults that agencies sign up to through their membership of the PASB. It seeks to ensure that all organisations and their staff understand their role, and the expectations on their organisations, in safeguarding adults
Agreement and sign off of the Safeguarding Adults, Multi-agency Policy, Procedures and Guidance, Southampton, Hampshire Isle of Wight and Portsmouth April 2013	Completed - Policy, Procedures and Guidance taken to relevant boards for noting and Policy launched July 2014
Locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour to be developed in line with DH recommendations following Winterbourne View report	All agencies presented plans to PASB in May 2013. Concordant Plan submitted to NHS England - June 2013
Ensure the governance arrangements for adult safeguarding meet local requirements and proposals in the Care and Support Bill and linkage to Health & Wellbeing Board	Governance arrangements for boards reviewed and agreement reached to have single Adult Safeguarding Board with agreed sub-groups Protocol in joint working arrangements between H&WBB, CBB and ASB agreed
Review of PASEB Sub-Groups to clarify governance and reporting arrangements	Completed - superseded by previous priority
Review of Training	Completed - New training courses developed to meet new Policy requirements. TNA completed and agreement reached on what training which staff require
Cross geographical and agency working	Completed - In principal agreement for cross geographical sub-groups established to ensure best practice is shared and best use of resources maintained.

Awareness raising and media campaign	Partially Achieved - Media and communications sub-group established.
Knowing how effective adult safeguarding is -	National Minimum Data Set currently provides only Key Performance Indicator (KPI) Data.
Information Governance and Information Sharing	Partially Achieved - review and updated Information Sharing Protocol developed between health and social care. Appropriate process are in place for information sharing between Police and LA as part of Safeguarding Processes

Key priorities for 2014 / 2017

The priorities for 2014 - 2017 and going to be covered by a PSAB business plan that will meet the direction and travel of Safeguarding for Portsmouth City Safeguarding and rather than an action plan from these priorities we have developed a robust plan for the PSAB which we will take forward these priorities and ensure governance

Below is a summary of the priorities to date.

Priorities for 2014 / 2015 for the Portsmouth Safeguarding Adults Board

Priority Areas and Action

The PSAB has an agreed vision, objectives and terms of reference, with 4 subgroups and 3 regional and inter-Board work streams taking forward its agreed priorities. It has formally agreed to work to Pan Hampshire multi agency policies and procedures to safeguard adults from harm. The key areas to be taken forward under this theme are;

The table below summarises the priority areas for the PSAB to progress through its work in 2014-15. It also indicates who is responsible for leading the action on the priority areas and those that will support this within the PSAB structure. Individual Board Members and other partnership and strategic boards will also support the delivery of these.

	Summary of priority areas	Lead	Supported by
1	Develop effective governance arrangements for the PSAB	DC	Board
2	Communications and promotion of safeguarding	TBC	Board
3	Personalisation (making Safeguarding personal)	RW	Board
4	Quality Assurance	IR	Board
5	Strategy and Performance	FW	Board
6	Training Development and learning	TBC	Board
7	Develop and implement relevant policies and procedures to improve practise	LB	Board
8	Develop and deliver Serious case reviews , ensure clear process for managing reviews and disseminating learning (learn from other cases that do not meet the threshold of SCR	TK	Board

	to ensure continued learning)		
9	Joint working between the LSAB and the LSCB	LB/ HD	Board
10	Continuation of Fire Safety Development group (Covers 4 LSABs)	LB	Board

Appendix 1

Portsmouth CITY COUNCIL

Safeguarding Adults

Yearly report 2013/14

Summary	Number of cases
Total Number of Alerts Received	1300
Number of Referrals	378
Number of Repeat Referrals	25
Number Not Investigated	897

Number of Last years referrals closed in this period.	76

Meetings	Number	Percentage
Strategy Meetings	29	9%
Case Conferences	159	51%
MDT Meetings	17	5%
Family conferences	2	1%
Unannounced Visits	99	32%
Management Meeting	5	2%
TOTAL	**311**	

Working Days	254
Alerts per day	0
Meetings per day **inlcuding Unannounced visits**	1.224409449

Please note: these figures do not include referrals or alerts relating to service providers where there are multiple VA's.

2. Nature of Abuse

Table 2.0

Nature of Abuse	Number of cases	Percentage
Physical	601	22%
Financial	234	8%
Institutional	321	12%
Sexual	71	3%
Neglect	950	34%
Psychological	477	17%
Discriminatory	25	1%
Self Harm	15	1%
Self Neglect	90	3%
TOTAL	**2784**	
Of which included Multiple abuse	730	26%

Figure 2.0

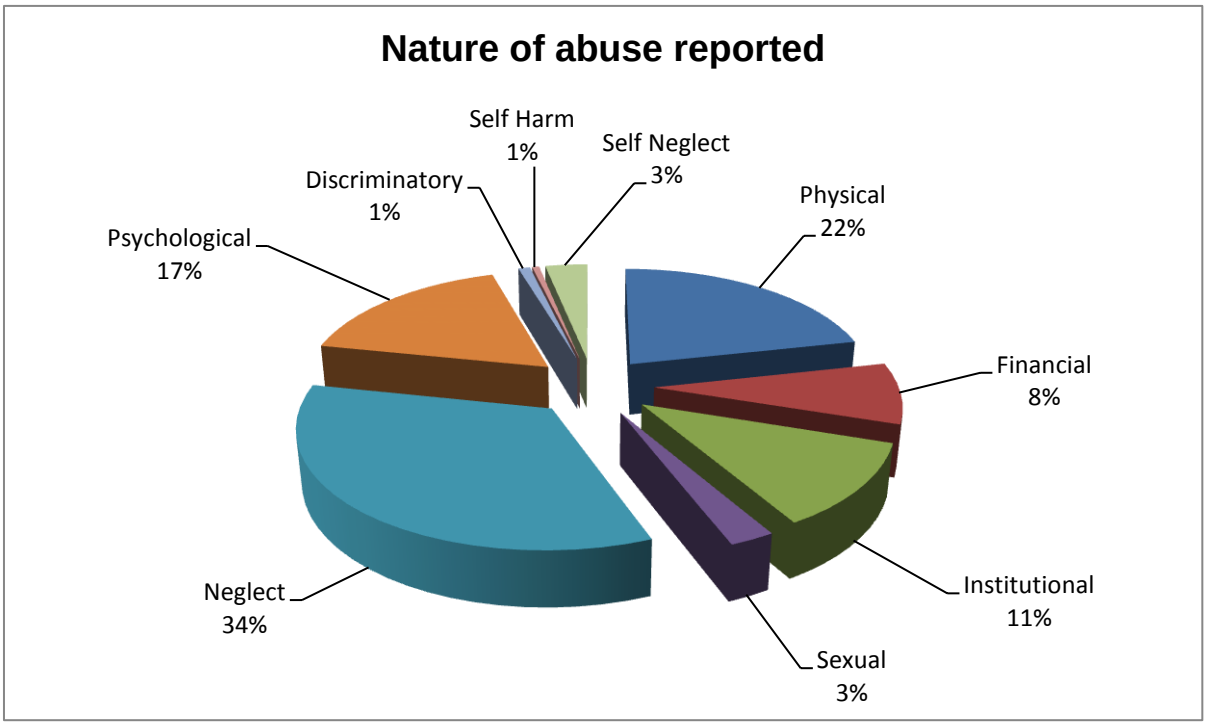


Figure 2.1

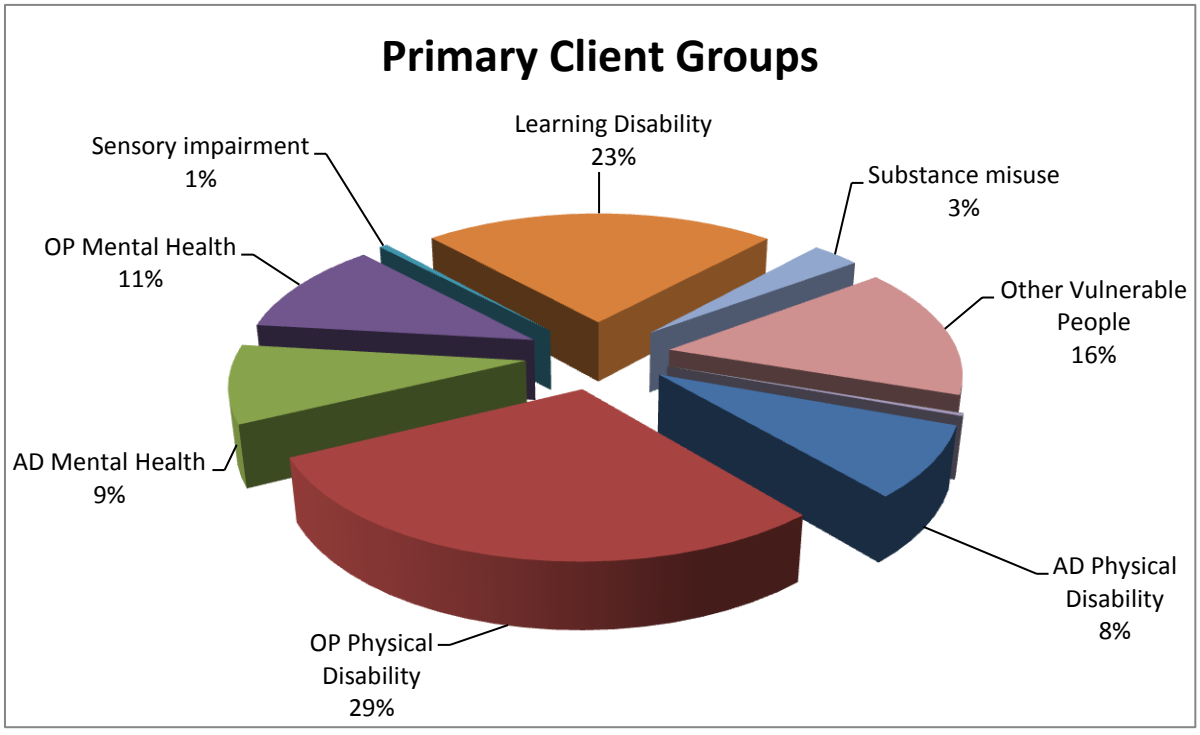
Hate Crimes	Number of Cases
LD	0
Racial	0
Religious	0
Other	0
Total	**0**

3. Safeguarding clients by Primary client group

Table 3.0

Client Group	Number of Cases	Percentage
AD Physical Disability	107	8%
OP Physical Disability	377	29%
AD Mental Health	118	9%
OP Mental Health	144	11%
Sensory impairment	7	1%
Learning Disability	302	23%
Substance misuse	41	3%
Other Vulnerable People	200	15%
Unknown	0	0%
Institution	4	0%
TOTAL	**1300**	

Figure 3.0



4. Referral source

Table 4.0

How did these Allegations come to light	Number of Cases	Percentage
Domicilliary Staff	100	8%
Residential Care Staff	157	12%
Day Care Staff	39	3%
Social Worker / Care Manager	102	8%
Self-Directed Care Staff	1	0%
Other Social Care Staff	46	4%
Primary/Community Health Staff	215	17%
Secondary Health Staff	235	18%
Mental Health Staff	30	2%
Self Referral	76	6%
Family Member	65	5%
Friend/Neighbour	11	1%
Other service user	2	0%
Care Quality Commission	56	4%
Housing	62	5%
Education/Training/Workplace Establishment	2	0%
Police	22	2%
Other	63	5%
GP	14	1%
Fire Service	2	0%
TOTAL	**1300**	

Figure 4.0 **Total number of referrals from each source**

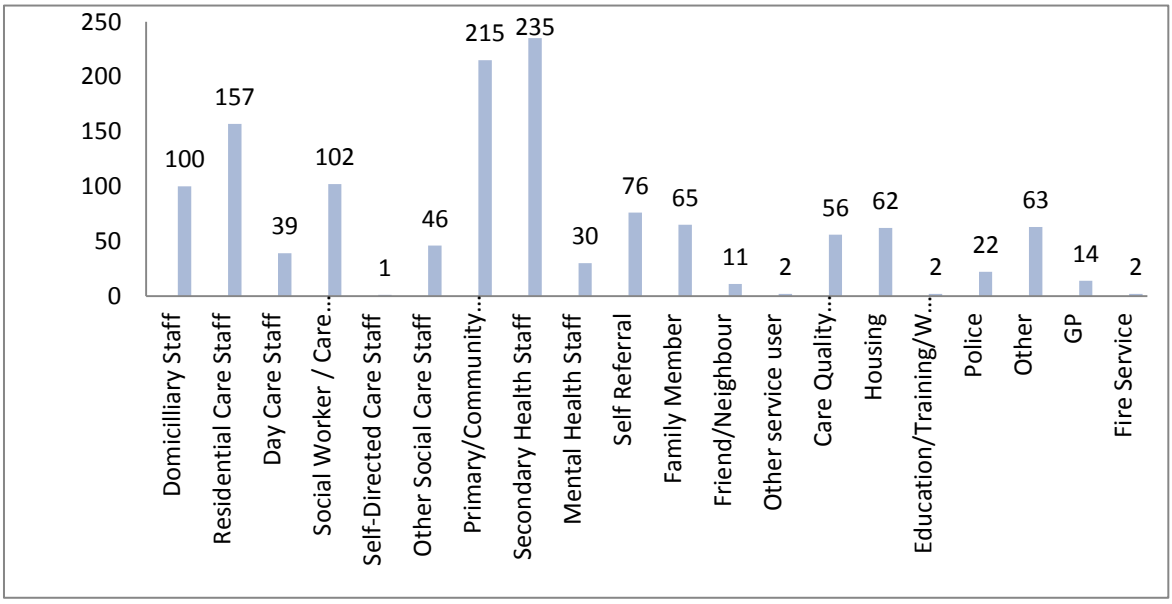
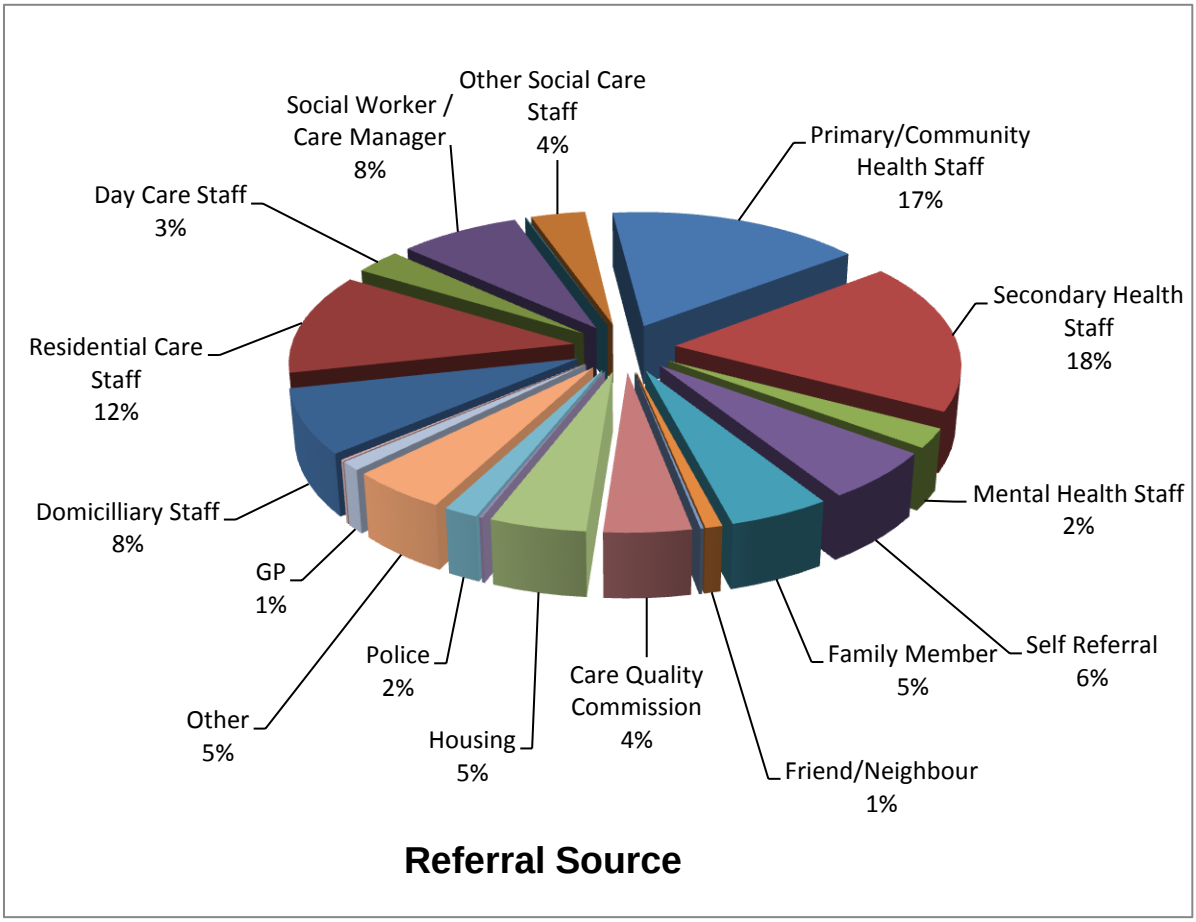


Figure 4.1

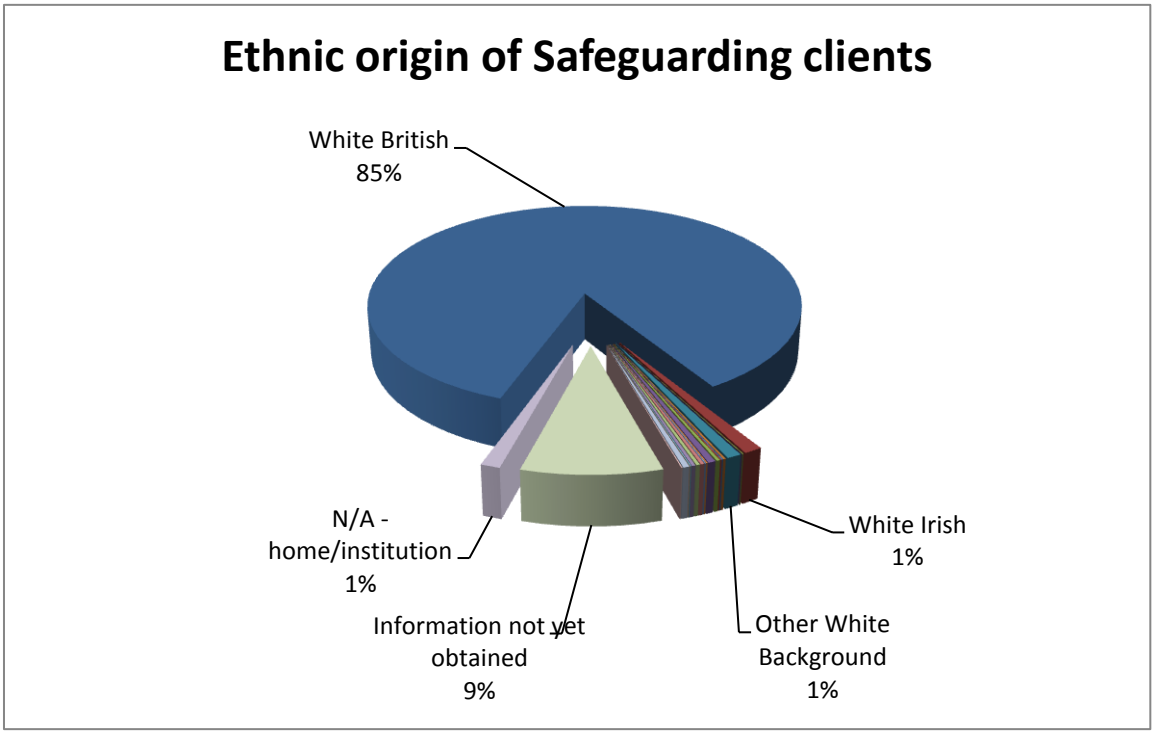

Other Social Care Staff 4%
Social Worker / Care Manager 8%
Day Care Staff 3%
Primary/Community Health Staff 17%
Secondary Health Staff 18%
Residential Care Staff 12%
Mental Health Staff 2%
Domicilliary Staff 8%
GP 1%
Police 2%
Other 5%
Housing 5%
Care Quality Commission 4%
Family Member 5%
Self Referral 6%
Friend/Neighbour 1%
Referral Source

5. Client Ethnicity

Table 5.0

Ethnicity of VA	Number of Cases	Percentage
White British	1111	85%
White Irish	15	1%
Traveller of Irish Heritage	1	0%
Gypsy/Roma	0	0%
Other White Background	12	1%
Mixed White and Black Caribbean	2	0%
Mixed White and Black African	1	0%
Mixed White and Asian	1	0%
Other Mixed background	3	0%
Indian	6	0%
Pakistani	0	0%
Bangladeshi	1	0%
Chinese	1	0%
Other Asian Background	3	0%
Black Caribbean	3	0%
Black African	3	0%
Any Other Black background	1	0%
Arab	0	0%
Any Other Ethnic Group	5	0%
Refused	1	0%
Information not yet obtained	114	9%
N/A - home/institution	16	1%
TOTAL	**1300**	

Figure 5.0

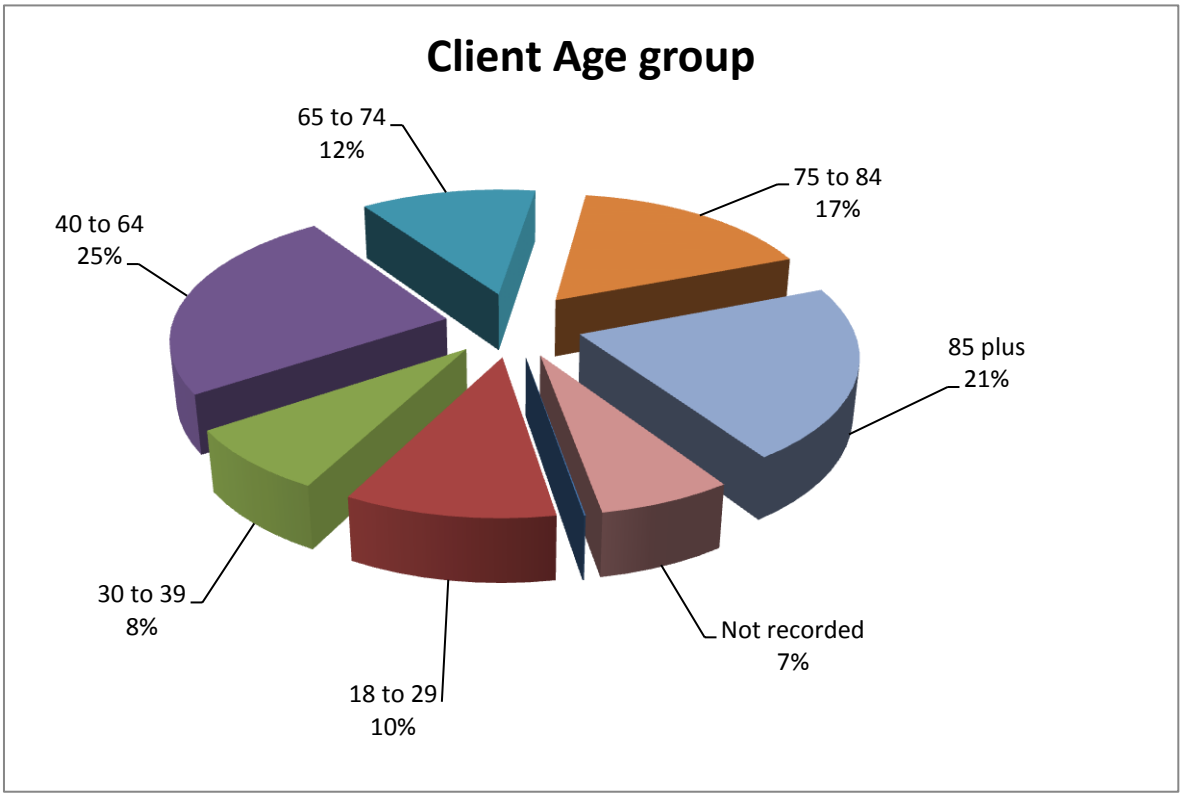


6. Client Age

Table 6.0

Client age	Number of Cases	Percentage
Under 18	1	0%
18 to 29	135	10%
30 to 39	102	8%
40 to 64	320	25%
65 to 74	156	12%
75 to 84	217	17%
85 plus	277	21%
Not recorded	86	7%
N/A - home/institution	6	0%
TOTAL	**1300**	

Figure 6.0



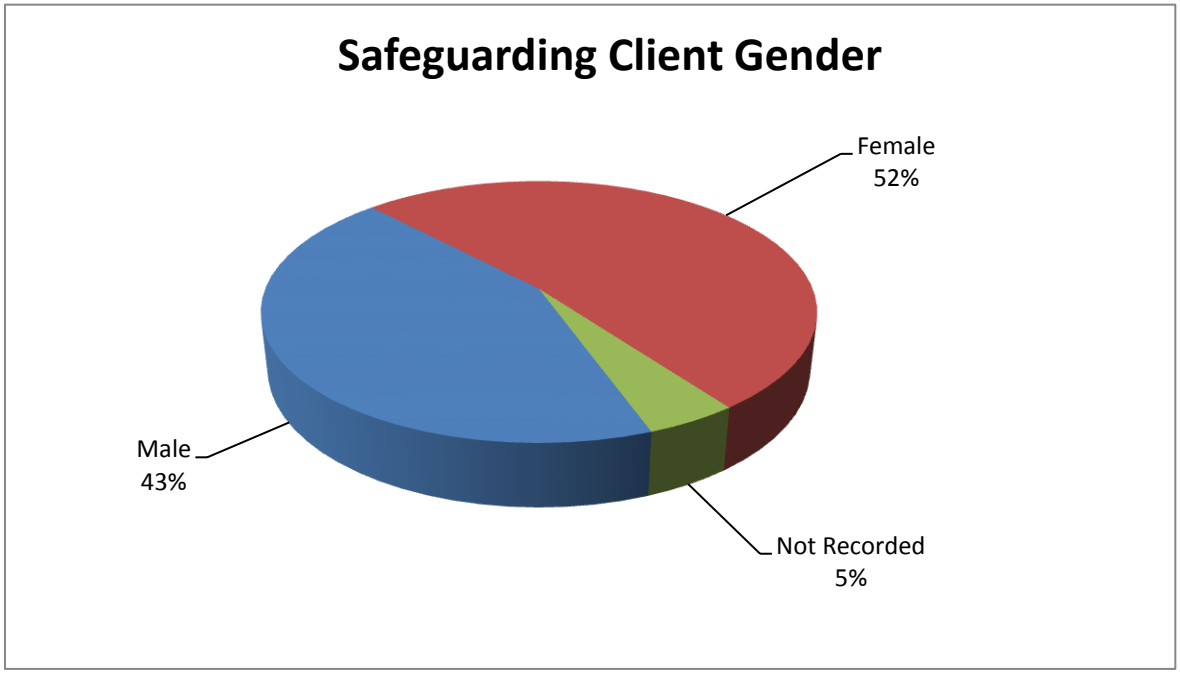
Nb. Figure 6.0 does not include alerts/referrals about agencies or residential care homes where there are multiple VA's, nor does it include referrals for which no data was recorded.

7. Client Gender

Table 7.0

VA Gender	Number of Cases	Percentage
Male	558	43%
Female	668	51%
Not Recorded	59	5%
N/A - home/institution	15	1%
TOTAL	**1300**	

Figure 7.0



Nb. Figure 7.0 does not include alerts/referrals about agencies or residential care homes where there are multiple VA's, nor does it include referrals for which no data was recorded.

8. Client's previous contact with Social Services

Table 8.0

Placed by another authority from outside council area?	Number of Cases	Percentage
Yes	72	6%
No	1121	86%
Not recorded	100	8%
N/A - home/institution	7	1%
TOTAL	**1300**	

Table 8.1

Known to this CASSR* in this financial year at the time of alert/referral?	Number of Cases	Percentage
Yes	1021	79%
No	200	15%
Not recorded	68	5%
N/A - home/institution	11	1%
TOTAL	**1300**	

* CASSR - Council with adult social services responsibility.

9. Location Incident took place

Table 9.0

Location incident took place.	Number of cases	Percentage
Own Home	627	48%
Care Home - Residential	212	16%
Care Home - Nursing	59	5%
Community Hospital	2	0%
Acute Hospital	153	12%
Other Health Setting	9	1%
Mental Health inpatient setting	8	1%
Day Centre/Service	22	2%
Education/Training/Workplace Establishment	4	0%
Other Person's home	14	1%
Supported Accomodation	95	7%
Alleged Perpetrators Home	20	2%
Public Place	42	3%
Other	16	1%
Not Known	17	1%
TOTAL	**1300**	

Figure 9.0

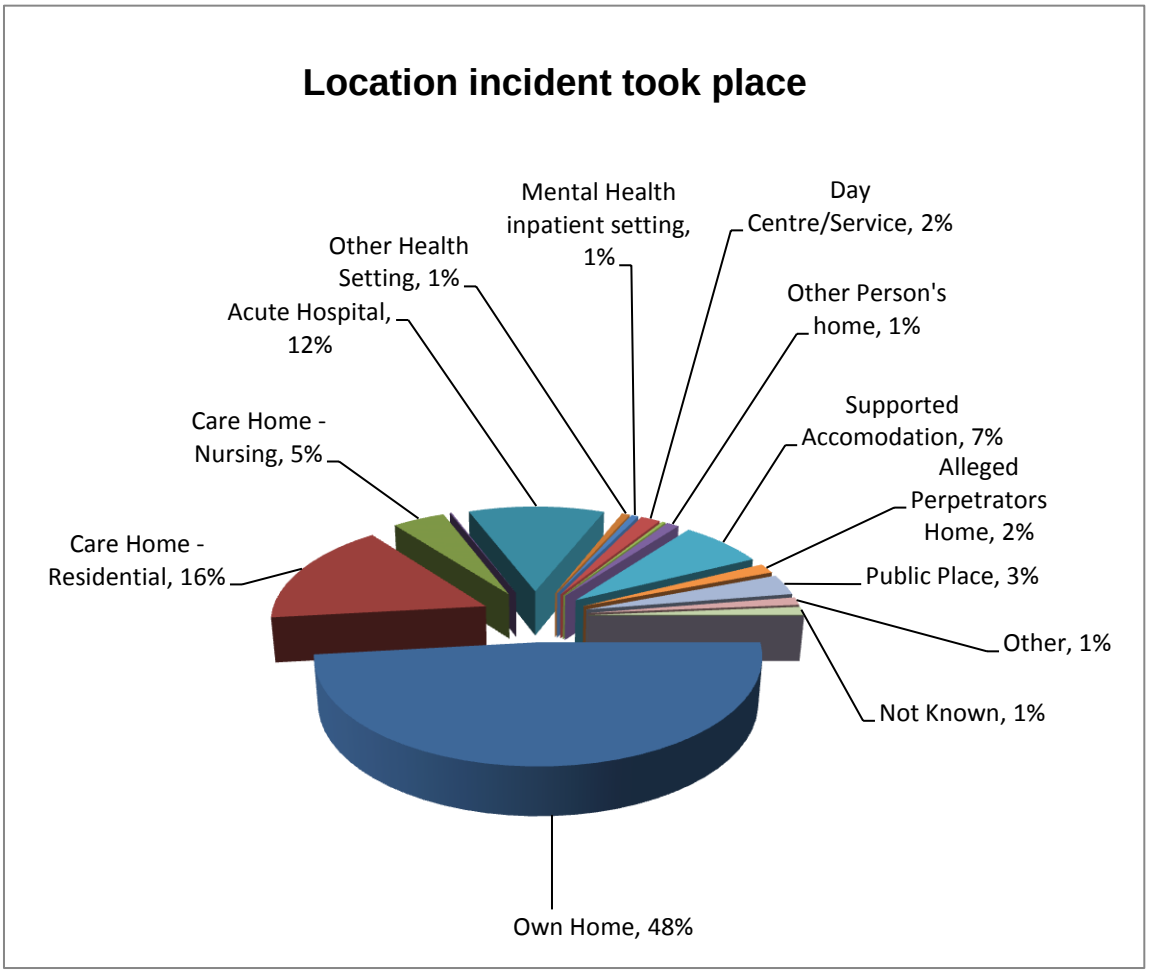
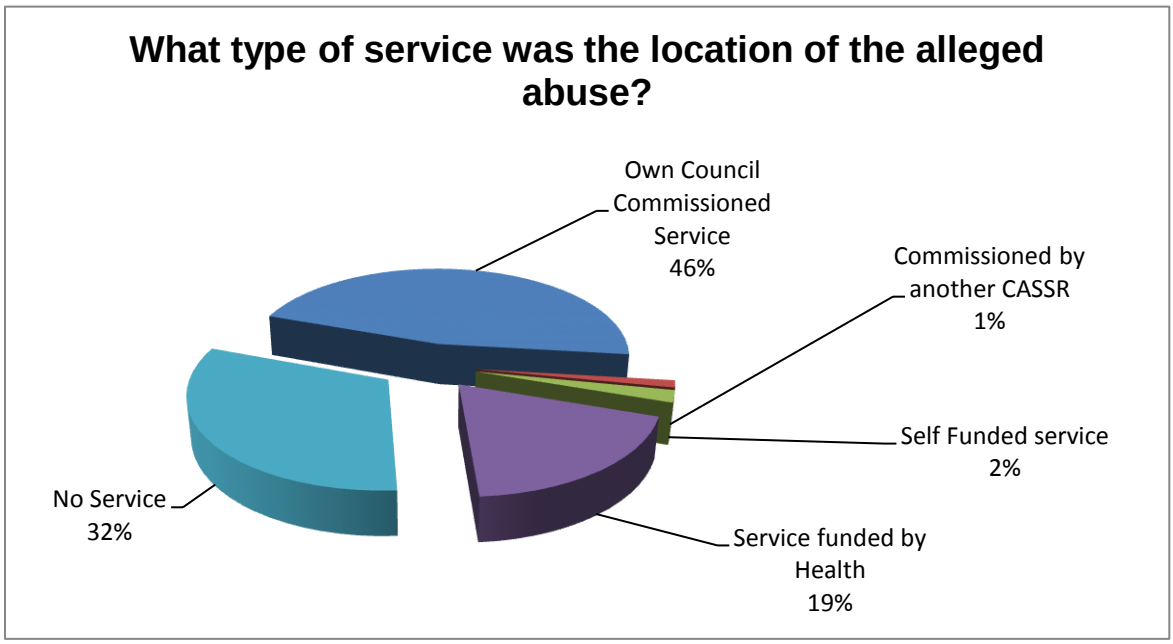


Table 9.1 What type of service was the location of the alleged abuse?

Type of Service	Number of cases	Percentage
Own Council Commissioned Service	602	46%
Commissioned by another CASSR	16	1%
Self Funded service	27	2%
Service funded by Health	244	19%
No Service	411	32%
TOTAL	**1300**	

Figure 9.1

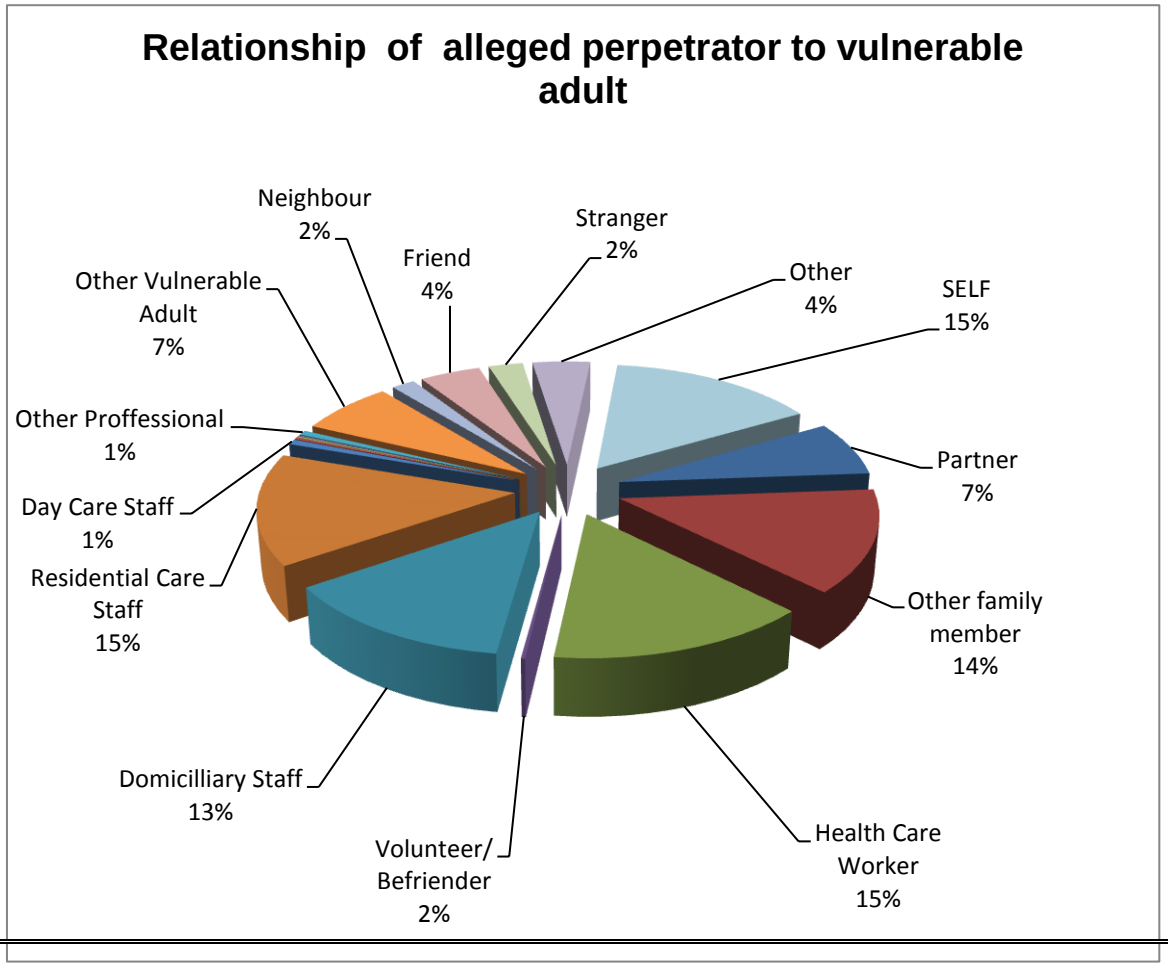


10. Alleged Perpetrator - Relationship to vulnerable adult

Table 10.0

Relationship of AP to VA	Number of Cases	Percentage
Partner	93	7%
Other family member	176	14%
Health Care Worker	189	15%
Volunteer/Befriender	3	0%
Domicilliary Staff	174	13%
Residential Care Staff	191	15%
Day Care Staff	9	1%
Social Worker / Care Manager	3	0%
Self Directed Support Worker	2	0%
Other Social Care Staff	2	0%
Other Proffessional	8	1%
Other Vulnerable Adult	90	7%
Neighbour	22	2%
Friend	57	4%
Stranger	32	2%
Other	54	4%
SELF	195	15%
TOTAL	**1300**	

Figure 10.0



11. Alleged Perpetrator info:

Table 11.0

AP Identified	Number of Cases	Percentage
Yes	911	70%
No	389	30%
N/A - home/institution	0	0%
TOTAL	**1300**	

Table 11.1 Does the Alleged Perpetrator live with the Vulnerable Adult?

Does the AP live with the VA?	Number of Cases	Percentage
Yes	414	32%
No	886	68%
N/A - home/institution	0	0%
TOTAL	**1300**	

Table 11.2 Is the Alleged Perpetrator the main family carer?

Is the AP the main family carer?	Number of Cases	Percentage
Yes	287	22%
No	1013	78%
N/A - home/institution	0	0%
TOTAL	**1300**	

12. Alleged Perpetrator Gender

Table 12.0

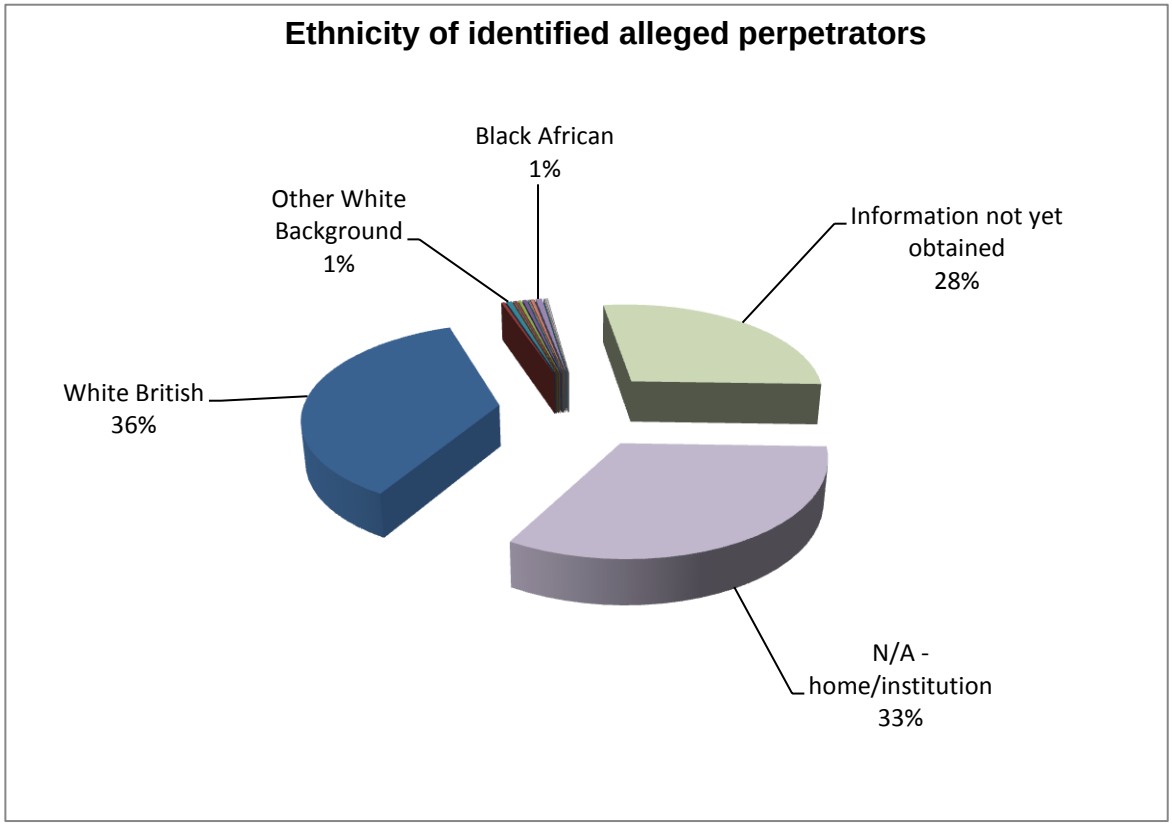
AP Gender	Number of Cases	Percentage
Male	481	37%
Female	276	21%
Not Recorded	90	7%
N/A - home/institution	453	35%
TOTAL	**1300**	

13. Alleged Perpetrator Ethnicity

Table 13.0

Ethnicity of AP	Number of Cases	Percentage
White British	472	36%
White Irish	4	0%
Traveller of Irish Heritage	0	0%
Gypsy/Roma	0	0%
Other White Background	7	1%
Mixed White and Black Caribbean	1	0%
Mixed White and Black African	1	0%
Mixed White and Asian	2	0%
Other Mixed background	4	0%
Indian	5	0%
Pakistani	1	0%
Bangladeshi	1	0%
Chinese	0	0%
Other Asian Background	4	0%
Black Caribbean	0	0%
Black African	8	1%
Any Other Black background	1	0%
Arab	1	0%
Any Other Ethnic Group	2	0%
Refused	0	0%
Information not yet obtained	359	28%
N/A - home/institution	427	33%
TOTAL	1300	

Figure 13.0

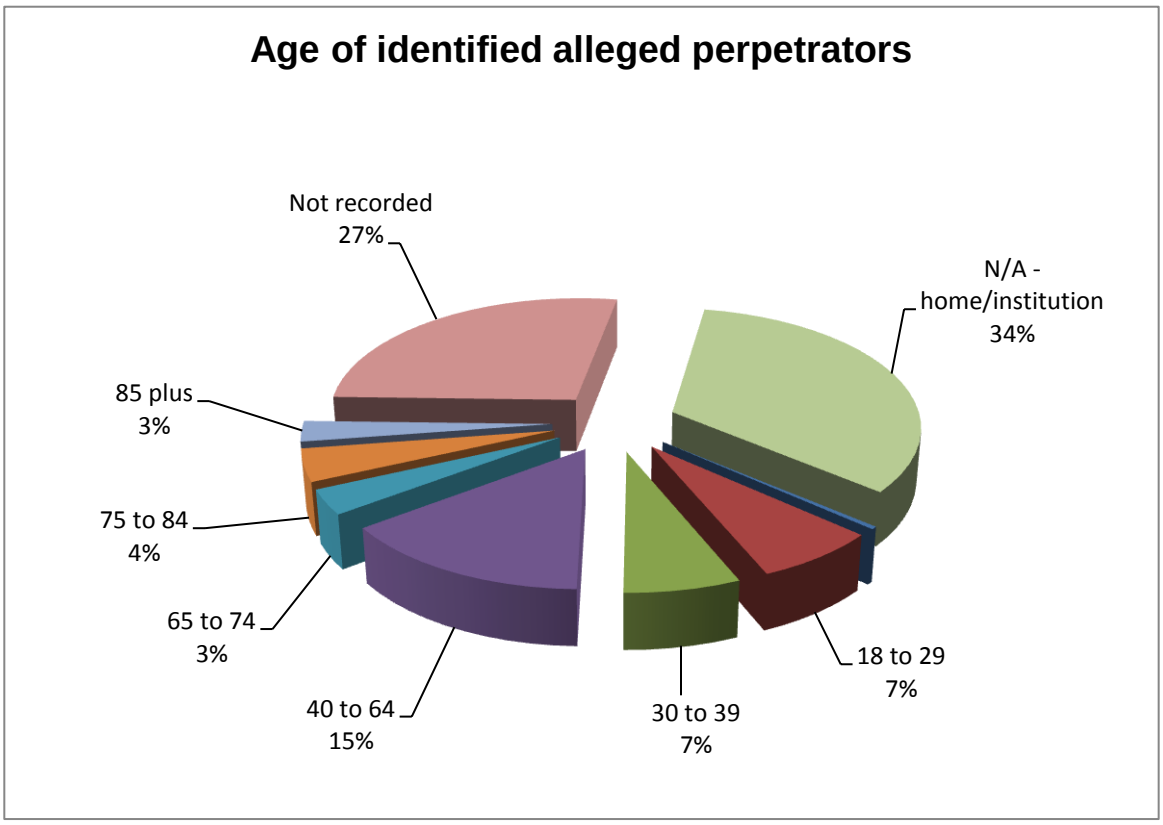


14. Alleged Perpetrator age

Table 14.0

Alleged Perpetrator age	Number of Cases	Percentage
Under 18	5	0%
18 to 29	93	7%
30 to 39	86	7%
40 to 64	190	15%
65 to 74	44	3%
75 to 84	57	4%
85 plus	36	3%
Not recorded	355	27%
N/A - home/institution	434	33%
TOTAL	**1300**	

Figure 14.0



15. Completed Cases

These tables include referrals which were not received this year but were closed in this period.

Table 15.0

Number of cases completed within 3 months	Percentage of Total Completed Referrals
199	63%

Table 15.1

Case Conclusion	Number of Cases	Percentage
Fully Substantiated	68	22%
Partialy Substantiated	70	22%
Not Substantiated	100	32%
Inconclusive	67	21%
Invest. Ceased at Ind Request	10	3%
TOTAL	315	

Figure 15.1

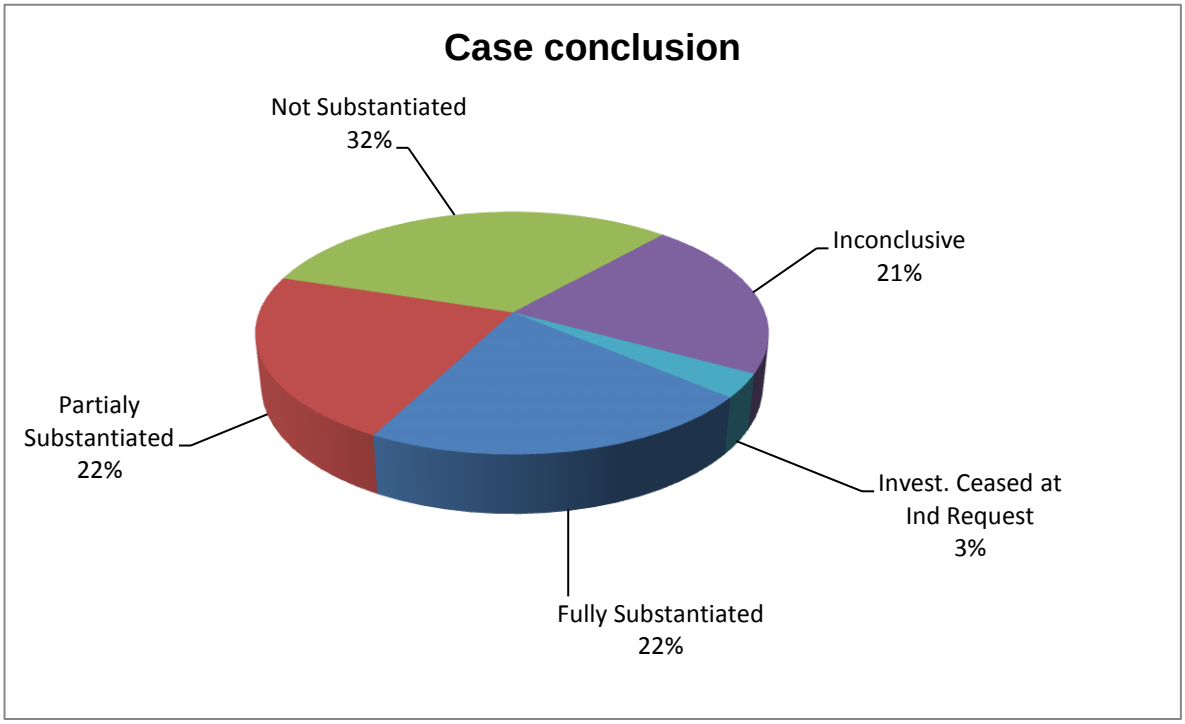


Table 15.2

View of VA on Case Conclusion	Number of Cases	Percentage
NFA Under Safeguarding	201	64%
Action : Risk Remains	15	5%
Action : Risk Reduced	55	17%
Action : Risk Removed	44	14%
TOTAL	315	

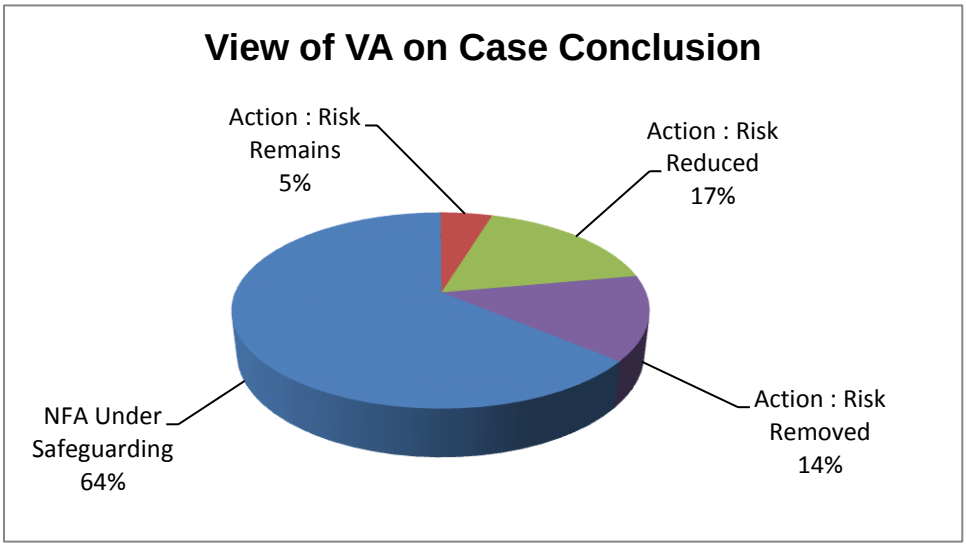
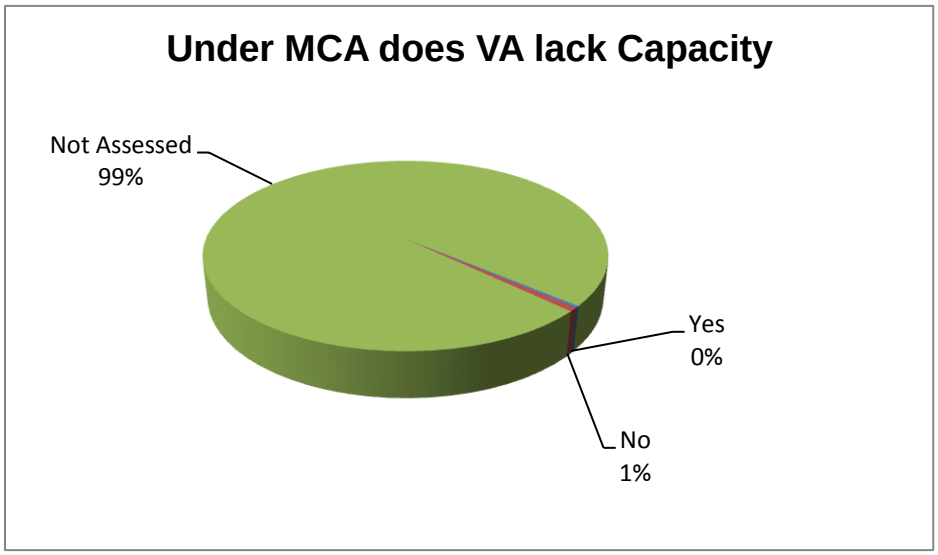


Table 15.3

Under MCA does VA lack Capacity	Number of Cases	Percentage
Yes	1	0%
No	2	1%
Not Assessed	312	99%
TOTAL	315	



16. Case Outcomes - Vulnerable Adults

Table 16.0

Outcomes for VA	Number of Cases	Percentage
Continued Monitoring	75	13%
Police Notified	25	4%
Family Notified	13	2%
GP/Health Notified	15	3%
Other Emergency Serv. Notified	0	0%
Regulator Notified	6	1%
Protection Plan Agreed	14	2%
Adjust. To Prot. Plan	1	0%
Person at Risk Removed	12	2%
Potential Risk Removed/averted	13	2%
Individual Excluded/Removed/Suspended	18	3%
Alt. Serv. put in place	15	3%
Service Suspended	1	0%
Invest. Under Complaints proc.	7	1%
Criminal Inves./prosec.	12	2%
Civil Action Taken	0	0%
Continuing Action via other procs.	30	5%
Further (new) Risk identified	1	0%
Further (change to exisiting) Risk Identified	0	0%
Re-Training	44	7%
Ind not wish to proc.(proc as Co fund serv.)	1	0%

Other	46	8%
No Further Action	242	41%
TOTAL	**591**	

Table 16.0 includes referrals which were not received this year but were closed in this period.

Figure 16.0 **Outcomes for Vulnerable Adults**