Portsmouth CITY COUNCIL

NOTICE OF MEETING

CABINET MEMBER FOR HEALTH, WELLBEING & SOCIAL CARE

TUESDAY, 31 JANUARY 2023 AT 4.00 PM

COUNCIL CHAMBER - THE GUILDHALL, PORTSMOUTH

Telephone enquiries to Anna Martyn 023 9283 4870
Email: Anna.Martyn@portsmouthcc.gov.uk

If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

Public health guidance for staff and the public due to Winter coughs, colds and viruses, including Covid-19

- Following the government announcement 'Living with Covid-19' made on 21 February 2022 and the end of universal free testing from 1 April 2022, attendees are no longer required to undertake any asymptomatic/ lateral flow test within 48 hours of the meeting; however, we still encourage attendees to follow the public health precautions we have followed over the last two years to protect themselves and others including vaccination and taking a lateral flow test should they wish.
- We strongly recommend that attendees should be double vaccinated and have received any boosters they are eligible for.
- If unwell we encourage you not to attend the meeting but to stay at home. Updated government guidance from 1 April 2022 advises people with a respiratory infection, a high temperature and who feel unwell, to stay at home and avoid contact with other people, until they feel well enough to resume normal activities and they no longer have a high temperature. From 1 April 2022, anyone with a positive Covid-19 test result is still being advised to follow this guidance for five days, which is the period when you are most infectious.
- We encourage all attendees to wear a face covering while moving around crowded areas of the Guildhall.
- Although not a legal requirement, attendees are strongly encouraged to keep a social distance and take opportunities to prevent the spread of infection by following the 'hands, face, space' and 'catch it, kill it, bin it' advice that protects us from coughs, colds and winter viruses, including Covid-19.
- Hand sanitiser is provided at the entrance and throughout the Guildhall. All attendees are encouraged to make use of hand sanitiser on entry to the Guildhall.
- Those not participating in the meeting and wish to view proceedings are encouraged to do so remotely via the livestream link.

Membership

Cabinet Member for Heatlh, Wellbeing & Social Care
Councillor Matthew Winnington (Cabinet Member)

Group Spokespersons
Councillor Brian Madgwick
Councillor Yinka Adeniran
Councillor Lewis Gosling

(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 Annual Safeguarding Report, Strategic Plan and Peer Review (Pages 3 - 30)

Purpose
To provide an update on the recent work of the Portsmouth Safeguarding Adults Board (PSAB) and an outline of the key messages of a peer review of adult safeguarding in Portsmouth which was carried out by the South East Association of Directors of Adult Social Services (ADASS) in November 2022.

4 Portsmouth Health & Care Discharge to Assess Model (Pages 31 - 34)

Purpose
To update Members on the progress of the planning in response to the request from the Integrated Care Board (ICB) to support the Portsmouth and Southeast Hampshire, (PSEH) Local Delivery System (LDS) Remedial Action Plan for reducing ambulance holds at PHU funded through the recently announced £500m Adult Social Care Discharge Fund, which forms part of the Government's 'Plan for our Patients'.

Members of the public are permitted to use both audio visual recording devices and social media during this meeting, on the understanding that it neither disrupts the

meeting nor 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 will be made to webcast this meeting, should technical or other difficulties occur, the meeting will continue without being webcast via the council's website.

This meeting is webcast (videoed), viewable via the council's livestream account at https://livestream.com/accounts/14063785

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Title of meeting:	Health, Wellbeing & Social Care Portfolio meeting
Subject:	Annual Safeguarding Report, Strategic Plan & peer review
Date of meeting:	31 January 2023
Report by:	Alison Lawrence, presented by Andy Biddle
Wards affected:	All

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1. Requested by

Councillor Matthew Winnington, Cabinet Member, Health, Wellbeing & Social Care.

2. Purpose

To provide an update on the recent work of the Portsmouth Safeguarding Adults Board (PSAB) and an outline of the key messages of a peer review of adult safeguarding in Portsmouth which was carried out by the South East Association of Directors of Adult Social Services (ADASS) in November 2022.

3. Information Requested

The PSAB Annual Report 2021-22, PSAB Strategic Plan 2022-23, and the key messages of the peer review of adult safeguarding.

4. Legislative and Policy Context

Section 43 of the Care Act 2014 requires local authorities to establish a Safeguarding Adults Board (SAB) for its area. SABs are multi-agency strategic partnerships that oversee and lead adult safeguarding in their area. The Cabinet Member for Health, Wellbeing & Social Care is an *ex officio* member of the PSAB.

The Care Act Schedule 2 sets out the responsibilities of SABs, which include the publication of a Strategic Plan and Annual Report.

The Care Act Statutory Guidance sets out that the main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who are experiencing, or at risk of, abuse or neglect. As part of PSAB's work to

seek assurance about the effectiveness of adult safeguarding arrangements in Portsmouth, and the operation of the Board itself, a peer review was commissioned from South East ADASS. The scope of the peer review also included the safeguarding duties of the Local Authority, which will assist with preparations for the new Adult Social Care assurance/inspection framework which is due to be introduced in April 2023.

5. Safeguarding Annual Report 2021-22

The annual report sets out the work of the PSAB in 2021-22 (see Appendix A). Key highlights include:

- The development of a new **4LSAB Fire Safety Framework** to help professionals manage fire risks within the home or residential care setting.
- Delivering online training on **Safeguarding Concerns**, **Female Genital Mutilation**, and **Safeguarding Vulnerable Dependent Drinkers: Using legal frameworks to protect high risk, chronic dependent drinkers.**
- Establishing a new **Engagement subgroup** to lead on developing and maintaining strong links with the community to ensure effective safeguarding.
- Carrying out **audits** of Multi Agency Risk Management and the quality of safeguarding concerns raised to the Adult Multi Agency Safeguarding Hub.
- The publication of two Safeguarding Adults Reviews, 'Pamela Ratsey' and 'YL', and the development of multi-agency action plans to address the recommendations.

The annual report will also be presented to the Health and Wellbeing Board at its February 2023 meeting.

6. PSAB Strategic Plan 2022-23

The PSAB Strategic Plan (see Appendix B) was developed during 2021-22 through a process which included looking at the available data and consulting with a range of stakeholders. Due to the context of the covid-19 pandemic at that time, the decision was taken to approve a one-year plan which would then be refreshed, rather than a longer-term plan as had previously been the approach.

The plan identified the following priority groups, which included some adults at risk who had not necessarily been the focus of safeguarding activity in the past:

- Homeless adults
- Substance misusing adults
- Young adults who are transitioning from children's services
- Learning disabled adults
- Adults living in residential/nursing home care or who need extra care or supported living or domiciliary care
- Adults who are socially isolated through mental health problems

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The 12-month action plan focussed activity on the following priority areas of work:

- 1: Community Engagement
- 2A: Interprofessional practice
- 2B: Relationship based practice
- 3: Safeguarding practice

The PSAB monitors progress against the plan on a quarterly basis. Key achievements to date include:

- Developing the newly established Engagement subgroup and widening its membership to include frontline staff from different organisations who work directly with the priority groups set out above. The subgroup's workplan includes developing accessible information about safeguarding with the input of service users, and developing a network of 'community champions' for safeguarding adults. The subgroup is also looking at how to involve people with lived experience more directly in the work of the Board.
- Holding a multi-agency workforce development meeting to consider a safeguarding adults training needs analysis, and delivering a multi-agency training programme to address the priority areas identified.
- Holding a face to face multi-agency safeguarding conference attended by over 100 people, which supported interprofessional dialogue and provided an opportunity for the Board to hear from frontline practitioners and people with lived experience.

Work has begun on refreshing the strategic plan, with a planning workshop held in October 2022 to review data, learning from Safeguarding Adults Reviews, and the output from the conference.

7. Peer Review

The peer review took place between 22 and 25 November 2022 with a team of five reviewers from South East ADASS, Local Government Association, other Local Authorities, and an independent carers' lead for an Integrated Care System with lived experience as an informal carer. The peer reviews are intended as a basis for improving services by providing an external critique, acting as a critical friend. They are not an inspection, or a detailed, scored assessment.

The scope of the review was:

In relation to the Portsmouth Safeguarding Adult Board:

- Governance and structure of the PSAB, including how well partners hold each other to account.
- Participation in the Board the culture of working together
- Impact
- Resource provision

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In relation to Portsmouth City Council Adult Social Care:

- The compliance of the local authority decision-making on safeguarding referrals with the Care Act requirements
- The quality of safeguarding enquiry reports
- The integration of 'Making Safeguarding Personal' principles into safeguarding practice

The methodology included a staff survey (which received 77 responses from a range of organisations and staff roles); case file audit of 17 files; review of documentation including minutes, strategy and policy documents, data; interviews and focus groups with a wide range of stakeholders including Board members and frontline staff.

The peer reviewers presented their findings to the PSAB on 7 December 2022, highlighting themes, areas of good practice and areas to consider for improvements. The full report will be presented to the Health & Wellbeing Board in February 2023.

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

There was also good practice highlighted in relation to PCC'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:
PSAB:

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

PCC - Multi-Agency Safeguarding Hub (MASH)

- Review organisation and capacity
- Training and education:

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  - 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/Multi-Agency Safeguarding Hub
- Consider establishing a framework for safeguarding meetings which involve the person as much as they wish to be involved

8. Next steps

The PSAB and PCC are currently working on preparing full responses to the peer review findings and will also be developing accompanying action plans. As part of the peer review process, there is an understanding that we will share the learning and areas for improvement with partners in the South East. The learning from the peer review will also help shape the updated PSAB strategic plan.

……
Signed by (Director)

Appendices:

Appendix A: PSAB Annual Report 2021-22
Appendix B: PSAB Strategic Plan 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

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Portsmouth Safeguarding Adults Board

Annual Report

2021 - 2022

Statement from the Independent Chair

I am pleased to introduce the annual report of the Portsmouth Safeguarding Adults Board for 2021-22.

During the year, all coronavirus restrictions were lifted, with organisations slowly adapting to new ways of working, and the pressures that had been stored in the system becoming evident. Primary and secondary health services, alongside adult social care, had been strained, and people across all organisations felt exhausted. I want to pay tribute to all staff working to safeguard adults in the city of Portsmouth for their dedication and continued efforts.

As you will see from the Board's key achievements later in this report, our work to coordinate adult safeguarding has continued.

We have involved Alcohol Change UK in some new training, following the publication of a report: **How to use legal powers to safeguard vulnerable dependent drinkers.** The new training, for safeguarding staff across Portsmouth and the Isle of Wight, highlights the long-term effects of alcohol on executive brain functions, and how this affects mental capacity. Lessons learnt from this training are altering policy and practice for the better.

We began work on a policy to manage the risks for young people moving into adulthood, a comprehensive new approach which will bring significant benefits to young adults at risk.

We launched our new strategic plan, which puts engagement at the heart of the Board's work. We also created a new subgroup to bring together those working, both formally and informally, to safeguard adults, with the aim of pooling our knowledge and experience about adults at risk in the city, and exploring new ways of working with these adults.

We also engaged with several safeguarding adults reviews, with two completed during the year. The recommendations from these two important but tragic cases are helping to improve the way services are delivered.

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.

We consulted widely with stakeholders and engaged our membership about our future direction. With the continuing impact of the COVID-19 pandemic on services, we agreed that the strategy would be underpinned by a one-year action plan initially. We plan to review the strategy in 2022-23 to consider what has been achieved and how future progress should be made.

The strategy and action plan both 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. We plan to promote the use of the Multi-Agency Risk Management framework, strengthen professional supervision, and provide more opportunities for multi-agency training and sharing of good practice.
3. **Safeguarding practice**: to continue our efforts to review experience when things have not gone as planned and to publicise best practice.

Work will start on the new action plan in 2022-23.

Case study**: **Fire safety framework (Jane*)

Jane was a single lady who lived alone in a first-floor flat owned by a housing association. She found walking difficult and at times also experienced poor mental health. There was a high level of hoarding in all rooms and the exit from the flat was blocked with clutter. Apart from having someone come to service her gas, she was distrustful of services and did not let anyone into her flat. There were multiple ignition sources in the flat.

Jane's housing association worked with her over a period of months to build her trust, initially speaking to her through her letterbox until she felt able to let them in. The member of staff used the 4LSAB hoarding guidance and completed a hoarding risk assessment. They also worked with other agencies, supporting Jane into therapy via her GP, and referring her to adult services.

Using the new fire safety framework, they also identified that Jane was vulnerable to fire risks due to the issues affecting her and her environment. They referred Jane for a 'Safe and Well' visit from Hampshire and Isle of Wight Fire and Rescue Service, and completed a 'person-centred fire risk assessment'. Jane was issued with smoke alarms and fire-retardant bedding, and professionals helped her to understand what she could do to reduce the risk of a fire.

*Name changed to protect identity

Key achievements in 2021-22

This year the Board has:

- Developed a new **4LSAB Fire Safety Framework** to provide professionals with support and guidance for the effective management of fire risks within the home or residential care setting. The four Boards held an online launch event which was attended by 135 people
- Published a new **Safeguarding Adults Review Policy** which incorporates the best practice identified in a national review of SARs
- Reviewed and revised the **4LSAB Multi-Agency Framework for Managing Allegations Against People in a Position of Trust** and **4LSAB Multi-Agency Learning and Development Guidance for Safeguarding Adults**
- Delivered online webinars with Hampshire SAB on **Safeguarding Concerns,** which were attended by 232 staff from a range of organisations
- Delivered six online training sessions with Isle of Wight SAB on **Safeguarding Vulnerable Dependent Drinkers: Using legal frameworks to protect high risk, chronic dependent drinkers,** part of a national project led by Alcohol Change UK. Findings from the project were presented to Board members and other strategic leaders in October 2021
- 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 MASH and the quality of decision-making about these referrals. The second was on the use of the

Multi-Agency Risk Management Framework (MARM) and included a staff survey to help the Board understand the perceptions and experiences of professionals using MARM. Action plans were developed following these audits

- Begun working on a new **Multi-agency Framework for Managing Risk and Safeguarding People Moving into Adulthood**. The aim of this work is 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. This framework will be completed and published in 2022-23
- Worked with the Portsmouth Safeguarding Children Partnership (PSCP) to set up a **Harmful Practices Group**. Harmful Practices includes abuse such as: honour-based abuse, forced marriage, and Female Genital Mutilation (FGM). The group is a multi-agency forum which includes community groups. It commits to working together to end harmful practices and to ensure there is appropriate support for all adults, children and young people who have experienced, or are at risk of, this type of abuse. The group led on activities linked to **FGM Zero Tolerance Day** including a training session for professionals, lesson plans for schools, and masterclasses for teachers
- Established a new **Engagement subgroup** to lead on developing and maintaining strong links with the community to ensure effective safeguarding
- Held new **workshop-style Board meetings** to promote discussion of key issues. One such workshop involved voluntary sector partners and looked at how organisations can work together more effectively to support people who have multiple and complex needs, such as: substance misuse, mental health issues, and homelessness
- Received analysis of data and learning from the new **Drug Related Deaths** process which is led by Portsmouth City Council Public Health
- Conducted a **training needs analysis** and met with workforce development leads from partner agencies to review the analysis and identify priority areas for multi-agency training
- Supported **National Safeguarding Adults Week 2021**. 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
- Chaired the **4LSAB Coordination and Liaison Working Group.** The group brings together the statutory partners of all the 4LSABs to discuss strategic issues affecting safeguarding across the region. The business included discussion of the implications and practicalities of the health sector reforms and establishing of the new Integrated Care Systems, homelessness, and domestic abuse

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 the adult, and death or serious harm arose from actual or suspected abuse'.

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 monthly meetings and during 2021-22 met jointly with the PSCP Learning from Cases Committee (LfC) when there were cases involving both children's and adult services.

Summary of SAR activity during 2021-22

The Board published two SARs in 2021-22, 'YL' and 'Pamela Ratsey', the findings of which are outlined in the next section.

Two reviews which were initially commissioned in 2019-20 are still ongoing and are due to be published in 2022-23. Due to the COVID-19 pandemic, work on these reviews was paused and they have therefore taken longer than usual to complete.

Two referrals were carried forward from 2020-21 as they were subject to an internal review by the referring agency. The SAR subgroup considered the findings from these and concluded they did not meet the criteria for a mandatory review as there was no multi-agency learning identified and the agency had already put in place an action plan to address its findings.

There were 15 new SAR referrals received in 2021-22. Four of these related to the deaths of people who had experienced self neglect in the period leading up to their

deaths. Following a review of the information held by different agencies about these people, the subgroup concluded that the criteria for a mandatory review were not et. For one of these cases, a meeting with the landlord (a housing association) identified some learning about the process for flagging and checking in with tenants who may be at risk. This learning was shared with other landlords in the city by Portsmouth City Council, who have this year set up a safeguarding forum. In view of the number of self neglect deaths identified, the SAR subgroup recommended to the Board that some assurance work on self neglect should be carried out in 2022-23 and the Board accepted this recommendation.

Two further referrals were considered but were also not found to meet the criteria for a mandatory review. In one case, actions were identified for individual agencies through a safeguarding enquiry that had been carried out by Adult MASH under section 42 of the Care Act, and plans were put in place to address these actions.

The remaining nine referrals were for the deaths of homeless people, who were either rough-sleeping or housed in temporary accommodation. None of these cases met the criteria for a mandatory review. In 2020-21, the Board commissioned a thematic review of homeless deaths to examine the issues relevant to such deaths in detail, using four cases as examples. The review will conclude in 2022-23 and will provide findings and learning relevant to the referrals for homeless people received this year.

YL Safeguarding Adults Review

The YL SAR was published in November 2021. YL was a young woman in her early twenties who had a history of mental illness and a diagnosis of Emotionally Unstable Personality Disorder. YL was also the mother of a young child. When her mental health began to deteriorate, she was placed in temporary accommodation due to the perceived risk to her child. YL's self harming behaviour began to escalate and she tragically took her own life some months later.

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

1. The multiagency partnership did not always work in partnership effectively.
2. Appropriate assessments were not always completed so needs were not always identified or risks mitigated.
3. Support was not always provided to meet identified need.
4. The voice of the adult was not always heard.
5. Safeguarding practice was not always optimal.

The Board accepted the findings of the review and a multi-agency workshop was held with senior managers from partner agencies to develop an action plan. Actions planned or underway include:

- Update and promote the Family Approach protocol and resources
- Develop guidance on supporting people who are or may become homeless including the 'Duty to refer'
- Ensure that the findings inform service development and the implementation of the Community Mental Health Framework

- Develop training and materials for staff on Emotionally Unstable Personality Disorder
- Review discharge-planning to ensure care and support needs are assessed as part of the discharge plan
- Develop a referral pathway to ensure early consideration is given to the care and support needs of adults at risk placed in temporary accommodation
- Build relationships between Children's Social Care and Mental Health services.
- Develop understanding of the Care Act 2014 and services for carers among Children's Social Workers.

The action plan is being monitored by the Quality Assurance subgroup.

Pamela Ratsey Safeguarding Adults Review

The Pamela Ratsey SAR was published in January 2022. It was the family's wish that Pamela's full name be used in the review instead of a pseudonym. Pamela was an older person who lived in Hampshire and was placed in a Portsmouth residential care home by Hampshire County Council. Concerns were raised by her family and other agencies about poor care and neglect, and a safeguarding enquiry was carried out by Portsmouth City Council. Pamela sadly died as a result of pneumonia and a pressure sore. The coroner found that neglect contributed to her death.

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

1. There was minimal engagement with Pamela's family and services did not seek their views or listen to their concerns.
2. There was a lack of clarity and consistency in the consideration of Pamela's mental capacity.
3. There was a lack of professional curiosity and risk management.
4. Pamela’s complex care needs were neglected at the home, and internal concerns about managing these needs were not shared with the placing authority or on hospital discharge.
5. Several services did not escalate concerns about Pamela’s increasing needs
6. Safeguarding enquiries were not personalised and did not effectively reduce the risk of neglect.
7. There were delays in reviewing Pamela's care and arranging for her to move.

The reviewer identified a number of improvements which had been made since the incident to address these findings, including the introduction of a Quality Improvement Team, new processes within the Adult MASH, improved electronic recording practices within Community Nursing, and a new Pressure Ulcer Panel.

The Board accepted the findings of the review and an action plan has been developed. Actions include:

- Review of the Multi Agency Risk Management Framework
- Improving cross border communication between Portsmouth City Council and Hampshire County Council about high-risk cases
- Reviewing the safeguarding information available for care homes

- Assurance work on Mental Capacity and reviews of care plans.

4LSAB Fire Safety Development Subgroup

The 4LSAB Fire Safety Development subgroup continues to review and share learning from serious fire incidents to ensure that effective inter-agency processes, procedures and preventative practices are in place.

In 2021-22 a total of four incidents, involving four injuries and one fatality, met the Fire Safety Development Subgroup criteria for review in the Portsmouth local authority area. One incident resulted in two injuries. It should be noted that, for the fatality reviewed, the cause of death is yet to be determined as the case is awaiting the Coroner's verdict at the time of writing.

For each of the cases a full review of the individual's risk factors, their supporting agencies and the cause of incident was conducted by the subgroup. In terms of the identified risk and vulnerability factors, the following themes emerged from these reviews:

- For 40% of the incidents reviewed, it was confirmed that the individual involved **lived alone**, and 20% identified the individual as being **homeless**.
- The **average age** of the individuals involved in the incidents reviewed was **66**.
- For 80% of the cases reviewed, the **gender** of the individual involved was **male**.
- For 40% of the cases reviewed, the individuals were known to Portsmouth Adult Services and were **in receipt of care and support services**.
- None of the cases reviewed identified hoarding and self neglect as a vulnerability factor.
- For 40% of the cases reviewed, **poor mental health** was identified as a vulnerability factor.
- For 20% of cases reviewed, **poor mobility** was identified as a vulnerability factor
- For 20% of cases reviewed, **substance misuse** was identified as a vulnerability factor

In reviewing causes of fire, the following themes emerged:

- 40% of the cases reviewed identified the most likely cause as ‘Accidental – carelessness with smoking material’.
- For the case resulting in two injuries (40%) the cause was identified as a gas explosion.
- 20% of the cases reviewed identified the most likely cause of the incident as ‘Accidental – unattended cooking’.

In December 2021, the subgroup reviewed its work and identified a series of best practice pointers.

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.

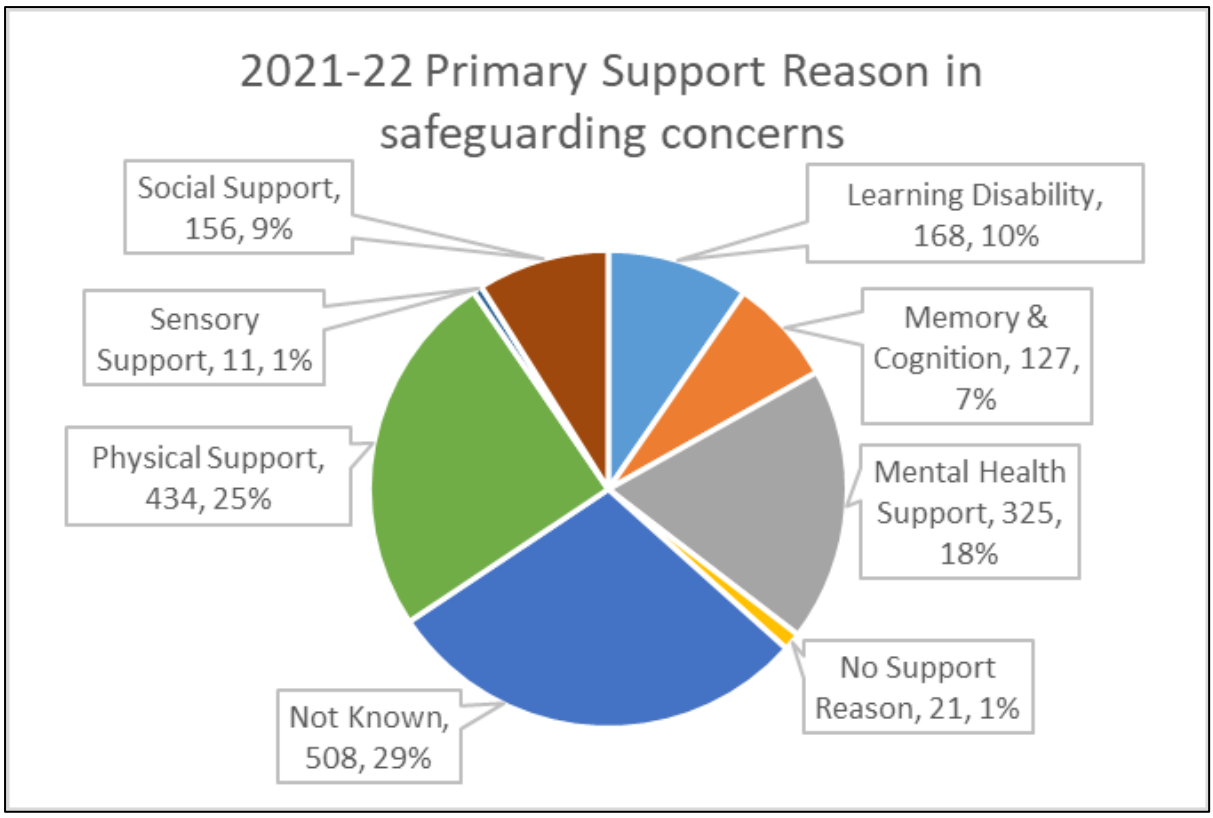
Portsmouth has an Adult Multi-Agency Safeguarding Hub (MASH) with a team of social workers and police officers working together who have direct links with colleagues in areas such as health, trading standards and children's safeguarding. The MASH manages a high volume of referrals.

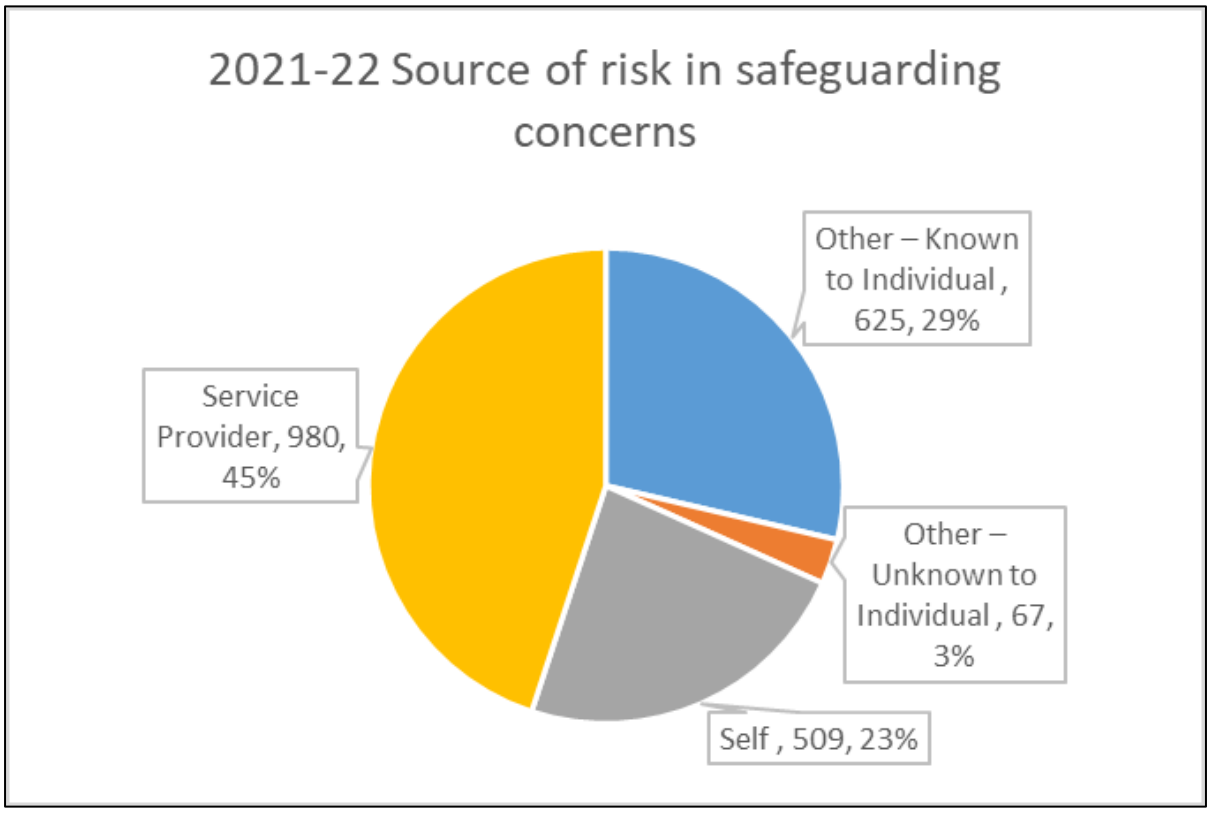
Data collected by the MASH gives further information about who has experienced abuse or neglect in Portsmouth, where abuse has taken place, and the types of risk they have experienced. The information below is taken from the NHS Digital Safeguarding Adults Collection end of year return.

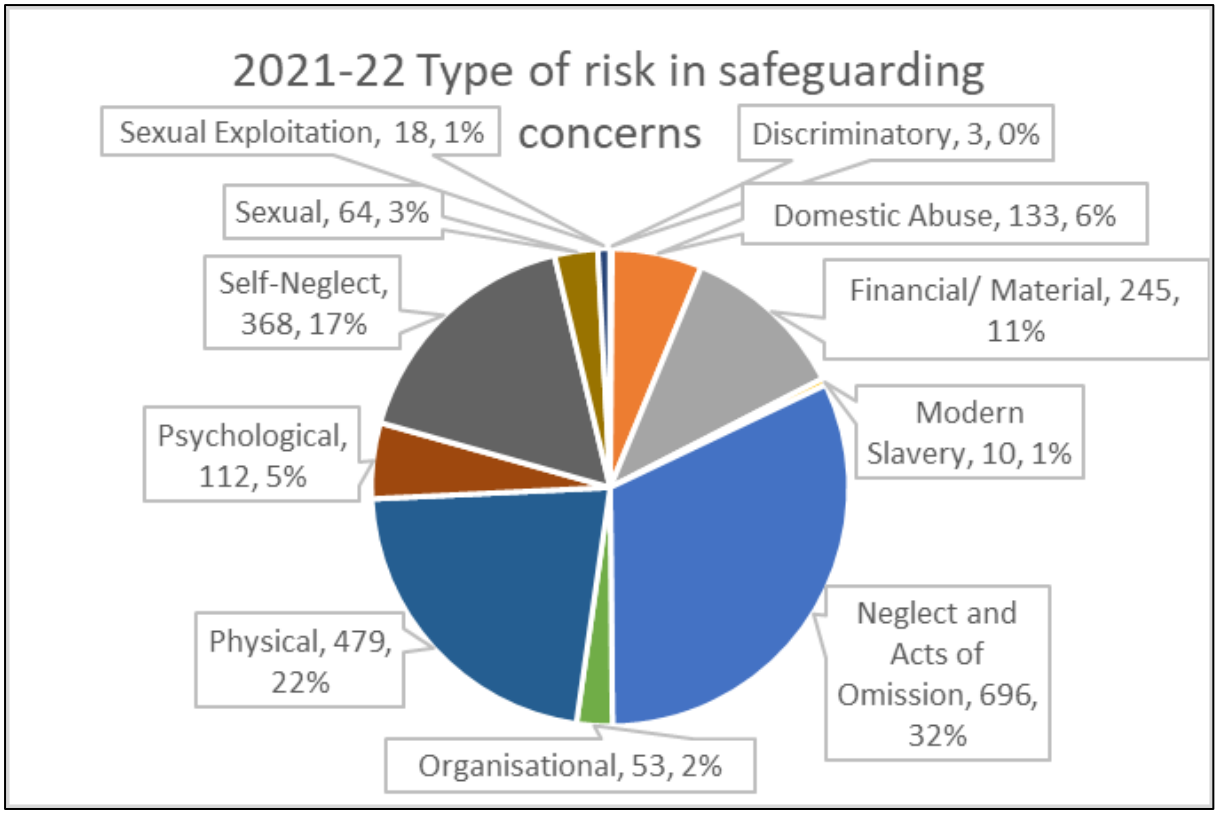
If an issue about an adult's safety or welfare is raised with the MASH, it is called a 'Safeguarding Concern'. The MASH will assess the concern and take appropriate action.

There were 2,181 concerns raised in 2021-22 about 1,502 individuals.

More information about the individuals involved in safeguarding concerns is shown below.


2021-22 Primary Support Reason in safeguarding concerns
Social Support, 156, 9%
Learning Disability, 168, 10%
Sensory Support, 11, 1%
Memory & Cognition, 127, 7%
Physical Support, 434, 25%
Mental Health Support, 325, 18%
No Support Reason, 21, 1%
Not Known, 508, 29%


2021-22 Source of risk in safeguarding concerns
Other – Known to Individual , 625, 29%
Service Provider, 980, 45%
Other – Unknown to Individual , 67, 3%
Self , 509, 23%



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.

758 formal Safeguarding Enquiries were concluded in 2021-22.

In 97% 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 98% 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 2021-22 Hampshire Constabulary reported:

- 13 incidents of honour-based violence where the victim was over 18
- 4 incidents of trafficking of a person over 18

- 746 high risk domestic crimes
- 848 incidents of hate crime.

Hampshire and Isle of Wight Fire and Rescue Service carried out 869 Safe and Well visits in Portsmouth in 2021-22.

There were 0 domestic homicides in Portsmouth in 2021-22.

There was 1 fire death in Portsmouth in 2021-22.

Contact us

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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.

FGM - Female Genital Mutilation

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

LfC - Learning from Cases 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

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.

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?

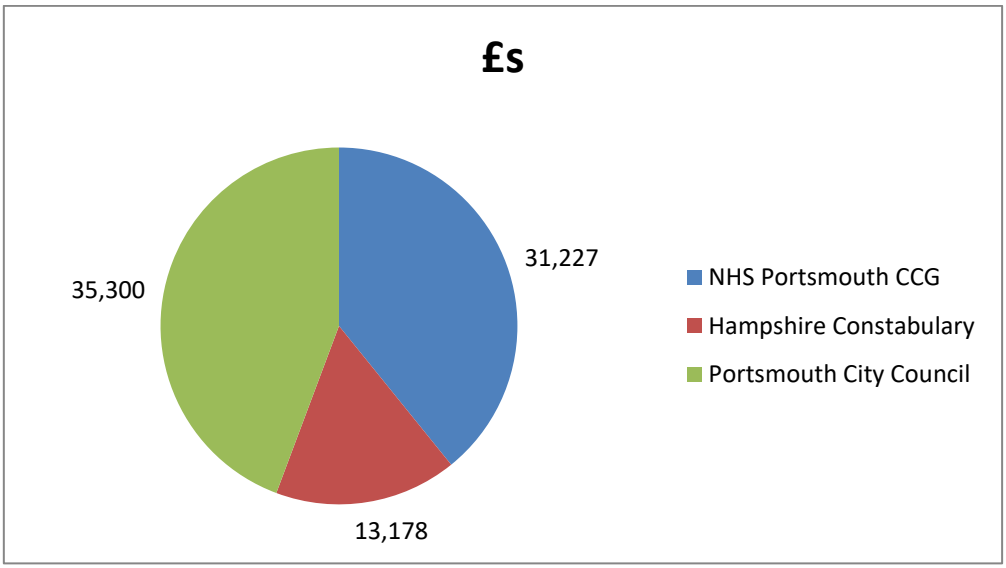
The Portsmouth Safeguarding Adults Board (PSAB) is a partnership of key organisations in Portsmouth who work together to keep adults safe from abuse and neglect. These include:

- adult social care
- health
- emergency services
- probation services
- housing
- community organisations.

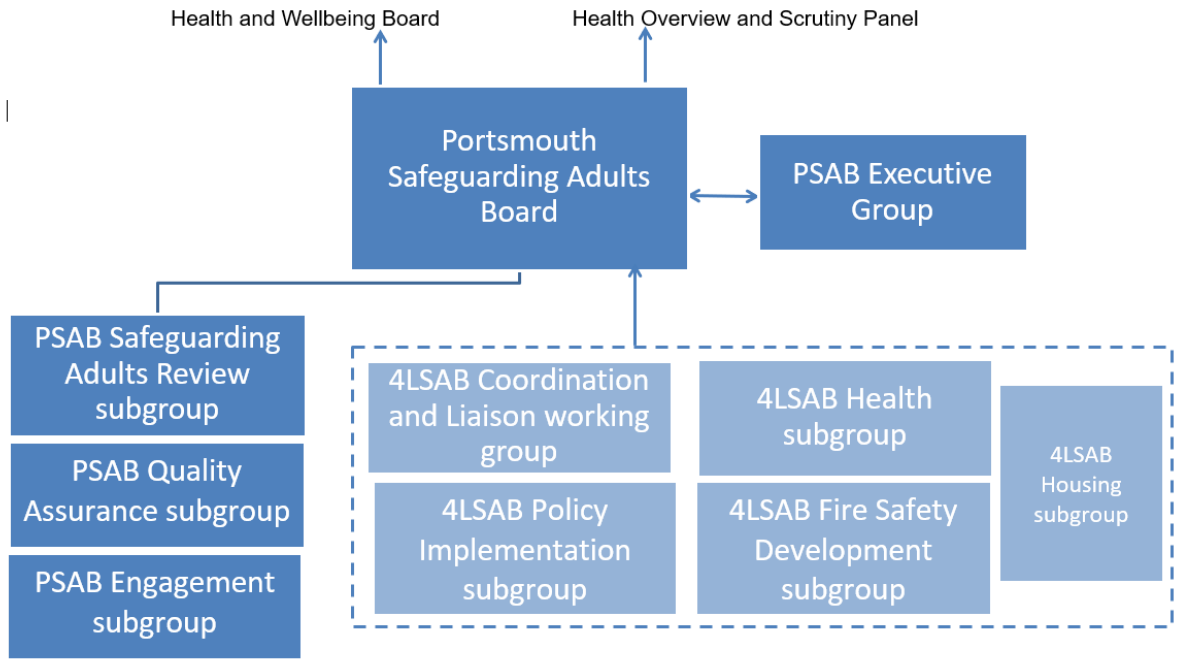
The Board has an independent chair that can provide some independence from the local authority and other partners. This is especially important in terms of:

- 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 and Hampshire Constabulary). The contributions received in 2021-22 were:



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' working groups with the neighbouring Boards (Hampshire, Southampton and the Isle of Wight). This helps ensure we work in a joined-up and coordinated way with our partners across the region on common priorities. The addition of a 4LSAB Health subgroup was also approved by the Board in March 2022 and this subgroup will start work from April 2022 onwards.



Portsmouth Safeguarding Adults Board

Strategic Plan 2022-23

The Care Act 2014 states that the purpose of a safeguarding adults board is ***to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the statutory criteria for safeguarding***, that is an adult who

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

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect.

Further a Board should:

- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- stop abuse or neglect wherever possible
- safeguard adults in a way that supports them in making choices and having control about how they want to live
- promote an approach that concentrates on improving life for the adults concerned
- raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult
- address what has caused the abuse or neglect

The role of the Board is to:

- *ensure that everyone, both individuals and organisations, are clear about their roles and responsibilities*

- *create strong multi-agency partnerships that provide timely and effective prevention of and responses to abuse or neglect*
- *support the development of a positive learning environment across these partnerships and at all levels within them to help break down cultures that are risk-averse and seek to scapegoat or blame practitioners*
- *enable access to mainstream community resources such as accessible leisure facilities, safe town centres and community groups that can reduce the social and physical isolation which in itself may increase the risk of abuse or neglect*
- *clarify how responses to safeguarding concerns deriving from the poor quality and inadequacy of service provision, including patient safety in the health sector, should be responded to*

To refresh its strategy the Board leadership has been consulting with its membership and engaged its membership in dialogue to explore an appropriate future direction. One of the key features of the dialogue to emerge has been the importance of engaging those in the City of Portsmouth who are directly involved in safeguarding adults at risk and those who need safeguarding. In respect of the former, Board members were keen to ensure that frontline workers are able to work effectively, confidently and competently with each other, and with the residents of Portsmouth so that those at risk are protected and properly engaged. By engaging with service user groups, the Board believes it will understand the needs of those adults at risk better and be able to ensure that frontline workers can respond to individuals with respect, supporting them in making choices and have control about how they want to live. The Board is also confident that closer engagement with service user groups will help it to ensure that abuse and neglect can be prevented by having better intelligence about what creates the possibility of harm to those adults at risk.

Portsmouth Health and Wellbeing Board has established that addressing the underlying factors that put people at risk of poor outcomes is essential. The relative picture of health is poorer in Portsmouth compared to the rest of the Southeast region. In addition, positive relationships (or the lack of) underpin many of the biggest challenges we face, from domestic abuse to poor mental health to social isolation for both the young and the old. Connectedness with each other, your family, your community underpins many outcomes. Evidence shows that people with high levels of social connectedness have longer and happier lives and are less dependent on public services by utilising their social capital. We further know that people experiencing trauma struggle to develop and maintain positive relationships and connectedness due to what is known as ‘blocked trust’.

Given the specific purpose of a safeguarding adults board, the PSAB’s new strategy and action plan is designed to contribute alongside the Health and Wellbeing Board and other statutory partners to promoting improvements in the way front line workers engage with service users at risk of abuse and neglect. The PSAB recognises that frontline workers in the City already do a good job but the Board believes that it can support those achievements by a greater investment in encouraging engagement, especially with service users group that have previously not always been included in

this area of work, such as homeless adults and adults who use substances as a support.

The Board has agreed that significant focus should be concentrated on the following groups:

- Homeless adults
- Substance misusing adults
- Young adults who are transitioning from children's services
- Learning disabled adults
- Adults living in residential/nursing home care or who need extra care or supported living or domiciliary care
- Adults who are socially isolated through mental health problems

The Board will work to develop improved community engagement with these communities by establishing a specific subgroup to champion communication.

To help frontline workers to work together collaboratively and with the service user's needs at the centre of their efforts, the Board will promote better joint working with a across agency training needs analysis, learning events that encourage dialogue and better communication, improved supervision and a new Safeguarding Adults Leads Network with representatives from all agencies. The network will help to spearhead practice improvements.

The Board will continue its statutory efforts to review experience when things have not gone as planned and it will seek to publicise best practice through newsletters and websites. The Board itself will aim to work differently. To promote better communication between frontline workers, the Board will engage more regularly in workshop style communication so that information sharing at a strategic level is improved. It will also be more focused in holding its member agencies to account for their work to safeguarding adults at risk.

The Board has agreed an ambitious 12-month action plan to kick start the goals mentioned here. It will review its progress towards the end of those 12 months and adjust where appropriate before exploring how to make further progress in the coming years.

David Goosey
Independent Chair
August 2021

PSAB Strategic Plan: 12 month action plan 2022-23

PRIORITY 1: Community Engagement				
ACTION		**RESPONSIBLE**	**TIMESCALE**	**MEASURING PROGRESS**
1.1	Establish an Engagement subgroup which includes service user representation	Chair	June 2022	# Groups engaged with # Individuals engaged with # Pieces of feedback received
1.2	Scope existing engagement with 6 priority groups	Engagement Subgroup Chair	September 2022	
1.3	Develop 3-year engagement and communication plan	Engagement Subgroup Chair	March 2023	

PRIORITY 2A: Interprofessional practice **PRIORITY 2B: Relationship based practice**				
ACTION		**RESPONSIBLE**	**TIMESCALE**	**MEASURING PROGRESS**
2.1	Establish an annual workforce strategy meeting to identify gaps in training	Quality subgroup Chair	June 2022	# multi agency learning opportunities # attendees at multi agency learning opportunities # attendees at multi agency event Staff feedback from learning opportunities Findings from repeat MARM audit
2.2	Promote resources for professionals to support effective interprofessional communication, challenge and reflection (including the use of MARM) and through the facilitation of multi agency events	Principal Social Worker	September 2022	
2.3	Promote the use of MARM	Safeguarding leads	March 2023	
2.4	Strengthen supervision by a. Producing and disseminating good practice tips for supervision	Quality subgroup Chair supported by Principal Social Worker	September 2022	

	b. Scope options for a multi professional supervision forum		December 2022	# MARM meetings held
2.5	Establish a Safeguarding Adults Leads Network	Board Manager	September 2022	

PRIORITY 3: Safeguarding practice				
ACTION		**RESPONSIBLE**	**TIMESCALE**	**MEASURING PROGRESS**
3.1	Establish a regular PSAB newsletter to include news, best practice and success stories from Portsmouth partners	Board manager	1st edition by September 2022	# newsletters circulated # views of newsletter Staff feedback on newsletter # views of podcast Website usage data
3.2	Identify and share best practice via PSAB website, podcasts, and at Board meetings	Quality subgroup Chair	September 2022	
3.3	Make the subgroups more accountable to the Board, through: • Annual presentations from subgroup Chairs at the Board • Reviewing subgroup ToR • Developing and monitoring subgroup business plans • Regular meetings between Independent Chair and subgroup chairs	Chair	September 2022	
3.4	Implement new format workshop-style Board meetings to encourage interprofessional dialogue	Chair	December 2021	
3.5	Act on the findings of reviews and audits published in 2022-23	Chair	March 2023	

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Portsmouth CITY COUNCIL

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Title of meeting:	Health, Wellbeing & Social Care
Subject:	Portsmouth Health & care Discharge to Assess Model
Date of meeting:	31 January 2023
Report by:	Simon Nightingale, Assistant Director, Health & Care Services
Wards affected:	All

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1. **Requested by**
   Councillor Matthew Winnington, Cabinet Member for Health, Wellbeing & Social Care

2. **Purpose**

   a) To update Members on the progress of the planning in response to the request from the Integrated Care Board (ICB) to support the Portsmouth and Southeast Hampshire, (PSEH) Local Delivery System[1] (LDS) Remedial Action Plan for reducing ambulance holds at PHU funded through the recently announced £500m Adult Social Care Discharge Fund, which forms part of the Government's 'Plan for our Patients'[2].

3. Information Requested

A £500 million fund has been announced by the Government[3] to support discharge from hospital into the community and bolster the social care workforce, to free up beds for patients who need them.

The funding will be pooled into the Better Care Fund (BCF) and paid partly to Integrated Care Boards, (ICB) and partly to Local Authorities. The funding will be provided in 2 tranches – the first (40%) in December 2022, and the second (60%) by the end of January 2023 for areas that have provided a planned spending report and fortnightly activity data and have met the conditions of the funding. Hampshire & Ise of Wight ICB has received an allocation of £12.4m. For Portsmouth City Council, our allocation is £742,014.00.

The fund can be used flexibly by local health and care systems, targeting the areas facing the greatest challenges and strengthening the sector's ability to recruit and retain staff. This

[1] The organisations that work around an acute hospital.
[2] Our plan for patients - GOV.UK (www.gov.uk)
[3] Letter to the health and social care sector from the Minister for Care - GOV.UK (www.gov.uk)

is expected to improve pathways for people leaving hospital when they are ready, and with the right care and support in place.

As part of ICB winter planning and in response to the Adult Social Care Discharge Fund, a Remedial Action Plan (RAP) has been developed by the ICB to reduce pressure experienced by the South Coast Ambulance Service (SCAS) when delayed transferring patients to Portsmouth Hospital University Trust (PHUT).

Adult Services are proposing the following schemes in response to the plan and available funding, to be in place until March 2023. These include increasing home care block contract to ensure care is available when needed and increasing social work capacity to complete timely assessments leading to more efficient use of Discharge to Assess, (D2A) resources.

Scheme ID	Scheme Name	Brief Description of Scheme (including impact on reducing delayed discharges).	Source of Funding	Planned Expenditure (£)
PCC 1	Care Assessment Capacity	Recruit locums to reduce delays awaiting Care act assessment	Local authority grant	£136,000
PCC 2	Bridging Care	Increase bridging capacity to support earlier discharges	Local authority grant	£65,824
PCC 3	Care Assessment Capacity	Additional SW Resource	Local authority grant	£151,770
PCC 4	Awaiting Assessment - Dom Care	Support for external client packages awaiting assessment post D2A	Local authority grant	£49,000
PCC 5	Awaiting Assessment - Nur / Red	Support for external client packages awaiting assessment post D2A	Local authority grant	£332,000
PCC 6	Admin	Admin support	Local authority grant	£7,420

A further option to staff the top floor of Shearwater residential home to create up to 16 care beds as part of the RAP was considered but not taken forward due to uncertainty of demand for this type of provision to support discharge / admission avoidance. Since that decision, Shearwater is now being used to support the closure of East Cosham House which happened recently so cannot be reconsidered for the RAP at this time.

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As part of the wider Portsmouth RAP, the ICB are also intending to fund additional Nursing Home beds within Mary Rose Manor in the city and increase capacity for home based reablement through Portsmouth Rehab and Reablement Team (PRRT). This funding is still to be confirmed but is expected to be made available to progress the actions before Christmas.

After this report was drafted, the government announced a further £200 million funding for discharging patients from hospital beds into 'step down beds' and made a statement to the House of Commons that confirmed these arrangements.

On 13/1/23, the government published guidance around this fund. Whilst this is an evolving picture, the money will be allocated to ICB, with Hampshire & Isle of Wight ICB receiving £6 million in additional funding. The guidance suggests that the care home beds and any clinical support required will be purchased directly by the ICB and includes the requirement that:

- ICBs must work with local authorities to ensure that an appropriate, locally benchmarked, rate is paid for care funded through these arrangements, with rates set at a level that does not lead to local inflation in the cost of care.
- Any costs that the NHS or local authorities incur on care from week five onward, until ongoing care requirements and funding routes have been determined, must be met from existing local budgets.
- In all cases, arrangements for procuring additional bedded capacity should be made with the full involvement of local authority partners, taking account of wider pressures on the care market.

At time of writing we do not have a clear picture of what this means for Portsmouth residents.

……

Signed by (Director)

Appendices:

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
CITY COUNCIL

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