Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 29 NOVEMBER 2023 AT 10.00 AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL, PORTSMOUTH

Telephone enquiries to Anna Martyn Tel 023 9283 4870
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If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

Health and Wellbeing Board Members
Councillors Lewis Gosling, Graham Heaney, Suzy Horton, Steve Pitt and Matthew Winnington (Joint Chair)
Dr Linda Collie (Joint Chair), Helen Atkinson, Roger Batterbury, Sarah Beattie, Andy Biddle, Natalie Brahma-Pearl, Sarah Daly, Penny Emerit, David Goosey, James Hill, Mark Lewis, Maggie MacIsaac, Gemma Nichols, Dr Jason Oakley, Lorna Reavley, Paul Riddell, Joanne Shankland, Dianne Sherlock, Alasdair Snell, Frances Soul, Jo York

(NB This Agenda should be retained for future reference with the minutes of this meeting.)

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

Deputations by members of the public may be made on any item where a decision is going to be taken. The request should be made in writing to the contact officer (above) by 12 noon of the working day before the meeting, and must include the purpose of the deputation (for example, for or against the recommendations). Email requests are accepted.

A G E N D A

1 Apologies for absence

2 Declarations of interest

3 Minutes of previous meeting - 27 September 2023 (Pages 5 - 14)

RECOMMENDED that the minutes of the meeting held on 27 September 2023

be approved as a correct record.

4 Portsmouth Safeguarding Adults Board Annual Report (Pages 15 - 60)

To provide an update on the recent work of the Portsmouth Safeguarding Adults Board (PSAB) in 2022-23 and to highlight the learning from three recently published Safeguarding Adults Reviews (SARs).

5 Portsmouth Safeguarding Children Partnership Annual Report (Pages 61 - 92)

To introduce the Annual Report 2022-23 of the Portsmouth Safeguarding Children Partnership (PSCP) on the effectiveness of multi-agency early help and safeguarding arrangements for children in Portsmouth.

6 Community Safety Strategic Assessment (Pages 93 - 98)

Community Safety Partnerships have a statutory requirement to produce an annual strategic assessment (or update) as well as a three-year partnership plan (refreshed annually). This document fulfils the obligation to produce the strategic assessment and informs the refresh of the partnership plan.

RECOMMENDED that the Health and Wellbeing Board use the information in this strategic assessment (and the previous full strategic assessment in 2020/21) to guide evidence-based day to day decision making and resource allocation.

7 Health & Wellbeing Strategy - Tackling Poverty (Pages 99 - 106)

1. To provide an update to the Health and Wellbeing Board on the tackling poverty priority area of the strategy, building on the evidence base and needs assessment provided by the Public Health Annual Report 2023.
2. To outline action to date and the next steps to strengthen and develop this area of work, highlighting resource pressures and the role of the Health and Wellbeing Board member organisations and other partners.

8 Education attainment - Update on 2023 results (Pages 107 - 124)

There will be a presentation at the meeting.

Members of the public are now permitted to use both audio visual recording devices and social media during this meeting, on the understanding that it neither disrupts the meeting or records those stating explicitly that they do not wish to be recorded. Guidance on the use of devices at meetings open to the public is available on the Council's website and posters on the wall of the meeting's venue. Whilst every effort is made to webcast this meeting, should technical or other difficulties occur, the meeting will continue without being webcast via the Council's website.

OF THE MEETING of the Health and Wellbeing Board on Wednesday, 27 September 2023 at 10.00 am in the Executive Meeting Room, Guildhall, Portsmouth

Present

Councillor Matthew Winnington, Cabinet Member for Community Wellbeing, Health & Care (Joint Chair, in the Chair)
Dr Linda Collie, Clinical Lead/ Clinical Executive (GP) Health & Care Portsmouth, Hampshire and Isle of Wight Integrated Care Board (Joint Chair)

Councillor Lewis Gosling, Conservative group

Helen Atkinson, Director of Public Health, PCC
Roger Batterbury, Healthwatch Portsmouth
Sarah Beattie, Probation Service
Andy Biddle, Director of Adult Care, PCC
Natalie Brahma-Pearl, Chief Executive, PCC
Sarah Daly, Director of Children's Services & Education, PCC
Paul Edwards, Probation Service
David Goosey, Portsmouth Safeguarding Adults Board
James Hill, Director of Housing, Neighbourhood & Building Services, PCC
Mark Lewis, Superintendent, Hampshire Constabulary
Terry Norton, Deputy Police & Crime Commissioner
Dr Jason Oakley, University of Portsmouth
Lorna Reavley, The Hive
Frances Soul, Portsmouth Education Partnership
Jo York, Health & Care Portsmouth

22. Chair's introduction and apologies for absence (AI 1)

Councillor Winnington, Cabinet Member for Community Wellbeing, Health & Care, opened the meeting. He welcomed two new organisations to the Board, Portsmouth Creates, represented by Gemma Nichols, and the Portsmouth Education Partnership, represented by Frances Soul. He also welcomed Natalie Brahma-Pearl, the council's new Chief Executive, Superintendent Mark Lewis, the new representative from Hampshire Police, and Dr Jason Oakley, the new representative from the University of Portsmouth. The Board thanked David Williams, the council's former Chief Executive, for his contribution to the Board, of which he had been a member since it started in 2012.

Apologies for absence were received from Councillor Steve Pitt, Councillor Graham Heaney, Councillor Suzy Horton, Penny Emerit (Portsmouth Hospitals University Trust), Gemma Nichols (Portsmouth Creates), Jo Pinhorne (Solent NHS Trust), Paul Riddell (Hampshire Fire & Rescue Service), Joanne Shankland (City of Portsmouth College) and Alasdair Snell (Solent NHS Trust).

The Board agreed to consider agenda item 11 (Superzone pilot) first as the item had been postponed twice from previous meetings. For ease of reference the minutes will be kept in the original order.

23. Declarations of Interests (AI 2)

There were no declarations of interest.

24. Minutes of previous meeting - 28 June 2023 (AI 3)

RESOLVED that the minutes of the Health and Wellbeing Board held on 28 June 2023 be approved as a correct record.

25. Stroke Recovery Service (AI 4)

Andy Biddle, Director of Adult Care, gave a verbal update. He outlined the situation to date and explained that short-term funding for the Stroke Recovery Service (SRS) had been secured until the end of December 2024. A reply was awaited from the Integrated Care Board (ICB) to show how the NHS stroke model would be configured.

The Chair raised the SRS at the ICB a few weeks ago. Other Integrated Care Systems (ICS) had a stroke pathway in place but not Portsmouth. However, work had started on a pathway and conversations would continue. The SRS had been discussed at the Health Overview & Scrutiny Panel last week and there was a meeting with the Stroke Association on 23 October.

Jo York said the recover pathway focused on acute stroke. The ICB had comprehensive acute and immediate recovery services; the issue was understanding the relationship with the voluntary and community sector (VCS) as the ICB did not want people to worry about getting help with after care. The Stroke Association's service had been in place for a long time but the new situation gave the opportunity to test what services Portsmouth needed to develop. The Chair noted in other places in Hampshire & Isle of Wight (HIOW) the Stroke Association ran services on behalf of the ICS. Portsmouth was the only place in HIOW with a post-stroke recovery service. There was much help available but it was not always very person-centred or clear how to access it. The Health & Wellbeing Board (HWB) would be kept up to date.

RESOLVED that the Health & Wellbeing Board note the update.

26. Health and Care Portsmouth Joint Forward Plan (AI 5)

Jo York, Integrated Care Board (ICB) Director for Portsmouth & Managing Director, Health & Care Portsmouth (HCP), introduced the report. She thanked Kelly Nash, Corporate Performance Manager, for succinctly collating the HWB's ideas and comments on the Joint Forward Plan.

The Chair thanked all those involved and noted the Integrated Care Partnership Strategy was statutory and the ICB's responsibility. It comprised the underlying principles the ICB worked to at an HIOW level. The HWB had done considerable work to show how its Health & Wellbeing Strategy reflected the HIOW's priorities. He noted the theme of the ICB's assembly today was mental health.

RESOLVED that the Health and Wellbeing Board

1. **Note the Health and Care Portsmouth Forward Plan**
2. **Note the relationship with the ICB Forward Plan presented at the July Health and Wellbeing Board meeting**
3. **Consider how the plan can support the Health and Wellbeing Strategy for the city.**

27. Portsmouth Safeguarding Adults Board (PSAB) - Funding (AI 6)

David Goosey, PSAB Chair, introduced the report and drew attention to inequities in funding. The Clinical Commissioning Group used to fund the PSAB but now it was funded on a much wider basis and Portsmouth ended up with a poorer deal than other SABs although he appreciated there was no spare cash anywhere. He noted how key areas from reviews were reflected in the third pillar of the ICB's Plan on a Page. It was important to hear lived experiences to improve how agencies worked across risk management. Unfortunately the PSAB was now at risk but having an SAB was a statutory duty so if it was not fulfilling its functions they still had to be done. As the Chair he had a duty to "shout out" if the PSAB at risk and he sought the HWB's support for the recommendation to write to the HIOW Constabulary and the HIOW ICB.

Andy Biddle offered his full support for the recommendation and said the PSAB had worked very effectively and met its duties over the years with a small resource. Recent learning events around a resident who had died had received very positive feedback, as they had involved family members, which brought the person's voice into the learning event for practitioners. Last year the annual conference was a fantastic experience to hear feedback. The PSAB was requesting the minimum amount to keep working. At the moment it would not have the funding to commission another safeguarding adult review in the 2023/24 year.

Terry Norton said his role was to ensure the Police carried out roles only they could do, for example, Street to Sweep. The Police challenged local authorities to deal with issues such as anti-social behaviour and not use the Police as the first port of call. The proposed amounts were recommended to force leads by officers who attended SABs and were proportionate to what partners were seeking to achieve. The same proportionate increase would be expected by all partners. A case could be made to the Constabulary if, firstly, the PSAB specified exactly what the increase was and, secondly, what the partners believed they could achieve with a higher amount. He pointed out the Police did not receive a community infrastructure levy like other partners.

Jo York noted a similar position with the ICB. Work done last year had highlighted variations amongst ICBs and she asked if it was possible to reduce variation. The ICB was looking at how to support the SABs proportionately and how to make the best use of finite resources. It recognised the PSAB's bid and was happy to support it. Sarah Beattie said good work was being done on the goodwill of a small number of individuals who went above and beyond their role.

David Goosey was a little frustrated as the PSAB was setting its budget and as its Chair he had to point out that its statutory duties were not being carried out. The business case had been laid out several times to agencies and the situation was repeating itself. The Chair took on board the comments. There were differences in funding with other SABs; Portsmouth's amount was less than the IOW and should be increased across the board. The safeguarding conference last year was wildly successful with maximum attendance and outstanding engagement, including from the Police who had had a very prominent role and showed what they did in the wider community. If funding was not increased the conference could not be held again. There was real concern if the PSAB could not meet its statutory responsibilities. He was happy to support the recommendation. It needed to be done in conjunction with others as all organisations were affected, not just Adult Social Care (ASC) and the Police, but especially those in the VCS, many of whom ASC commissioned to carry out safeguarding properly in the community.

Sarah Daly suggested sharing funding formulas across the children's safeguarding partnerships in HIOW. Portsmouth was in a stark position so needed to consider the position and modelling of the adults' and children's SABs together. She could not understand how the PSAB was in this position. The formula for the children's SAB felt fairer and the same partners contributed to the children's and adults' SABs so it would be a sensible way forward.

The Chair agreed to amend the recommendation to include "with a mind to the funding formulas that are used for the Children's Safeguarding Boards" and that matters proceed at pace.

RESOLVED that the Health and Wellbeing Board write to Hampshire and Isle of Wight Constabulary and Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) to request that they set out their formulas for funding the respective Safeguarding Adults Boards (SABs) in their area and how they intend to enable the PSAB to meet its obligations in 2023-24 and 2024-25, with a mind to the funding formulas that are used for the Children's Safeguarding Boards.

28. Director of Public Health's Annual Report (AI 7)

Helen Atkinson, Director of Public Health, introduced the report. She thanked Matthew Gummerson (Head of Strategic Intelligence & Research) and Mark Sage (Tacking Poverty Co-ordinator) for the huge amount of work they had done to deliver the report. It was very timely as poverty was not only a corporate priority for the council but having a huge impact on Portsmouth residents across the city. It would be followed up with an executive summary.

Matt Gummerson thanked all those who had contributed to the report and gave a brief summary of some main points, for example, the gap in life expectancy within Portsmouth; the gap between children receiving free school meals and those who did not was wider than elsewhere; employment could help relieve poverty but some people who were employed were still living in poverty. The cost of living crisis meant significantly more people were affected than before and additional challenges made the situation worse for

those already struggling. The crisis was not going to go away for the foreseeable future. The powerful case studies showed what poverty meant to people but also the value of support, for example, data sharing agreements to ensure low-income households were on social water tariffs. John Attrill, the Learning Disability Champion, had said the council did not do enough about the effect of the cost of living crisis on people with learning disabilities so extra research was being done to further inform this work. Tackling poverty impacted on everything organisations did, otherwise the same problems would recur. Poverty would return to the next HWB meeting as a priority of the Health & Wellbeing Strategy. There was an open invitation to anyone who wanted to be involved with the Tackling Poverty Steering Group.

The Chair thanked Matt Gummerson for the overview. Kelly Nash reinforced the importance of the poverty theme in the Health & Wellbeing Strategy. A report being published today on the effects of deprivation and poverty on mental health showed its importance and how it linked to other issues such as housing and social isolation.

HWB members thought the report was sobering reading and reinforced what they saw every day. Jo York said there were heartening pieces of work being done, for example, in Paulsgrove and Portsea, to understand the impact of poverty and the challenges, for example, of accessing services. The infrastructure within Portsmouth was quite good but work needed to be maximised.

Helen Atkinson noted how Portsmouth partnership working was really strong and it was the most integrated place she had worked. However, Portsmouth has seen some of the worst outcomes which has worsened during both Covid and the cost of living crisis. This was a shame as she did not want to detract from the vibrant nature of the city. It was more than a noting report as it would help partners to understand the scale of the issues and strengthen how they supported communities to turn around outcomes.

David Goosey noted poverty was an underlying feature in serious case reviews. He was interested in the fourth recommendation of empowering the workforce as there were synergies with the PSAB's strategy which had an emphasis on enabling people to work together.

Dr Collie thought the report was very interesting and the sample household budgets were useful. She asked if budgeting was taught in schools, especially at the college age. Sarah Daly said some schools did but Education needed to consider it going forward. It was not just educating children but working with parents and the home environment. Gaps were increasing every day with outcomes deteriorating rather than improving; the differences in life expectancy were particularly not good. Terry Norton noted there was a disparity in how education was delivered, for example, on County Lines and relationships.

The Chair thanked all those who had contributed to the report. The situation would be significantly worse without Portsmouth's integrated working so it was important to continue current work. He had worked with food banks and

churches and seen that working together with the goal of best practice was the best way to navigate extremely difficult circumstances. It was also important to emphasise "the causes of the causes." The report showed poverty had been understood and partners were on the right track but they had to pull together. The biggest point was preventing it in the future, for example, by helping young people learn to budget. He thanked Helen Atkinson, Matthew Gummerson and the rest of the team for the timely report. Whether HWB partners were statutory organisations, businesses or in the VCS, they needed to examine poverty and see what they could do.

RESOLVED that the Health and Wellbeing Board note the report.

29. Portsmouth Strategic Youth Justice Plan 2023-2025 (AI 8)

Lisa Morgan, Service Leader for Youth Justice Services, introduced the report and explained the council had a legal duty to produce a two-year plan, which would be reviewed at the mid-point to support longer-term planning. She thanked the Youth Justice Partnership Management Board members for offering consistent support. The genuine passion in the team and partnership was recognised in the HMI Probation inspection. The team's name had been changed to "Youth Justice" from "Youth Offending" to recognise that children were children, many of whom were vulnerable. The team now sat within the Adolescents and Young Adults Service as that increased opportunities to collaborate across services and pull together as a wider management team. Good headway had been made in three of the five key performance indicators (KPI); the remaining two were new ones. In addition, from April 2023 there were ten new KPIs.

Sarah Beattie recognised Ms Morgan's excellent leadership. Terry Norton said as the Police part funded the service it was great to see synergy but also to see children being treated as children first, a policy the Police also emphasised. It was also good to see the Plan included young people up to the age of 24 as the 18 to 24 age range was when habits formed and young people could be at risk of criminality. David Goosey noted that even those young people who caused the greatest harm had vulnerabilities. The broad partnership approach was invaluable in tackling what could be difficult problems to solve.

The Chair noted that the Plan was another example of the partnership working that Portsmouth did so well. He thanked officers for the very detailed report and appreciated the contributions.

RESOLVED that the Health and Wellbeing Board note the report.

30. Health and Wellbeing Strategy - Positive Relationships (AI 9)

Helen Atkinson, Director of Public Health, introduced the report and thanked Kelly Nash, Matthew Gummerson and Hayden Ginns (Assistant Director, Commissioning & Partnerships, Children, Families & Education) for their contribution. She emphasised the importance of social capital as the lack of it showed in the number of school exclusions, adults with complex needs and isolated older people. However, much work was already happening, for example, with the adoption of the Violence Against Women and Girls and

Domestic Abuse Strategies. Adult Social Care was tackling social isolation through strength based approaches and the Independence & Wellbeing Team's Community Connectors. The homeless healthcare team had received additional funding to expand their services beyond housing. She wanted progress to continue and asked the HWB if there were any pieces of work or interventions that could be included in the priority so that it was more than the sum of its parts, for example, shared communications campaigns. She asked how partners could use their might as the HWB to accelerate matters. Changing Futures (a programme for adults with complex needs) would be a good focus for the HWB's next informal meeting but perhaps it could be progressed faster.

Kelly Nash noted the way the report connected examples was valuable as it showed how partner organisations built positive relationships amongst professional groupings. It highlighted how they worked was valuable as well as what they did.

James Hill was happy for his Directorate to participate with housing related matters and to continue to take a whole system view. The council had a tendency to carve up the city which was not wrong but the HWB's informal sessions gave the opportunity to challenge how services were designed against particular needs.

Others agreed that organisations needed to consider how to deliver services differently rather than "slice and dice" needs. It was important to treat people holistically to find out their real and embedded needs and not just those they presented with. Jo York agreed, especially with services so stretched and winter approaching. There was a risk organisations could look inward but this was wrong as the crisis grew. For example, it could be that some people had an extended length of hospital stay because organisations did not know what to do with them. The Portsmouth Provider Partnership could consider a holistic approach when it did its winter planning. Andy Biddle agreed organisations could often over-medicalise or over-professionalise approaches. Organisations often had to fire fight but had the opportunity to change how they delivered services.

David Goosey said three serious case reviews (SCR) due to be published today (if the Coroner allowed) showing how social conditions had exacerbated the situations could be part of the discussion. As soon as homelessness was mentioned organisations looked to Housing to provide an answer but organisations needed to consider all services. Helen Atkinson agreed the SCRs were tragic. Two of them were discussed at the Combatting Drugs Partnership the previous day. Although she recognised some people had complex needs and were not always easy to support, organisations as multiple services had failed. The SCRs showed the impact of partner organisations' actions on people's lives.

Sarah Daly said the report showed the challenges and mounting pressures that schools faced and the importance of relationships and addressing trauma before learning could take place. She asked how the workforce could be made resilient and kept strong enough to work. If people were not sleeping or

eating well their relationships started to crumble. David Goosey noted the number of frontline practitioners who talked about vicarious trauma and asked how staff could be "repaired."

The Chair emphasised the importance of the language used to describe people. For example, calling someone a "patient" permeated through society so they were not thought of as a wholly rounded person. However, if they were thought of as a person they were seen holistically and not passed around services. He thanked officers for the report.

RESOLVED that the Health and Wellbeing Board

1. **Note the activity underway across partners in the city to support positive relationships and developing relational capital.**
2. **Consider whether there are other case studies that could usefully be shared across partners to build knowledge and effectiveness of interventions.**
3. **Consider if there are areas where further development or acceleration of work could be beneficial.**

31. Portsmouth as an age friendly city (AI 10)

Andy Biddle, Director of Adult Care, introduced the report and explained the "age friendly" theme brought services together for residents in the most helpful and meaningful way. There was not a separate strategy as the report pulled together the positive practices organisations were already doing for older people. ASC proposed to identify areas for development and collaboration on how to ensure Portsmouth was age friendly, including work between HWB meetings, and reports would return to the HWB and the Community Wellbeing, Health & Care portfolio. There were no financial implications as the activities described in the report were already being done. He also noted the links with other work to improve residents' lives, including on poverty.

Helen Atkinson was very supportive of the life course approach. Everything which had been discussed today impacted the life course. She mentioned the Marmot approach of the first 1,001 days of life being critically important for future physical and emotional health. Doing the best at every stage would impact positively on healthy ageing. It was noticeable how little age was respected in society whereas other cultures respected what older people could contribute.

Jo York noted how language was used, particularly with older people and hospital discharge, so perhaps organisations should talk more in a more age friendly approach and be more person centred. Health & Care Portsmouth and ASC could suggest their teams adopt this approach.

The Chair thanked all contributors to the report. If Portsmouth was an age friendly city it would be good for everyone.

RESOLVED that the Health and Wellbeing Board consider the information in the paper, and agree next steps as set out in paragraph 6.1.

32. Superzone pilot (AI 11)

Dominique Le Touze, Assistant Director of Public Health, introduced the report.

Sarah Daly welcomed the report as a positive step and looked forward to seeing the initiative rolled out across the city. Public Health's attendance had been well-received at a headteachers' meeting.

In response to the increasing challenges with vaping faced by primary and secondary schools, Ms Atkinson said that central government was aware of the problem. She was chair of the Regional Tobacco Control Group, which was launching tool kits for schools on how to tackle vaping in CYP. Mixed messages around vapes were confusing as their use was encouraged to help adults quit smoking but an unfortunate consequence was that they were marketed to children and young people, often in the same way alcopops were, for example, cheap and used bright colours and sweet flavours. As well as damaging health there were environmental concerns with the litter that disposable vapes created. The council wanted to give a clear message so there was considerable communications work with young people and schools as well as work with ASH (Action on Smoking and Health) and the Royal Colleges to ban disposable vapes. The HWB noted that the council's Trading Standards team had recently closed down a vape shop, which showed what could be achieved across the council as vapes were not just one department's problem.

There had not been interest from other headteachers yet in the Superzone pilot but Public Health were in touch with Superzone schools in London boroughs as they would like to work with other schools in Portsmouth.

The Probation Service asked how they could help with promoting school meals for adults under their supervision. Dominique Le Touze welcomed support as the council was working on the same issue and was particularly looking at work on the opt out from meals in Sheffield. In the current economic climate they especially wanted to promote sources of healthy food. The lunch box audit had shown that boxes often contained either a low amount or poor quality food.

James Hill proposed recording a note of thanks to Public Health and the University of Portsmouth for the Athletic Skills Garden, due to open in October and to which HWB members would be invited. It would be good to see if it could be rolled out across the city.

The Chair noted that there had been competition to be the first city to launch an Athletic Skills Garden. It would benefit neighbouring schools as well as residents.

RESOLVED that the Health and Wellbeing Board note the update.

The next meeting is at 10 am on Wednesday 29 November. Dates for 2024 meetings (all Wednesdays at 10 am) are 6 March, 26 June, 25 September and 27 November.

The meeting concluded at 11.48 am.

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Councillor Matthew Winnington (Chair) and Dr Linda Collie

THIS ITEM IS FOR INFORMATION ONLY
(Please note that "Information Only" reports do not require Integrated Impact Assessments, Legal or Finance Comments as no decision is being taken)

Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Subject:	Portsmouth Safeguarding Adults Board: Annual Report 2022-23 and Safeguarding Adults Reviews
Date of meeting:	29 November 2023
Report by:	Portsmouth Safeguarding Adults Board Independent Chair
Wards affected:	All

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1. **Requested by** Portsmouth Safeguarding Adults Board Independent Chair

2. **Purpose**

To provide an update on the recent work of the Portsmouth Safeguarding Adults Board (PSAB) in 2022-23 and to highlight the learning from three recently published Safeguarding Adults Reviews (SARs).

3. Information Requested

PSAB Annual Report 2022-23

The Care Act 2014 requires Safeguarding Adults Boards to publish a report on their activities each year (Appendix A).

Key achievements in 2022-23 were:

- Held an adult safeguarding conference which brought frontline professionals from different organisations together and heard from service users.
- Introduced a new PSAB newsletter to share information and good practice with the workforce.
- Published a new Multi-agency Framework for Managing Risk and Safeguarding People Moving into Adulthood.
- Addressed issues arising from the closure of a number of care homes in the city by holding a multi-agency workshop investigate barriers to earlier identification of safeguarding concerns in care homes.
- Commissioned a peer review to help the PSAB to gain assurance about how well the safeguarding system is working.

Priorities for 2023-24 are:

- Publish a new strategy and action plan for 2023-24 onwards, including resolving the ongoing resourcing issues for the PSAB.
- Hold another Safeguarding Adults Conference on the theme of Managing Risk.

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- Review the Multi-Agency Risk Management Framework and produce new tools for professionals to help them manage risk effectively.

Safeguarding Adults Reviews (Kim, Ronnie and Paul)

The Care Act 2014 requires Safeguarding Adults Boards to carry out reviews of cases in certain circumstances, and gives them the discretionary power to review any case involving an adult with care and support needs in their area. In October 2023, the PSAB published reviews of the deaths of three adults, all of whom were experiencing homelessness at the time of their deaths (appendices B, C and D). These reviews were discretionary reviews and were carried out because the individuals had experienced abuse or neglect in the period leading up to their deaths and it was felt there was important learning about how services worked together to keep them safe. The reviews also built on the learning from the thematic review of homeless deaths published by the PSAB in 2022.

The following key themes emerged from the learning from the reviews:

- *Multi-agency risk management:* risk was not managed effectively with the appropriate level of oversight and accountability, and the existing Multi-Agency Risk Management (MARM) framework and toolkit was not used.
- *Legal literacy*: the Care Act and other legal frameworks were not always used effectively to keep the adults safe.
- *Accommodation and support*: there are a lack of accommodation and support options for adults with complex needs who are experiencing homelessness.
- *Roles and responsibilities:* services were not always clear about each other's roles and responsibilities, particularly when working across the statutory and voluntary sector.
- *Whole family approach:* services did not always recognise the person's family networks, or take into account the needs of all members of the family.
- *Marginalisation, stigma and unconscious bias:* there was evidence that adults with complex needs sometimes experience marginalisation, stigma and unconscious bias, which can create a barrier in seeking effective support from services.

Action plans have been developed to address the recommendations and are being monitored by PSAB's Quality Assurance subgroup.

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Signed by (Director)

Appendices:
Appendix A: PSAB Annual Report 2022-23
Appendix B: Kim Safeguarding Adults Review
Appendix C: Ronnie Safeguarding Adults Review
Appendix D: Paul Safeguarding Adults Review

Background list of documents: Section 100D of the Local Government Act 1972
The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

Portsmouth Safeguarding Adults Board

Annual Report

2022 - 2023

Statement from the Independent Chair

I am pleased to introduce the annual report of the Portsmouth Safeguarding Adults Board for 2022-23.

It was a busy year - we published three Safeguarding Adults Review reports; two relating to the deaths of older people who experienced neglect, and a third report on the theme of homelessness, which reviewed the experiences of four men who died. Details of the learning from these reviews can be found later in this report and on the Board's website.

In respect of Mrs E and Mr F, the older people who experienced neglect, improvements to the way multi-agency risk assessments are conducted would have helped, as would better information sharing between the agencies. The thematic review into homeless deaths demonstrated that some homeless adults struggle to navigate a complex system, which can mean the risks they face are not well understood. We are currently completing action plans for these reviews.

During the year, we engaged with a peer review provided by colleagues from the Association of Directors of Adult Social Services. By being 'critical friends', these colleagues helped the Board to review its work, systems, and structures. The review led to several recommendations, detailed later in this report, and helped the Board to reconsider its strategic direction.

We have focused on developing better community engagement, facilitating improvements in interprofessional and inter-agency working, and reviewing practice whenever possible. Actions under each of these headings have been progressed, but the peer review enabled a desire for further change in the way the Board does its work. At the tail end of 2022-23, work had started on these changes and will be reported on in next year's annual report.

In September 2022, we organised a conference to bring together people from the different agencies that make up the Board. The spotlight for the conference was hearing about what it is like to be at the 'coal face' of safeguarding work in Portsmouth. Several groups of practitioners showcased their work and presented information about the daily challenges they face.

Everyone who attended found it a powerful and useful learning experience, and we hope to offer an annual conference now that COVID-19 has receded sufficiently to enable large face-to-face gatherings.

The work of the Board is facilitated by only two people (Alison and Wendy) who work strenuously and achieve a great deal. The key achievements noted in this report are a testament to their efforts, and my thanks go to them for all that they do.

David Goosey

Independent Chair

Our vision

"Working throughout the city with our communities and other partnerships to make Portsmouth a city where adults at risk of harm are safe and empowered to make their own decisions and where safeguarding is everyone's business."

Our strategic priorities

During 2021-22 we refreshed our strategy, aiming to be more ambitious and link with the work of other strategic partnerships in Portsmouth - including the Health and Wellbeing Board.

The strategy and its supporting action plan set out the following priorities:

1. **Community engagement**: to engage more effectively with our service users, carers, and communities, including people from groups we have not always engaged with in the past, such as homeless adults and adults who misuse substances.
2. **Interprofessional practice and relationship-based practice**: to build a competent, confident workforce, by supporting professionals from different agencies to work together.
3. **Safeguarding practice**: to continue our efforts to review experience when things have not gone as planned and to publicise best practice.

We have made progress in relation to these priorities by:

- **Developing the work of the new engagement subgroup**, which has expanded its membership and has been gathering information on services working with different communities.
- Holding an **adult safeguarding conference** which brought frontline professionals from different organisations together and heard from some service users (see conference report on page seven).
- Establishing a new Portsmouth Safeguarding Adults Board quarterly **newsletter** to share information and good practice with the workforce.
- Developing a **Systems Learning and Improvement Framework** (SILF) to bring together learning from reviews across the Four Local Safeguarding Adults Boards (4LSAB) area - Portsmouth, Southampton, Hampshire, and Isle of Wight.
- **Reviewing our subgroups' terms of reference** and working with the new health subgroup to extend its focus from Hampshire to 4LSAB.

We also started consulting on our strategic plan for future years, building on what we have achieved this year.

Other key achievements in 2022-23

This year, the Board has:

- Published a new **Multi-Agency Framework for Managing Risk and Safeguarding People Moving into Adulthood**. This framework was developed to strengthen the safeguarding support available to young adults aged 18 years with pre-existing vulnerability and risk factors as they move into adulthood. It recognises that safeguarding arrangements for young adults need to take account of their distinct safeguarding needs. Portsmouth City Council's adults and children's services are now working together alongside partners to introduce a Transitional Safeguarding Panel to help put the framework into practice.
- Published a new **briefing for practitioners on homelessness,** which was developed by the housing subgroup as part of the action plan in response to our thematic Safeguarding Adults Review of the deaths of four homeless people**.** The four Boards held an online launch event which was attended by 90 people.
- Addressed issues arising from the closure of a number of care homes in the city by holding a **multi-agency workshop to investigate barriers to earlier identification of safeguarding concerns in care homes.** This resulted in recommendations and a series of workstreams to address them, which will be reported back to the Board.
- Completed **multi-agency audits** to provide assurance to the Board about the effectiveness of safeguarding in Portsmouth. The first was on the quality of safeguarding referrals submitted to the Adult Multi-Agency Safeguarding Hub (MASH) and the quality of decision-making about these referrals. The second was carried out jointly with the Portsmouth Safeguarding Children Partnership (PSCP) on transition, and set out to assure the Board that changes made in response to the Mr D Safeguarding Adults Review, which was published in 2019, had been effective.
- Requested that partners carry out an **organisational safeguarding self-audit** to help them evaluate the effectiveness of their internal safeguarding arrangements and to identify and prioritise any areas needing further development. The Board analysed the results and identified common themes for further work, including an increased focus on Making Safeguarding Personal (MSP) and better understanding of the Mental Capacity Act (MCA).
- Supported **National Safeguarding Adults Week 2022**. Working jointly with the other 4LSABs, the Board developed and promoted resources on a different key topic each day using our website and social media. The Portsmouth Prevent Team also hosted two virtual events during the week.
- Continued our **focus on alcohol and safeguarding**. We commissioned further training from Alcohol Change UK and received a presentation from the alcohol care team at Portsmouth Hospitals University NHS Trust. As a result, a task and finish group is being set up to look at the pathways and services for users of this service.
- Reviewed and revised the **Multi-Agency Hoarding Guidance**.

Case study**: **Managing Risk and Safeguarding People Moving into Adulthood (Bea*)

Bea is an 18-year-old young woman living in supported living accommodation. She was in local authority care as a child and was being supported by leaving care services. Bea received support from Child and Adolescent Mental Health Services (CAMHS) but was not known to Adult Mental Health services and missed several GP appointments to discuss her mental health. Support workers became increasingly concerned as Bea was frequently going missing for a week or more at a time. The last time Bea was reported missing, the police located her 80 miles away with people who have been linked to county lines drug dealing. Bea has recently disclosed that she has a new boyfriend who is reportedly 10 years older than her and who tells her not to inform staff of her whereabouts. Other young adults within the accommodation have said that Bea has self-harmed and upon her return appears under the influence of substances.

A safeguarding concern was raised by Bea's personal assistant within the local authority through care team due to concerns that she may be at risk of, or experiencing, domestic abuse and/or sexual or criminal exploitation. The adult safeguarding team, in partnership with the leaving care service, applied the Multi-Agency Risk Management Meeting (MARM) framework.

Bea disclosed that her boyfriend was asking her to stay at addresses she felt uncomfortable with. Bea consented to a referral to a voluntary sector organisation that supports young people aged 18+ who may be at risk of trafficking. Neighbourhood policing teams have spoken with Bea and provided safeguarding advice. Bea felt empowered to speak to her GP and, though she doesn't yet feel ready to begin therapy, she has been accessing Samaritans telephone support. Bea is now working with the team of professionals around her to explore career aspirations.

*Name changed to protect identity

Peer review

The Board commissioned a peer review of adult safeguarding from the South East Association of Directors of Adult Social Services. The aim of the review was to gain some constructive challenge from a group of 'critical friends' to help the Board to understand and gain assurance about how well the safeguarding system is working. Peer reviewers visited Portsmouth and spoke to a wide range of staff and managers from different organisations. They also carried out a staff survey, did a case file audit, and looked at data and documents.

Some of the key messages included:

- Passion about Portsmouth and determination to work together to make people safe
- Well led and 'good analytical chairing of the board'

- Almost all survey respondents were confident that they knew how to raise a safeguarding concern, that they could access safeguarding policies and procedures and that they had undertaken adequate safeguarding training for their role

Good practice was highlighted in relation to Portsmouth City Council's safeguarding functions:

- The triage process was robust
- Safeguarding professionals were regarded as skilled, helpful and professional in their approach
- Safeguarding enquiries were largely person centred and inclusive of the person's wishes, views and outcomes

The suggested actions included:

Portsmouth Safeguarding Adults Board:

- Review PSAB current representation, roles, responsibilities and how Board issues and actions are fed back into their home organisations
- Widen the membership of the Board to include representatives from people with lived experience, unpaid carer organisation(s), communities of interest, voluntary and community sector umbrella organisations, and the business community.
- Track Safeguarding Adults Review and other recommendations over time and share with practitioners to ensure changes are embedded into practice

Portsmouth City Council:

- Multi-Agency Safeguarding Hub (MASH)
    - Review organisation and capacity
    - Training and education
- Consider undertaking a review of Mental Capacity Act training and a plan to then audit whether Mental Capacity Act has become part of practice
- Consider how to ensure that the children's safeguarding process is understood by Adult Social Care practitioners and the Multi-Agency Safeguarding Hub
- Consider establishing a framework for safeguarding meetings which involve the person as much as they wish to be involved.

An action plan has been developed to address the areas raised in the peer review and this is being monitored by the Board.

PSAB Conference and Training Programme

In 2022-23, for the first time, we secured contributions from non-statutory Board members which were ringfenced to provide multi-agency training and development in line with a training needs analysis which we carried out with our partners.

Our multi-agency training offer included:

- Safeguarding concerns online training

- Safeguarding concerns e-learning, delivered on the PSAB website
- Transition learning event
- Safeguarding Vulnerable Dependent Drinkers, including Mental Capacity Act
- Emotionally Unstable Personality Disorder
- PREVENT
- Mental Capacity Act and Executive Functioning
- Chairing Multi Agency Risk Management Framework (MARM) Meetings
- Homelessness and the Duty to Refer

"Very in depth and gave many examples which helped with my understanding"
~ Attendee at Safeguarding Concerns training

"It was obvious from those delivering the training that they have great expertise and are very passionate about what they do. It made me feel confident to be able to approach the team and have conversations."
~Attendee at Homelessness Training

On 28 September, we held a Portsmouth Safeguarding Adults Board conference at Portsmouth Football Club - 'Safeguarding adults at risk: Feedback from the frontline'.

This was a conference with a difference - rather than hearing from leaders and experts, the aim of the conference was to hear from practitioners about what it is really like to do safeguarding work and the challenges they face on a daily basis. We also heard from people with lived experience of homelessness and substance misuse, and service users from the Integrated Learning Disability Service.

Attendees were encouraged to be curious, make new connections and find out about each other's roles. The conference was a great success, with over 100 people attending from a mix of organisations, including adult social care, housing, health, police, fire, and the voluntary sector. There was a real buzz about the day and the feedback was very positive, with lots of comments including "fabulous for networking", "fantastic", and "a warm and friendly atmosphere".

Volunteers from the Chat Over Chai community group presenting about their experiences of working in Portsmouth.

Learning from Safeguarding Adults Reviews

The Care Act 2014 states that a Safeguarding Adults Review (SAR) must take place when there is reasonable cause for concern about how the Safeguarding Adults Board, members of it, or others, worked together to safeguard an adult with care and support needs, and death or serious harm arose from abuse or neglect.

The Care Act also gives Safeguarding Adults Boards the discretionary power to review cases where these criteria are not met.

The Board has a SAR subgroup which is multi-agency, with members who have a specialist role or experience in safeguarding adults. The group holds bi-monthly meetings and during 2022-23 met jointly with the PSCP Learning from Children & Practice Committee (LCPC) when there were cases involving both children's and adult services.

Summary of SAR activity during 2022-23

The Board published three Safeguarding Adults Reviews in 2022-23: 'Mrs E', 'Mr F', and a 'Thematic review following the deaths of Mr G, Mr H, Mr I and Mr J', the findings of which are outlined in the next section.

There were 10 new SAR referrals received in 2022-23. SARs have been commissioned for four of these cases and the reviews will be published in 2023-24.

The other six cases did not meet the criteria for a mandatory SAR, and it was not considered that a discretionary SAR was required. Two of these are subject to a domestic homicide review. For one of the other cases, the SAR subgroup reviewed the information held by different agencies about the adult and concluded that the criteria for a mandatory review were not met, but the case was referred to the

Hampshire Safeguarding Adults Board as concerns were identified about services in Hampshire.

Mrs E - Safeguarding Adults Review

The Mrs E SAR was published in June 2022 alongside the Mr F SAR, which had some similar themes. Mrs E was a frail older woman in her eighties with a diagnosis of dementia and complex physical and mental health needs. She lacked mental capacity in relation to decisions about her care and support needs. Her main carers were her son and her husband. There were safeguarding concerns about Mrs E in 2019, but Mrs E was not seen face-to-face by any services after December 2019 due to the coronavirus pandemic.

Mrs E died at home in June 2020. Mrs E was found in a poor state and covered in dried faeces, and her family had delayed calling an ambulance for several days after she became acutely unwell. Her death was found to be partly due to an infected pressure sore.

The SAR was conducted by an independent reviewer and the key findings were:

1. There was some good practice in how professionals had applied the Mental Capacity Act. However, there was no review or monitoring following the decision to cancel paid carers, despite the high risk of neglect.
2. The care was cancelled by the family in part due to financial concerns, which increased the risk of harm to Mrs E. Some safeguards could have been put in place to ensure the family was not misusing Mrs E's money.
3. There was little evidence of multi-agency communication and information sharing.
4. Mrs E could have been offered an advocate to help make her views known.

The Board accepted the findings of the review, and a multi-agency action plan was developed, drawing together actions from both the Mrs E and Mr F reviews.

A learning briefing was also developed for practitioners, giving key points for learning and reflection to improve frontline practice.

Mr F - Safeguarding Adults Review

Mr F was a man in his eighties who had several mental and physical health conditions. Mr F lived with his stepson, who was his main carer. Mr F was referred to Adult Social Care and following a hospital admission, he was discharged with a package of care.

He reduced his care package and eventually cancelled it, putting him at significant risk of harm. Although he was considered to have mental capacity to make this decision, he was influenced by his stepson, and his mental capacity was sometimes doubted by professionals. Professionals had concerns about the care provided by Mr F's stepson. In September 2019, Mr F was found in a poor condition by a visiting professional who called an ambulance. No action had been taken by his stepson. Mr F died in hospital three days later.

An independent reviewer carried out the SAR and the key findings were:

1. There was good practice identified in the determination and persistence of frontline staff in continuing their contact with Mr F, despite Mr F's resistance to care and treatment.
2. Mr F's mental capacity was never formally assessed, despite the doubts of professionals, which meant there was no clarity about the legal framework for interventions.
3. The coercion by his stepson and how it influenced Mr F's decisions was not recognised.
4. It was suspected that Mr F's care package may have been cancelled for financial reasons. This could have been explored further and options considered to enable care to continue.
5. Professionals did not take opportunities to use the Multi Agency Risk Management framework to work together to address the risks to Mr F more robustly and in a coordinated way.
6. There could have been better information sharing between professionals.
7. Mr F could have been supported by an independent advocate.

The action plan for the Mrs E and Mr F reviews is being monitored by the Quality Assurance subgroup.

Actions planned or carried out include:

- Adult social care have appointed a Mental Capacity Act lead, who has been working on training and audit to improve Mental Capacity Act practice.
- A case review of adults living in the community without capacity to consent to their care and support arrangements, to assure the Board of practice in this area.
- Actions to raise awareness among staff of financial abuse, the Multi Agency Risk Management Framework, palliative care, escalation, and advocacy.
- A review of training to ensure that coercion and control is well understood.
- Improvements in how information is shared with care providers.

Thematic Safeguarding Adults Review

During 2020, the PSAB's monitoring of the deaths of adults who were experiencing homelessness highlighted that there had been a number of similar deaths at this time. The PSAB decided to carry out a discretionary thematic review to see what could be learned and to identify improvements in the way services in the city support homeless people. Four cases were chosen because they seemed representative.

The review highlighted the unprecedented challenges experienced by individuals and services at the height of the coronavirus pandemic in 2020 and made a number of recommendations for change. The key findings from the review were:

1. Homelessness is not routinely recorded by health services, leading to difficulties in identification and in prioritising interventions.
2. Supported accommodation for homeless people is not commissioned to provide high levels of support, and there is a lack of housing available for people who want to abstain from substances.

3. Services for homeless people can be hard to navigate, and services are not always clear about each other's roles.
4. The impact of long-term alcohol and drug use on mental capacity needs to be recognised in assessments.
5. Homeless people need to be listened to and respected but feel blamed.
6. There are challenges in relation to prison release.
7. Services do not always consider the person's family relationships.

A significant amount of work has already been done to improve outcomes for homeless people, including:

- The introduction of a healthcare team based in Portsmouth City Council's homeless day service
- Strengthened links between housing and social care services, including a specialist council social worker based in the homeless service run by the Society of St James
- Homeless liaison officers from Two Saints based at Queen Alexandra Hospital, who support patients and visitors with housing issues
- A new Probation Navigator role, to help people released from prison who are at risk of homelessness
- New substance-misuse services, including abstinent housing
- Publication of new 4LSAB guidance on homelessness to support staff
- Training for staff on homelessness services in Portsmouth and the statutory Duty to Refer
- Training for staff on mental capacity and alcohol, and mental capacity and executive functioning.

An action plan has been developed, which is being monitored by the Quality Assurance subgroup. Planned actions include:

- A refresh and relaunch of the Family Approach toolkit
- Escalating learning about prison release and homelessness at a national level.

4LSAB Fire Safety Development Subgroup

In addition to the work of the SAR subgroup, the 4LSAB Fire Safety Development subgroup has continued to review and share learning from serious fire incidents, to ensure that effective inter-agency processes, procedures and preventative practices are in place. The subgroup published a learning briefing in November 2022 to highlight the learning established from the 15 fire deaths or near misses reviewed across the 4LSAB area in the preceding year.

4LSAB System Improvement and Learning Framework (SILF)

The SILF is a new initiative, set up to give the four local Safeguarding Adults Boards the opportunity to look more broadly and delve a little deeper than a SAR can and to triangulate the regional learning from SAR findings to understand the functioning of the safeguarding system. This includes aspects of safeguarding delivery that (a) are

functioning well and (b) that need improvement. The work is in its early stages, and the working group has developed coding techniques to establish themes to articulate the underpinning ‘why’ reasons behind the more surface learning about ‘what happened’ in a case.

Safeguarding activity in Portsmouth

Safeguarding Duty

Under Section 42 of the Care Act, a local authority has a duty to make enquiries, or cause others to make enquiries, in cases where it has reasonable cause to suspect:

- That an adult has needs for care and support (whether or not the local authority is meeting any of those needs) and
- Is experiencing, or is at risk of, abuse or neglect and
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or experience of, abuse or neglect.

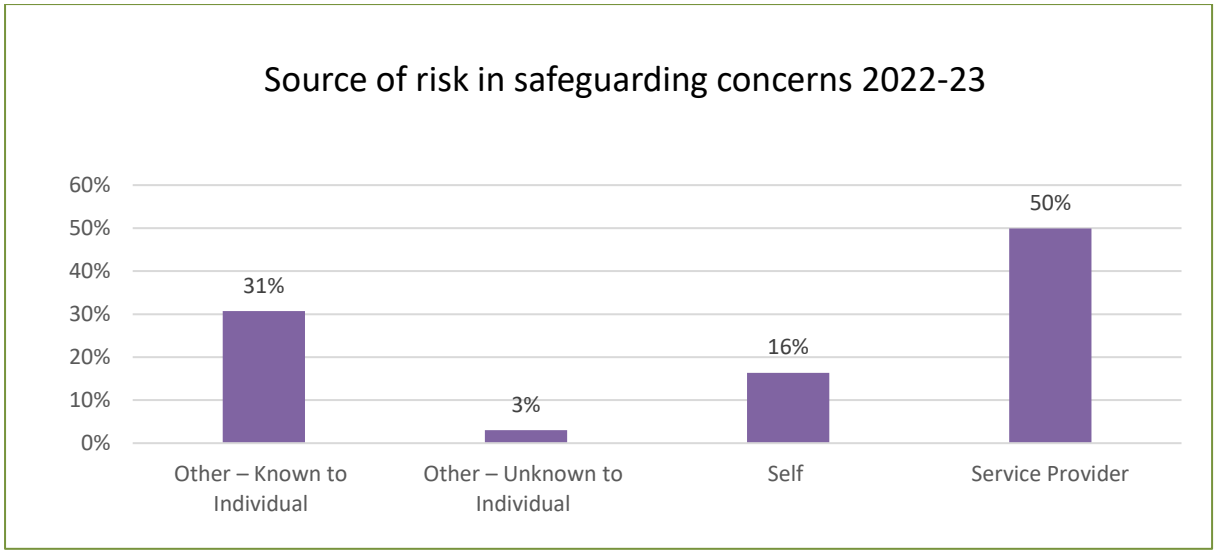
Portsmouth has an Adult Multi-Agency Safeguarding Hub (MASH) with a team of social workers and police officers working together who have direct links with colleagues in areas such as health, trading standards, and children's safeguarding. The MASH manages a high volume of referrals.

Data collected by the MASH gives further information about who has experienced abuse or neglect in Portsmouth, where abuse has taken place, and the types of risk they have experienced. The information below is taken from the NHS Digital Safeguarding Adults Collection end of year return.

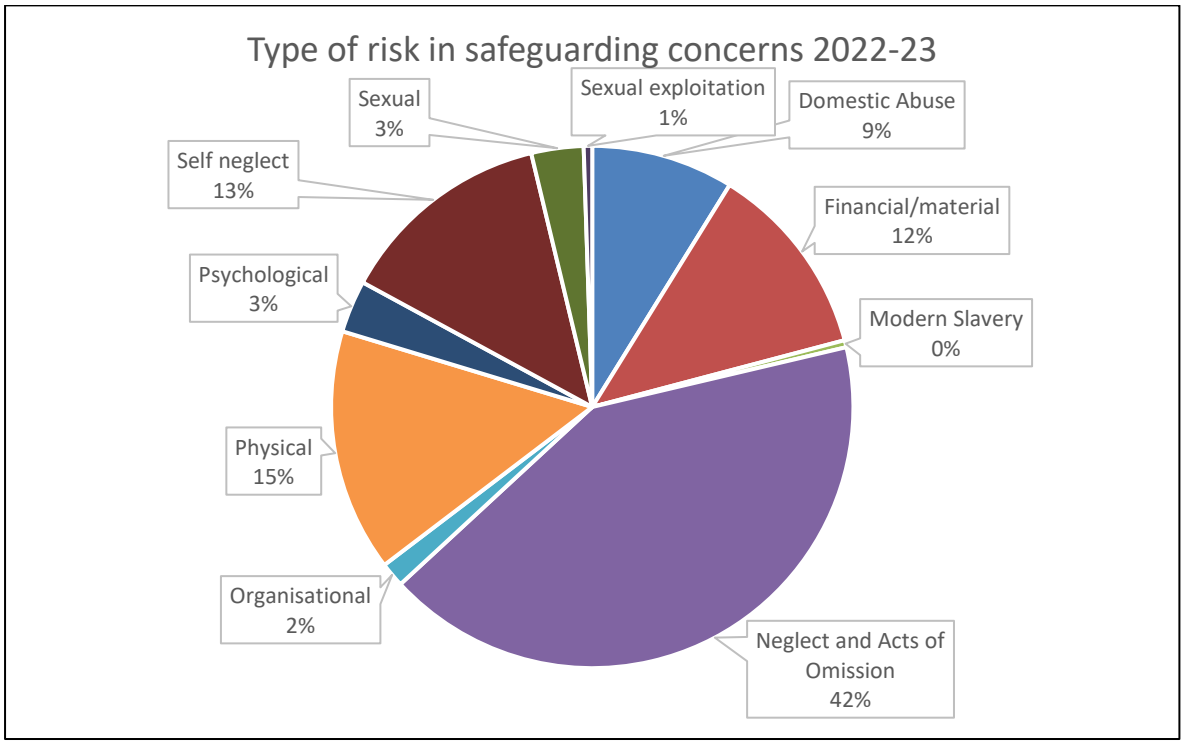
If an issue about an adult's safety or welfare is raised with the MASH, it is called a safeguarding concern. The MASH will assess the concern and take appropriate action.

There were 2,181 concerns raised in 2022-23.

More information about the safeguarding concerns is shown below.



The chart above shows the source of risk in safeguarding concerns from 2022-23. The sources are shown as follows: 31% - other, known to individual, 3% - other, unknown to individual, 16% self, and 50% service provider.



The chart above shows the type of risk in safeguarding concerns from 2022-23. The types of risk are shown as follows: neglect and acts of omission - 42%, organisational - 2%, physical - 15%, psychological - 3%, self neglect - 13%, sexual - 3%, sexual exploitation - 1%, domestic abuse - 9%, financial/material 12%, and modern slavery - 0%.

If a safeguarding concern meets the criteria from section 42 of the Care Act (see above) a Safeguarding Enquiry will be initiated. The local authority has the power to carry out discretionary enquiries if the criteria are not met.

842 formal Safeguarding Enquiries were concluded in 2022-23.

In 99% of enquiries where risk was identified, action taken led to the risk being reduced or removed.

In line with 'Making Safeguarding Personal (MSP)', where possible, the adult involved in the enquiry will be asked about what they want to happen or what they want to be achieved during the enquiry. In 97% of cases when the adult expressed their desired outcomes, these were fully or partially achieved at the conclusion of the enquiry.

The Board also receives data regularly from Portsmouth City Council housing and trading standards services, Portsmouth Hospitals University NHS Trust, Solent NHS Trust, Hampshire Constabulary, and Hampshire and Isle of Wight Fire and Rescue Service.

In 2022-23 Hampshire Constabulary reported:

- 17 incidents of honour-based violence where the victim was over 18
- 0 incidents of trafficking of a person over 18
- 765 high risk domestic crimes
- 768 incidents of hate crime.

Hampshire and Isle of Wight Fire and Rescue Service carried out 857 safe and well visits in Portsmouth in 2022-23.

There were 2 domestic homicides in Portsmouth in 2022-23.

There were 0 fire deaths in Portsmouth in 2022-23.

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Glossary

4LSAB - The Portsmouth, Southampton, Hampshire and Isle of Wight Safeguarding Adults Boards.

CCG - Clinical Commissioning Group. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. In July 2022 the CCGs ceased to exist and were replaced by Integrated Care Boards (ICBs).

ICB - Integrated Care Board. An NHS organisation responsible for developing plans to meet the health needs of the population which includes managing the NHS budget and arranging for the provision of health services within an Integrated Care System (ICS).

ICS - Integrated Care System. Integrated care systems are partnerships of organisations that come together to plan and deliver joined up health and care services.

LCPC - Learning from Children & Practice Committee (a committee of the Portsmouth Safeguarding Children Partnership, which also meets jointly with the Safeguarding Adults Review subgroup of the Portsmouth Safeguarding Adults Board).

LSAB - Local Safeguarding Adults Board

MARM - Multi-Agency Risk Management

MASH - Adult Multi-Agency Safeguarding Hub. A multi-agency team including social workers and police officers which is the first point of contact for adult safeguarding concerns.

MCA - Mental Capacity Act 2005. The Act is in place to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment.

MSP - Making Safeguarding Personal. A personalised approach that enables safeguarding to be done with, rather than to, people.

NHS - National Health Service

PREVENT - A government strategy to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism. Prevent is about safeguarding people and communities from the threat of terrorism.

PSAB - Portsmouth Safeguarding Adults Board. A multi-agency partnership which oversees and coordinates work to keep adults at risk safe in Portsmouth.

PSCP - Portsmouth Safeguarding Children Partnership. A partnership which brings together all the main organisations who work with children and families in Portsmouth, with the aim of ensuring that they work together effectively to keep children safe.

SAB - Safeguarding Adults Board

SAR - Safeguarding Adults Review. A multi-agency review process which Safeguarding Adults Boards must carry out to identify learning when an adult at risk dies or is seriously harmed as a result of abuse or neglect, and there are concerns about the way in which organisations worked together to safeguard the adult.

SILF - 4LSAB System Improvement and Learning Framework

Appendix

What is Safeguarding?

“Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.” (Care Act 2014)

Who are we?

The Portsmouth Safeguarding Adults Board (PSAB) is a partnership of key organisations in Portsmouth who work together to keep adults safe from abuse and neglect. These include:

- Adult social care
- Health
- Emergency services
- Probation services
- Housing
- Community organisations.

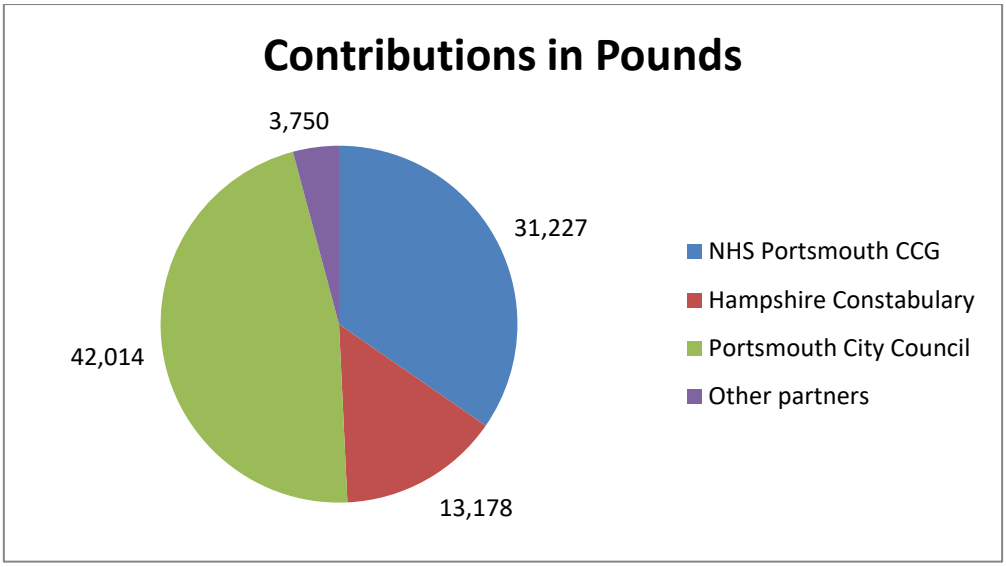
The Board has an independent chair that can provide some independence from the local authority and other partners. This is especially important in terms of:

- Offering constructive challenge
- Holding member agencies to account
- Acting as a spokesperson for the Board.

The Board is funded through contributions from its statutory partners (Portsmouth City Council, NHS Portsmouth Clinical Commissioning Group[1] and Hampshire Constabulary). Other partners also made contributions for the first time in 2022-23, which were ringfenced for training and development.

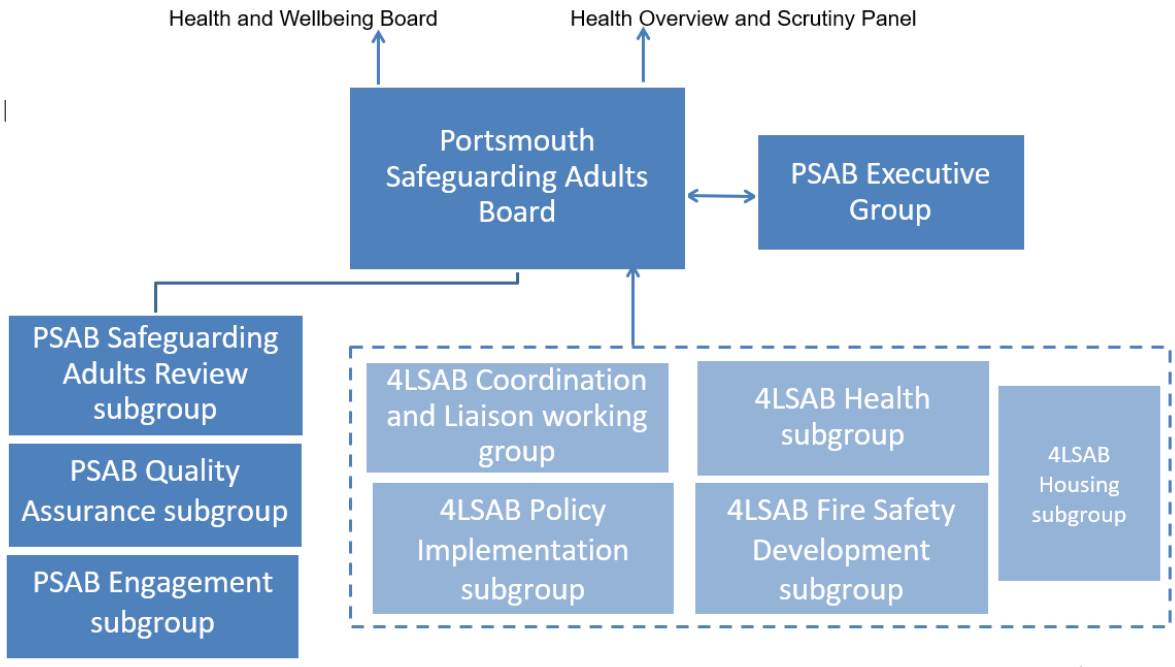
The contributions received in 2022-23 were:

[1] NHS Portsmouth Clinical Commissioning Group ceased to exist on 1 July 2022 and the new statutory partner is Hampshire and Isle of Wight Integrated Care Board.



The diagram above shows the contributions in pounds received by the Portsmouth Safeguarding Adults Board. The contributions are shown as follows: NHS Portsmouth CCG - 31,227, Hampshire Constabulary - 13,178, Portsmouth City Council - 42,014 and other partners - 3,750.

The structure of the Board and its subgroups is shown in the diagram below. In the areas of policy implementation, fire safety and housing, we have shared '4LSAB' subgroups with the neighbouring Boards (Hampshire, Southampton and the Isle of Wight). This helps ensure that we are working in a joined-up and coordinated way with our partners across the region on common priorities.



Portsmouth Safeguarding Adults Board

'Kim' Safeguarding Adults Review

What is a Safeguarding Adults Review?

The primary purpose of a Safeguarding Adults Review (SAR) is to draw out organisational learning about how the local agencies are working together, to support improvement.

Under section 44 of the Care Act 2014, Safeguarding Adults Boards (SABs) must arrange a SAR when an adult in its area with care and support needs 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. They may arrange a SAR for other cases under section 44(4), for example where there is important learning to be identified.

The Portsmouth Safeguarding Adults Board (PSAB) SAR subgroup considered the case referral for Kim at their meeting on 14.09.22. As the death of Kim also involved the death of her unborn baby, the PSAB met again with the Portsmouth Safeguarding Children Partnership (PSCP) Learning from Children and Practice Committee on 11.01.23, when it was concluded that the above criteria had not been met. It was decided to carry out a discretionary review under section 44(4) of the Care Act.

The Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

Who was Kim?

It is important for the SAR to place Kim at the centre of the work. Kim's family have been involved with the review throughout, and it was the family's wish that Kim's name be used in this report, instead of a pseudonym. Kim was a White British woman. Her sister attended the workshop for practitioners and provided some information about her life and personality. The information is summarised in this section.

Kim was 36 years old when she passed away in August 2022. All her family miss her and wish that both her and her baby boy were here with us today.

Kim was my younger sister, she was blonde haired, pretty and had a real mischievous side to her. From the moment she was born she had us laughing with things she would say and do, she had so much fun and laughter in her from the very start. She certainly made some mistakes and sometimes she did the wrong thing, but the real Kim was kind, caring, funny and a person that many people loved to be around.

One of my memories of Kim is that she was a huge fan of Michael Jackson growing up and that never changed, if a song of his came on the radio she would sing it on the top of

her lungs and would imitate his dance moves, she didn't do a bad moonwalk… but her singing was a different story!

Kim was always able to make friends easily and she was a good friend to have. She could talk to anyone, it didn't matter where or who she was with. She was kind, she was loyal and would give you the shirt off her back if you asked. Even times when Kim was struggling and going through tough times, she was still always polite and respectful to people she interacted with.

Kim loved her family. In the later years we didn't always see her that often, but we know she cared and I like to think she knew how much we loved and cared for her too. She's left behind two sons who both miss her. They have fond memories of family bike rides round the park and trips to the cinema.

Kim did well with her first two pregnancies. For the first pregnancy she lived with her dad. Kim was able to go through the term of her pregnancy with just methadone[1] to help control her addiction. Kim maintained this after the baby's birth and took really well to motherhood but eventually she did slip and moved out from her dad's when her son was around 4 years old. Her son remained with his nana and grandad who were eventually granted special guardianship.

During Kim's second pregnancy, she was given housing at a hostel for vulnerable families experiencing homelessness, where she did well. Kim was able to complete the term of her pregnancy once again with methadone to help control her addiction. Kim was a good mum for many months and coped well but eventually she started to slip into old patterns. Eighteen months later Kim had to move into other accommodation [where alcohol was allowed] where her son could not go with her. He came to live with me, Kim's sister, on a temporary basis whilst Kim took steps to change her lifestyle, but unfortunately this didn't happen and I was eventually granted special guardianship.

Key events leading up to Kim's death

- September 2021 - Kim was released from prison and was placed at the Registry[2] by Portsmouth City Council Housing services.
- December 2021 - Kim reported difficulties with sleep and anxiety and spoke to the Solent NHS Homeless Health Care Mental Health Nurse.
- January 2022 - There were concerns about Kim's increased substance misuse including incidents when Kim was found unconscious. Regular multi-agency meetings were taking place, coordinated by Integrated Offender Management (IOM).[3] A referral was made to the Adult Multi-Agency

[1] Methadone is a synthetic opiate manufactured for use as a painkiller and as a substitute for heroin in the treatment of heroin addiction.

[2] The Registry is a service commissioned by Portsmouth City Council and provided by the Society of St James. It accommodates up to 41 adults at risk of rough sleeping and provides a high level of housing-related support.

[3] Integrated Offender Management (IOM) brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together. IOM involves working closely with each offender and partner organisations to identify the root cause of offending including any

Safeguarding Hub (MASH). This was triaged and, as a result, the use of the Multi-Agency Risk Management Framework (MARM) was recommended, but the referral was closed by the MASH as there were already a range of professionals supporting Kim.

- January 2022 - Kim was experiencing domestic abuse and a referral was made to Stop Domestic Abuse, the specialist domestic abuse service. She was offered 'Respite Rooms'[4] accommodation but declined this. Kim said she wanted to move into Recovery Housing, but this pathway was assessed as being insufficient to meet her need for 24-hour support.
- Late January 2022 - Kim's pregnancy was confirmed and a referral was made to Children's Services. Kim requested detoxification for alcohol and benzodiazepines.
- February 2022 - an inpatient alcohol detoxification was agreed. Kim missed appointments with midwifery and physiotherapy. Kim's medication was reviewed. Children's Services allocated a social worker to Kim and a pre-birth assessment was started. It was recommended that the unborn baby should be subject to Child in Need Planning with escalation to Child Protection Planning later in the pregnancy due to the risk of harm from Kim's use of substances and the domestic abuse.
- March 2022 - Kim completed an in-patient alcohol detoxification and moved into abstinent housing as part of the recovery pathway. Contingency plans were put in place for alternative accommodation in case Kim were to relapse. On leaving hospital, Kim was unable to access her Methadone prescription due to confusion about which pharmacy the prescription would be available from and the fact that this could not be rectified as it was the weekend. She then used substances to manage her opiate withdrawal.
- March 2022 - Portsmouth City Council housing department concluded that Kim was "non-priority" status (ie not considered to be "vulnerable" for the purposes of the legislation, and therefore not owed a full rehousing duty by Portsmouth City Council).[5]
- April 2022 - IOM ended their involvement with Kim as she had not committed any IOM-qualifying offence for 18 months. IOM's involvement with Kim's partner also ended at this time. Kim reported that other residents at the abstinent accommodation were using substances and expressed the wish to move to mother and baby supported accommodation.
- May 2022 - Kim experienced physical abuse from her partner. Referrals were made to Stop Domestic Abuse and the Children's Services Family

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other complex needs and vulnerabilities. Safety plans are then developed and interventions put in place unique to each offender which aim to reduce re-offending.

[4] 'Respite rooms' provide safe accommodation with specialist support in single gender spaces, for women at risk of rough sleeping who are experiencing domestic abuse and multiple disadvantage..

[5] Vulnerability in homeless legislation has a very specific meaning and context and the Homeless Code of Guidance suggests [chapter 8.16]) that when assessing vulnerability, authorities consider whether "an applicant would be significantly more vulnerable than an ordinary person would be if they became homeless. The assessment must be a qualitative composite one taking into account all of the relevant facts and circumstances, and involves a consideration of the impact of homelessness on the applicant when compared to an ordinary person if made."

Safeguarding Team, but Kim did not want to pursue these as she felt there were too many professionals involved with her. Safety advice was given and Kim was advised to call if her situation changed. A referral was made to Adult MASH but was triaged as needing no further action as the Care Act statutory criteria were not met. She also disclosed using substances.

- June 2022 - Kim's substance misuse increased and she had a number of positive drug tests. She was asked to leave the abstinent accommodation due to alcohol and substance use, and having her partner stay on the premises (he had been banned due to the risks to Kim and her unborn baby). Kim returned to stay in the Registry.
- Early July 2022 - Kim did not sleep in her room in the Registry and spent two nights rough sleeping in a tent with her partner. Police made a referral to Children's Services due to the risk to Kim's unborn baby. A multi-agency strategy meeting was held and Children's Services started a section 47 Child Protection enquiry.
- Late July 2022 - there were further incidents where Kim did not sleep at the Registry and on one occasion Kim was reported as a Missing Person. She returned to the Registry the following day. Staff called the Police when Kim's partner arrived at the Registry looking for her. Kim was twice found semi-conscious by Registry staff at the end of July. Kim also called 111 for pain and swelling in her leg and was referred to her GP.
- End July 2022 - Kim was admitted to hospital as a safety precaution due to recent high levels of intoxication and risk management for unborn baby.
- Early August 2022 - Kim was detained by the Police having been caught shoplifting. The following day Kim was admitted to the Emergency Department at the hospital for a suspected opiate overdose.
- Mid August 2022 - SSJ staff called 999 due to a cut on Kim's leg following a fall in her room. She was experiencing pain and swelling in her legs. She was admitted to hospital and found to have an infection. The baby was also being monitored due to a low heartrate. A referral was made to Perinatal Mental Health services, and Kim was assessed. It was agreed there would be follow up from the perinatal psychiatrist. Kim was discharged from hospital a week later.
- Mid August 2022 - Plans were made by professionals for the birth of Kim's baby, including applying for a court order after the birth so that the baby could be placed in foster care. Plans were later made to place the baby into the care of Kim's sister under a Special Guardianship Order.
- Late August (3 days prior to Kim's death) - The social worker submitted a safeguarding concern to Adult MASH due to domestic abuse and substance misuse and Kim feeling unsafe at the Registry. Further information was still being sought by Adult MASH at the time Kim died. The social worker also submitted a referral for supported housing in a mother and baby unit.
- Late August (2 days prior to Kim's death) - Kim was followed up by the Perinatal Mental Health consultant psychiatrist. It was concluded that there was no ongoing role for this service and online substance misuse support groups were suggested.

- Late August (1 day prior to Kim's death) Kim attended a medical review with the substance misuse services and spoke to her Health Visitor on the phone.
- Kim was found unconscious in her room at the Registry by staff making a welfare check. An ambulance was called and Naloxone and CPR were given. Sadly, paramedics pronounced Kim and her unborn baby deceased at the scene.

Review methodology

It was agreed that the review would address the following themes:

a. Hospital discharge including risk management and multi-agency planning and communication.
b. Involvement of mental health services.
c. Availability of and responsiveness of services for people who misuse substances.
d. Pre-birth planning.
e. Whole family approach.
f. Involvement of, communication with, and support for family carers.
g. Appropriateness of accommodation.
h. Consideration of Kim as a vulnerable adult.
i. Availability and use of Naloxone.
j. Response of agencies following the death including the various review processes (including debrief meetings and identified actions).
k. Consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.
l. How Kim was supported as a victim of domestic abuse.
m. Duty of candour process whilst waiting on an agreed investigation.

The following methodology was used:

- Review of scoping information detailing each agency's involvement with Kim.
- Workshop for frontline practitioners who were involved in supporting Kim, which included a pen picture of Kim from her family.
- Further workshop with senior managers from each agency to explore strategic issues.
- Meeting of key agency representatives to finalise recommendations.
- Dialogue with Kim's family throughout the process to understand their questions and ascertain their views.

The review was facilitated by two senior managers (from Portsmouth City Council Adult Social Care Department and the Hampshire and Isle of Wight Integrated Care Board (ICB)), neither of whom had any operational responsibility for any of the services involved at the time of Kim's death.

Questions from Kim's family

As part of the review, Kim's family had several questions they wanted answering. The family submitted a detailed letter with their questions which informed the scope of the

review. Some of these questions were about the actions of single agencies and about Kim's final hours, which have been directed to the relevant agencies to answer.

Two of the key questions were highlighted by Kim's family and are summarised below, in the words of Kim's sister.

1. **Why was Kim accommodated in the Registry during this pregnancy?**

Kim really struggled with living at The Registry and she was quite vocal about it. There was far too much temptation for her to cope with, in the form of alcohol and drugs. She would often have other residents knocking on her door and Kim, being the kind of person she was, friendly but also very easily tempted by whatever might be available, would always let them in. I often wonder, had she been given the same opportunity as she had in her previous pregnancies and had moved into a hostel or perhaps another property, would there have been a different outcome? Remembering, she'd already had two successful pregnancies where she'd been content in her circumstances and felt safe in her surroundings.

2. **Why was there no weekend procedure to access Methadone in an emergency?**

Kim left The Registry in March 2022 and entered into an alcohol detox program at Queen Alexandra Hospital. She successfully completed the program and was to move straight into abstinent housing. Kim was full of optimism at this point, she honestly thought she had a chance of succeeding. She felt she was older and wiser than in her previous pregnancies and she was convinced that this time round it was going to be different. Unfortunately, the day after her release from Queen Alexandra Hospital Kim went to collect her methadone script from the chemist, but it wasn't there. Due to it being a Saturday there wasn't anyone who could help Kim which led to her downfall on that first weekend and her using, she hadn't used since finding out she was pregnant up until this point. It worries me that there isn't some kind of emergency procedure or someone to contact in the event of something like this happening, I really feel that there is something missing here or at the very least, better communication is needed.

These questions are addressed in the findings set out later in this report and the recommendations (numbers 8, 10 and 11).

Good practice identified

The workshop for practitioners identified a number of areas of good practice in how agencies worked together to support Kim:

- There was generally good communication between the Health Visitor, social worker, and maternity services.
- Kim's other children were within the family unit and Kim had contact with them.

- Kim was motivated to undertake alcohol detoxification and was listened to in relation to this.
- The Alcohol Specialist Nurse Service spoke to the consultant and was able to secure an alcohol detoxification placement for Kim although she did not meet the criteria. There was prompt booking once referred and a good patient centred plan. Kim did engage well with the Health Visitor and Social Worker and completed the inpatient alcohol detoxification.
- Kim felt 'safe' in hospital.
- There was early notification and awareness of the pregnancy by agencies.
- There were appropriate follow ups regarding the missed maternity booking.
- There was continuity of care in the maternity service/community midwife, lead consultants, and social worker.
- Children's Social Care (CSC) developed regular contact and rapport with all Kim's family.
- Pre-birth planning, Child in Need planning and Child Protection planning were in line with good practice.
- Stop Domestic Abuse was involved and supported professionals with Domestic Abuse advice.
- Specialist social workers from the family safeguarding service gave advice and support to the Children's Social Worker.
- Children's Services ensured that Kim kept the same social worker throughout, even though the standard process is a change in social worker.
- When Integrated Offender Management (IOM) were coordinating, there were weekly multi-agency meetings, dedicated to Kim. IOM also worked with Kim's partner.
- There was a good level of communication (especially with accommodation support providers) and emotional support between partners/professionals.

Changes made since Kim's death

A number of changes have already been made by services in response to Kim's death:

- At Portsmouth Hospitals University NHS Trust (PHUT), the Emergency Department now inform Maternity of all attendances of pregnant women over 12 weeks' gestation.
- At PHUT's Maternity department, a consultant now reviews all complex cases prior to discharge.
- The PHUT Maternity department now has increased knowledge and better developed communication arrangements with the homeless health navigator service in the hospital.
- Monthly reviews of all alcohol services users within PHUT are being held between the alcohol team, the Portsmouth Community Assessment Team (PCAT) and the safeguarding team, commencing in May 2023.
- There are now defibrillators at the Registry and other homeless accommodation in the city.

- There is now increased Naloxone[6] access at the Registry: it is now available on every floor and at both ends of the building as well as in the office. Service users also have their own Naloxone.
- Society of St James (SSJ) staff are now trained in emergency first aid in addition to general first aid.
- All PPN1s (police concerns) submitted to the Adult Multi-Agency Safeguarding Hub (MASH) about an adult who has been previously known to Adult Social Care are now added on the adult's file so that Adult MASH have a fuller picture of risk and to ensure concerns are not being triaged in silo.
- The Portsmouth Safeguarding Children Partnership (PSCP) now has a process for any child death/referral to ensure there are arrangements and places for staff to share reflections and be supported, aside from any case review process.
- SSJ has introduced a more comprehensive risk identification framework.
- SSJ has commenced a retraining programme for all staff on the changes that have been made.
- There is now a greater awareness of the Multi-Agency Risk Management Framework (MARM) amongst Housing staff and MARM is used more systematically.

Findings

- **Multi-agency working was not always effective (Recommendation 1, 11).**
    - There were a considerable number of agencies involved in supporting Kim, and she felt that there were too many professionals involved in her life. Despite numerous professionals involved, there was a lack of robust oversight and coordination, as there was no lead agency or professional identified.
    - Although during the period that IOM was involved, regular multi-agency meetings were held, these did not involve all relevant partners, did not have senior level oversight from all partners who attended, and so did not ensure all partners were accountable for the effectiveness of the plans. Once the involvement of IOM ceased, no documented risk management plan was passed to the remaining agencies still involved. However, Kim's probation officer did continue her involvement.
    - The referral for family supported housing was made too late, which was a result of the lack of multi-agency coordination of the plan for Kim.
    - While there was a robust Child Protection Plan in place to consider the needs of the unborn baby. The focus was on the unborn child rather than on Kim's needs as a vulnerable person with her own needs.
    - The use of MARM was recommended by Adult MASH but was never implemented by any agency. MARM was not well understood and professionals did not feel confident in using it. Had the MARM framework been used there would have been senior level oversight and risk would have been documented. A multi-agency approach which

[6] Naloxone is a medicine that rapidly reverses an opioid overdose.

took into account risk could also have been taken at the point of hospital discharge.
    - Short/medium/long term approaches with the goal of enabling Kim to keep her baby had been discussed by agencies and with Kim in the early stages of her pregnancy, while she was open to IOM. However, a robust plan with actions and accountability was not produced, shared or followed.
- **Services did not take a person-centred approach to domestic abuse (Recommendation 2, 3).**
    - Services recognised Kim's partner as a risk to her and her unborn baby but did not consider his own needs and risks. He was not involved in the birth planning. Kim did not want to leave her partner and perceived that services were trying to keep them apart. Services did not appreciate the extent to which Kim's partner's rough sleeping increased the risks to her. Kim may have been more willing to engage with domestic abuse services if their needs had been considered together.
- **Services did not support the family effectively after Kim's death and in line with the Duty of Candour. Review processes were not coordinated effectively (Recommendation 4, 5).**
    - Following Kim's death, there was confusion about practical arrangements and information sharing with the family. Kim's death took place at a bank holiday weekend which contributed to this. The family lacked a single point of contact.
    - The learning and review processes following the death were not clear, nor were they open and transparent. Although prompt referrals were made to the PSAB for the consideration of a SAR, the decision was postponed while a Serious Incident Review process took place within health. It was not clear who was leading this and communication between agencies, the PSAB, and the family, was poor, leading to a delay in the commissioning of the SAR.
- **The Care Act was not used effectively to safeguard Kim or secure the support she needed (Recommendation 1, 6).**
    - Professionals lacked understanding of relevant legal frameworks, PSAB policies and procedures, and operational processes within Adult Social Care. This meant opportunities were missed to seek advice, to make effective referrals for assessments and for safeguarding, and to use existing frameworks like MARM.
    - Although referrals were made to Adult MASH by the police, due to processes at the time, not all PPN1s (police concerns) were uploaded to Adult Social Care records, meaning a chronology of concerns was not available to evidence the level of risk. Had a fuller picture been known, Adult MASH would have considered initiating a MARM. This process was changed after initial scoping by the Adult MASH into Kim's death.

- **There was a lack of access to Methadone at the weekend (Recommendation 7).**
    - Kim was unable to collect her methadone at the weekend when she was discharged from hospital. Although it appears that in this case this was due to a misunderstanding or miscommunication between Kim and her Recovery Worker about which pharmacy would have the prescription, there is a wider issue that there is no emergency out of hours access to methadone in the City.
- **There is a lack of appropriate accommodation and support options for adults with complex needs who are experiencing homelessness (Recommendation 9, 10).**
    - Portsmouth City Council's Housing services were experiencing significant operational pressures at the time and have since allocated more resources to address the marked increase in customer demand. They should have assessed Kim as being in 'priority need' for Housing due to her pregnancy. However, a correct priority need assessment would not have resulted in different temporary accommodation being provided; there was a lack of appropriate housing available for Kim, as her need for support was so high due to the scale of her substance misuse and the domestic abuse she was experiencing.
    - Staff in the homeless accommodation felt under significant pressure to manage high risk situations, such as the medical detoxification and the birth plan.
- **Where clients perceive there is marginalisation, stigma and unconscious bias, this can create a barrier for them when they are seeking effective support from services** (**Recommendation 12).**
    - Kim's family reported that Kim had perceived some professionals as rude and dismissive when she was seeking treatment.
    - At times Kim was signposted to other services, when it has been found as part of previous reviews that signposting is often ineffective for people who are experiencing homelessness and more direct support is needed.
    - Services missed opportunities to involve Kim's partner, partly because he was experiencing homelessness and substance misuse.

Context - other reviews

- In 2022, the PSAB published a Thematic Review into the deaths of four adults who were experiencing homelessness, all of whom died in 2020. That review looked at the national learning about homelessness and had gathered information from homeless people, staff and family members. Some of the findings of that review are pertinent to this review: the impact of the stigma experienced by people experiencing homelessness; the challenges of commissioning accommodation for people with complex needs; and the need for services to take a whole family approach. Significant progress has already been made on an action plan in response to the findings of the thematic review.

- Alongside this review of Kim, PSAB has also been carrying out another SAR in relation to the death of an adult which took place some months earlier at the same accommodation. Some similar findings have been identified, including: missed opportunities for multi-agency risk management; evidence of unconscious bias from professionals towards adults who are experiencing homelessness and who have complex needs; a lack of appropriate accommodation options for adults with complex needs; and communication with families following a death.

Recommendations

1. PSAB and PSCP to work with all agencies to ensure that MARM has been embedded in practice, is in their safeguarding training and discussed at case management supervision. This will be supported by a task and finish group and the workforce will be consulted on how MARM can be more widely and appropriately used to identify and manage vulnerability and risk. (PSAB and PSCP).

2. PSAB and PSCP to ask their partners to raise within their organisations the importance of assessing the adults they work with who are victims of domestic abuse to identify the support they may require from their agency to manage the risks posed by their abusive partner (All agencies).

3. Include the voice of the partner in pre-birth planning and risk management, even when they pose a risk or do not engage (Children's Social Care, Maternity, and Health Visiting).

4. Housing and Police to develop an information sharing protocol in the event of the death of an adult who is homeless or is living in supported housing provision, to ensure there is a lead senior manager in Housing to coordinate the response and decide who will liaise with the family and/or other key individuals as their single point of contact (Housing and Police).

5. Put in place a process to identify a key contact for adults referred to PSAB for review, to lead on contact with the family and provide the SAR subgroup Chair with regular, formal updates in relation to any additional or parallel review processes (PSAB).

6. Seek assurance that the recommendations from the 'YL' SAR[7] have been included in training and embedded in practice by Children's Social Care, particularly in relation to the understanding of Care Act 2014, eligibility criteria, and how to refer for Care Act assessment (PSCP).

[7] YL action plan identifiers YL8 (ASC to work with CSC to ensure the Family Safeguarding Service Lead and Team Leads can review the findings and disseminate the learning across the whole service) and YL9 (ASC to support CSC to increase their understanding of the Care Act 2014, particularly in relation to the assessment of care and support needs for adults)

7. ICB to review commissioning and funding issues relating to emergency access to methadone both a) when there is an existing prescription and b) when someone needs a prescription out of hours (ICB).
8. To ensure that the IOM process supports multi-agency risk management by engaging with Probation about their understanding of MARM and the processes in place when withdrawing from IOM (PSAB).
9. To hold a citywide review of commissioned supported housing, including the Rough Sleeping Pathway, and which will consider the housing offer for pregnant women. The learning from the review to be embedded in the new Homelessness Strategy (Housing).
10. Review the current supported housing offer and identify what additional provision is required to meet the needs of a diverse client group, by making use of relevant funding opportunities where available (Housing).
11. Review the discharge planning process for pregnant women who are homeless and/or misusing substances where there are identified risks to provide assurance that it is robust and safe (PHUT).
12. Raise staff awareness of unconscious bias and the importance of not labelling/appropriate use of language by providing assurance that it is embedded in staff training (PSAB/all agencies).

A detailed 'SMART' action plan will be developed with the input of all agencies and will be monitored by the PSAB Quality Assurance Subgroup.

Portsmouth Safeguarding Adults Board

'Ronnie' Safeguarding Adults Review

What is a Safeguarding Adults Review?

The primary purpose of a Safeguarding Adults Review (SAR) is to draw out organisational learning about how the local agencies are working together, to support improvement.

Under section 44 of the Care Act 2014, Safeguarding Adults Boards must arrange a Safeguarding Adults Review when 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. They may arrange a Safeguarding Adults Review for other cases under section 44(4), for example where there is important learning to be identified.

The PSAB SAR subgroup considered the case referral for Ronnie on 14.09.22 and concluded that the above criteria had not been met. It was decided to carry out a discretionary review under section 44(4) of the Care Act.

The Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

Who was Ronnie?

Ronnie was a 44-year-old White British man. He had a long history of substance misuse. He had first approached housing services for support in 2002 and was accommodated in the rough sleeping pathway following the 'Everyone In' initiative. He was a son and a father, and his family were hugely important to him. He was a carer for his mother and visited her every day to cook for her. He was also devoted to his daughter. His goals were to live independently in his own flat so that his daughter could stay with him. Ronnie engaged well with his support worker and the staff at the Registry found him polite, pleasant and respectful. His support worker described him as having a wicked sense of humour. Ronnie had a brother, who had been in and out of prison for much of his life. Ronnie wanted to be liked and as a result he was often exploited, with other residents borrowing money from him. He was the victim of regular serious assaults in the community and was also at times a perpetrator of violence and of domestic abuse. He was reluctant to seek help from health services or the police.

Local context - services

There are several supported housing services in Portsmouth, provided by organisations commissioned by Portsmouth City Council. These services include "general needs" provision for all adults threatened with homelessness and also more specialist settings commissioned for service users with additional or specific needs,

such as those in recovery from substance or alcohol dependency or requiring support with their mental health.

The Council commissioned a rough sleeping support service in Portsmouth following the Covid-19 pandemic, during which there was a significant increase in the numbers of single adults seeking assistance due to homelessness, and an "Everyone In" directive from central government requiring all homeless people to be provided with accommodation to mitigate the risk of infection.

The rough sleeping pathway comprises several sites in the centre of Portsmouth providing supported temporary housing, with varying levels of staffing cover. This includes a service called the Registry, which accommodates up to 41 adults at risk of rough sleeping and providing a high level of housing-related support.[1] Ronnie was provided accommodation within this setting during the final months of his life.

Key events leading up to Ronnie's death

- Early 2021 - Ronnie attended the Emergency Department (ED) and outpatient departments at hospital due to physical health concerns, in part related to alcohol misuse.
- September 2021 - Two incidents resulted in Ronnie sustaining head injuries while intoxicated, requiring ED attendances. He was admitted for alcohol detoxification but self-discharged from hospital against medical advice.
- October 2021 - Ronnie shared that he was unhappy living at Kingsway House and moved to the Registry. He restarted his Methadone prescription. He also attended ED via ambulance with head injuries after being assaulted and then hitting his head after collapsing.
- December 2021 - January 2022 - Ronnie reported feeling more positive, was engaging well with his support worker and with substance misuse services. There were two 111 contacts due to health concerns. Ronnie reported difficulties in his caring role for his mother.
- February 2022 - further health concerns are recorded. Ronnie was engaging with mental health services.
- February 2022 - there were concerns about Ronnie as a perpetrator of domestic abuse. The police investigated and there was a referral to the Multi Agency Risk Assessment Conference (MARAC).
- March 2022 - Ronnie overdosed and Naloxone[2] was administered. He was taken to hospital but did not stay for treatment. Ronnie was offered a room in a shared house which he viewed with his support worker. The offer was withdrawn because of his overdose. Ronnie suffered a further assault in the community. The day after this assault he was arrested by Police as he was carrying a weapon, but he was taken to hospital from custody due to his injuries.

[1] Housing related support includes help with independent living skills, budgeting and managing a tenancy, emotional support, and support to access other services such as health care and substance misuse services.
[2] Naloxone is a medicine that rapidly reverses an opioid overdose.

- April 2022 - Ronnie again overdosed in the community. Ronnie was present at a fight in which his brother was arrested for assault.
- Early May 2022 - an ambulance was called for Ronnie by Registry staff due to a suspected overdose, but Ronnie declined medical intervention. Ronnie sustained a further assault in the community. There were concerns about his increasing drug and alcohol use and his disengagement with Registry staff.
- End of May 2022 - Ronnie overdosed at the Registry and Naloxone was administered.
- Ronnie was taken to hospital following a physical assault by two other residents of the Registry in early June 2022. He sadly died two days later.
- Ronnie had had no prior history with the perpetrators, but there had been concerns escalated to the police by the Society of St James (SSJ) the previous day about their behaviour including threats made to staff.

Review methodology

- Review of scoping information detailing each agency's involvement with Ronnie.
- Questionnaire to gather the views and experiences of practitioners who worked with Ronnie.
- Dialogue with Ronnie's family to ascertain their views.
- Workshop including a pen picture of Ronnie and to explore strategic issues involving SSJ, Hampshire Constabulary, Portsmouth City Council Housing Department, Public Health and Adult Social Care.
- Further workshop to explore his health issues.
- Meeting to finalise recommendations.

The review was facilitated by a senior manager who had no connection with any of the services involved at the time of Ronnie's death.

Involvement of family members

The reviewer met with Ronnie's mother and aunt to explain the purpose of the review and about the review process. A further meeting took place to feed back on the findings and recommendations. Ronnie's mother and aunt were invited to give their perspective on the review. Their main concerns were:

- the response of the Registry staff following the incident (these concerns have been investigated and no evidence found to support their claims)
- the appropriateness of the accommodation
- the ineffectiveness of services in protecting Ronnie from the assaults he experienced
- the lack of family support and communication following the death and the length of time the police investigation has taken.

Good practice identified

- Ronnie had a close relationship with his support worker and engaged well.
- Ronnie had a person-centred support plan.

- Portsmouth Hospitals University NHS Trust Critical Care staff were diligent in maintaining Ronnie's dignity and confidentiality towards the end of his life under challenging circumstances.
- The South Central Ambulance Service call handler had been very calm and professional and issued clear instructions to others in a difficult situation.
- The GP had been diligent in making referrals to ED.

Changes made since Ronnie's death

- There is now a more effective and multi-agency approach to risk management when individuals move into the rough sleeping pathway accommodation than was the case at the time of Ronnie's death. Risk plans are now stored on the database. Cases requiring the use of the Multi-Agency Risk Management (MARM) Framework are now identified and MARM meetings initiated in a more proactive and structured way.
- SSJ is introducing a comprehensive risk identification framework.
- SSJ has commenced a retraining programme for all staff.
- It is now possible to use non-protected licenses under certain circumstances, which was not the case at the time of Ronnie's death.[3]
- A Police Constable has been assigned as the Single Point of Contact for the Registry and the collaborative professional relationship between Police and accommodation staff has improved.

Context - other reviews

In 2022, the Portsmouth Safeguarding Adults Board (PSAB) published a Thematic Review into the deaths of four adults who were experiencing homelessness, all of whom died in 2020. That review looked at the national learning about homelessness and had gathered information from homeless people, staff and family members. Some of the findings of that review are pertinent to this review: the impact of the stigma experienced by people experiencing homelessness; the challenges of commissioning accommodation for people with complex needs; and the need for services to take a whole family approach. Significant progress has already been made on an action plan in response to the findings of the thematic review.

Alongside this review of Ronnie, PSAB has also been carrying out another SAR in relation to the death of an adult which took place some months later at the same

[3] A condition of the grant funding provided to Portsmouth City Council to commission its rough sleeping services included the requirement to provide protected accommodation licence agreements to anyone housed in the pathway. This type of licence agreement cannot be terminated by a landlord without recourse to a court order, following the expiry of a 28-day notice to quit. Individuals presenting a risk to others could not therefore be excluded or evicted from the pathway accommodation following a serious incident (and where so doing would support the management of such risks). More recently, Portsmouth City Council has worked with the Department of Levelling Up, Housing and Communities (DLUHC) to secure agreement to be able to provide some pathway residents with a non-secure licence agreement, instead, in exceptional circumstances. This type of agreement can enable temporary or permanent exclusions of residents who may present an unmanageable risk to others within the pathway.

accommodation. Similar findings have been identified, including: missed opportunities for multi-agency risk management; evidence of unconscious bias from professionals towards adults who are experiencing homelessness and who have complex needs; a lack of appropriate accommodation options for adults with complex needs; and communication with families following a death.

Findings

- Within some homeless services, including larger accommodation settings and hostel buildings, there can be a level of desensitisation to violence. This may have an impact on victims, perpetrators, their families and communities, and how services and staff are able to support them. This led to Ronnie not being identified as vulnerable by services and therefore opportunities to exercise professional curiosity, rather than making assumptions, were not taken, and safeguarding concerns were consequently not referred to the Adult Multi Agency Safeguarding Hub (MASH).
- There is some evidence of unconscious bias from professionals towards male-on-male violence. This can lead to a different approach being taken from that which is used for other forms of violence such as domestic abuse, where services, legislation and approach leads to more effective interventions.
- There is some evidence of unconscious bias insofar as males are less likely than females to be perceived as vulnerable. They are also less likely to be considered as parents even where they have children.
- Some victims are unlikely to want to be rehomed outside the area due to strong family and community ties.
- Risk assessments and risk management plans are not always updated after incidents. Risk management plans in respect of risks to self and risks of exploitation are not always effective. There is not always an effective multi-agency approach to risk.
- It is not always easy to identify patterns which could indicate escalating risk, due to staffing changes, staffing structures, and recording constraints. In Ronnie's case, use of the Multi Agency Risk Management Framework (MARM) could have been considered, but was not commenced. There may be insufficient awareness of MARM, insufficient MARM training at the right level, a barrier due to bureaucracy associated with MARM, and a lack of accountability for actions among partners.
- Support plans are in place and are person centred, but for Ronnie there was not the multi-agency support and common understanding to support him to realise his aspirations within the support plan, and there was a lack of suitable commissioned services to meet his specific needs.
- Ronnie was offered support from the homeless social worker and a Care Act assessment but did not accept this. Ronnie's mother was offered but did not accept a Care Act assessment. Ronnie's potential needs as a carer were not fully considered.
- Where there is evidence of marginalisation, stigma and unconscious bias, this creates a barrier for homeless clients seeking effective support from services.

- The relationship with the police and homeless services could be improved. Police did not always appreciate the urgency of some reports from SSJ staff and were unable to bring prosecutions against the perpetrators of assaults because Ronnie was afraid to engage with police.
- Staff in homeless accommodation provision sometimes feel unsupported by other services in managing high risk situations.
- Although Ronnie received clinically appropriate healthcare from health services, interventions were reactive rather than proactive. Information was not shared between agencies, so the full picture of Ronnie's needs and presenting risks was not known, and patterns such as the repeated head injuries and leaving hospital without receiving care were not identified.
- Services may not have considered the impact of repeated head injuries and executive functioning when assessing Ronnie's mental capacity.

Recommendations

1 Seek assurance from partners that MARM has been embedded, including in frontline practice, internal guidance, supervision and training. The PSAB Quality Subgroup to audit impact (PSAB)
2 Implement new 'red flags' risk assessment framework and ensure it is embedded into day to day management oversight including supervision (SSJ/Housing)
3 Increase provision of peer mentors, ensuring that anyone who is actively using substances has access to a peer mentor (Public Health)
4 Raise awareness among housing staff of how families can be engaged in supporting clients, with their consent, to better understand their wider circumstances (Housing)
5 Work to understand the gaps in the current supported housing offer and identify what additional provision is required to meet the needs of a diverse client group, by making use of relevant funding opportunities where available (Housing)
6 Raise staff awareness of unconscious bias (including misconceptions and assumptions surrounding the vulnerability of males with multiple needs) and the importance of not labelling/appropriate use of language (PSAB/all agencies).
7 Ensure professionals recognise people as carers and offer appropriate support, including referral for a carers assessment (all agencies able to identify carers and Adult Social Care/Health able to deliver referrals).
8 Develop an information sharing protocol in the event of the death of an adult who is homeless or is living in supported housing provision, to ensure there is a lead senior manager to coordinate the response and decide who will liaise with the family (Housing).
9 Hold a Citywide review of the rough sleeping pathway and commissioned supported housing, to include Adult Social Care, Public Health and Children's Services colleagues. Review to inform the new Homelessness Strategy, due to be published by the end of December 2023 (Housing)

Portsmouth Safeguarding Adults Board

"Paul" Safeguarding Adults Review

What is a Safeguarding Adults Review?

The primary purpose of a Safeguarding Adult Review (SAR) is to draw out organisational learning about how the local agencies are working together, to support improvement.

Under section 44 of the Care Act 2014, Safeguarding Adults Boards must arrange a Safeguarding Adults Review when 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. They may arrange a Safeguarding Adults Review for other cases under section 44(4), for example where there is important learning to be identified.

The PSAB SAR subgroup considered the case referral for Paul on 26.10.22 and concluded that the above criteria had not been met. It was decided to carry out a discretionary review under section 44(4) of the Care Act.

The Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

Who was Paul?

Paul was a 51-year-old White British man. He had limited involvement with agencies and served in the British Army for a period in the 1990s. Paul had a relationship with his ex-partner for four years and with whom he had an eleven-year-old daughter. Paul's relationship with his ex-partner broke down in 2015. Paul continued to live with his mother until she moved into sheltered housing in 2022. Paul was actively engaging with and receiving support from non-profit organisations for veterans such as Helping Homeless Veterans UK (a national charity) and All Call Signs (a local peer-to-peer support organisation set up by a veteran). Paul was a sociable person, well regarded by friends and family, and worked in security. Paul reported experiencing several mental health issues including anxiety, depression and Post-Traumatic Stress Disorder (PTSD), and disclosed he had been abused in the past.

Paul was described by his ex-partner as a bit 'manic' – up and down but he would bounce back quickly. She described his daughter as his world. Paul also left behind a 48-year-old sister.

Key Practice Episodes

- Paul periodically lived with his mother in Portsmouth for approximately twenty years. His mother was a Council tenant who moved into sheltered housing. This was a significant event that contributed to Paul becoming homeless in May 2022. Paul was told by his mother that he needed to look for alternative accommodation but he would not accept his mother's proposed move to sheltered accommodation. Paul gave up his employment prior to his mother's move on the basis that he considered this would prioritise his housing needs.
- Paul moved to the home address of his girlfriend's friend with his girlfriend. Their relationship lasted four and a half years. However, their relationship ended in May 2022 and living together then became untenable. Paul was offered a place in a hotel by a charity, Helping Homeless Veterans UK (HHVUK) and advised him to approach Portsmouth City Council (PCC) Housing Needs, Advice and Support (HNAS) before HHVUK sourced a private address in shared accommodation. HHVUK paid Paul's rent, deposit and provided furniture and food.
- Paul's housing application was not progressed because he was not considered to be imminently street homeless. Street homeless is the term used for those who routinely find themselves on the streets during the day and with nowhere to sleep at night. At that time and due to exceptional demand and staff resourcing challenges, HNAS were prioritising the assessment and support of customers presenting to the service who had actually become homeless. HHVUK made numerous attempts to contact HNAS but they were unable to get a response.
- During June / July 2022 HHVUK noticed a deterioration in Paul's mental health and consequently referred him to a non-profit organisation, "All Call Signs" who offer peer to peer support. "All Call Signs" staff have received some basic suicide alertness training but they are not mental health professionals. "All Call Signs" were never informed by Paul that he may have had thoughts of self-harm and his behaviours were considered to be alcohol related.
- During July and August 2022 Paul's mental health further declined. There were several incidents requiring police involvement - including domestic abuse incidents involving his ex-partner, and threats towards public house staff, who reported unpredictable behaviour and a declining mental state.
- On 8th August 2022 Paul was responsible for damaging the property he was living in. He voluntarily relinquished his tenancy and subsequently experienced homelessness. Paul was arrested for the damage and whilst in police custody he disclosed his previous suicide attempts. He was referred to, but was not seen by, the Hampshire Liaison and Diversion Service (HLDS). Paul was then temporarily housed at a hotel in Portsmouth by HHVUK and there was then a period of mental health decline.
- During August 2022 Paul engaged with the Rough Sleeping Hub in Portsmouth, PCC housing and his GP and he spoke about his worsening mental health.

- On 11th August 2022 Paul engaged with HNAS because HHVUK would only fund his stay at the hotel until the 15th August 2022 when he would once again be homeless. HNAS completed a housing assessment for Paul. He was assessed as not being in 'priority need', and was therefore referred to HNAS' commissioned rough sleeping services.[1] He was assessed for accommodation within the rough sleeping pathway but deemed to be too high risk to place in that service.
- On 12th August 2022 Paul presented at his GP surgery reporting that he was expressing suicidal thoughts. The GP referred him to the mental health crisis team. The referral stated that "he worked in the army, and he suffers with severe PTSD" however his military status was not recorded on his record. The referral was marked urgent for both the Crisis and Assessment to Intervention (A2i) team. The crisis team spoke to the GP that day and made an appointment with the A2i team for 1st September 2022. At about 02:00 hours on 15th August 2022 Paul called the Police reporting he was having suicidal thoughts but was open to speaking to mental health professionals. The call was transferred to the South Central Ambulance Service (SCAS). Paul later called the Police again at about 05:00 hours and reported he had spoken to SCAS and did not want the Police to attend. The 111 Mental Health Practitioner from Southern Health NHS Foundation Trust tried to call Paul back, but there was no answer so messages were left.
- On 1st September 2022 Paul visited the Emergency Department at Queen Alexandra Hospital after reporting suicidal thoughts and he was referred to the Southern Health Mental Health Liaison Team (MHLT) at the hospital. He was seen by the team who reported no immediate concerns of suicide and no evidence of an acute mental health need. MHLT contacted Solent NHS Trust Community Mental Health Team and asked them to continue to offer Paul support. While in hospital, he missed his A2i appointment.
- On 2nd September 2022 Paul was arrested by police for public order offences after initial concerns regarding alcohol and self-harm. Following investigation, he was bailed for Crown Prosecution Service advice on 3rd September 2022. He was recorded as homeless at the time of his release albeit he had stated an intention to speak with the HHVUK regarding his housing situation. Paul was provided with a train ticket to facilitate his travel back to Portsmouth. Paul was not seen in person by a HLDS practitioner whilst in custody but his records were screened remotely. He was assessed by the police as presenting with no thoughts of self-harm on his release.
- Paul was found by members of the public that night and later died in hospital.[2]

[1] The Housing Act 1996, Part 7 (as amended) sets out that local housing authorities must fulfil certain duties for people who are homeless and who are considered to be particularly vulnerable. The law sets out categories of people who may fulfil this "priority need" criteria.

[2] At the time of publication the inquest into Paul's death has not been held and therefore the cause of death has not yet been determined.

Review methodology

- Review of scoping information detailing each agency's involvement with Paul.
- Workshop on 28th March 2023 including pen picture of Paul and to explore strategic themes involving Portsmouth Hospitals University NHS Trust, Solent NHS Trust, Southern Health NHS Foundation Trust, Society of St James, Hampshire and Isle of Wight Constabulary, Portsmouth City Council Housing department, Hampshire and Isle of Wight Integrated Care Board and Helping Homeless Veterans UK.
- Themes included:
    1 Provision of housing and associated support for people with complex needs, including those who may pose a risk to others.
    2 How well agencies support people who may disengage from services, or who may not attend appointments, or who may not benefit from signposting to other services.
    3 How well veterans' organisations work together and with statutory agencies to support veterans
    4 Access to and quality of services for homeless veterans (and in particular primary care services).
    5 How effectively services take a whole family approach and support homeless people/homeless veterans to maintain healthy relationships,
    6 Consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.
- Telephone conference with All Call Signs.
- Meeting to finalise recommendations.

- The author of this review is a Temporary Detective Chief Inspector employed within the Corporate Insights Directorate of Hampshire and Isle of Wight Constabulary as the head of the Serious Case Review Team. The author was also supported by a senior manager with Portsmouth City Council Adult Services. Neither person has had any involvement in the case under review and are independent for the purpose of conducting this review.

Involvement of family members

The reviewer has spoken with Paul's ex-partner who did provide a pen picture of Paul and his life to assist the panel when discussing events leading to his death. The reviewer has also spoken with Paul's father who declined to assist in the preparation of this report but does wish to be made aware when it is published. The author has also met with Paul's mother and aunt who have assisted this review.

Good Practice Identified

- HHVUK was responsive to Paul's request for their help and developed a good relationship with him. He said that he appreciated their advice and support. They provided him with accommodation and other financial support and encouraged him to seek help from other agencies. They made repeated attempts to advocate on his behalf.
- All Call Signs developed a good relationship with Paul and provided advice and support.

Changes made since Paul's death

- The Housing Needs, Advice & Support (HNAS) service has been provided with additional resources to manage demand and ensure enquiries are processed quickly. This includes a dedicated staff resource to assess "Duty to Refer" homeless referrals from other agencies, and a specialist homeless case officer for individuals at risk of rough sleeping.
- A team of officers delivered a targeted intervention successfully addressing the work backlog for the housing service.
- HNAS now initiates the Multi Agency Risk Management Framework (MARM) for high-risk clients who are difficult to accommodate and/or homeless, and has worked with its accommodation providers to explore how accommodation placements can be more easily secured for individuals assessed as presenting an increased risk.
- HHVUK now has more robust screening processes for client risk factors.
- The Police now have dedicated resource to review Mental Health related 'PPN1' reports and update care plans. There is a process in place to share Mental Health PPN1s with the person's GP even without consent if safeguarding risks warrant this, and a process in place to share PPN1s for homeless clients with Adult Social Care.

Learning

- Housing services did not fully consider the implications for Paul when the decision to move Paul's mother to sheltered housing was made. This was not a statutory obligation, but would be considered good practice.
- HNAS were under-resourced at the time, having experienced a sharp increase in demand. There were backlogs in answering emails, carrying out housing assessments, and long waits for callers to the phone line.
- Paul did not always disclose the extent of his mental health and substance misuse issues (in common with many veterans). This made it difficult for agencies to assess vulnerability and risk effectively and provide appropriate support and services.
- HNAS did not assess Paul as being in 'priority need'. An appropriate assessment and with more information available should have identified this. Paul's needs meant supported housing would have been appropriate and a

service may have been identified which would be able to accommodate Paul and manage his risks effectively.

- Agencies' IT systems did not make it clear that Paul was a veteran even when it was known to the service. Paul did not always identify as a veteran and tell services this information. This meant he did not receive specialist veterans' mental health services that he would have been eligible for.
- There was confusion about the referral to Mental Health services, both in the referral and the triage, which meant that Paul received a non-urgent A2i appointment, rather than an urgent crisis response. This was contributed to by a recording error.
- Agencies experienced difficulties in contacting Paul which made it hard for them to engage with him.
- As Paul had a mental health appointment pending, agencies did not assess it necessary to take more urgent action.
- Agencies worked in silos and held information which was not shared to identify the picture of escalating risk.
- There was no trigger for a MARM for any agency, which would have provided a forum for the risks to be shared and mitigations to be identified to reduce the level of risk.
- The voluntary sector organisations were not well linked in with statutory services and were not clear on each other's roles. Assumptions were made that voluntary sector services would provide mental health and other support, without checks that this was happening, or that the organisations/individuals were able to provide this support.

Recommendations – multi agency

- Police and the local authority to explore information sharing mechanisms and governance to allow sharing of PPN1s for homeless clients.
- PSAB to seek assurances from all agencies that the MARM Framework is known and understood by all practitioners.
- PSAB to seek assurances from all agencies that a duty to refer under the Homelessness Reduction Act 2017 is being understood and being used by public authorities.
- Armed Forces Covenant - ensure systems are in place to identify veterans. Ensure staff understand the meaning of the Covenant. Improve awareness of veteran's services including Op Courage.
- Voluntary sector supporting veterans - promote better understanding and communication between statutory services and voluntary sector organisations including roles and responsibilities.

Recommendations – single agency

- PCC housing directorate to review its processes around supporting customers to transfer or downsize accommodation and the impact such a move may

have on other members of their household, so that the possible risk of those individuals becoming homeless is mitigated.

- HHVUK and All Call Signs to ensure they refer to statutory services where there are safeguarding concerns and that they are aware of local safeguarding/risk management protocols in the areas they operate in.
- Solent NHS Trust to review triage/recording processes to ensure practice is compliant with policy.

T/DCI Toby Elcock

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Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Date of meeting:	29 November 2023
Subject:	Portsmouth Safeguarding Children Partnership Annual Report
Report by:	Lucy Rylatt, PSCP Safeguarding Partnerships Manager
Wards affected:	All
Key decision	No

1. **Requested by:**

   Sarah Daly, Director of Children, Families and Education

2. **Purpose:**

   To introduce the Annual Report 2022-23 of the Portsmouth Safeguarding Children Partnership (PSCP) on the effectiveness of multi-agency early help and safeguarding arrangements for children in Portsmouth.

3. **Information Requested**

   The Portsmouth Safeguarding Children Partnership (PSCP) is a statutory, multi-organisation partnership coordinated by a business unit, which oversees and leads upon children's safeguarding across Portsmouth. The main objective of the PSCP is to gain assurance that local safeguarding arrangements, comprised of partner organisations, are working effectively, both individually and together, to support and safeguard children who are at risk of abuse and neglect. The PSCP acts as a critical friend and a champion for best practice.

   This year, there is evidence of continuing impact of the Covid pandemic upon children and their families in the city. We continue to see high levels of referrals to our Multi-Agency Safeguarding Hub (MASH), alongside increased pressures in our schools, our health system and across our partnership. In addition, families in Portsmouth are having to deal with a cost of living crisis that has resulted in higher food costs, huge increases in energy costs and wider inflation. In Portsmouth, 23.9% of children under 16 years (8,870 children) were living in relative low income families in 2021/22. This was a 10.6% increase (a further 355 children) compared to 2020/21. Across the partnership our workforce has worked hard to engage with and support these families to prevent the need for them to access statutory services.

   In February 2023, the Partnership met to review the impact of the previous Safeguarding Strategy 2020-2023, that had been drawn up as part of the Portsmouth Children's Trust Plan. As a result it was agreed to renew the vision and principles for the Partnership; to amalgamate the priorities within the 2022-25 Business Plan into the PSCP-Strategy-2023-26-FINAL.pdf; and to have one overarching document that set out the multi-agency priorities for safeguarding and promoting the welfare of children in Portsmouth**.** The eight priorities agreed are:

   - Children and families' needs will be identified at the earliest point, and they will receive effective early support and help.
   - Families will receive effective and timely support when children are at risk of experiencing neglect.

- Families will receive effective and timely support when children are at risk of experiencing sexual abuse.
- Young people will be kept as safe as possible from all forms of extra-familial harm, and there will be effective transitional safeguarding arrangements in place to support vulnerable young adults.
- Children and young people have access to appropriate support that recognises the impact of trauma resulting from adverse childhood experiences (ACEs).
- There is an effective response to safeguarding children with additional needs and those from diverse communities.
- Providing sufficient professional and organisational development to ensure there is effective response to safeguarding children within Portsmouth.
- We will ensure there is a good understanding of safeguarding risks for children within education settings and an effective response to these.

Signed by:

Scott MacKechnie,

Independent Chair and Scrutineer of Portsmouth Safeguarding Children Partnership

Appendices: Portsmouth Safeguarding Children Board Annual Report 2022-23

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	**Location**
Working Together to Safeguard Children 2018	Gov.uk


Portsmouth
Safeguarding
Children
Partnership
ANNUAL REPORT 2022 - 2023

Contents

Foreword

It is my pleasure to introduce the Annual Report for Portsmouth Safeguarding Children Partnership (PSCP) for 2022/23. I joined PSCP in the latter part of this reporting year as the Independent Chair and Scrutineer.

The scrutineer part of my role is about challenging and supporting our safeguarding partners in their leadership role. It is about providing scrutiny to audits, assurance work, case reviews and partnership decision making. Thereby ensuring ours is a multi-agency safeguarding system that continues to learn, develop, and remain effective in keeping our most vulnerable children safe from harm and abuse. A partnership based on the premise of mutual respect, high support, and high challenge, working collaboratively to resolve issues.

I am very aware the year continued to be shaped by the impact of COVID-19, other world events and the cost-of-living crisis being felt across our communities. Partner agencies continued to face additional challenges as a result. Senior leaders from the statutory safeguarding partners remained visible and engaged, working collectively to ensure we effectively safeguard and promote the wellbeing of our most vulnerable children, their families, or carers. Our wide range of partners continued to maintain a clear focus on safeguarding children, continuing to deliver the partnership's priorities and active workstreams. Our priorities reflect the issues facing children and their families: neglect, sexual abuse, exploitation, and exclusion from education, with a focus on adolescents and the impact of our collective activity.

July of this year saw a significant change take place for one of the statutory safeguarding partners - the NHS Clinical Commissioning Groups were restructured to form a single Integrated Care Board across Hampshire and the Isle of Wight.

The current landscape is challenging, and this is likely to remain, impacting the children and families we work with, alongside the practitioners who provide support and services.

2023/24 will bring change as we move through consultations in response to the government's Stable Homes, Built on Love publication and a new iteration of Working Together to Safeguard Children, which we remain hopeful will strengthen the role of our education partners. I will remain resolutely focused on ensuring local multi agency safeguarding practice remains effective for our children, their families or carers during any changes that may result.

This Annual Report contains information about the work of PSCP which is a partnership of us all, of everyone who works with children and families in Portsmouth. As you read through all the work undertaken this year, you will see our collective effort and the positive impact we have made together.

Thank you.

Scott MacKechnie
Independent Chair & Scrutineer for Portsmouth Safeguarding Children Partnership

Introduction

We are pleased to present this report of the Portsmouth Children's Safeguarding Partnership which covers the period from 1 April 2022 to 31 March 2023.

As ever it has been a busy year, with the continuing repercussions of the Covid pandemic having a profound impact on children and their families. We continue to see high levels of referrals to our Multi-Agency Safeguarding Hub (MASH), alongside increased pressures in our schools, our health system and across our partnership. In addition, families in Portsmouth are having to deal with a cost of living crisis that has resulted in higher food costs, huge increases in energy costs and wider inflation. In Portsmouth, 23.9% of children under 16 years (8,870 children) were living in relative low income families in 2021/22. This was a 10.6% increase (a further 355 children) compared to 2020/21. Across the partnership our workforce has worked hard to engage with and support these families to prevent the need for them to access statutory services.

Our commitment to continuous learning is robust and supported by the work undertaken in our committees, all of which are chaired by partner members of the Executive Board. As a result of this our learning and development offer goes from strength to strength and engagement is strong across the partnership workforce.

We are all immensely proud of our workforce across the partnership and would take this opportunity to thank them for their hard work over the past year. Their commitment to the work of the PSCP and all that has been achieved is to be celebrated.

Sarah Daly, Director of Children, Families & Education
Portsmouth City Council

Superintendent Clare Jenkins, Eastern Area Commander
Hampshire Constabulary

Sarah Shore, Interim Director of Quality and Safeguarding
Hampshire & Isle of Wight Integrated Care Board

What we achieved against our priorities in 2022/23

In April 2022 five areas of concerns were set out as priority areas in the PSCP's Business Plan. Over the course of this year actions were progressed to meet the required outcomes or are still in progress. These include:

1. Early identification & support:

The PSCP Team continued to collaborate with partner agencies to complete a pilot of the re-designed Early Help Assessment. This is based on the 10 outcomes within Supporting Families and, following consultation with families in Portsmouth, has been called the Family Support Plan (FSP).

The FSP officially launched in January 2023, supported by a redesign of the multi-agency Early Help Training. It is used to support families with needs across Tiers 2 and 3 and is used by both universal settings and targeted early help services. A leaflet and a video have been designed in collaboration with the Portsmouth Parent/Carer Board to help families understand the process.

As well as training, guidance was produced for practitioners to help them explain to families how the process of creating and reviewing an FSP works, and to support them in asking questions around the 10 aspects of life. The Link Coordinators Team have supported the Partnership to put together a comprehensive guide as to the support available under each of these aspects.

The FSP, along with an intense focus on relational and restorative practice, has begun to equip the workforce with tools, processes and practice which are helpful and most importantly focus on the relationship with families, resulting in better outcomes for children.

In the first 3 months since it was launched, a total of 67 plans have been submitted and the feedback so far has been overwhelmingly positive:

> *"We've been finding the FSP so positive for families. After an FSP conversation with one mum she said she felt she was leaving the school feeling so much lighter".*
>
> *"We feel it worked incredibly well for the family. The questions worked effectively in terms of the family being able to talk openly and they are now very hopeful that the plan we have put together will be positive in moving things on".*
>
> *"The form is so much better than before. It really helped being able to show mum the 0-10 scale and they were able to first cover all the positive areas and then focus on their areas of concern. Mum reported that she felt listened to".*

A quality assurance framework is being developed in order to monitor the implementation and effectiveness of FSPs

2. Responding to neglect:

Since the PSCP concluded a deep dive into multi-agency practice in response to children experiencing neglect in 2021, the following work has been undertaken:

- A review of research of evidence-based tools and interventions for working with families where neglect is a concern;
- A review of the approach used by neighbouring LSCPs and those across England where the local authority has been graded as 'outstanding' by Ofsted;
- 2 workshops with practitioners to understand the opportunities and challenges they find in using the current practice guidance and Neglect Identification & Measurement Tool (NIMT);
- Liaison with the perinatal mental health steering group (that has since been established) to understand the work being taken forward to support maternal mental health more effectively; and
- Supporting the work being undertaken to develop a parenting pathway, as part of the Public Health Strategy, to ensure there is appropriate support for families at all tiers of need.

This work concluded that having separate strategies for specific forms of abuse or harm can be confusing for the workforce, and therefore responding to neglect will be embedded into the comprehensive Portsmouth Safeguarding Strategy when it is refreshed in April 2023.

It also found that the NIMT is not an evidence-based tool, was not widely used, and many practitioners found it unhelpful when they did attempt to use it. With the extensive work that has been undertaken to replace the Early Help Assessment with the FSP, indicators of neglectful parenting will be better identified through the Family Support Conversation. Through considering all aspects of family life practitioners will have a better understanding of the impact of neglect, as well as potential causal factors and be able to work with the family to develop an appropriate plan of support in place to address these.

In addition it was felt that a specific tool to help practitioners (especially those working in Children & Families Service) work with a family to capture a child's lived experience was need. It was agreed to adopt The Day in the Life (DIL) Tools developed by Professor Jan Horwath.

Finally it was concluded that having a supporting Practice Guide for responding to children experiencing neglect was helpful to clarify the expected response and approach in Portsmouth across all tiers of need (especially for newer and/or less experienced practitioners). So the Practice Guide has been refreshed to be clear on how and when to use the FSP and DIL tools to effectively identify and support families where children are experiencing neglect. These have been published on the PSCP website and disseminated across the children's workforce

3. Exploitation:

During 2022-23 the PSCP supported the Head of Service for Adolescents and Young Adults in working with partner agencies to develop a Multi-Agency Missing, Exploited and Trafficking (MET) Integrated Pathway. The Pathway is designed to support the understanding and response across emerging, complex, and acute need.

In response to learning by the Partnership about the need for collaborative and coherent plans to support children who go missing or are vulnerable to exploitation, we have adopted a 'Safer Plan' model. The aim of the plan is that is developed with the child and belongs to them and brings together key information about the child to share across police, health and social care to better enable them to and respond to their risks and vulnerabilities.

We recognise a child going missing is often a significant indicator of the presence of exploitation and that a missing episode may indicate a time-critical window to identify and intervene to reduce increasing vulnerability to exploitation. Op Endeavour has been introduced to ensure schools are notified by Police of children who have gone missing, so that any information the school has that may help locate them or prevent them from going missing in the future can be shared. The school can also offer appropriate support to the child when they return to education.

The Partnership understands that the risks of exploitation for some children are still ongoing when they reach their 18th birthday and can no longer be supported by Children's Services. The LSCPs across Hampshire, Isle of Wight, Portsmouth, Southampton (HIPS) have worked with the respective Local Safeguarding Adults Boards on a transitional safeguarding framework - Multi-agency framework for managing risk and safeguarding people moving into adulthood. In Portsmouth, a Transitional Safegaurding Forum meets regularly, chaired by the Head of Adolescents and Young Adults, to ensure the needs of these young people are understood and appropriate plans of support are developed with them.

Police have relaunched Hotel Watch with the hospitality industry to ensure they are aware of potential safeguarding risks and responding with appropriate actions. Within the monthly operational MET meetings areas of concern in the city are explored and a contextual approach is taken to consider how best to work with these premises.

The PSCP continues to offer a significant amount of training to the workforce on exploitation to improve the identification and response to children at risk of this form of harm. A particular focus this year has been on delivering a masterclass on supporting practitioners to consider their language and avoid victim blaming. Examples of the impact this training has had is:

> *"One thing I have been guilty of is maybe not saying but thinking "the parents could be doing more". But the training has shown me that actually maybe the parents are doing all the can, and that they are in fact at a loss and don't know what to do to help their children"*
>
> *"This has started to shape language that is more restorative and really builds a culture where children are supported as victims and not just seen by their actions on the surface."*
>
> *" When speaking to families I have always tried to choose my words carefully but perhaps hadn't been as considered when writing up documents. Following the input I try to ensure my reports do not have an underlying judgemental or blaming tone."*

4. Family Safeguarding:

During 2022-23 the PSCP has worked with other LSCPs and Local Safeguarding Adults Boards across HIPS to re-fresh the Family Approach Toolkit. This will be relaunched in 2023.

Within the tools used to complete Rapid Reviews and Deep Dives, we have included questions to consider whether decisions and/or actions are appropriately considering the impact on the child when one or more significant parental risk factors are present. This has highlighted that where parents/carers are supported by the Family Safeguarding & Support Services to address parental needs around mental health, substance misuse and/or domestic abuse, the support given by the adult workers embedded within these teams is effective.

Within the FSP and the redesigned Early Help Training, there is a renewed focus on supporting practitioners in having honest conversations with parents/carers. The aim being to identify existing strengths that can be built upon, as well as potential needs within a family, thus enabling the joint development of a plan of support that builds parental capacity to appropriately safeguard children.

5. Safeguarding in Education:

The PSCP training team continue to support schools across the city in a variety of ways of to further grow a safeguarding culture in an education setting, this includes through a diverse range of Masterclasses, bespoke and inset training, as well as coaching.

The training program offers a robust package of learning and reflective opportunities, which is continually being updated and added to in line with Keeping Children Safe in Education (KCSiE) and emerging safeguarding themes and learning from Child Safeguarding Practice Reviews. This year, sessions to cover topics such as Cyber Choices, Working Sexual Harmful Behaviour, Family Support Planning, Clare's and Sarah's Law were included. We continue to work in partnership with experts in these specific areas to ensure the content is of a high standard. 75.4% of schools across Portsmouth are engaged in PSCP Designated Safeguarding Lead (DSL) Training, alongside The City of Portsmouth College.

Intensive bespoke training was developed to support two schools who were deemed inadequate in regard to safeguarding in their OFSTED inspection. For these a project plan was developed which incorporated specific

training, reflection and coaching to enhance staff's knowledge and skills, and focus on strengthening the school's safeguarding culture. Coaching has also been offered to the Designated Safeguarding Leads (DSLs) and Leadership Teams within six schools which provides a supervision type service.

The local authority has a team of Education Link Coordinators who provide a supportive link between the Children, Families and Education Directorate and education settings, (including Early Years, Schools, and Colleges) to ensure they are aware of their vulnerable children. Children that are identified as vulnerable include those with attendance below 50%; children with 2 or more suspensions; children at risk of exploitation; children with an unmet special educational need; those open to the Youth Offending Team; and children open to the Early Help or Family Support and Safeguarding teams

The Link Coordinators have a fortnightly conversation with the education setting's designated safeguarding lead in regard to those vulnerable children who attend their setting. The aim being to provide regular advice, guidance, challenge, and support with a key focus on ensuring the right support is in place on a multi-agency basis to improve the outcomes for children and their families. The Family Support Plan is promoted for children who do not have a lead professional in place, and actions agreed where appropriate.

About Portsmouth Safeguarding Children Partnership

The Portsmouth Safeguarding Children Partnership (PSCP) is a statutory, multi-organisation partnership coordinated by a business unit, which oversees and leads upon children's safeguarding across Portsmouth. The main objective of the PSCP is to gain assurance that local safeguarding arrangements, comprised of partner organisations, are working effectively, both individually and together, to support and safeguard children who are at risk of abuse and neglect. The PSCP acts as a critical friend and a champion for best practice.

Quality assurance remains our key driver across all the committees, using frameworks that will measure the impact of activities and challenge those working in the safeguarding arena. We also continue to ensure that our policies and procedures are embedded in practice; that toolkits, guidance, and procedures draw on the knowledge of subject experts locally and nationally to inform them; and that we can demonstrate the impact of learning that has taken place.

The Partnership has an Independent Chair who provides leadership, vision, support & scrutiny and who is responsible for ensuring that all organisations contribute effectively to the work of the PSCP. Effective communication between the Business Manager and Chair ensures that there is a clear link between the committees and executive group, enabling risks, themes and opportunities to be highlighted at an executive level, which in turn provides direction to the work of the committees.

In February 2023, the Partnership met to review the impact of the previous Safeguarding Strategy 2020-2023, that had been drawn up as part of the Portsmouth Children's Trust Plan. To enable this, an analysis of the available data was provided that highlighted some of the key themes, trends and needs of families and children across Portsmouth. Agencies were also asked to review knowledge held within their own setting of the current risks, pressures and opportunities that related to the effectiveness of the multi-agency safeguarding arrangements in Portsmouth. As a result it was agreed to renew the vision and principles for the Partnership; to amalgamate the priorities within the 2022-25 into the Strategy; and to have one overarching document that set out the multi-agency priorities for safeguarding and promoting the welfare of children in Portsmouth.

Our Vision

Our children and young people within Portsmouth will grow up being and feeling safe, protected, and cared for by their families and in their community. As a multi-agency partnership, we will achieve this by working with families to enable them to keep their children safe from all types of harm by providing the right advice, support, and intervention, from the right services, at the right time.

Our Priorities for 2023-25

1. Children and family's needs will be identified at the earliest point, and they will receive effective early support and help
2. Families will receive effective and timely support when children are at risk of experiencing neglect
3. Families will receive effective and timely support when children are at risk of experiencing sexual abuse
4. Young people will be kept as safe as possible from all forms of extra-familial harm, and there will be effective transitional safeguarding arrangements in place to support vulnerable young adults
5. Children and young people have access to appropriate support that recognises the impact of trauma resulting from adverse childhood experiences (ACEs)
6. There is an effective response to safeguarding children with additional needs and those from diverse communities
7. Providing sufficient professional and organisational development to ensure there is effective response to safeguarding children within Portsmouth
8. We will ensure there is a good understanding of safeguarding risks for children within education settings and an effective response to these

More details about these priorities, how we aim to achieve these, and our principles can be found in the Portsmouth Multi-Agency Safeguarding Strategy 2023-26

Our Partners

Working Together 2018 is statutory guidance that provides children's safeguarding with a legal framework, setting out the responsibilities of local authorities and their partners. From a statutory perspective the three legally required bodies are:

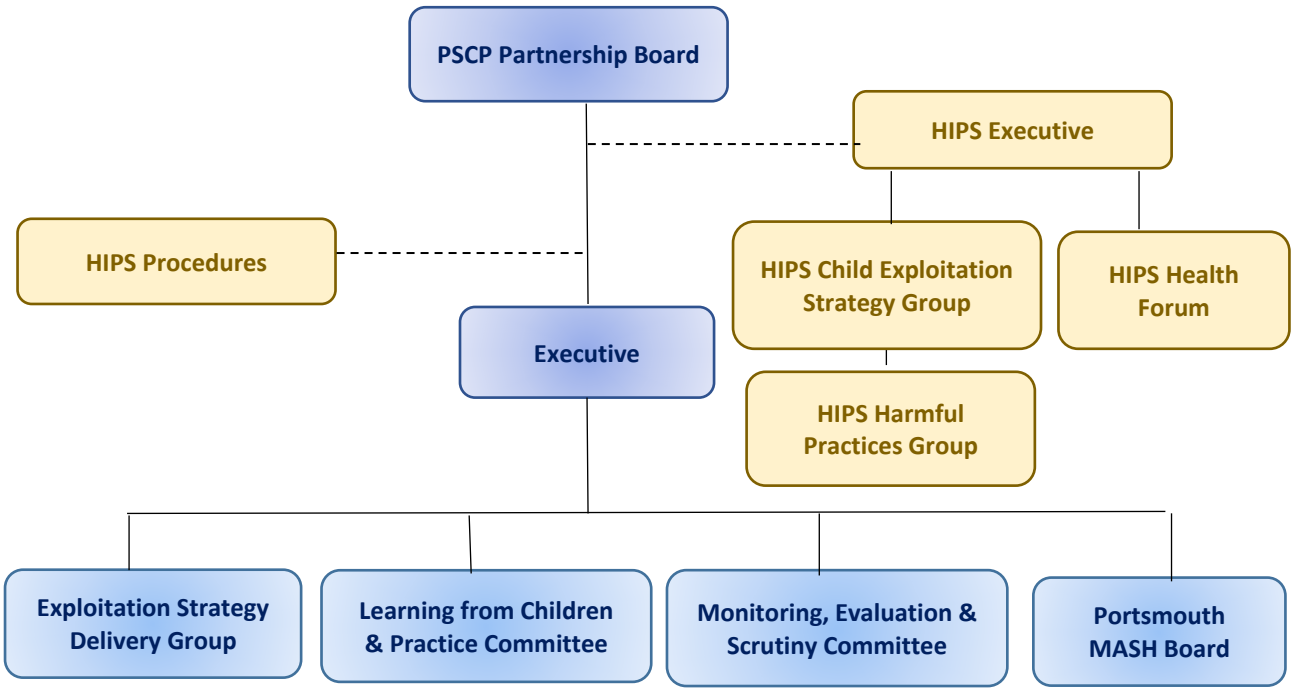
Portsmouth City Council

Hampshire & Isle of Wight Constabulary

NHS Hampshire and Isle of Wight

The strength of local partnership working is built upon the safeguarding partners working collaboratively together with all other relevant agencies and services in Portsmouth who come into contact with children and families. A full list of these relevant agencies can be found here within our Partnership Arrangements.

Our Structure



In addition to the Board and Executive, Portsmouth has the following sub-groups and Committees.

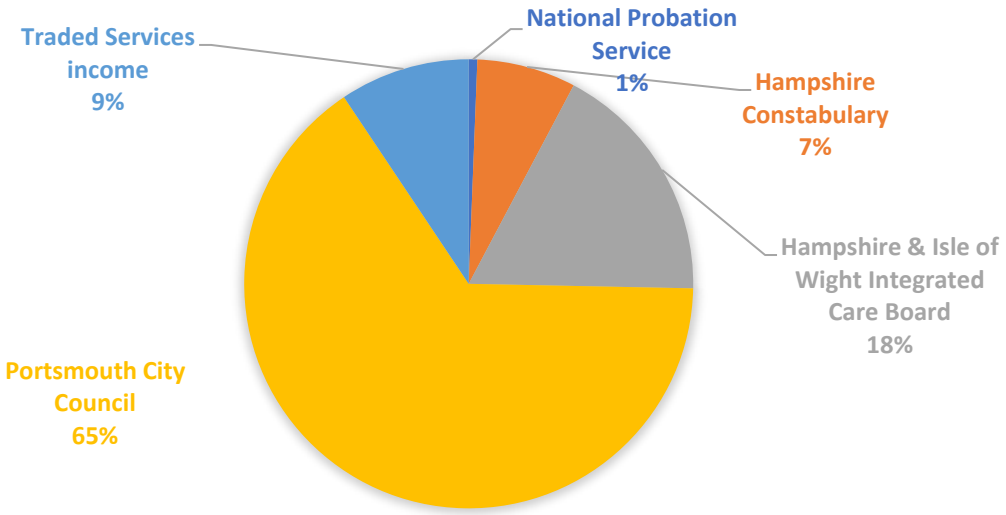
- **Learning From Children and Practice Committee** - which oversees safeguarding notifications and Child Safeguarding Practice Reviews, commissions external authors and reviews actions and learning
- **Monitoring Evaluation and Scrutiny Committee** - which oversees our comprehensive dataset and analysis, multi-agency audits of practice, recommendation tracking and compliance with safegaurding standards set out in the Portsmouth Safeguarding Compact which is completed every two years by over 200 agencies in the city.
- **Exploitation Strategy Delivery Group** - leading our strategy to tackle child exploitation
- **Portsmouth MASH Board** - ensuring effective resourcing, delivery, and quality of decision-making at the multi-agency front door

Our partnership is part of a wider HIPS safeguarding arrangement, which whilst not statutory, enables effective joint working across a wider geographical footprint - shared with the Constabulary and the Integrated Care System. The same Independent Chair covers all the local partnerships and the HIPS Executive.

The PSCP also works closely with the HIPS Child Death Overview Panel to ensure that any matters relating to the death, or deaths, which are relevant to the welfare of children in Portsmouth are considered and acted upon where appropriate.

Financial contributions to support the Partnership

The total budget for the Partnership in 2022-23 was £324,296.



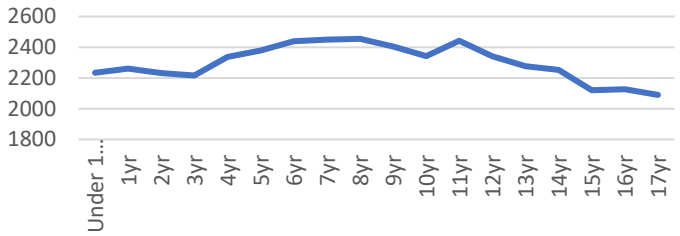
The four biggest areas of Partnership spending for this year were:

- Staffing = £284,026 (including the Business Unit, Training Team, and the Independent Chair)
- Contribution to CDOP = £12,000
- Provision of websites and online learning = £11,398
- Safeguarding Practice Reviews = £2,500

Context & Key Facts About Portsmouth[1]

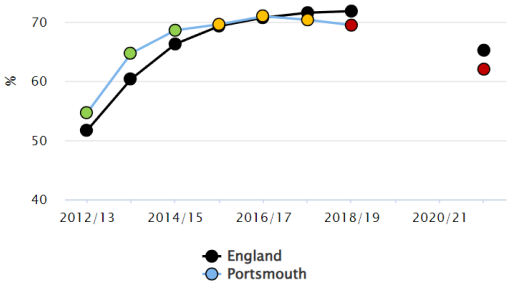
Portsmouth is a city on the south coast of England. It remains the local authority with the highest population density outside of London, with around 37 people living on each football pitch-sized area of land. According to the ONS Census completed in 2021, the population size in Portsmouth is 208,100.

Numbers of children aged 0-18yrs living in Portsmouth



Education

Within Portsmouth there is 1 all through school, 47 primary schools, 10 secondary schools, 5 special schools, 1 state-funded FE colleges and 5 independent schools.



The percentage of children in Portsmouth schools achieving a good level of development at the end of Reception has fallen to 62% in 2021-22 compared to a national average of 65.2%. This decrease from 69.4% in the previous year may be an indicator of the impact of national lockdowns as a result of Covid.

In Portsmouth, the rate of persistent absentees is higher than the national average.

Persistent absence rate	Portsmouth	England
Primary	18.2%	17%
Secondary	32.1%	27.4%
Special	51.8%	38.7%

On census day in Spring 2023, in Portsmouth there were 40 children missing education who are not registered pupils at a school and not receiving suitable education otherwise. At the same point in time there were approximately 200 children registered as receiving elective home education. Where a reason was given for choosing EHE, the top two were dissatisfaction with the school SEND provision and health concerns relating to COVID-19.

4.5% of pupils in Portsmouth have an Education, Health, and Care Plan (EHCP) which is in line with the national average of 4.3%. The rate of pupils receiving Special Educational Needs (SEN) support without an EHCP is 14.9%, slightly higher than the national average of 13%

69% of pupils in Portsmouth are from a white British ethnicity, which is lower than the national average of 62.6%.

[1] Public Health Data & Child Health Profile & Gov.UK Education Statistics

Percent of pupils by ethnicity	Portsmouth	South East	England
Any other ethnic group	2.1	1.3	2.3
Asian - Any other Asian background	1.9	2.2	2.1
Asian - Bangladeshi	3.4	0.6	1.8
Asian - Chinese	0.7	0.7	0.7
Asian - Indian	1.7	3.6	3.7
Asian - Pakistani	0.4	2.7	4.5
Black - Any other Black background	0.4	0.4	0.8
Black - Black African	4.9	3.0	4.3
Black - Black Caribbean	0.3	0.3	0.9
Mixed - Any other Mixed background	1.7	2.7	2.7
Mixed - White and Asian	1.5	2.0	1.6
Mixed - White and Black African	1.5	1.0	0.9
Mixed - White and Black Caribbean	0.8	1.3	1.6
Unclassified	1.9	1.6	1.7
White - Any other White background	7.5	7.2	7.2
White - Gypsy/Roma	0.1	0.4	0.3
White - Irish	0.1	0.3	0.2
White - Traveller of Irish heritage	0.0	0.1	0.1
White - White British	69.0	68.6	62.6

Young people aged 16-17 who are not in education, employment, or training (NEET) are at greater risk of a range of negative outcomes, including poor health, depression, or early parenthood. In 2021-22 the percentage NEET in Portsmouth is 5.1%, a reduction from 5.6% in the previous year and close to the national average of 4.7%.

Health

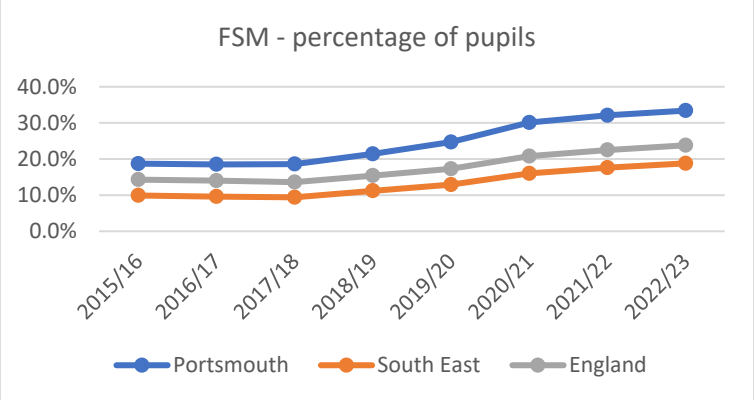
The infant mortality rate is 3 per 1,000 and the child mortality rate is 8.1 per 100,000. Both of these are below the national average of 3.9 per 1,000 and 10.3 per 100,000 respectively, and are the lowest rates amongst Portsmouth's statistical neighbours

Money

The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. There is also a wide variety of evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health

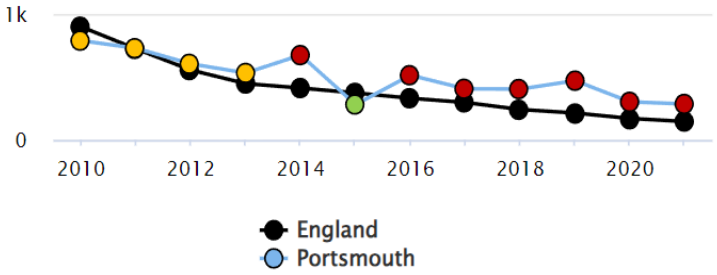
Portsmouth is ranked 59th of 326 local authorities for deprivation, where 1 is the most deprived. 8,870 children, which equates to 23.9% of all under 16's, are in relative low-income families. Of all the households owed a duty under the Homelessness Reduction Act, 21.4 per 1,000 include dependent children. This is the highest rate compared to Portsmouth's statistical neighbours and is higher than the national average of 14.4.

The percentage of pupils in Portsmouth that are eligible for free school meals (FSM) is 33.4%, which is higher than both the national and regional average and has increased significantly over the past 7 years.



Extra-familial contexts

The rate of first-time entrants to the youth justice system is 286.7 per 100,000, which is almost double that of the national average of 146.9 and is the highest amongst Portsmouth's statistical neighbours. However this does continue the downward trend over the last 11 years.



Learning from Monitoring, Evaluation and Scrutiny

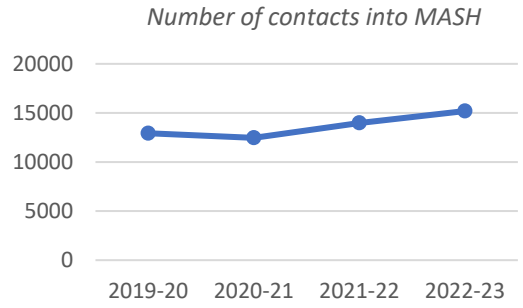
Learning from Data

The Partnership's dataset framework provides performance information to the PSCP to inform the assessment of the effectiveness of the support being provided to children and families. Data relating to key safeguarding and early help processes, and particularly vulnerable groups of children, is provided by partner agencies each quarter. This is reviewed by the Monitoring, Evaluation and Scrutiny Committee (MESC) who provides the Executive Committee with an analysis of any trends and areas for consideration.

Contacts into the Multi-Agency Safeguarding Hub (MASH)

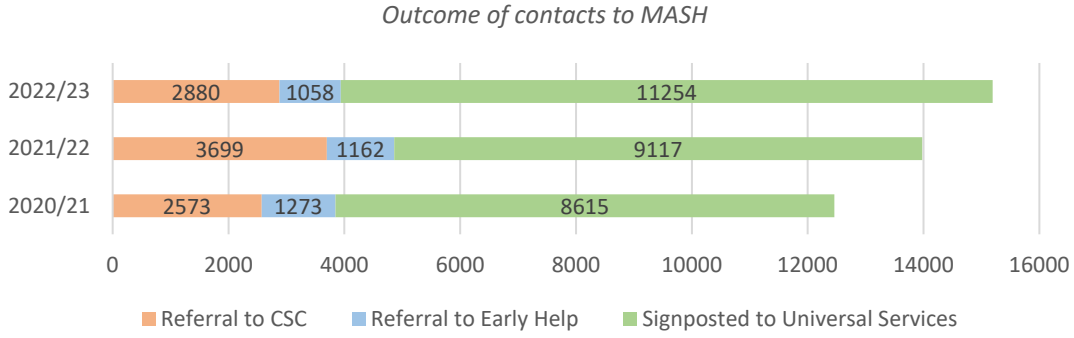
The Portsmouth MASH was established in November 2015. It is the multi-agency front door that manages child safeguarding concerns and determines an appropriate response. The services represented within MASH are Family Safeguarding and Support, Early Help and Prevention, Hampshire Constabulary, Solent NHS Trust, Youth Offending Team, Youth Service and Education.

The MASH process continues to allow for a manager to oversee the allocation of all work and to endorse the recommendations from the multi-agency team for response. When a contact is received by the MASH an initial decision is made by a manager in accordance with the information provided and the PSCP thresholds for services document.



Since 2019-20 there has been a 43% increase in the number of contacts made to MASH. It has risen from 12,924 contacts in 2019-20, to there being **15,192** contacts in 2022-23.

These contacts across the year related to 11,055 individual children, which represents a significant increase of 40.6% increase from 2021-21.



Of these contacts there was a 22% reduction in those that met the threshold for a referral to Childrens Social Care, and a 9% reduction in those that met the threshold for a referral to Early Help when compared to the numbers from the previous year.

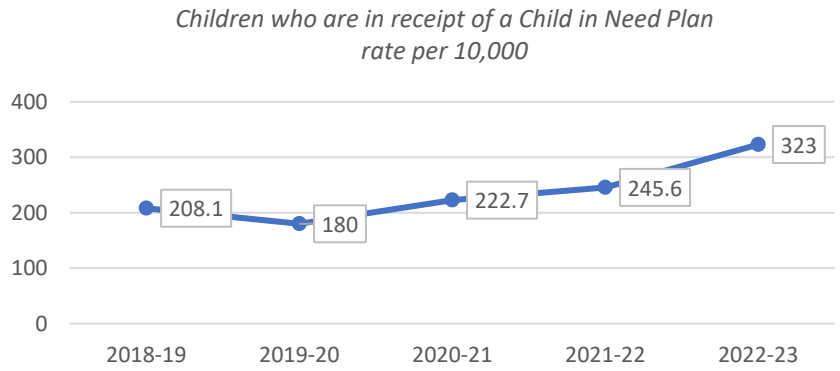
Agency	Number of Contacts	% of overall contacts	% that met Tier 4 threshold	% that met Tier 3 threshold
Police	4,171	27.5%	18.6%	1.3%
Schools	2,400	15.8%	25.1%	26.4%
Health[2]	2442	16.1%	17.1%	6.5%

[2] This includes hospital, GPs, Health Visitors, School Nurses etc

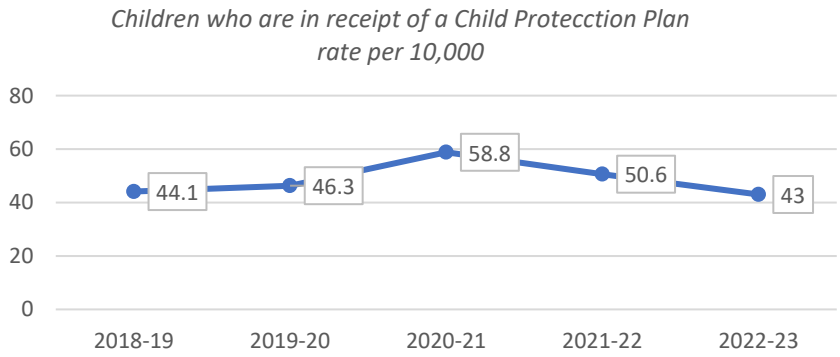
When considering the source of the contacts made to MASH, it is clear that the police make the largest number of contacts. However in terms of whether these contacts result in a referral to either the Family Support and Safeguarding Service or the Early Help Service, it is schools that make the greatest percentage of referrals that meet either the Tier 3 or Tier 4 threshold.

Child in Need, Child Protection and Looked After Children

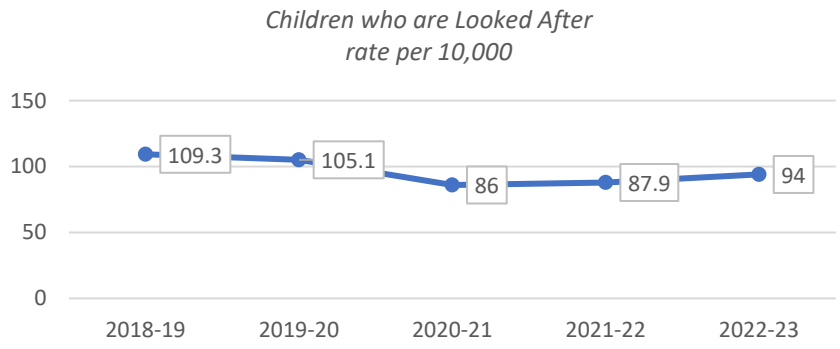
The rate of children in receipt of a Child in Need Plan in 2022-23 has increased by 31.5% from 2021-22.



Whereas the rate of children on a Child Protection Plan in 2022-23 has decreased for the second year by 15% from 2021-22.



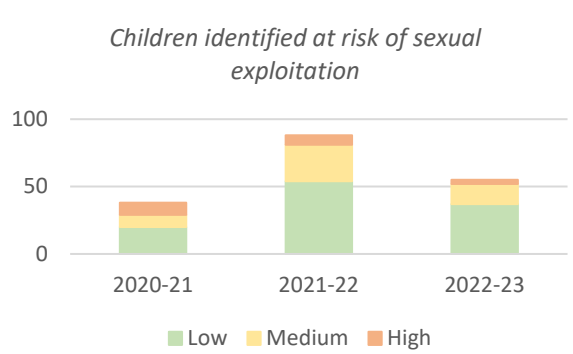
There has been a 6.5% reduction in the rate of children who are looked after in 2022-23.

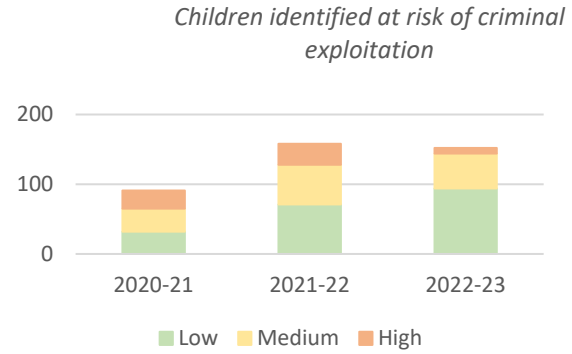


This overall picture indicates that whilst there are more concerns about children's safety and wellbeing notified into MASH, proportionally their needs are being managed at a lower tier of support than in previous years.

Extra-familial Harm

In 2022-23 there has been a 31.8% decrease in the number of children identified at risk of sexual exploitation from the previous year; and a 9.5% increase in those identified at risk of criminal exploitation.

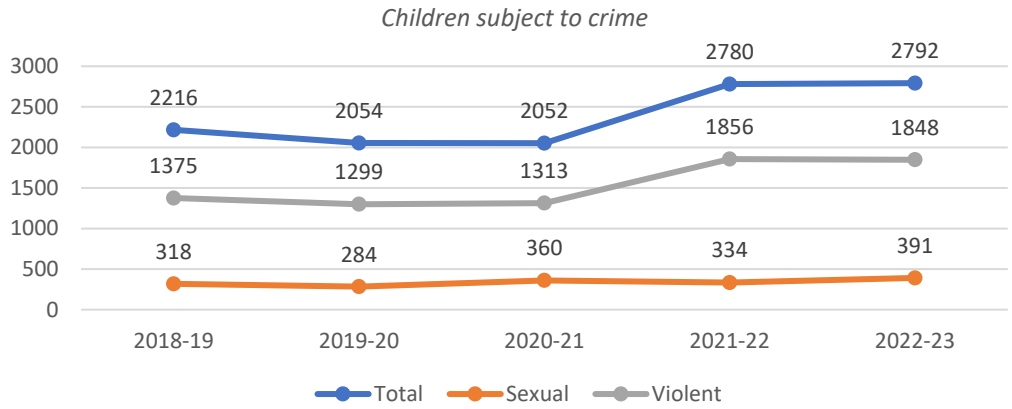




Within the last three years the percentage of children identified at low risk of exploitation compared to high risk has increased. This is a positive indication that the workforce is now better equipped to identify an emerging risk, so that support can be provided to the child sooner before they experience more significant harm.

The youth offending police team have noted that between 1 in 4 and 1 in 3 children referred have been identified as at risk of exploitation. This indicates that children at risk of exploitation are more likely to come to police attention for criminal behaviour than their peers. This is why in response to the strategic priority to keep young people as safe as possible from extra-familial harm in the revised Safeguarding Strategy, a Youth Forum is being developed. The aim is that by bringing together specialist knowledge and expertise from the Youth Offending Team, Violence Reduction Unit and child exploitation teams, we will develop a more effective response to the prevention and disruption of exploitation and be better able to divert young people from becoming involved in criminality.

There also continues to be a steady increase in the number of children subject to crime over the last 4 years. Since 2018-19 reported sexual crimes have increased by 18.7%, violent crimes have increased by 25.6% and the total number of crimes have increased by 20.6%



Neglect

Following last year's Annual Report, in response to the 305% increase in the number of crimes recorded for neglect noted from 2017 to 2022 Hampshire Constabulary completed an analysis of their cruelty and neglect profile. They concluded that the Force had seen an increase in these occurrences over the last 5 years and that there were multiple contributing factors identified for this.

There has been an upward trend seen nationally, with the NSPCC reporting a 25% increase in cruelty and neglect during 2021/2022. It is predicated that volumes will continue to increase over the next few years in line with all child abuse offences.

Although Hampshire Constabulary are recording significantly higher volumes than other forces within the region, they felt that this does not necessarily equate to increased risk being seen. Crime Data Integrity (CDI) accounts for approximately a third of all cruelty and neglect occurrences recorded within Hampshire over the last 5 years. The forces approach to crime recording as a whole has changed and progress has been made year on year. It is recognised that when neglect is reported and there are multiple children within a household, each child will be recorded as a victim on a separate occurrence. These recording improvements will likely account for some of the increase, particularly in areas where there are larger families with multiple children.

Despite the impact of CDI, in 2019 cruelty and neglect offences increased disproportionately compared to all crimes across the force and, more specifically, to all child abuse crimes. This coincides with a large amount of training and emphasis across Police to ensure that incidents of neglect are reported. This remains a strategic priority for all agencies and it is likely the improved identification and recording have contributed to the increases in recorded cruelty and neglect during this time.

MASH demand analysis has shown that the total number of all Public Protection Notice (PPN1) volumes have increased over the last few years. Safeguarding teams (predominantly MASH) are recording the greatest proportion of cruelty and neglect and this has increased by 94% (from 297 in 2017 to 577 in 2021). The rise in MASH volumes coupled with a confidence in the team's data recording accuracy suggests that there is an increased understanding of what constitutes cruelty and neglect within Hampshire.

Concerns were also raised that despite an increase seen in commission rates the arrest rate remained relatively stable for these offences. It is acknowledged that an arrest is not always the best course of action and analysis confirms that there were multiple occasions where a series of crimes were investigated under the one arrest record. Therefore an arrest may fall within that of a linked offence and will not be reflected in the arrest data for cruelty and neglect, but positive action was still taken.

Additionally, those neglect occurrences resulting in Formal Action Taken (FAT) have increased to higher levels than all other child abuse crimes, suggesting that there are more positive outcomes for children who are victims of cruelty and neglect. Community Resolutions (CR) account for the greatest proportion of FAT outcomes, and these have increased since 2019 whilst arrests and charges have remained relatively stable. Since 2018, all neglect offences recorded by MASH are automatically referred to CAIT who are specially trained in working with partners to support a positive safeguarding outcome for children. Analysis has confirmed that the Child Abuse Investigation Team's (CAIT) use of Out of Court Disposals (OOCD) was positive and effective, particularly in cases of neglect where it is a positive early intervention tool.

Deep Dives and Audits

Multi-Agency Safeguarding Hub (MASH) Audits

Every quarter representatives from the PSCPs three statutory partners undertake an audit of contacts into the MASH, to consider:

- Quality of information provided,
- Use of parental consent, and
- Application of threshold

Each quarter the MASH Board agrees a focus or thematic aspect for the audit which is informed by either learning from performance data or agency requests. (Please note that where any contacts are considered to be inadequate, feedback is provided to the individuals to support their learning and any remedial action to ensure the child is appropriately safeguarded is taken.) In 202223 the audits undertaken were as follows:

Quarter 1: Application of threshold and consent

17 contacts were reviewed that had varying outcomes in order to assess the application of threshold and the appropriateness of the decision making. Within this we also considered whether consent had been appropriately sought and recorded.

In terms of the application of threshold we were confident that the decision making and outcomes were appropriate in all 17 cases. There was clear recording of the rationale for the outcome in all instances, noted within a 24-hour time period. There is clear strong management oversight at point of contact and throughout. It was felt that 4 of the contacts were unnecessary and this was fed back as learning to each of these agencies.

Quarter 2: Contacts into MASH that do not progress to contact and referral

In this audit 10 contacts that came into the MASH that then did not progress to being a formal contact, and so were not recorded on MOSAIC (Children Social Care - Computerised Record System), as it was deemed as not being proportionate to record them.

The question of management oversight on these was considered. However, whilst there is a process in place that each contact will be seen by either a Service or Team Leader and the decision not to record will be made by them, as these contacts are not recorded, we were unable to review whether this process had been followed.

Of the 10 children where contacts made into the MASH in August were not recorded on a contact and referral record on MOSAIC, these were made up of 5 from police, 4 from health and 1 from a nursery. Of these the decision made in 9 of the 10 instances was agreed to be appropriate and proportionate.

Quarter 3: Contacts into MASH where the Single Assessment Framework (SAF) is completed, but the child was not seen as part of the assessment

This audit considered 6 contacts that were assessed by MASH as meeting Threshold at Tier 4 and an assessment was completed, but the child was not seen as part of this process.

The initial assessments where the child was not seen as part of process were reviewed, with hypothesis that these would show assessments closed down by management agreement prior to completion. This was borne out in the sample considered and there were 3 themes that ran strongly through the sample:

- A lack of curiosity in the assessment
- Assumptions about consent and lack of engagement
- How robust and assertive are we in our engagement with families

On more than one occasion visits and work were undertaken with the family, but then deemed that a full assessment was not needed. So the start and finish of the assessment was completed with a rationale given for this. It was felt that this rationale lacked curiosity and challenge and often involved taking the families' word for something, regardless of the information contained in referral.

Quarter 4: Application of thresholds

14 contacts were selected from March that had varying outcomes in order to assess the application of threshold and the appropriateness of the decision making.

The audit found confidence with 13 of the 14 threshold decisions. 1 was challenged which involved a child who had disclosed historical sexual abuse. This was referred back to MASH who reviewed the findings and held a strategy discussion post audit.

Child Protection Plan Audit

In October 2020, the PSCP published a serious case review of Child H. One of the recommendations was that "*The Safeguarding Partnership commission a multi-agency audit of Child Protection Plans to gain assurance that information taken in to Initial Child Protection Conferences via single agency reports accurately captures and analyses known and knowable risks to the child, that the record from the ICPC reflect such risks and these*

are translated into the Child Protection Plan". This was undertaken in 2021-22 and the findings reported to the Partnership in July 2022.

Areas of strength:

- Assessments were consistently comprehensive and detailed. They provided clear summaries of risks to children.
- Appropriate and broad multi-agency attendance at Strategy Meetings
- The Chairs were consistently restorative, empathetic, and caring.
- The use of motivational interviewing was strong. Discussions were strengths based and there was open ended questioning and positive affirmations.
- Families had always been well briefed in advance of the meeting by the Chair, and the purpose was well explained again within the meeting.
- Families were well supported throughout conferences and the process in general. Professionals demonstrated high levels of empathy and consideration.
- The Chairs made sure that each professional had multiple opportunities to provide updates, feed into the meeting and raise any comments/questions throughout.
- All professionals had provided a report in each of the conferences.
- Families were usually given frequent opportunities to share their views and feed into the creation of the plan.
- A Family Safeguarding Approach had been considered where appropriate, with Adult's workers involved in several cases.

Areas for development:

- Risks were not consistently followed through from referral and assessment to the plan. If the risk identified in an assessment is unsubstantiated, it should be recorded in the ICPC minutes/ on the plan that this is no longer a risk.
- There were examples were there seemed to be a focus on one parent, especially if they were more engaged.
- Due to the pandemic, conferences were being held virtually or as hybrid meetings. Unfortunately, many of the conferences were hindered by IT issues. This was always managed well by the Chair but not an ideal scenario for these types of meetings.
- Although professionals had consistently had sight of reports, the family often had not seen them in advance of the meeting.
- Inclusion of the child's views was not consistent. The voice of the child and family was not always strong in both conferences and plans, it was broadly felt that the lived experience could have been clearer.
- There were some examples of professional language being used that families may not understand e.g. 'Toxic Stress', 'Restorative Approach'
- Outcomes on plans and timescales for those were not always achievable e.g. school attendance going from 25% to 97% in a period of less than two months. Contingency plans were also not measurable and would benefit from clear timescales.
- There were some examples of partner agencies not feeling like their views had been incorporated into the assessment or resultant plan.
- There were a number of cases where there had been limited inclusion or attempts to include the father/ partner.

What has been done as a result:

- A dip sample of current child protection plans was undertaken in May 2022 that demonstrated an increased expectation within Childrens Social Care relating to the quality of child protection plans, and a significant shift in outcome focussed plans.
- Continued focus remains within the Rapid Improvement Group relating to Care Planning. There is specific focus on SMART planning, outcome focussed plans, and the voice of the child.
- Hybrid technology has now been installed in the Civic Centre, with all conferences now being offered with hybrid capacity.
- Information relating to the sharing of agency reports is now included in the Child Protection Advisor's audit form that is completed as part of the record of the meeting.
- A 'One Minute Guide' was published regarding Our Model of Conferencing in November 2021. This includes clear guidance for professionals about expectations for sharing reports in advance of meetings
- Improvements have been made to the electronic recording system to ensure that the most recent plan is reviewed as part of all Review Child Protection Conferences - informed by the progress of the Core Group.
- 'Mind of My Own' is promoted within the service. Information regarding MOMO, a digital tool enabling children to give their views, is included with all invitations to CPC's. All children age over 4 years subject to CPC's are also referred for Advocacy support.
- Child Protection Advisors have been offered development work around analytical recording. Specific workshops have been delivered and this is an ongoing element within the Service Quality Team business plan

Transition Deep Dive

This was done in response to the Learning Review of Child G and the Safeguarding Adults Review of Mr D both undertaken in 2019. These both concluded there should be a joint exploration with the Portsmouth Safeguarding Adults Board (PSAB) of the effectiveness of transition arrangements for young people with significant learning difficulties and/or disabilities; and to consider the impact of the revised Transition Protocol that was revised a result of these reviews.

This was undertaken in 2021-22 and the findings reported to the Partnership in June 2022.

Areas of strength:

- Referrals to Adult Social Care (ASC) are made from Children's Social Care (CSC) when the child reaches 14yrs old in line with the Protocol and Care Act 2014 duties
- The staff within special schools and the child's social workers engage early with families to explain transition and the process that will be undertaken
- There were timely health transition and Continuing Health Care assessments. Child Paediatric Medical Services continue providing support until the young person reaches 19 years of age, and so (where they are open to CPMS) the Paediatrician is able to offer consistency in care during the young person's transition to ASC
- For children who are looked after, their Independent Reviewing Officer provided additional scrutiny by checking that a transition plan was in place and managed effectively by their 18th birthday.

Areas for development:

- Quality of practice was reliant on the workers supporting the child - there was inconsistent practice evident seen with some particularly good practice from individual workers, but we need to improve the consistency of practice to make sure all young people have a good transition
- ASC were not adding young people to their recording system before their 18th birthday. When CSC referred a child aged 14yrs, it was therefore unclear where this information was stored and how ASC were monitoring these to ensure effective planning for transition was occurring

- Some children were not referred to ASC as CSC believed their needs meant they would not meet the threshold for receiving services. However, all children whose needs will continue to make them vulnerable into adulthood should be referred, as even if they are not eligible for services ASC will be able to signpost them to other appropriate sources of support
- There was limited understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards within the children's workforce and the impact these have upon including children and their families withing transition planning, including consent for referrals and information sharing
- There needs to be an improvement in the information available to families regarding services and support available preparing for & during transition, and into adulthood. This information should also be supplied in accessible formats.

What has been done as a result:

- Adult Social Care has employed a Transition Lead who works closely with Childrens Services and the Inclusion Service, to ensure that there is now strong oversight of the transition planning for young people
- A member of staff has been recruited with responsibility for maintaining the Local Offer website, to improve the information available to families and across the workforce regarding services and support available.
- Within the Preparing for Adulthood core group, transition champions across the partner agencies have been identified.

Obesity Deep Dive

Data from the National Child Measurement Programme (NCMP) for the school year 2021/22 showed that:

- Portsmouth is the only upper tier local authority in the region that has a percentage of Reception children living with obesity that is statistically significantly worse than the England average.
- Portsmouth is one of 3 UTLAs in the region that are statistically significantly worse than the England average for Year 6 children living with obesity.

Childhood obesity can be associated with various diseases (often called co-morbidities) such as sleep apnoea, type 2 diabetes, liver disease and orthopaedic problems. However, being overweight as a child can affect more than their health. It can also impact self-esteem, ability to participate in activities, mental health, and quality of life. All of which can last into adulthood.

This was undertaken in 2022-23 and the findings reported to the Partnership in January 2023.

Areas of strength:

- In the majority of the children reviewed their GP had been proactive in identifying that the child's weight was rapidly increasing and that they were overweight or obese. This was even the case when it was the child's first appointment at that practice, or the child had attended for another reason other than related to measuring their weight. In all instances there was evidence of the GPs making appropriate referrals to other health services to help the family with their child's weight management.
- The Complications from Excess Weight (CEW) Clinic appears to be effective in helping children reduce their weight. For the children who had been receiving support from the CEW Clinic they had all managed to reduce their weight.
- There was evidence of health professionals recognising the child's reluctance/fear of attending the hospital to receive interventions from the CEW Clinic. Examples of how there were overcome were nurses going out to complete weight measurements or blood tests in the community; or supporting attendance by providing transport and accompanying them from home to the hospital.

Areas for development:

- Children not being brought to appointments meant that in many of these instances the child was either discharged from the service or opportunities to identify concerns earlier and offer support were missed.
- For many of the families additional needs were identified that included bereavement, parental ill-health, domestic abuse, social isolation and/or poor parental mental health. Where these were identified, there was limited evidence of exploration of how these potentially impacted on the family's ability to engage in the support and advice being offered. However, this consideration was consistently apparent once a family was supported by the CEW Clinic.
- There was reference in the records to parents' lack of awareness of the complications upon their child's physical and emotional health and wellbeing from them being obese.
- There was limited evidence of the use of the Obesity Pathway and the Thresholds Document in helping practitioners consider an appropriate response.
- Practitioners need to ensure that there are no assumptions made about other services knowledge of the impact the child's weight might be having upon them. As such references to weight or BMI may not be meaningful to practitioners not familiar with what a healthy weight range should be for that child.
- There were examples of schools not recognising concerns about the child's excess weight or not being confident as to how to appropriately respond.

What has been done as a result:

- The PSCP has engaged with Public Health to advise them of the findings of this audit. Until now they have utilised national resources in their public campaigns regarding childhood obesity. They now aim to review these and consider how these can be better targeted. They are also leading on a review of the Obesity Pathway.
- The PSCP Training Team has collaborated with the Consultant Paediatrician from the CEW Clinic to develop a multi-agency workshop ' Working Together to Effectively Safeguard Obese Children' that will become part of the core offer from September 2023.
- The learning from this audit has been shared with education and early years settings, and examples given of how they can use the FSP to support early intervention when a child's weight is increasing. These messages are being shared within the PSCP Early Help training.

Recommendation Tracking

The PSCP has evolved a method of tracking the recommendations made to the multi-agency safeguarding system in Portsmouth (from case reviews, data analysis, audits, and inspections) whereby once every 2 months relevant agencies are sent a request to update their progress against these. The returns are presented to the Monitoring, Evaluation & Scrutiny Committee whose role is to consider whether the action fully meets the ambition as set out in the recommendation; and whether there is sufficient evidence of the robustness of its implementation and/or impact on the effectiveness of improving safeguarding arrangements.

	Number at start of year	New, added in year	Completed in year	Outstanding at end of year
Children's Social Care	14	17	30	1
Adult Social Care	0	1	0	1
Education Service	1	0	0	1
General Practices	0	1	1	0
Hants & IoW ICB - Portsmouth place	0	1	0	1
Hampshire Constabulary	0	1	0	1
Portsmouth Hospital University Trust	4	0	3	1
PSCP	19	13	14	18

Solent NHS Trust	0	3	2	1
University Hospital Southampton Foundation Trust	4	0	4	0
Total	**42**	**37**	**54**	**25**

Safeguarding & Early Help Compact Audit

The Partnership is collectively responsible for the strategic oversight of local safeguarding arrangements, to ensure that organisations working with children and families in Portsmouth are compliant with their statutory duties to safeguard and promote the welfare of children

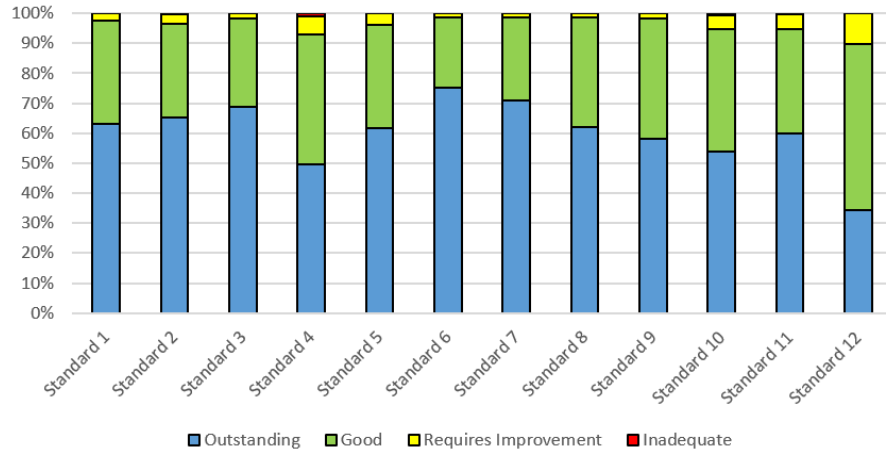
Part of the way in which the PSCP does this is to require all services that work with (or regularly come into contact with) children and families, to complete a self-assessment once every two years against 12 standards with varying indicators to reflect the varying statutory requirements. This is referred to as the Compact Audit and more details of this can be found here on the PSCP website[3].

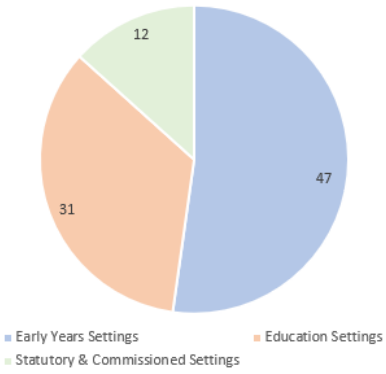
1. Senior management commitment	5. Induction, training & appraisal	9. Information sharing
2. Staff responsibilities & competencies	6. Recruitment	10. Equality of opportunity
3. A clear line of accountability	7. Allegation management	11. Disabled children
4. Service development	8. Effective inter-agency working	12. Commissioning

For each standard there are a set of indicators, which describes the behaviours, processes and policies that would be expected. Settings are then asked to assess themselves against these as to whether they feel their current practice is outstanding, good, requiring improvement or inadequate and to provide the evidence which they believe demonstrates this. Where this is less than good, they are asked to develop an action plan describing what they will do to improve practice.

There is a quality assurance process in place overseen by the Monitoring, Evaluation & Scrutiny Committee to review the individual returns and progress against the action plans. By reviewing all the returns, it allows us to engage both at a setting and sector level to address any gaps in knowledge and/or practice. Briefings are produced summarising the learning at a sector level, and the learning is used to inform future PSCP training and support development.

This year a total of 89 returns were received:





The overall analysis of the returns submitted this year indicates that there are 4 areas of practice where there is a significant need for improvement, these are:

[3] https://www.portsmouthscp.org.uk/10-learning-from-practice/10-2-portsmouth-safeguarding-and-early-help-compact-audit/

Standard 4. Service development takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families = 6.12% RI and 1.05% inadequate

Standard 10. Equality of opportunity = 4.76% RI and 0.56% inadequate

Standard 11. Special Educational Needs & Disabilities (SEND) = 4.97% RI and 0.17% inadequate

Standard 12. Additional specific requirements for commissioning bodies = 10.29% RI and 0% inadequate

What is noticeable is that the areas requiring the most improvement are the same as last year, with the addition of the areas in relation to Standard 11. This demonstrates that more needs to be done to work with settings across Portsmouth to communicate effectively how they can improve their safeguarding arrangements in these areas.

The PSCP requests that settings who completed the Compact Audit last year and marked any indicators as requiring improvement or as inadequate submit an update on the progress and impact of these actions. Some of the examples given are:

- *Completion of the Compact Audit has helped to highlight the importance of what we do and how, if things are not done correctly, the consequences of this.*
- *The focus on safeguarding from point of induction and safer recruitment training for managers has promoted a positive safeguarding culture.*
- *All staff understand that safeguarding is everybody's responsibility and a culture of it could happen here. Safeguarding procedures in school are secure and staff are more vigilant around the nuances of change for the children.*
- *The work completed alongside the children has been particularly beneficial and empowered the children in their knowledge also.*
- *Ensuring that any future changes are assessed, ensures that the impact upon all children and other stakeholders are considered and not unfairly discriminated against.*
- *Implementing Safeguarding Board Meetings where every term the DSL, Safeguarding Link Governor, and Senior Safeguarding Officers meet. These allow the team to review patterns and trends on a termly basis, including making comparisons to previous years.*
- *Contactors are challenged when coming onto school site if no DBS or accompanied by school staff at all times so that children are not exposed to adults without DBS.*

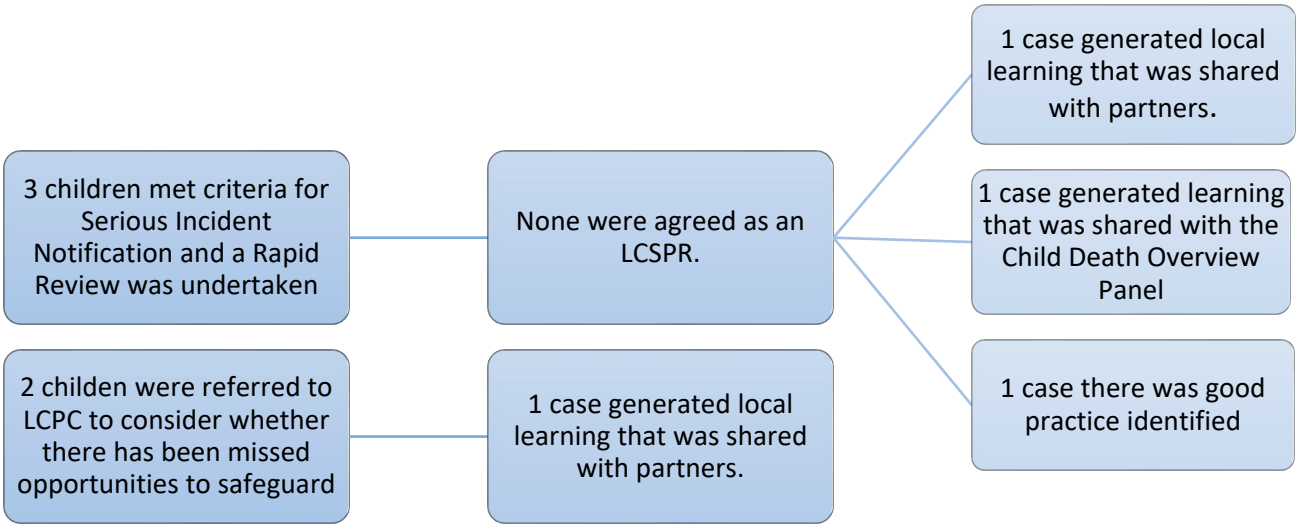
Learning from Children & Practice

In accordance with Working Together 2018, a Local Safeguarding Partnership should consider undertaking a Local Child Safeguarding Practice Review (LCSPR) when it is thought that the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- is one which the Child Safeguarding Practice Review Panel has considered and concluded a local review may be more appropriate.

If a case meets the above criteria, it does not mean that a LCSPR must be agreed. It is for the local area to determine the relevance and opportunity for local learning and development.

Where a case meets criteria for a Serious Incident Notification as per Working Together 2018, the Local Authority is required to notify Ofsted. The Partnership then has 15 days to conduct a Rapid Review and make a formal decision regarding any further review. All decisions are agreed by the Learning from Children & Practice Committee (LCPC), the Safeguarding Partners, and the Independent Chair.



LCSPR Reports are published on our Safeguarding Children Partnership website in our learning from practice section. During the period April 2022 to March 2023 the PSCP has not published any Child Safeguarding Practice Reviews. However it has completed the following:

Thematic Review into availability of Tier 4 beds - The instances of 3 young people were referred to the LCPC between Oct/Nov 2021 that had common concerns as they been placed on paediatric wards with significant mental health and/or 'behaviour' issues where the local hospital is deemed a 'place of safety' because no other option was available. Whilst there were no concerns that met the threshold for a LCSPR, it did highlight what is both a local and national challenge of placement bed availability. The Head of Integrated Commissioning for the local authority and Portsmouth Clinical Commissioning Group undertook a thematic review into this issue. This considered the journey of 13 young people to their admission to hospital. 6 actions were developed in response to this review, which were:

1. Investment was made into the Paediatric Psychiatric Liaison Service at the hospital and will be monitored through the quarterly Child and Adolescent Mental Health Services (CAMHS) Performance Review.
2. The CAMHS Closer to Home Service started to take cases during March 2022 which should support more young people at home and avoid admission.

3. Portsmouth CCG have committed to investing in 3 new mental health roles to support the 'Team around the Worker', to be hosted in the Integrated Targeted Early Help Service as part of a new approach to chronic absence.
4. Portsmouth CCG have committed to investing in an additional role in the CAMHS LD team to provide greater capacity for crisis support.
5. A multi-agency bid to the DfE respite programme has been submitted, jointly with Southampton, for out of school activity.
6. Engaged with Hampshire Childrens Social Care to develop system-wide mechanisms to support young people in avoiding hospital admission or to speed up discharge.

'Henry' was a 2-month-old baby who was suspected of being physically harmed by his parent, resulting in substantial injuries. This incident was notified to Ofsted by the Local Authority and a Rapid Review was completed. Whilst the case met the criteria for a LCSPR, there were similarities in learning to those identified in Child E, Child I, Freya and Skylar. Instead, the learning identified in the Rapid Review will be shared with relevant agencies, appropriate recommendations developed and consideration of the appropriateness of the response built into the Deep-Dive on the Unborn Baby Protocol being undertaken in 2023. This will include consideration of what the barriers may have been in effectively implementing the recommendations from the previous reviews. The National Panel has agreed with our decision.

Workforce Development

The PSCP training programme has grown in strength and depth over the past year. Following the significant changes made to adapt to the consequences of Covid19, the team have reformed the offer again to meet the growing need for connection. Through extensive feedback gained from across the workforce, it was clear that learning 'in person' is of far greater benefit and the networking gained in being together improves relationships resulting in more effective safeguarding practices. However shorter courses remain on-line as this supports easier access to them, and has the benefit that delegates are off-site from their place of work for a shorter period of time

The PSCP training offer has strengthened its focus the importance of growing a safeguarding culture in line with Keeping Children Safe in Education (KCSiE) and other statutory guidance, research and evidence. Underpinning much of this work is the focus on language and how it reflects our values. Building on the relational and restorative work, language forms an essential part of how we develop practice which is inclusive, accessible and kind. An essential element of all of the taught sessions on the PSCP training programme, is that delegates are given time and support to consider application of their learning in practice. The feedback from attendees is overwhelmingly positive, that in particular this has enabled their practice to improve and strengthened how they work together across the multi-agency network and how they connect with children and families.

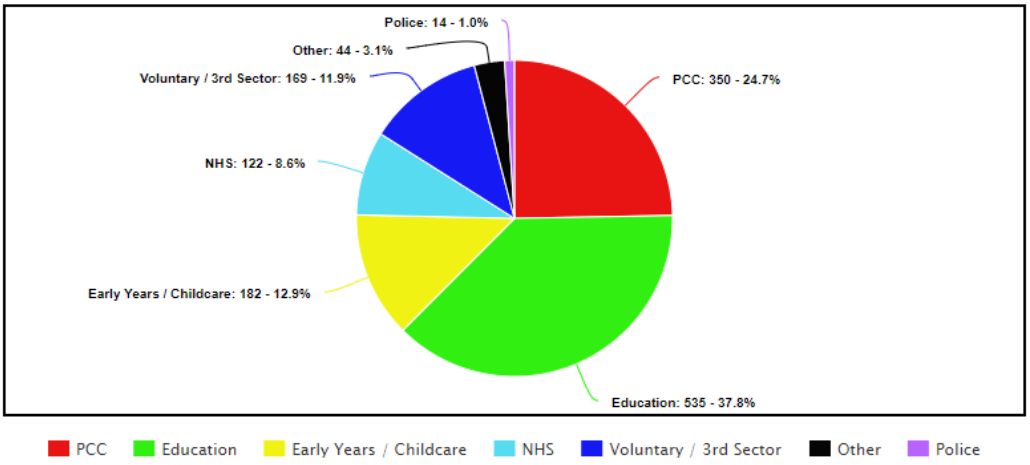
Another key focus this year has been to strengthen how we embed learning from both our audit and scrutiny activity and from learning from children and practice into training. In combination with the feedback from delegates through evaluation of the courses they have attended, this allows for adaptations to be made to the programme throughout the year to ensure the training remains meaningful and current.

Going forward the priority is to continue to strengthen the PSCP training in line with local and national learning. The training team will respond to bespoke work in line with the growing momentum around language development and relational practice. Re-think will be a central strategy in supporting the workforce to improve outcomes for children and their families. And finally the team will work together with the PSCP Business Manager to ensure effective improvement activity is designed in line with learning gained from the Partnership's activity.

Attendance on PSCP Training

Despite there being a 5.2% decrease in the number of multi-agency training courses available in 2022-23 compared to the previous year, there was a 7% increase in bookings and a 5.6% increase in attendance.

Multi-agency training data	2020-21	2021-22	2022-23
Number of courses run	129	134	127
Number of bookings	1,972	1,636	1,766
Number of attendances	1,556	1,337	1,416
Booking attendance %	79%	81.72%	80%



As can be seen in the chart above, the majority of attendees on these courses come from education settings and Portsmouth City Council

However, caution needs to be applied when making a comparison to the preceding years for both single and multi-agency training, due to many of these courses being impacted by restrictions applied following the Covid19 pandemic.

The requests for single agency (bespoke) training grew significantly in 2022-23 with a 133% increase in the number of courses ran. Throughout the year, as well as the inset training delivered to education settings, there has been considerable work carried out on a single agency basis with Hampshire Constabulary, and teams within Solent NHS and Portsmouth City Council.

Single Agency Data	2020-21	2021-22	2022-23
Number of courses run	17	27	63
Booking Attendances	408	1,220	1,506

A contributing factor for this high growth in single agency training is how practitioners and managers experience the multi-agency training programme. Following reports of positive learning experiences, managers often contact the team for further input, wanting to have a more specific and targeted training input delivered to their team. Equally those who have had bespoke training previously have come back again for further input.

Re-think

In the PSCP 2021-22 Annual Report, the development of the Re-think approach was described in relation to the learning from the Skylar LCSPR. Over the past year Re-think has grown in strength and momentum, and a growing number of sessions have been facilitated in order to support the workforce in relation to their safeguarding work with children and families to:

- Address and repair professional disagreement and / conflict
- Find creative solutions to 'stuckness'
- Define roles and responsibilities to ensure effective multi-agency collaboration

Giving and receiving honest challenge about our work with families can be difficult and taking time to ‘slow down’ and consider how to go about hearing challenge is vital to ensure children and their families are kept at the centre of our work. Resolving concerns is beginning to be seen as an integral part of how we advocate for children and their families in Portsmouth. Re-think is beginning to support the workforce to address such challenges.

Further work in evaluating the impact of Re-think is being prioritised over the coming year and will build on the existing evidence showing impact on practice.

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Portsmouth CITY COUNCIL

Title of meeting: Health & Wellbeing Board

Date of meeting: 29 November 2023

Subject: Partnership Strategic Assessment of Crime, Anti-social Behaviour, Reoffending and Substance Misuse: Update for 2022/23

Report by: Helen Atkinson, Director of Public Health

Written by: Sam Graves, Community Safety Analyst

Wards affected: All

Key decision: No

Full Council decision: No

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1. Purpose of report

1.1 Community Safety Partnerships have a statutory requirement to produce an annual strategic assessment (or update) as well as a three-year partnership plan (refreshed annually). This document fulfils the obligation to produce the strategic assessment and informs the refresh of the partnership plan.

1.2 The *'Partnership Strategic Assessment of Crime, Anti-social Behaviour, Re-offending and Substance Misuse: Update for 2022/23'* provides an update on crime trends, identifies any emerging issues, and reviews the community safety priorities.[1] This strategic assessment also includes the Serious Violence Strategic Needs Assessment (Chapter 3) which will inform the Serious Violence Strategy.

1.3 Taking the updated crime data into consideration, it is recommended that the priorities identified in 2020/21 remain the same:

(i) Tackling violent crime, continuing to focus on violence against women and girls, sexual violence, domestic abuse, and knife-enabled violence.

(ii) Tackling drug-related harm, with a focus on increasing access to treatment and closer working across physical and mental healthcare.

(iii) Early identification of and interventions with children and young people at risk of exploitation or abuse, of misusing substances and of anti-social behaviour and offending.

[1] For the full wealth of data and analysis please refer to the full Strategic Assessment for 2020/21 at Strategic Assessments - Safer Portsmouth or contact the community safety researchers directly - csresearchers@portsmouthcc.gov.uk

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(iv) Improve accessibility and capacity of mental health provision for children, young people, and adults.

(v) Increase the awareness of cyber-related harm and how it impacts service users.

2. Recommendations

2.1 It is recommended that the Health & Wellbeing Board:

(i) Use the information in this strategic assessment (and the previous full strategic assessment in 2020/21) to guide evidence-based day to day decision making and resource allocation.

3. Background

3.1 The Safer Portsmouth Partnership was incorporated into the Health and Wellbeing Board in June 2019. The constitution of the board was amended to take on the statutory duties of a local community safety partnership. The Health and Wellbeing Board is now the vehicle through which the five statutory partners - council, fire, police, health and probation[2] - work together to reduce crime, anti-social behaviour, substance misuse and reoffending as required by Sections 5 and 6 of the Crime and Disorder Act 1998 (as amended).[3]

3.2 The responsible authorities are required by sections 5 of the Act to produce a detailed piece of analysis (strategic assessment), that identifies local priorities for action. Strategic assessments and updates are produced by the Public Health Intelligence Team using a range of data from partner agencies, including police recorded crime, to provide a summary of local and national crime trends, checks the partnership's current priorities and identify any emerging issues.

3.3 The Serious Violence Strategic Needs Assessment (Chapter 3) is a requirement of the Serious Violence Duty, which was introduced in Chapter 1, Part 2 of the Police, Crime, Sentencing and Courts Act, 2022. The Serious Violence Duty requires specified authorities[4] to work together to prevent and reduce serious violence by completing a Strategic Needs Assessment (SNA) to identify the kinds of serious violence occurring in the area and likely causes where possible, which should then inform a strategy. Analysts in upper tier local authorities have collaborated with the Office for the Police and Crime Commissioner and police to produce individual SNAs for the HIPS[5] districts, using a bottom up approach. These district level SNAs will be used to produce an overall HIPS-wide SNA but will give detail for the lower level areas which is often lacking from HIPS-wide documents. The Portsmouth SNA has been situated within the Partnership Strategic Assessment so that it can be considered in

[2] Also referred to as the 'responsible authorities'
[3] https://www.legislation.gov.uk/ukpga/1998/37/section/5 and https://www.legislation.gov.uk/ukpga/1998/37/section/6
[4] Similar to the responsible authorities - but with the addition of Youth Offending Teams as well as Probation.
[5] Hampshire, Isle of Wight, Portsmouth and Southampton.

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the context of other crime and ASB trends and used to inform the crime and ASB and priorities for Portsmouth.

3.4 Please see attached Appendices for the findings of the strategic assessment update.

(i) Appendix A - Key Messages from the Partnership Strategic Assessment of Crime, Anti-Social Behaviour, Substance Misuse and Reoffending: Update for 2022/23

(ii) Appendix B - Partnership Strategic Assessment of Crime, Anti-Social Behaviour, Substance Misuse and Reoffending: Update for 2022/23 (this is not for public distribution due to the inclusion of provisional data, a version which can be publicly disseminated will be produced after final amendments are made and will be available on the Safer Portsmouth website).

4. Reasons for recommendations

The Crime and Disorder Act 1998 (as amended) Secs 5 and 6 set out the requirements for community safety partnerships to prepare a strategic assessment in accordance with Regulations 5 to 7. The 2020/21 strategic assessment identified five main priorities that address the underlying issues of crime and anti-social behaviour.

This assessment update will inform the refresh of the partnership plan, and by providing collaborative leadership alongside our partners in order to address these issues, the levels of crime and anti-social behaviour should reduce and make residents safer.

5. Integrated impact assessment

Impact Assessments will be undertaken as required on the specific work to take forward the priorities identified in this needs assessment.

6. Legal implications

The report is compliant in that it is a statutory function to produce a strategic assessment.

7. Director of Finance's comments

There are no direct financial implications arising from the recommendations within this report. Any future requests with potential financial impact will be assessed on case by case basis.

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Signed by: **Helen Atkinson, Director of Public Health**

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Appendices:

(i) Appendix A - Key Messages from the Partnership Strategic Assessment of Crime, Anti-Social Behaviour, Substance Misuse and Reoffending: Update for 2022/23

(ii) Appendix B - Partnership Strategic Assessment of Crime, Anti-Social Behaviour, Substance Misuse and Reoffending: Update for 2022/23

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

Portsmouth CITY COUNCIL

Appendix A - Key Messages from the Partnership Strategic Assessment of Crime, Anti-Social Behaviour, Substance Misuse and Reoffending: Update for 2022/23

- There were 27,239 police recorded crimes in Portsmouth during 2022/23, which equates to a crime rate of 132 per 1,000 residents and is higher than the average for other similar local authority areas (112 per 1,000). This is a slight reduction (3%, n741) from 2021/22.

- Police trend data for Portsmouth is showing signs of stabilising and when other data sources are considered, it is likely that overall levels of crime have remained fairly stable over the last decade.

- Previous increases in police recorded violence from 2014 are thought to be largely due to improved recording practices, an increased willingness by victims to report violence, and the addition of some new offences. Other data sources (such as local survey data and emergency department attendances and hospital admission data) show a stable or reducing trend in violence overall, which means that we can be quite confident that the previous increases in police recorded violence did not reflect a genuine increase in violence in Portsmouth.

- Domestic abuse continues to be the largest known driver of violent crime, accounting for 40% of assaults recorded by police. While levels of police recorded domestic abuse offences also seem to be stabilising, the Domestic Abuse Monitoring Report has identified that there is still work to be done to challenge, support and hold domestic abuse perpetrators to account.

- The Serious Violence SNA has found that levels of serious violence have remained similar to last year, but higher than pre-Covid years due to increases in possession of a weapon offences and robbery over the few years. It should be noted that possession of a weapon offences are impacted by police activity and we cannot be certain this means there has been an increase in weapons in the community.

- The most common offences making up the category of serious violence are possession of a weapon (40%), violence with injury (30%) and robbery of personal property (26%).

- There are higher levels of serious violence from Friday to Sunday and in the evenings. This suggests that the night time economy could be a significant driver, particularly because over 60% occurred in public spaces and where there was a victim relationship recorded, the most common relationship was stranger. Young males aged between 18 and 34 years were most affected by serious violence, both as victims and suspects. There has also been an increase from 2021/22 in young victims and suspects aged between 10 and 17 years.

- Portsmouth compares poorly with the Hampshire and England averages for many of the measures associated with an increased likelihood of violence across family,

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accommodation, employment, income, education, young people at risk, mental health, and substance use domains.

- The number of young people at risk of CCE has increased since 2021/22, and this is likely to be partially due to better awareness and referral pathways, but also to a small genuine increase linked to exploitation of young people by local drug networks. And while there has been a reduction in drug offences since last year, levels are still higher than they were prior to the Covid-19 pandemic.

- While it was suggested that the cost of living crisis might increase theft offences, local police data shows a mixed picture with vehicle crime increasing and shoplifting and burglary reducing. However, shoplifting data from other sources suggests there is likely to have been an increase in shoplifting but that shops are less likely to report it to the police.

- There has been a substantial and sustained reduction in ASB reported to the police. While approximately one quarter of the reduction can be accounted for by the increases in public order offences, there has still been a reduction of between around six or seven thousand reports of ASB since 2011/12. Data from the CSS 2022 have shown that levels of ASB have remained fairly stable, and while some other sources have seen an increase in reports, there are still a large shortfall in the number of ASB incidents reported to local agencies. Not tackling ASB could affect confidence in the police and agencies dealing with these issues.

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Title of meeting:	Health and Wellbeing Board
Subject:	Tackling poverty in Portsmouth
Date of meeting:	29th November 2023
Report by:	Helen Atkinson, Director of Public Health
Report Author:	Mark Sage, Tackling Poverty Co-ordinator
Wards affected:	All

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1. Requested by Director of Public Health

2. Purpose

2.1. To provide an update to the Health and Wellbeing Board on the tackling poverty priority area of the strategy, building on the evidence base and needs assessment provided by the Public Health Annual Report 2023.

2.2. To outline action to date and the next steps to strengthen and develop this area of work, highlighting resource pressures and the role of the Health and Wellbeing Board member organisations and other partners.

2.3. The City Council's Cabinet has been updated and a link to that report is shown in the document table.

3. Information Requested

3.1. The Health and Wellbeing Strategy outlines why tackling poverty underpins health improvement outcomes, building on the work of the Marmot Review[1] to identify the wider determinants of health.

[1] https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

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3.2. Social inequality is considered the fundamental underlying cause of poor health outcomes and therefore tackling poverty is central to addressing health inequalities.

3.3. The Strategy includes a shared commitment across the services represented by the Board to take action to help local residents to escape poverty, and to reduce the impact of poverty for those affected.

3.4. This report provides an update on the work that has taken place since the last update on this priority area in September 2022.

3.5. This report also highlights the significant role for Board member organisations working collectively to take action to tackle poverty.

3.6. Poverty in Portsmouth

3.6.1. The Public Health Annual Report 2023: Poverty and the cost of living crisis in Portsmouth - Needs Assessment[2], provides an updated evidence base to support the city's tackling poverty work and response to the cost of living challenges facing many residents.

3.6.2. The report highlights the challenges many residents face, with one in six children (6,408 children) in the city growing up in poverty. It also demonstrates the inequalities within the city, with one in four (1,041) children in Charles Dickens ward in poverty, compared to one in fourteen (175) in Drayton and Farlington.

3.6.3. Although children in out of work families are more likely to be in poverty, two thirds of children in poverty in Portsmouth live in families where at least one parent works.

3.6.4. Nationally, almost one in six adults are in poverty after their housing costs are taken into account, but this increases to more than one in four adults living in a family with a disabled member. In Portsmouth the 2021 Census showed 18% of residents (36,600) identified as having a disability.

3.6.5. The report outlines how poverty intersects and interacts with other forms of disadvantage and exclusion, highlighting groups of residents in greater need of support.

3.7. Cost of living pressures for households

3.7.1. Although inflation is beginning to fall, the higher prices caused by inflation and interest rate pressures are not expected to reduce rapidly. Wages and welfare benefit entitlements have not kept pace with inflation, leaving an ongoing shortfall in household spending power.

3.7.2. Two of the primary causes of cost of living pressures for lower income households since 2022 have been energy prices and food prices.

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2 https://democracy.portsmouth.gov.uk/documents/s47960/Director%20of%20Public%20Healths%20Annual%20Report%20-%20Full%20report.pdf

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3.7.3. The energy price cap from October is £1,923 a year for a typical dual-fuel household paying by direct debit. This has reduced from £2,074 in July, and £2,500 for the period October 2022 to June 2023, under the Energy Price Guarantee[3].

3.7.4. However, the price cap this October remains 50% higher than in 2021, and the standing charge element of the price cap has increased, so the less energy a household uses, the less money they will save under the new price cap.

3.7.5. The Resolution Foundation has estimated that a third of households will face higher energy bills this winter compared to last year[4], following the removal of the Energy Bills Support Scheme, which provided every household paying energy bills with payments totalling £400 last winter. Therefore energy bills and cold homes continue to be a significant concern.

3.7.6. Food price inflation peaked at 19.2% in March this year, the highest rate in over 45 years[5]. Since then it has slowed, and was at 10.1% in the year to October 2023. Although inflation is reducing, this only means that prices are increasing at a slightly slower rate; food prices remain one of the biggest pressures on household budgets.

3.7.7. The Bank of England's Monetary Policy Committee has been increasing interest rates since December 2021[6], in an attempt to curb inflation. This increases the cost of borrowing including mortgages, which increases housing costs for homeowners and places additional pressure on the rental market, with increased demand from those unable to afford a mortgage, and higher mortgage costs being passed on to tenants in rent increases.

3.7.8. With many mortgage holders in fixed term deals, rising mortgage rates affect households at different times, so some household budgets will not yet be affected, but will face a sudden increase when their fixed term expires.

3.7.9. Interest rate rises feed through more quickly into unsecured personal borrowing, with the Money Charity reporting that nationally average credit card debt stood at £2,394 per household in August 2023, an increase of 8% on the year before[7].

[3] https://commonslibrary.parliament.uk/research-briefings/cbp-9714/
[4] https://www.resolutionfoundation.org/publications/gotta-get-through-this/
[5] https://www.ons.gov.uk/economy/inflationandpriceindices/articles/costoflivinginsights/food
[6] https://commonslibrary.parliament.uk/research-briefings/sn02802/
[7] https://themoneycharity.org.uk/money-statistics/

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3.7.10. To inform the local response to the cost of living crisis, the council's Public Health Intelligence Team created a cost of living dashboard, bringing together key local and national data. This has now been published on the council's Joint Strategic Needs Assessment webpage[8], providing statutory, voluntary and private sector organisations and residents with access to data, to better understand the impact of the crisis and needs in the city.

3.8. Action to tackle poverty and the cost of living

3.8.1. The council continues to deliver support to residents under the Household Support Fund (HSF), provided to local authorities by the Department for Work and Pensions (DWP). A report to Cabinet in June outlined the council's plan to use this resource to support residents in financial hardship during 2023/24[9].

3.8.2. The guidance for this round included a new requirement for councils to extend the provision of application-based support, where instead of identifying residents in need of additional support, the council would invite residents to apply for assistance.

3.8.3. As in previous rounds, Portsmouth's scheme has four main principles:

3.8.3.1. To make full use of the funding available;
3.8.3.2. To fund a range of provision to meet different needs;
3.8.3.3. To target assistance towards those missing out on other forms of support;
3.8.3.4. To provide a holistic offer of support where possible.

3.8.4. The requirement for councils to extend the provision of application-based support was not achievable within existing resource, and required the creation of a new delivery team.

3.8.5. Portsmouth's HSF delivery team (four full time equivalent posts) is now fully operational, consisting of a project lead, two local welfare assistance officers and a business support officer, with the Tackling Poverty Co-ordinator providing the overall strategic lead. The team are complemented by dedicated support from the council's city helpdesk and cost of living support worker.

3.8.6. These are fixed term posts funded by the Household Support Fund grant under administration costs, and therefore this service to residents is dependent on continued funding from the DWP.

[8] https://www.portsmouth.gov.uk/services/health-and-care/health/joint-strategic-needs-assessment/
[9] https://democracy.portsmouth.gov.uk/ieListDocuments.aspx?CId=126&MId=5352

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3.8.7. Delivery is assisted by the digital customer team, who build and manage the application systems, marketing and communications, and other corporate services, including finance, legal and procurement support.

3.8.8. The team have launched the first two application-based schemes; Household Support Fund Family Vouchers and Household Support Fund Cost of Living Payments. Full details of these schemes and how customers can apply are published at portsmouth.gov.uk/household-support and via the dedicated HSF helpline 023 9268 8010.

3.8.9. The team are working at pace to develop further application-based provision, including a warm home payment for disabled people and a discretionary grant scheme for people in hardship.

3.8.10. The focus of these schemes is to reach people who are missing out on other forms of support, who are struggling financially but do not qualify under other means-tested provision.

3.8.11. The schemes are being developed in partnership with a number of agencies that support people in financial hardship, and uptake will be cross-referenced with needs identified in the cost of living dashboard, to ensure assistance is reaching residents in need.

3.8.12. Alongside the application-based provision, HSF is being used to support and extend the food support offer, including foodbanks, larders and pantries, holiday activities and food provision, and support for people at risk of fuel poverty.

3.8.13. The council also delivers additional hardship support through Discretionary Housing Payments (DHP) to assist with rental costs, and the Council Tax Support Exceptional Hardship Fund.

3.8.14. DWP funding for DHP was insufficient in 2022-23, and the council provided an additional £40,000 to meet the needs of residents. DWP funding has been frozen at £428,432 in 2023-24, so the council has allocated additional funding of £50,000 from its Cost of Living Hardship Fund.

3.8.15. A further £27,500 made available by the council for this Hardship Fund has been used to extend the provision of outreach money advice services by Advice Portsmouth and Citizens Advice Portsmouth.

3.8.16. The annual report provides further information on customer demand and outcomes from the council's dedicated cost of living support.

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3.9. Capacity and resources

3.9.1. As outlined above, significant support is being delivered to residents in financial hardship through short-term, granted funded measures, which cannot be sustained beyond April 2024 unless further funding is identified.

3.9.2. The council's Housing service currently fully funds the role of Tackling Poverty Co-ordinator, who works corporately across the council and with partner agencies to promote and coordinate work to reduce poverty in the city, and for Portsmouth City Council tenants living in Havant. This role also provides the overall strategic lead for Portsmouth's local welfare provision, including Household Support Fund delivery.

3.9.3. The Government's autumn budget statement is expected on 22 November, after the publication date for this report, and is expected to include a decision on whether further funding will be made available to local authorities through the HSF to provide local welfare assistance.

3.9.4. HSF funding has remained the same across the first four rounds of the scheme, with no increase to reflect increasing cost of living pressures and demand, and therefore if further HSF funding is made available, there remain significant challenges in how to prioritise and allocate funding across a wide range of needs,

3.9.5. Once the funding decision is known, the Tackling Poverty Co-ordinator will bring forward to the council's Cabinet a set of recommendations to support residents in financial hardship during 2024/25.

3.9.6. If HSF funding is withdrawn, this will significantly reduce capacity to support people in financial hardship, both in terms of access to advice and support, and in direct financial assistance and meeting other essential needs for residents, with the Tackling Poverty Co-ordinator role being the only remaining funded role focussed solely on this agenda.

3.9.7. Alongside work to provide immediate support and advice to people in financial hardship, the Tackling Poverty Co-ordinator is the lead for a wider programme of work to lift people out of poverty and mitigate the effects of poverty for people in Portsmouth, outlined in a local tackling poverty action plan.

3.9.8. The Health and Wellbeing Strategy outlined three areas for key activity in the short term:

3.9.8.1. providing immediate support to people in financial hardship;
3.9.8.2. helping people access the right employability support at the right time;
3.9.8.3. supporting a community-level response to local needs.

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3.9.9. These three areas formed the basis of the tackling poverty action plan for 2022-2023, overseen by the Tackling Poverty Steering Group, the local partnership group for action on poverty.

3.9.10. This partnership group is now a formal sub-group of the Health and Wellbeing Board (HWB), and brings together representatives of HWB member organisations with other services and voluntary sector groups in the city that have a role in tackling poverty.

3.10. Developing and strengthening work to tackle poverty and support residents with the cost of living

3.10.1. The next quarterly meeting of the Tackling Poverty Steering Group on 30 November will focus on the evidence base and learning from the Public Health Annual Report 2023, including the review of approaches in other areas, stakeholder views and local communities' perspectives.

3.10.2. Building on the conclusions and recommendations of the report, the group will review and refresh its purpose, aims and composition to ensure it holds a shared vision and an effective structure for action.

3.10.3. This includes an important role in aspiring to break intergenerational cycles of poverty and drive transformative change to tackle deep-rooted and longstanding issues in the city.

3.10.4. The partnership group should provide a strong voice for action that can influence and guide HWB member organisations in how they respond to these challenges.

3.10.5. The Annual Report recommendations focus on four areas for action:

3.10.5.1. To provide adequate financial support for families and services;
3.10.5.2. To champion policy innovation to maximise available support;
3.10.5.3. To monitor the long-term health impacts of poverty and the cost-of-living;
3.10.5.4. To support and empower the workforce so they can support us all.

3.10.6. Developing the effective work already taking place, within the resource constraints facing services and residents, the approach aims to maintain the current work that has the greatest impact, enhance and expand the use of resources and methods that have been proven to be effective, and extend activity into areas where gaps and opportunities have been identified.

3.10.7. The work will continue to operate across three levels of intervention:

3.10.7.1. Providing an immediate response to the needs of residents in financial hardship;

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3.10.7.2. Providing a holistic offer of support to complement the immediate response and help residents prevent future or recurring financial crises;

3.10.7.3. Taking action to understand and address the root causes of poverty and financial hardship.

3.10.8. The partnership group will continue to develop and scrutinise activity to tackle poverty and address cost of living pressures, and act as the formal sub-group with responsibility for the tackling poverty priority reporting to the HWB, while HWB member organisations will be asked to play their part in contributing to, and learning from, the work of the sub-group.

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Signed by Helen Atkinson FFPH, Director of Public Health

Appendices: None

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location
Public Health Annual Report 2023: Poverty and the cost of living crisis in Portsmouth - Needs Assessment	https://democracy.portsmouth.gov.uk/documents/s47960/Director%20of%20Public%20Healths%20Annual%20Report%20-%20Full%20report.pdf
Cabinet 31st October 2023	https://democracy.portsmouth.gov.uk/documents//s48507/Update%20on%20cost%20of%20living%20and%20Household%20Support%20Fund%20provision.pdf

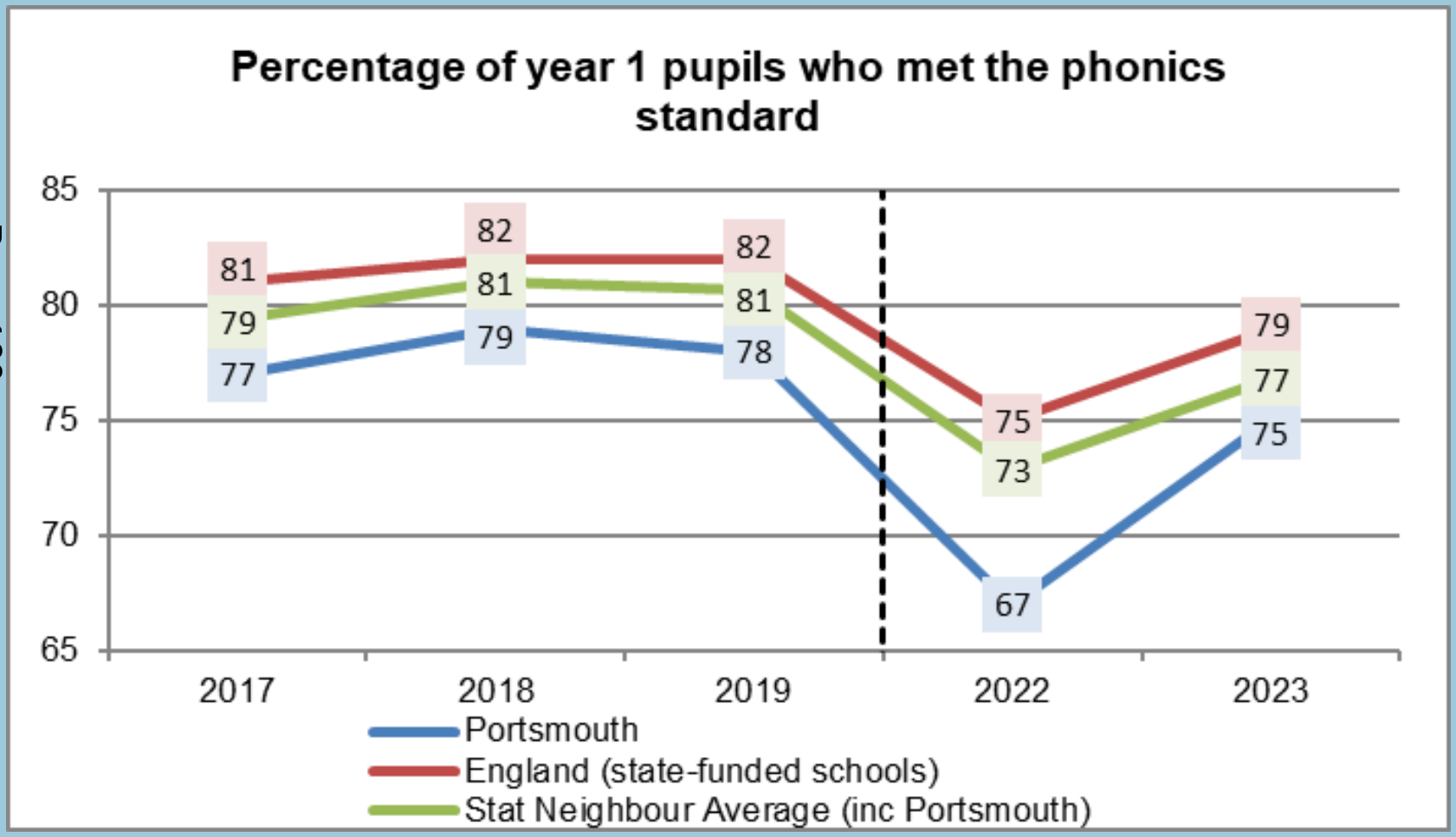
Portsmouth Education Strategy 23 - 26

Portsmouth 2023 provisional results

Agenda Item 8

Health and Wellbeing Board
29th November 2023

Year 1 phonics screening check – expected standard



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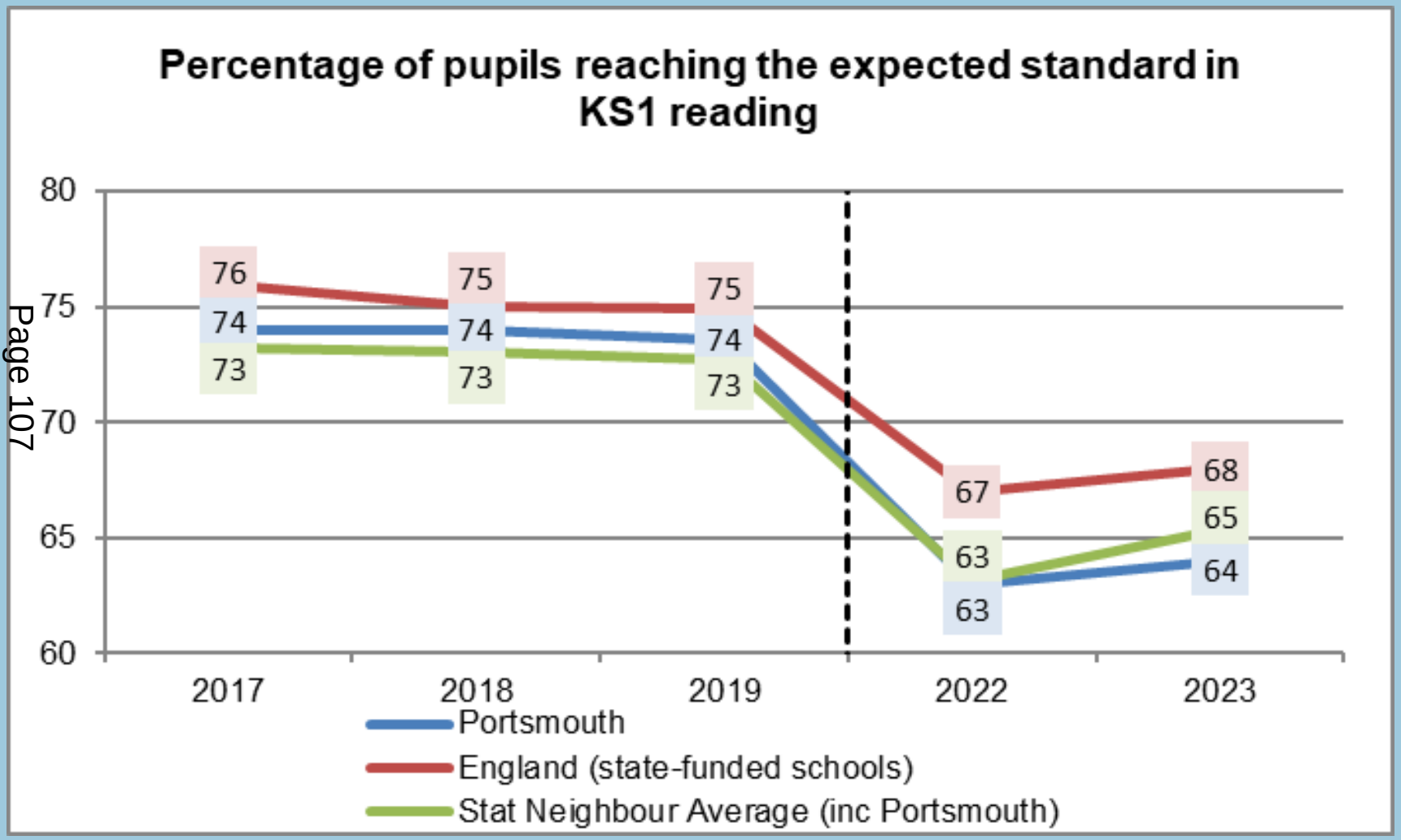

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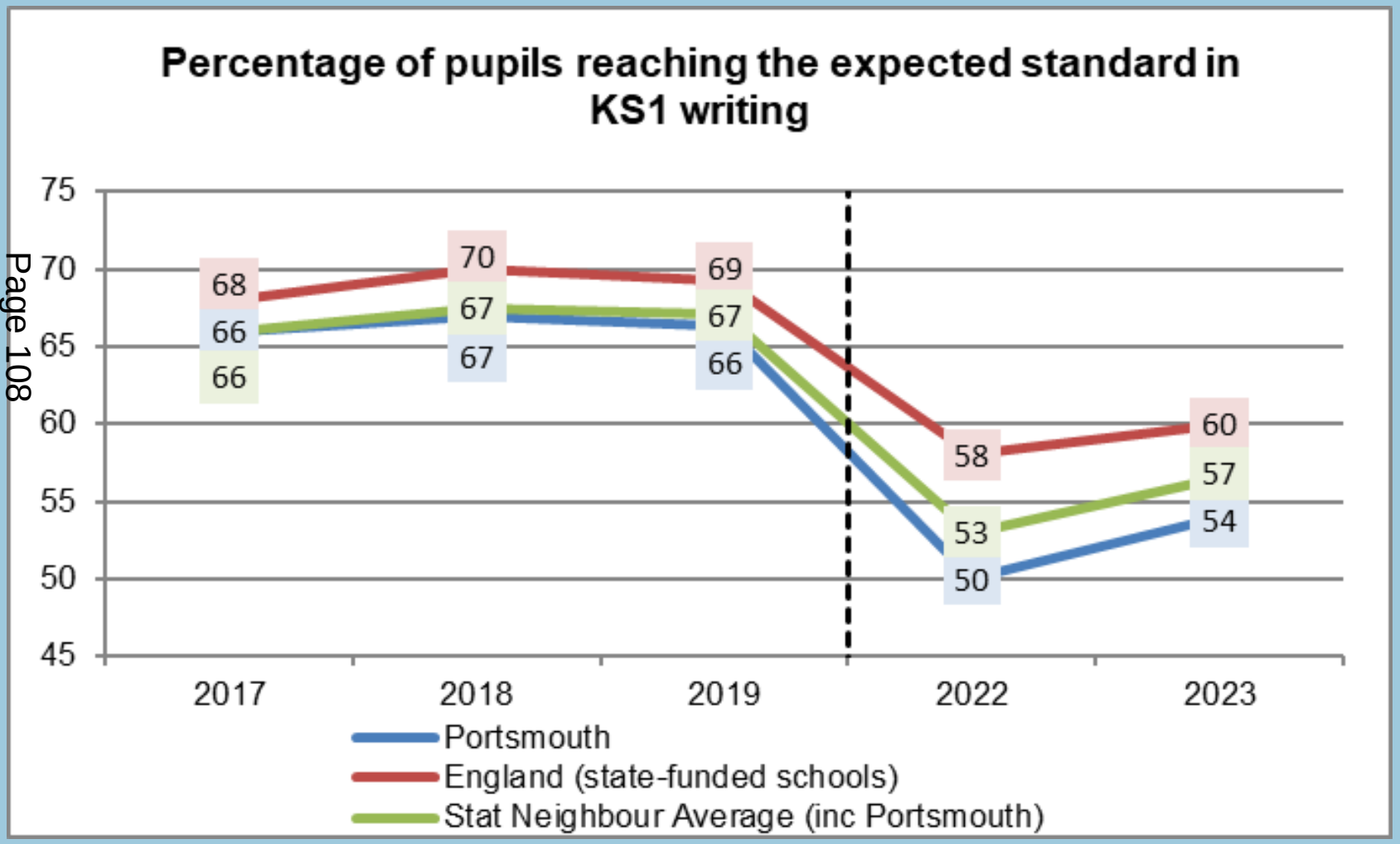

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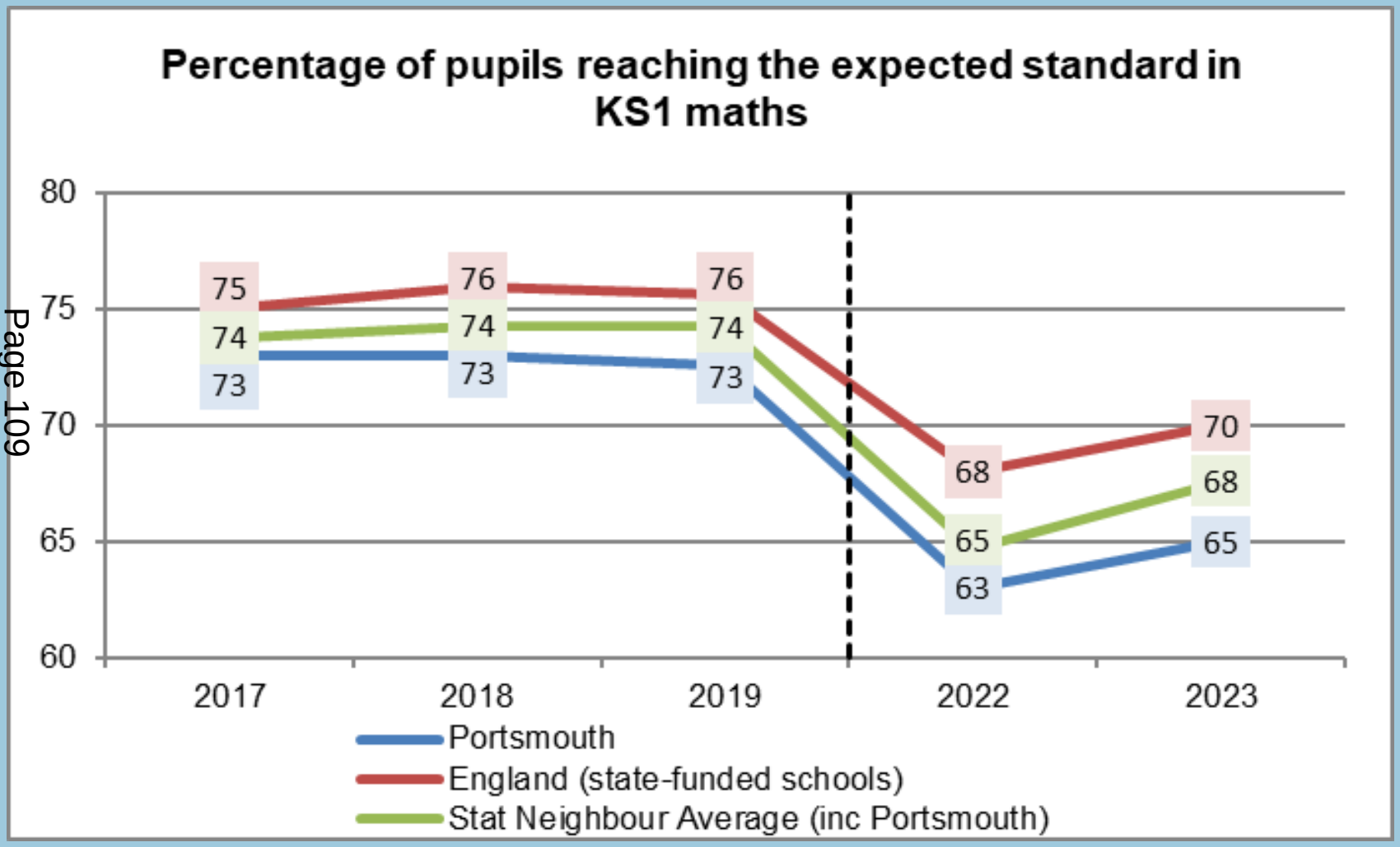
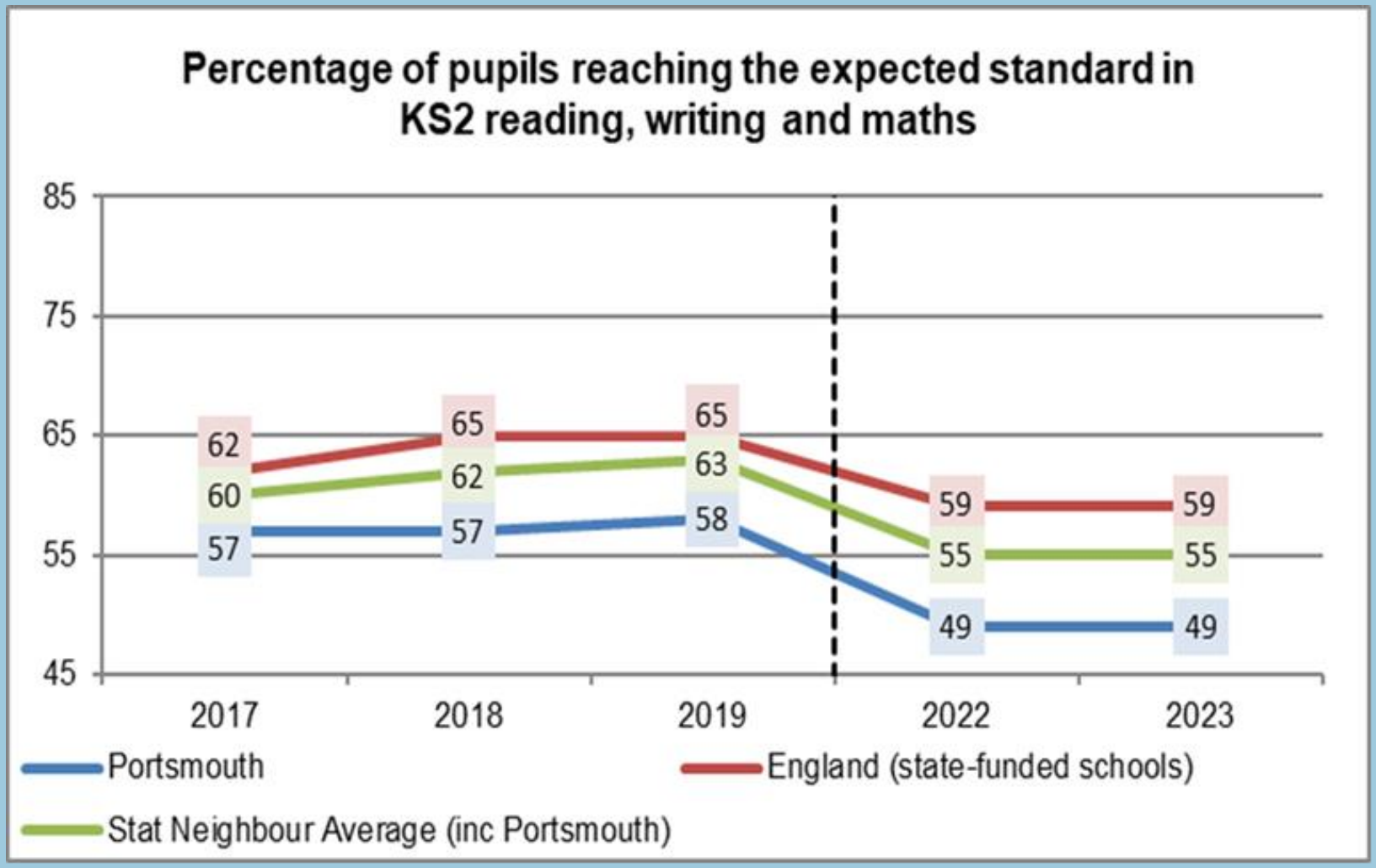
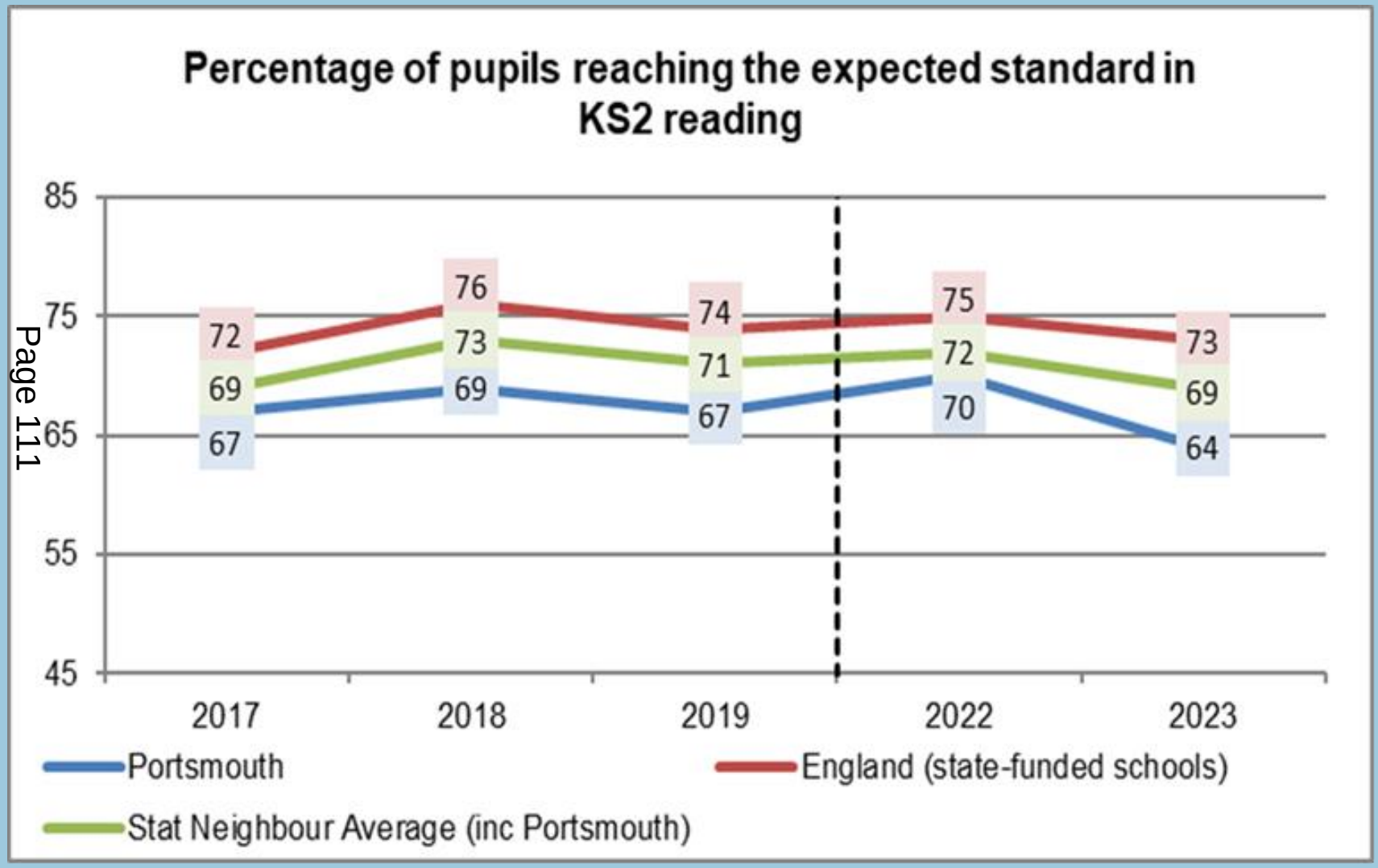


KS2: reading, writing and maths combined – expected standard



KS2: expected standard in reading



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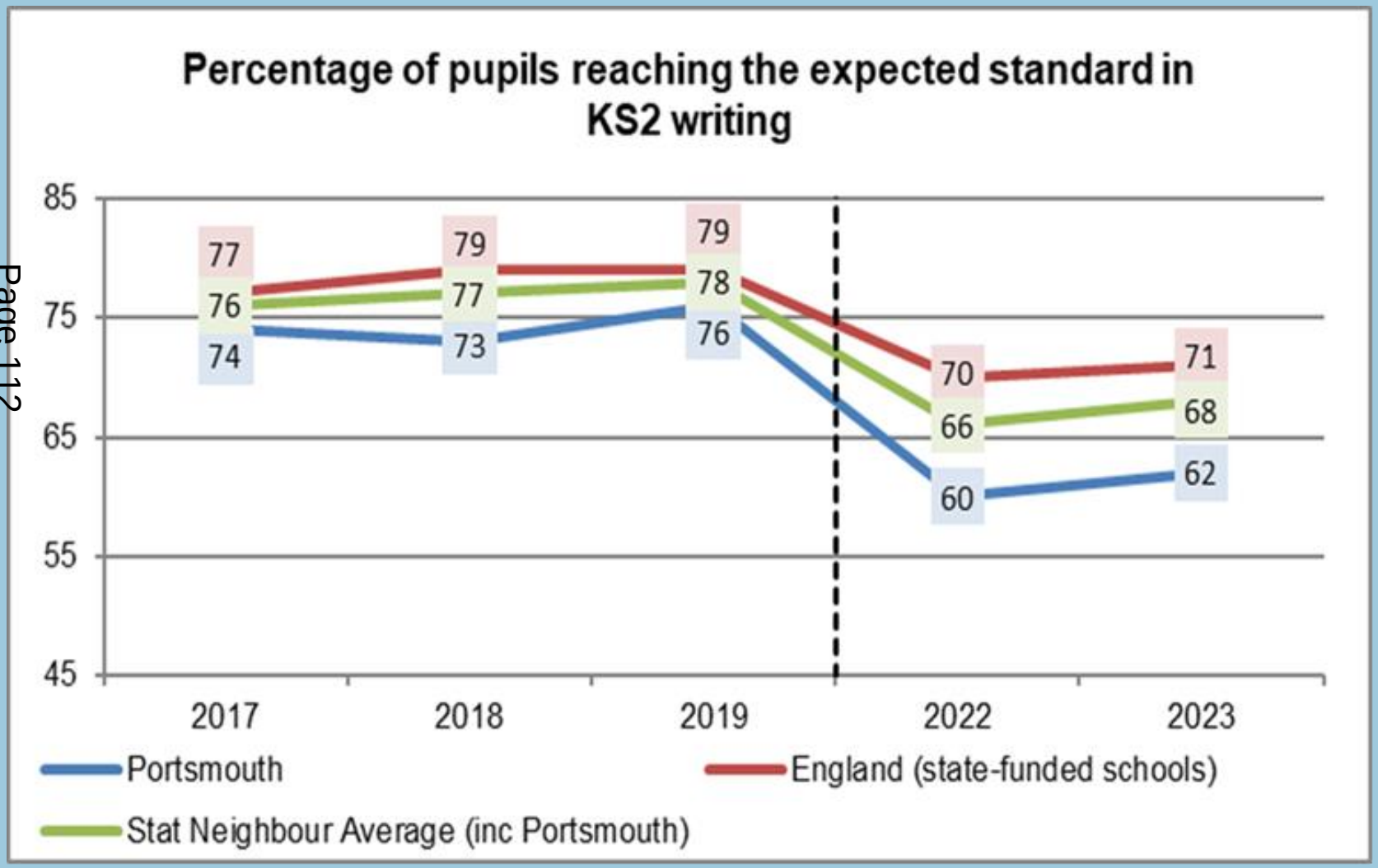
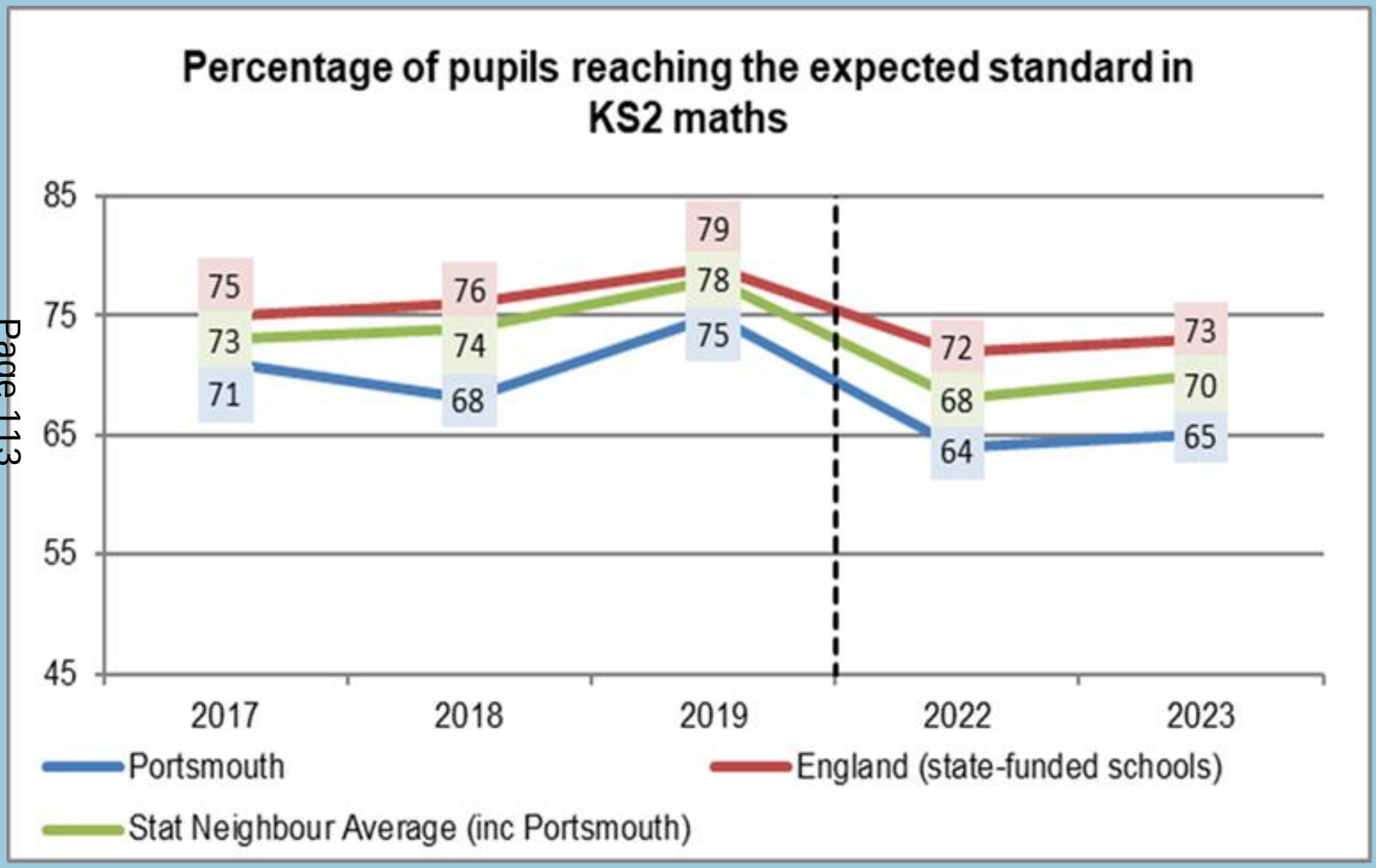


KS2: expected standard in maths



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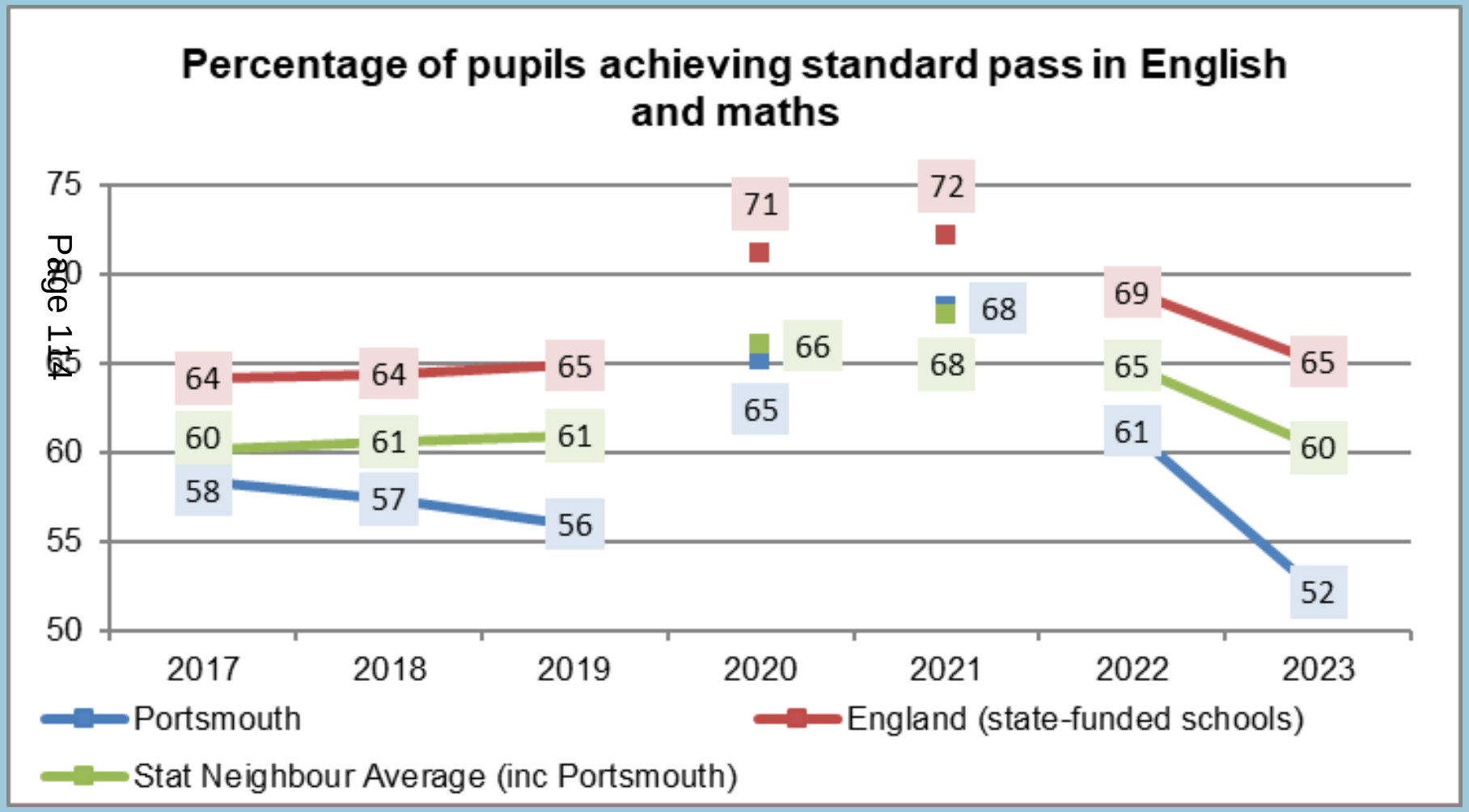

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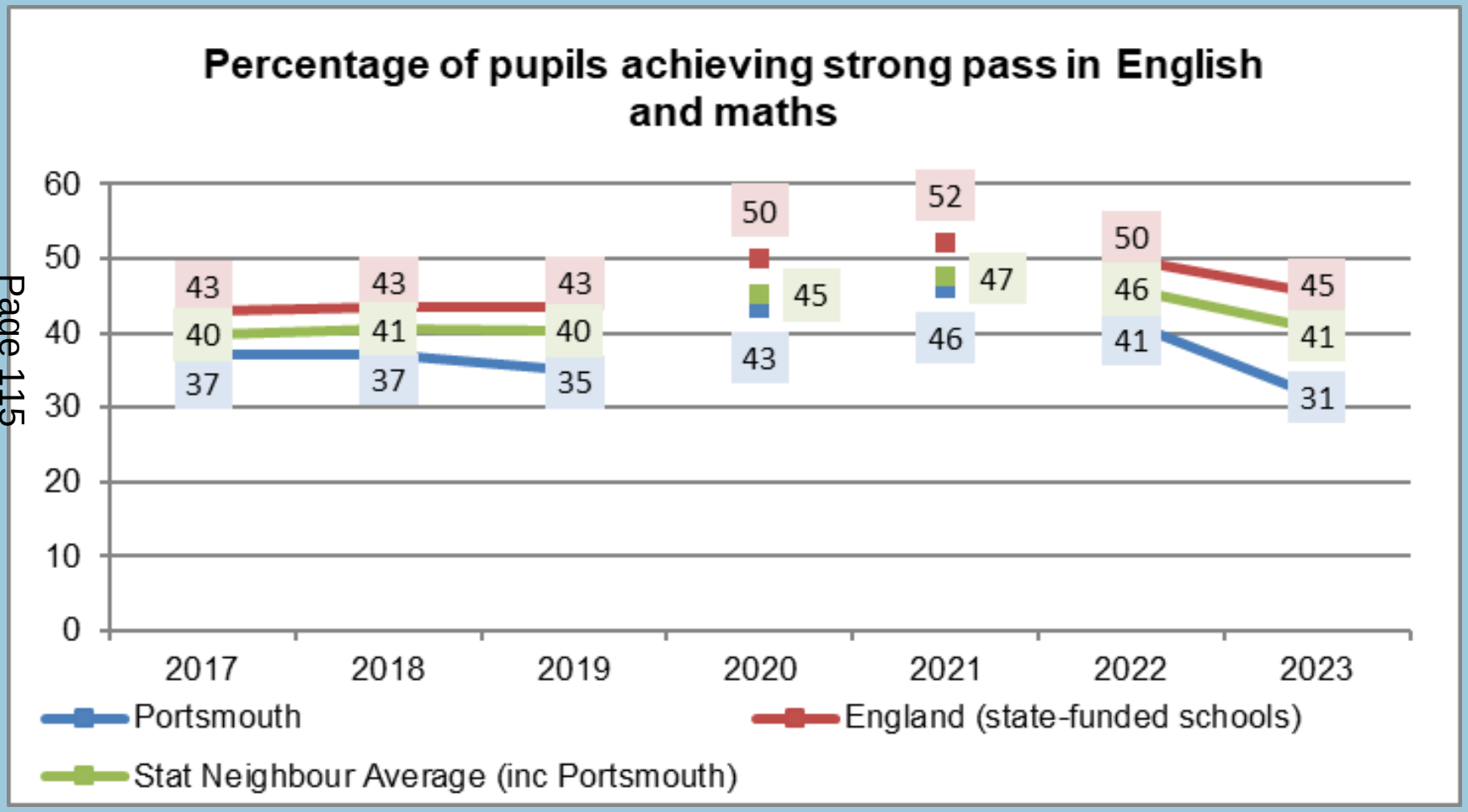

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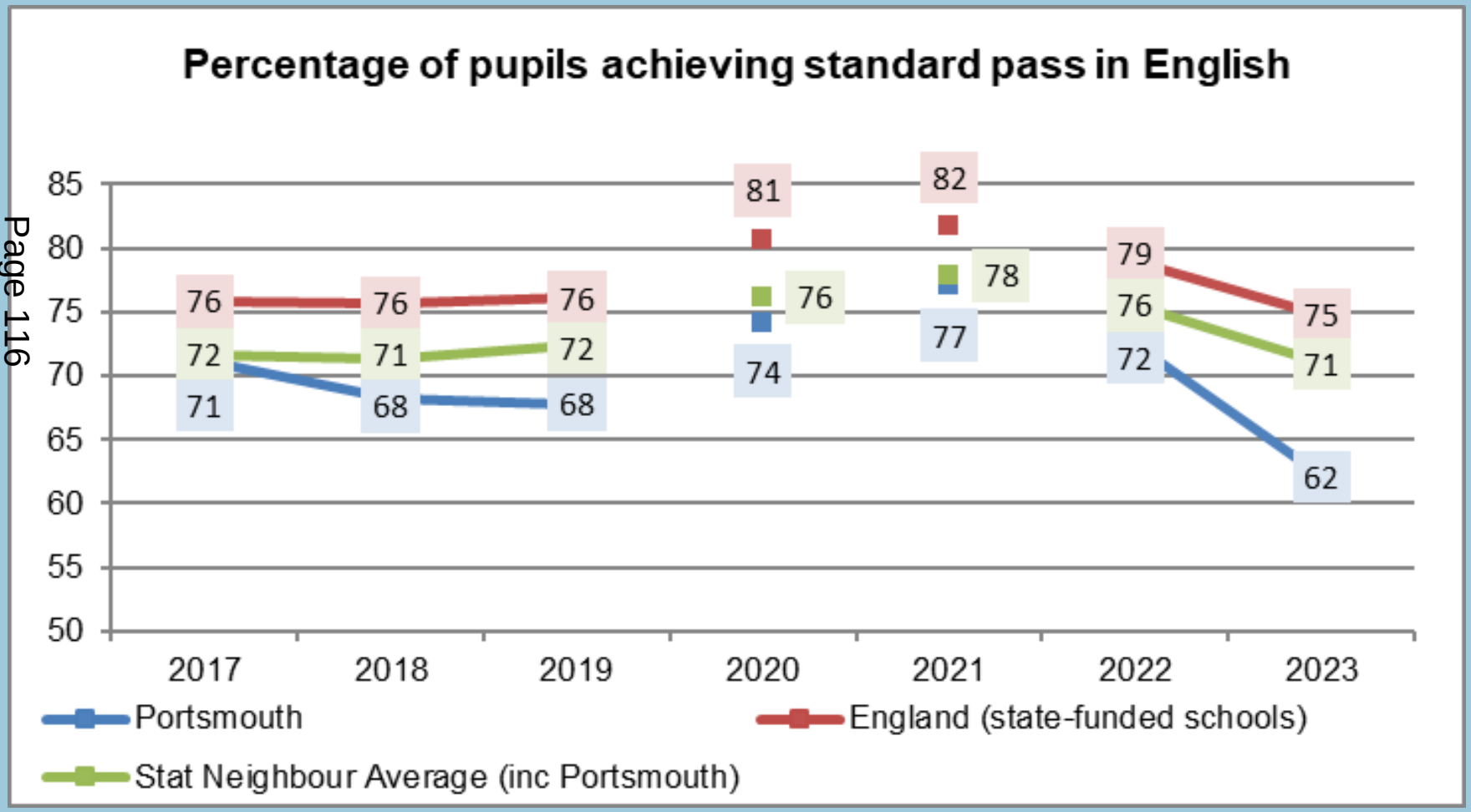

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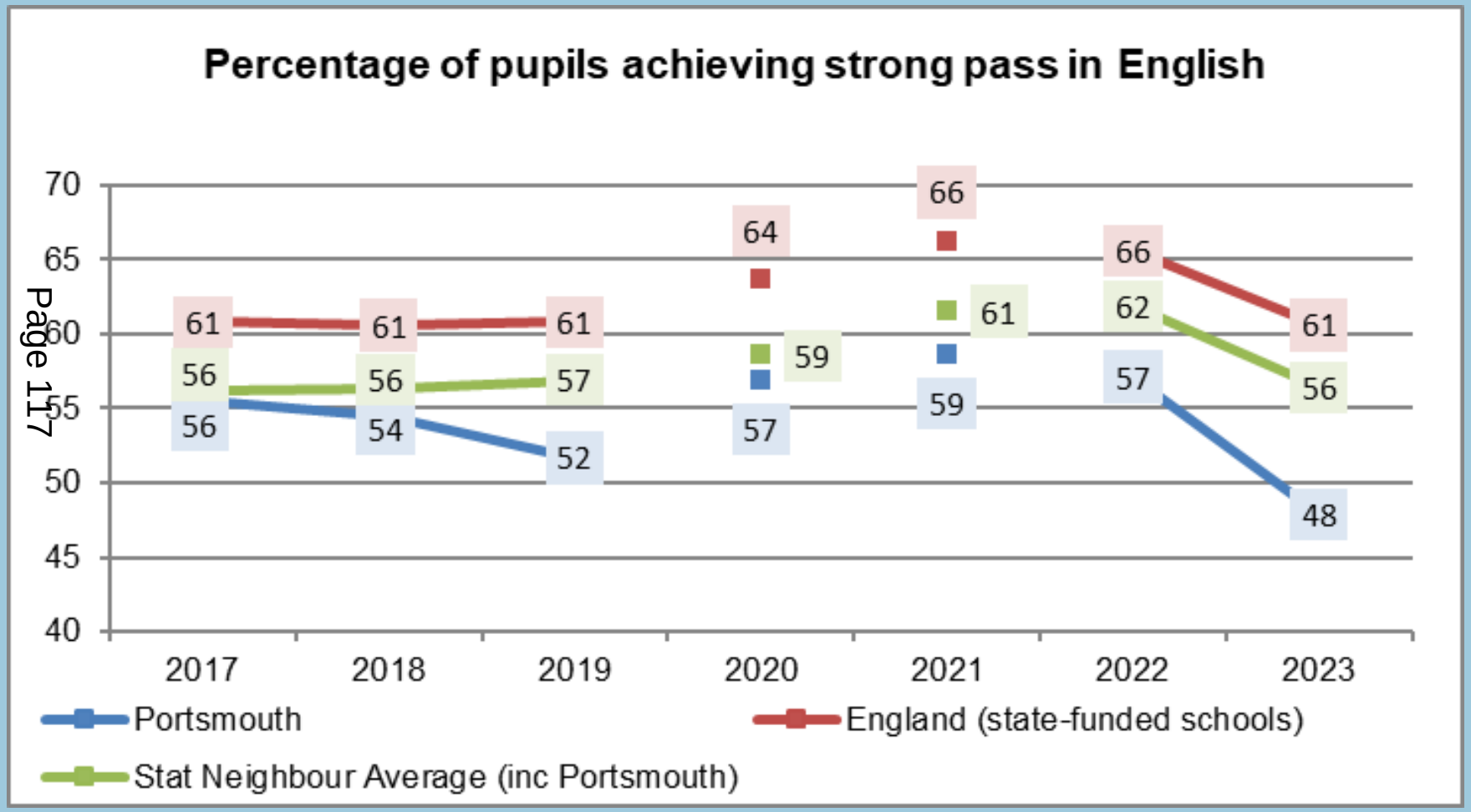
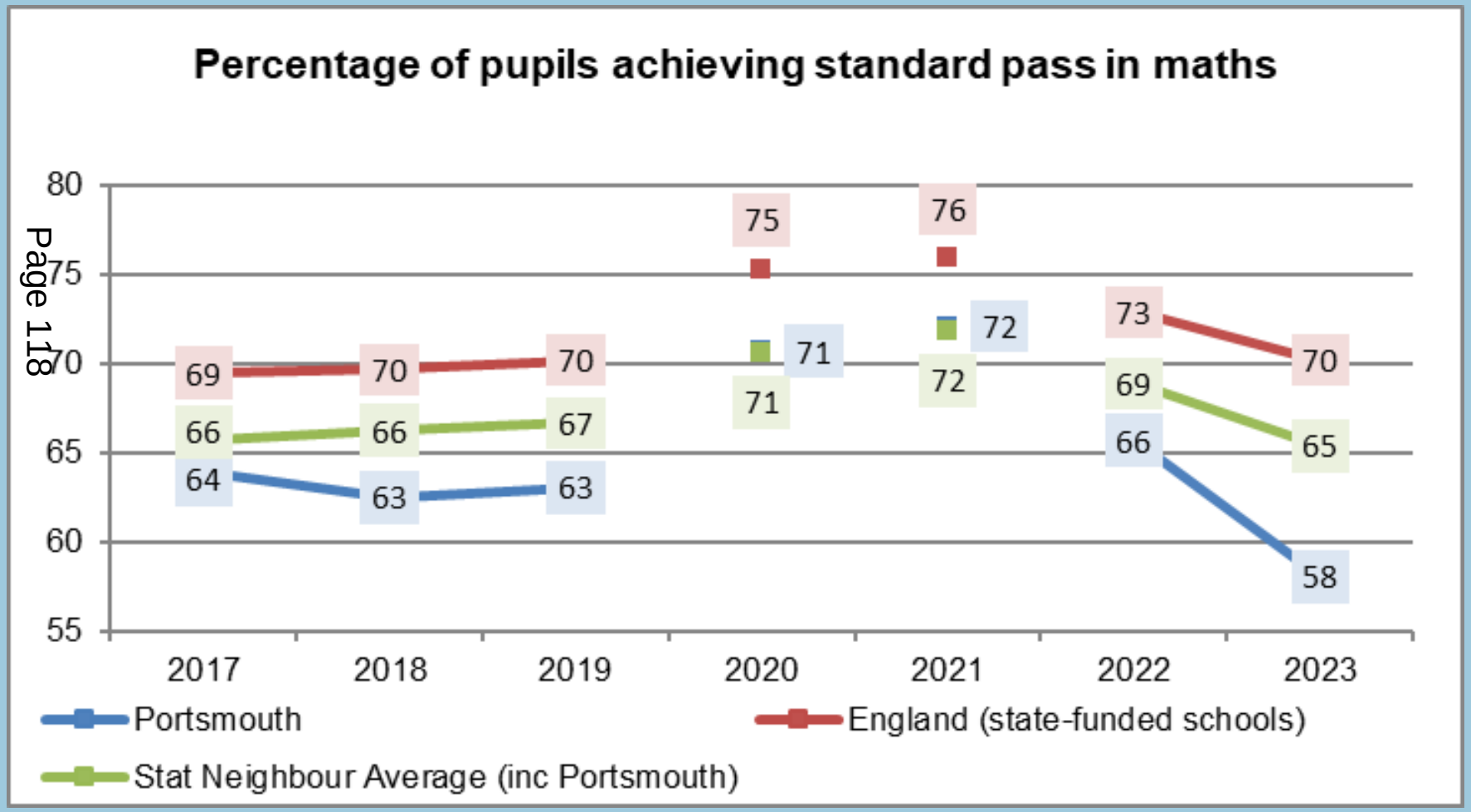
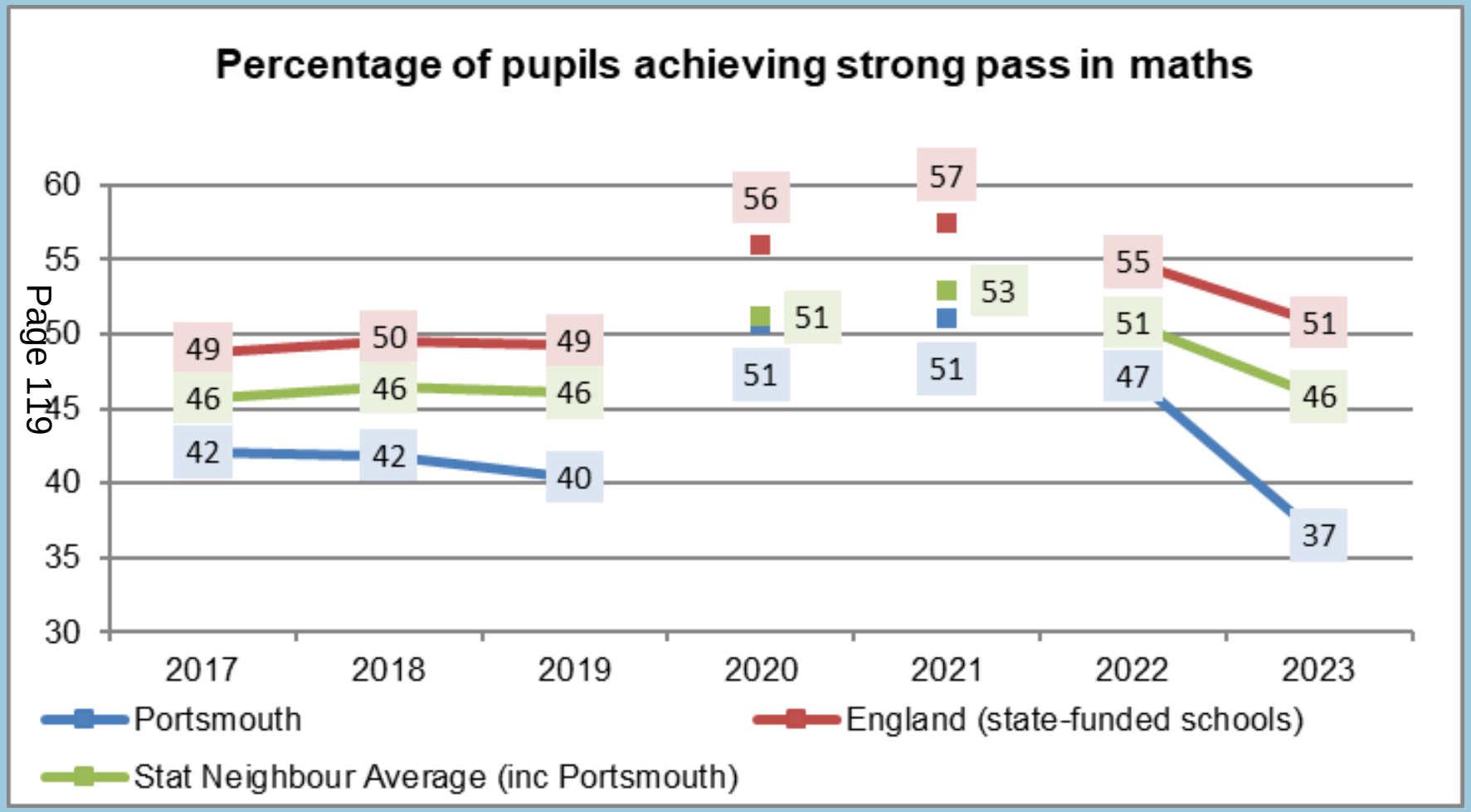


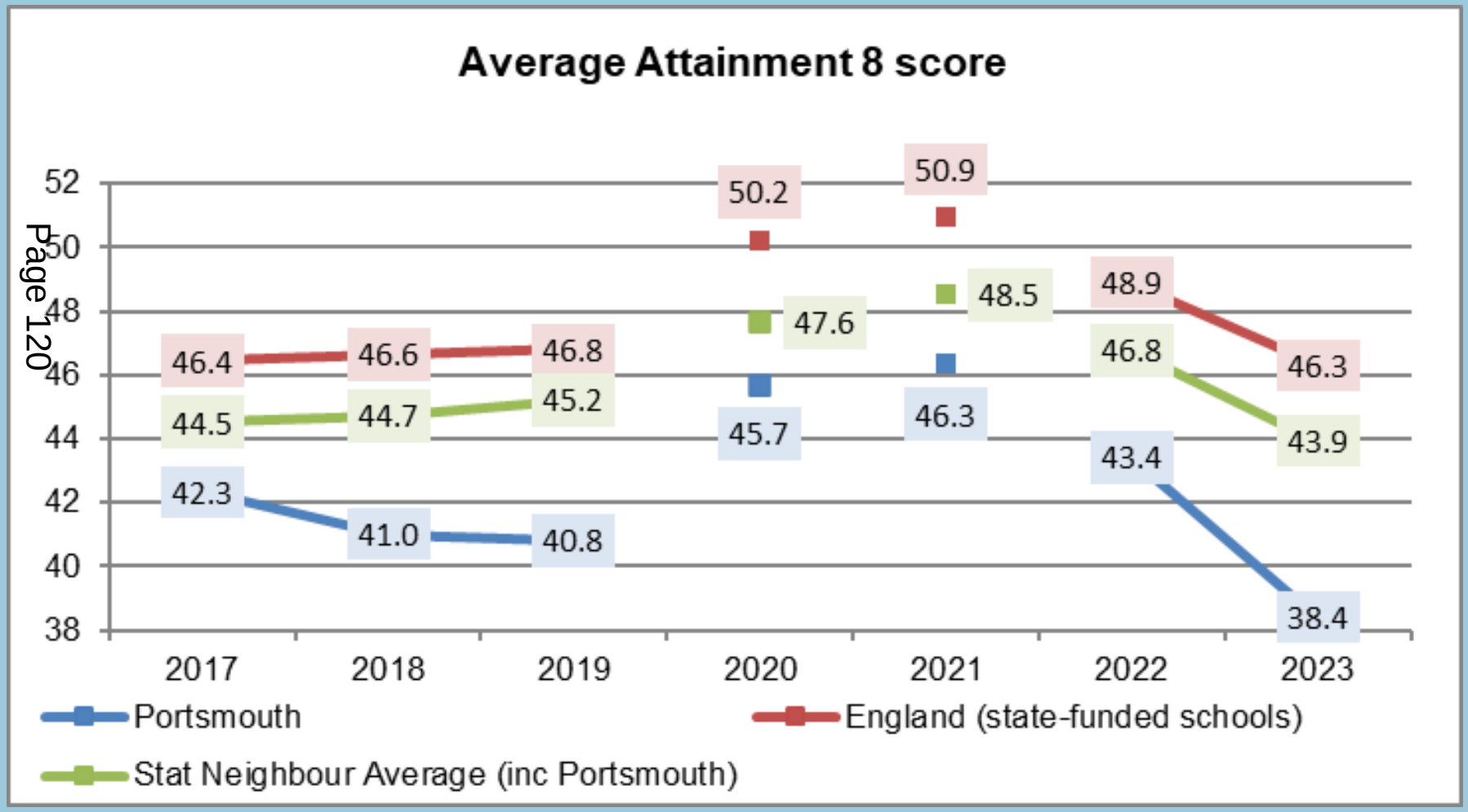
KS4: standard pass in maths



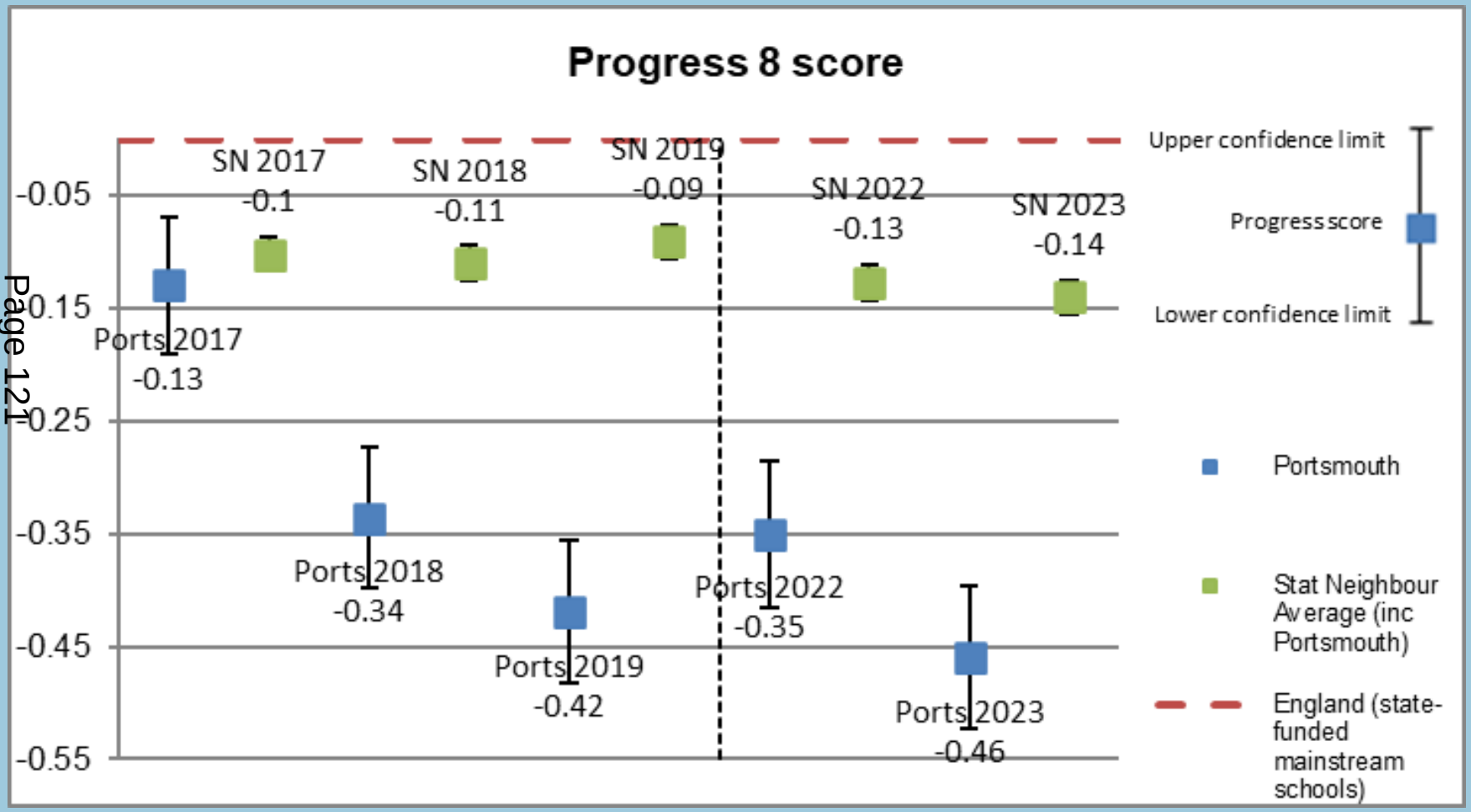
KS4: strong pass in maths



KS4: average attainment 8 score



KS4: Progress 8 score



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