Portsmouth Safeguarding Adults Board
Annual Report

PSAB

2020 - 2021

Statement from the Independent Chair

I am pleased to be able to introduce the Portsmouth Safeguarding Adults Board's Annual Report for 2020-21.

The last 12 months have brought a pandemic the likes of which none of us have seen before, and it's fair to say that services in Portsmouth were taken by surprise.

However, I was delighted to see that everyone involved with safeguarding adults at risk responded brilliantly. Services were reorganised so that staff and service users were kept as safe as possible and attempts were made to ensure the business of safeguarding could continue where feasible. The Board adapted to new ways of working, such as virtual meetings, to keep business going amidst the coronavirus restrictions.

Tragically some adults at risk in care homes and in the community died from the virus. I want to pay tribute to the professionals in the NHS and social care especially and in other organisations who worked tirelessly to try to ensure adults at risk were kept safe.

We have begun to explore a new strategic plan for safeguarding adults at risk in Portsmouth, with our previous business plan having come to an end. The new, ambitious strategy is nearing completion and will mark a bold shift in emphasis, targeting particular service user groups for intervention who have previously received less attention, such as homeless adults. We are working with other strategic partnerships, including the Health and Wellbeing Board, to ensure we are working in a coordinated way across our city to keep adults at risk safe from harm.

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

Priority 1: Improve practice in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

Priority 2: Increase the number of care providers rated good or outstanding by CQC

Priority 3: Pan-Hampshire working

Priority 4: Improve the quality of transition

Priority 5: Ensure Portsmouth Safeguarding Adults Board decision making is underpinned by robust data

Priority 6: Improve safeguarding adults practice within Portsmouth

Priority 7: Develop engagement with service users, carers and the public

During 2020-21 the Board continued to work on these priorities, which were identified as part of a three-year planning cycle. The new Independent Chair has led a review of the strategic priorities during the year. The new strategy aims to be more ambitious and will link to the work of other strategic partnerships within Portsmouth. The strategy will be finalised in 2021-22 and work will start on a new action plan in 2022-23.

COVID-19 pandemic

The year has, for obvious reasons, been dominated by the COVID-19 pandemic, affecting the lives of individuals and the work of our partners at the most fundamental level.

COVID-19 has presented particular challenges to adults at risk of abuse or neglect - with many of them both clinically extremely vulnerable and also acutely impacted by restrictions, such as bans on visits to care homes or the cancellation of their usual support groups.

Our partners had to focus on ensuring frontline services were safely delivered and adults at risk were supported. This meant, in some cases, there were changes in organisational priorities, and staff being redeployed to where they were most needed: supporting care homes, the Intensive Care Unit, and the vaccine roll-out.

COVID-19 case study:
Portsmouth City Council and Portsmouth Clinical Commissioning Group supporting care providers

Portsmouth has a long history of integrated health and social care commissioning and the benefits of this were seen in the city's response to COVID-19, with the support for care providers and ability to resolve operational issues quickly and collaboratively.

Measures put in place included:

- **webinars with senior leaders** to address immediate issues such as: finance, personal protective equipment (PPE) and staffing
- **daily afternoon call** jointly hosted by the council and CCG, where providers could raise issues so commissioners could address them early
- **central local PPE helpline**
- **assistance with staffing** where there were capacity issues in care homes, sourced using a bridging agency or redeployment of own staff
- **financial package for reimbursements** mutually agreed with care provider representatives and commissioners, including guaranteed income support based on the previous three months
- face to face infection prevention and control training provided by the quality improvement team to all care home providers, as well as assistance with testing.

Read the full case study here

Actions taken by the Board in response to the pandemic have included:

- **Executive Group meetings** - the group met more regularly via conference call to keep abreast of pressures on partners and impacts of the pandemic on adult safeguarding
- **Re-evaluation of Board work and priorities** - ensuring a focus on the most essential work, recognising the operational pressures on partners. Safeguarding Adults Reviews were delayed during the first peak and the timetable for developing a new strategic plan was slowed.
- **New ways of working** - Microsoft Teams was used for Board meetings, training, and practitioner workshops. Face to face training on the Multi-Agency Risk Management framework was replaced with online training and a podcast staff could view in their own time.
- **Adult safeguarding huddle** - included safeguarding practitioners from adult social care, police, Portsmouth Hospitals University NHS Trust (PHUT), Solent NHS Trust, housing and domestic abuse. Partners shared key updates from their services and worked together to solve operational issues as they arose and share best practice. The huddle met weekly at the height of the pandemic with meetings later reduced to monthly.
- **Coordinating work of partners** - for example providing guidance to police around enforcing coronavirus restrictions on adults with learning disabilities.

- **External communications:** supported new volunteers with a one-minute guide to safeguarding adults for coronavirus volunteers, which was adopted by Association of Directors of Adult Social Services (ADASS) and shared nationally. Distributed local and national information and guidance about COVID-19 and highlighted relevant training opportunities on our website.
- **Oversight and assurance of partners' response** - using the ADASS assurance framework the Board asked all agencies to complete COVID-19 proformas on learning for the June 2020 Board meeting and held a COVID-19 task and finish group to identify learning. Our quality assurance subgroup compared trends in Portsmouth to national data from the Local Government Association Insight Project to help understand the impact of COVID-19 and lockdowns on safeguarding activity. Public Health presented their findings on COVID-19 deaths in Portsmouth to the Board.

***COVID-19 case study**:*
PHUT emergency department addressing domestic abuse

With a predicted increase in domestic abuse following the first COVID-19 lockdown in March 2020, the PHUT emergency department's safeguarding team introduced a number of measures to ensure staff recognised domestic abuse, knew what action to take and could help victims access support. Measures included:

- step by step guides to referral for staff to attach to their ID badges
- screening questions added to the computer system to help staff start difficult conversations and risk-assess patients
- safety barcode stickers which can be stuck to any item the victim feels is safe (e.g. lip balm). These were co-produced with victims of domestic abuse.
- introducing 'Ask for Angela' where adults feeling unsafe can approach a member of staff and ask for 'Angela' to indicate they need help.

Key achievements in 2020-21

This year the Board has:

- developed, consulted on, and published **new 4LSAB Safeguarding Concerns Guidance** providing a framework to help professionals across partner organisations to make decisions on when to raise safeguarding concerns. The guidance is accompanied by a **decision support tool**. Online training will be offered in 2021-22 and e-learning is also under development.
- worked to embed the **4LSAB Multi-Agency Risk Management (MARM) Framework** in practice in the city. We had seen learning from Safeguarding Adults Review referrals showing that the MARM framework was not always being used to take a multi-agency approach in cases where there is a high level of risk but criteria for safeguarding are not met. The Board held online training for key staff and produced an introductory podcast, which was viewed by over 400 people. Senior managers undertook to embed MARM in the

culture of their organisations. An audit of MARM including a staff survey is planned for 2021-22.

Case study: MARM framework (Peter*)

Peter was a man in his 50s, living in homeless accommodation in Portsmouth. He had a long history of substance misuse, self-neglect and had been diagnosed with a life limiting condition. Due to his complex needs, previous lack of engagement with support services, and the unsuitability of his current living situation, a MARM was initiated to bring all the people involved in Peter's care together to risk-assess and plan next steps.

During his MARM, Peter was asked about his views and wishes. He said his main wishes were to be nearer to his family and that he did not want to die in homeless accommodation. A number of MARM meetings were held involving health professionals, social workers, housing officers and representatives from the local authority where Peter's family lived.

The outcome of the MARM process was that Peter was assessed formally via a Care Act Assessment, a package of care was put in place, and thanks to cooperation between local authorities, Peter was moved to more suitable accommodation near his family, fulfilling his wishes.

**Name changed to protect identity*

- established a new **Quality Assurance subgroup** to carry out data collection and analysis, conduct multi-agency audits, and ensure that lessons learned from cases have been embedded across Portsmouth. Since it began in May 2020 the new subgroup has reviewed a full year of data and developed an annual audit programme.
- been a partner in the **national Safeguarding Vulnerable Dependent Drinkers project** led by Alcohol Change UK. The project surveyed staff and developed a briefing on the different legal powers available to help chronic dependent drinkers. Staff had the opportunity to attend a series of online webinars in December 2020. Online training sessions are planned for 2021-22.
- ratified a new **'Preparing for Adulthood' policy** in partnership with the Portsmouth Safeguarding Children Partnership (PSCP) providing guidance on arrangements for young people between 14 and 25 years old who have special educational needs and/or disabilities (SEND). The new policy aims to help professionals across education, health and social care, to support young people with SEND - in preparing for an adult life and to go on to achieve the best possible outcomes in employment, independent living, health, and community participation. An audit of transition, to be conducted jointly with the PSCP, is planned for 2021-22.

- supported **National Safeguarding Adults Week 2020**. 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.

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 chaired by the Serious Case Reviewer from Hampshire Constabulary. The group is multi-agency, with members who have a specialist role or experience in safeguarding adults. The group holds monthly meetings and during 2020-21 has 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 2020-21

Three SAR referrals were carried forward from 2019-20. None of these referrals were found to have met the statutory criteria for a mandatory SAR. For one of these cases, no learning was identified. In the second, assurance was sought from the two health partners involved that the findings of their internal reviews had been acted upon. For the third ('Ms A'), it was felt that learning may be identified through the use of the SAB's discretionary power to conduct a review. The CCG therefore led a learning event for practitioners involved in the case. Although there were no system-wide recommendations identified, some learning points for practitioners were published in this briefing. In response to the review, the Quality Assurance subgroup developed a factsheet for contractors to help them identify adults who may be at risk of abuse or neglect, and take appropriate action in response. Our review found that although Ms A was the tenant of a large social landlord, they were unaware of the concerns professionals had about Ms A and her property and could have provided support had they known. It was recognised that contractors are often the only people to visit adults at risk in their homes.

There were 20 new SAR referrals received in 2020-21.

Of the 20, 14 of the referrals were for the deaths of homeless people, who were either rough sleeping or housed in temporary accommodation. Although none of these cases met the criteria for a mandatory review, the increase in the number of homeless deaths in the city was a cause of concern for the Board. While none of the deaths were due to COVID-19, extensive changes had been made to services for homeless people during COVID-19, including rapidly rehousing all homeless people in hotels in response to the Government's 'Everyone In' policy. Therefore factors relating to the pandemic may have contributed to the increase in deaths. In light of this the Board has decided to commission a thematic review of homeless deaths to

examine the issues in detail, using four of the cases as examples. The review will take place in 2021-22.

Two referrals met the statutory criteria for a mandatory SAR - they have been commissioned and will take place in 2021-22.

One referral did not meet the criteria for a mandatory review. The subgroup reviewed the findings of the safeguarding enquiry that had been carried out by Adult MASH under section 42 of the Care Act and found no significant causes for concern.

One referral was for a death which took place in another area, so this was passed to the SAB for that area, as they hold the statutory responsibility to review the death. The Board and its partners liaised with the SAB to ensure they had the information they needed and that there was no specific learning for Portsmouth partners.

Two referrals are subject to an internal review by the referring agency, and the subgroup is awaiting the findings from those before considering the cases. These will be carried forward to 2021-22.

Two further reviews which were commissioned in 2019-20 are ongoing. Due to the COVID-19 pandemic, work on these reviews was paused. They will be published in 2021-22.

4LSAB Fire Safety Development Subgroup

The 4LSAB Fire Safety Development Subgroup looks at fire deaths and near misses in the 4LSAB area, to identify learning applicable to all areas. In 2020-21, a total of two incidents occurred within the Portsmouth Local Authority area which met the Fire Safety Development Subgroup criteria for review. Both incidents sadly resulted in a fatality. 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 group.

Risk and vulnerability factors identified:

- individual lived alone in one case
- average age of the individuals involved in incidents was 77
- individual in receipt of daily care and support services in one case
- individual known and open to Mental Health Services in one case
- poor mobility identified as a vulnerability factor in one case
- For one of the cases reviewed, it was identified that there was insufficient smoke detection within the property. The investigation was unable to determine if the working smoke detector in the property activated at the time of the incident.

In terms of causes of the fire incidents, the following themes emerged from the reviews:

- One of the cases reviewed identified the most likely cause of the incident as – ‘Accidental – unattended cooking’.

- One of the cases reviewed identified the most likely cause of the incident as being a ‘deliberate act’

The subgroup published a learning briefing summarising its findings for the year and has also developed a **4LSAB Fire Safety Framework** which will be launched in 2021-22.

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 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.

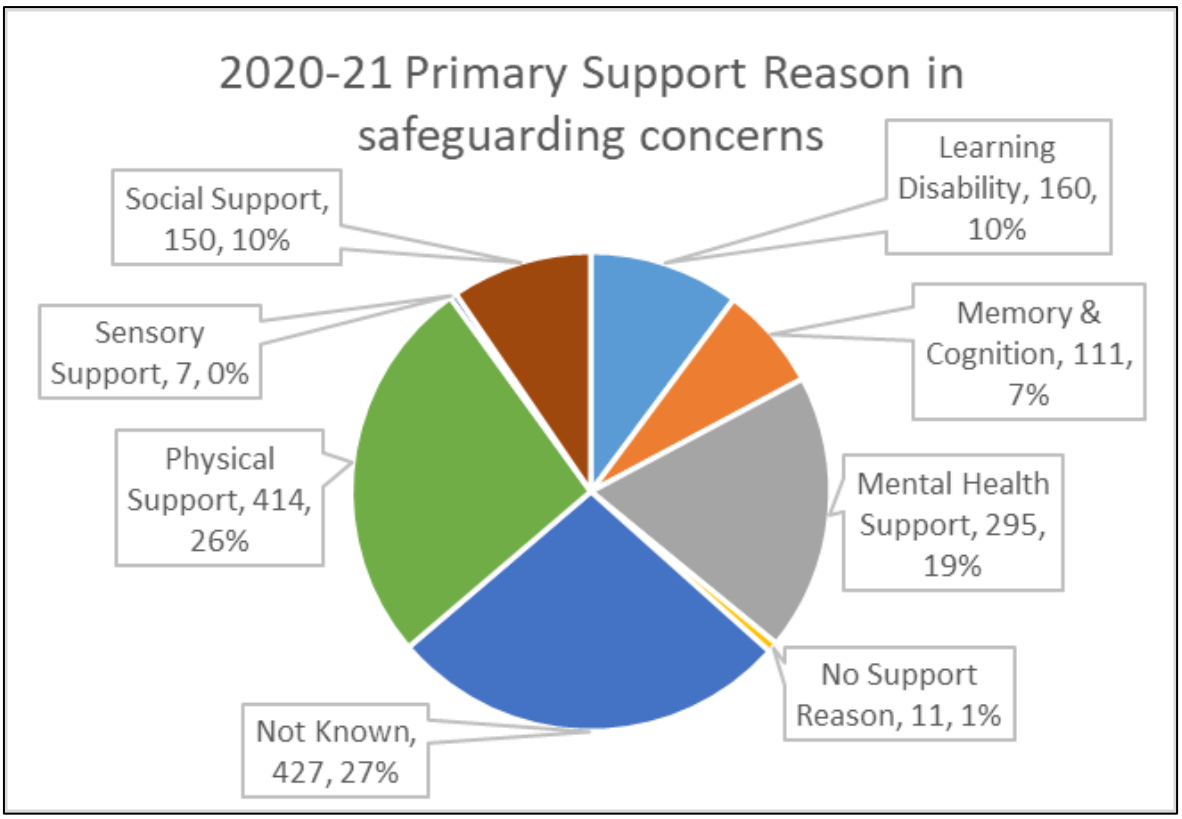
Portsmouth has an Adult Multi-Agency Safeguarding Hub (MASH) with a team of social workers and police officers working together who have direct links with colleagues in areas such as health, trading standards and children's safeguarding. The MASH manages a high volume of referrals.

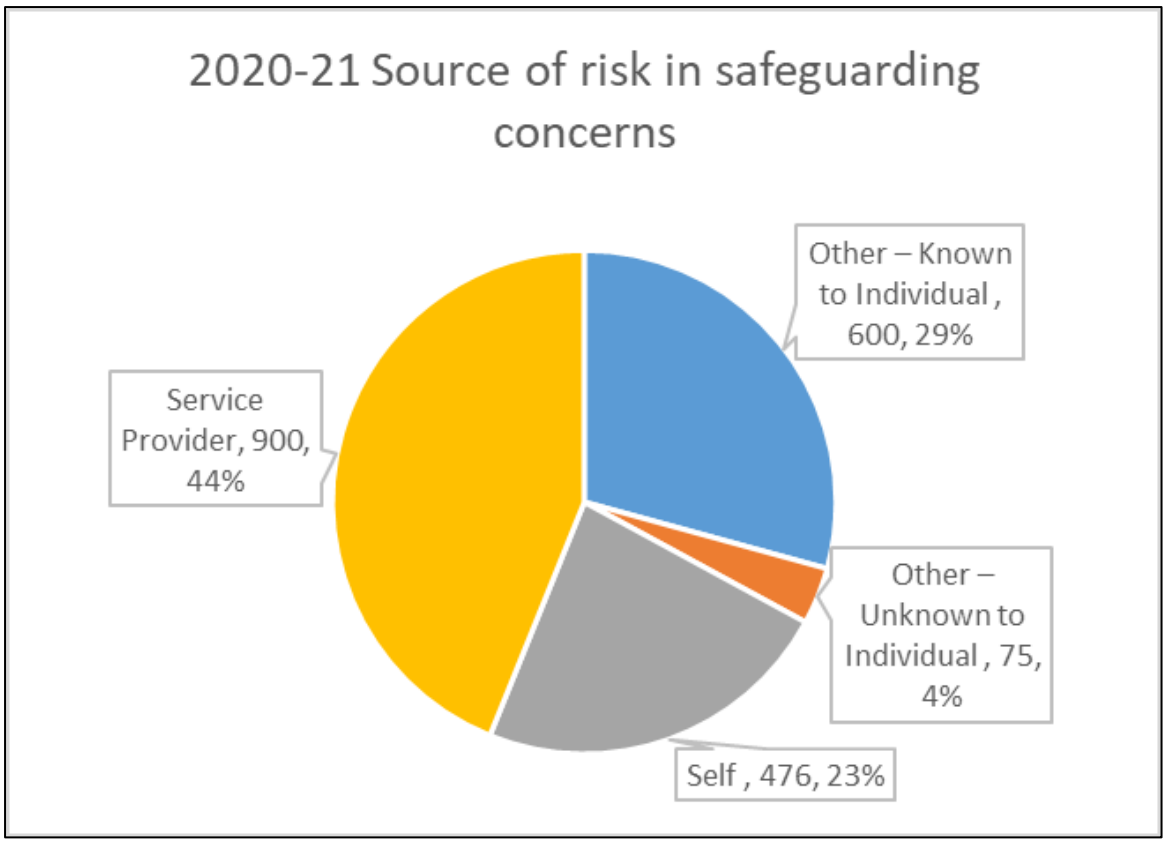
Data collected by the MASH gives further information about who has experienced abuse or neglect in Portsmouth, where abuse has taken place, and the types of risk they have experienced. The information below is taken from the NHS Digital Safeguarding Adults Collection end of year return.

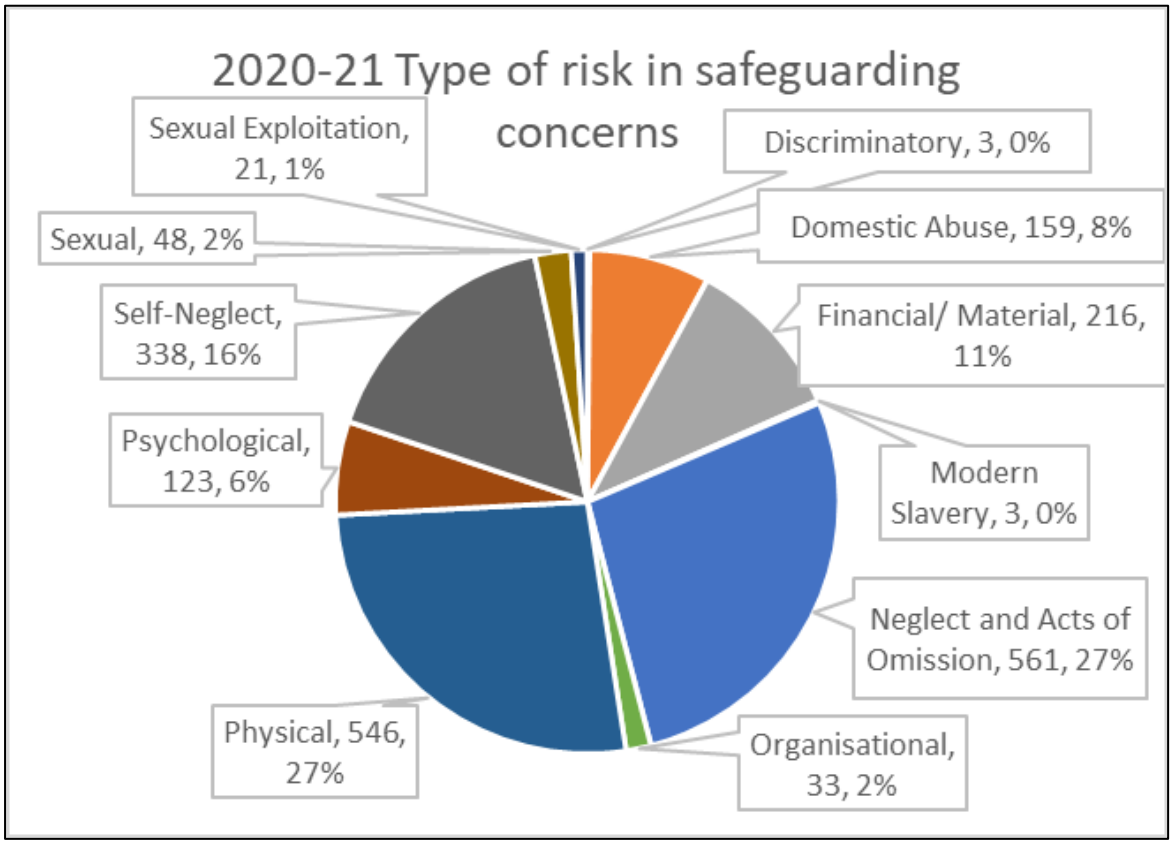
If an issue about an adult's safety or welfare is raised with the MASH, it is called a 'Safeguarding Concern'. The MASH will assess the concern and take appropriate action.

There were 2,051 concerns raised in 2020-21 about 1,363 individuals.

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


2020-21 Primary Support Reason in safeguarding concerns
Learning Disability, 160, 10%
Memory & Cognition, 111, 7%
Mental Health Support, 295, 19%
No Support Reason, 11, 1%
Not Known, 427, 27%
Physical Support, 414, 26%
Sensory Support, 7, 0%
Social Support, 150, 10%


2020-21 Source of risk in safeguarding concerns
Other – Known to Individual , 600, 29%
Service Provider, 900, 44%
Other – Unknown to Individual , 75, 4%
Self , 476, 23%


2020-21 Type of risk in safeguarding concerns
Sexual Exploitation, 21, 1%
Discriminatory, 3, 0%
Sexual, 48, 2%
Domestic Abuse, 159, 8%
Self-Neglect, 338, 16%
Financial/ Material, 216, 11%
Psychological, 123, 6%
Modern Slavery, 3, 0%
Neglect and Acts of Omission, 561, 27%
Physical, 546, 27%
Organisational, 33, 2%

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.

708 formal Safeguarding Enquiries were concluded in 2020-21.

In 94% 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 what they wanted to happen or what they wanted 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.

Case study: Making Safeguarding Personal (Charles*)

Initial concerns were raised about Charles, a man in his 70s, as he was rough sleeping and appeared to be confused and disorientated. Charles was assessed under the Mental Health Act and was briefly hospitalised for assessment. Adult MASH opened a Safeguarding Enquiry to assess the risks to Charles and decide on actions to be taken to reduce risk, in line with Charles' wishes.

During his time in hospital Charles' capacity to make decisions about his treatment and where he wanted to live was assessed and he was found to have capacity to make these decisions. Charles stated that he had lived in a manmade shelter outside the Portsmouth area for a number of years and was adamant that all he wanted was to return there. It appeared Charles was well supported by the local community and was visited frequently by the homeless outreach team.

At the conclusion of the enquiry, a meeting was held with social workers from the local authority where Charles' permanent shelter was and it was agreed that a social worker would be assigned to Charles with the aim of building rapport and assisting him to claim benefits he was entitled to and to attend medical appointments. The homeless outreach team also agreed to continue to visit Charles to check on his welfare. This action meant that Charles was able to move back to his shelter, in line with his expressed wishes, but the risks to him were reduced, via support and monitoring by a number of agencies.

**Name changed to protect identity*

The Board also receives data regularly from Portsmouth City Council Housing Services, Portsmouth City Council Trading Standards, PHUT, Solent NHS Trust, Hampshire Constabulary, and Hampshire and Isle of Wight Fire and Rescue Service.

Trading Standards received 27 referrals regarding financial abuse in 2020-21.

In 2020-21 Hampshire Constabulary reported:

- 6 incidents of Honour Based Violence where the victim was over 18
- 1 incident of trafficking of a person over 18
- 684 high risk domestic crimes
- 609 incidents of hate crime.

Hampshire and Isle of Wight Fire and Rescue Service carried out 829 Safe and Well visits in Portsmouth in 2020-21.

There was 1 domestic homicide in Portsmouth in 2020-21.

There were 2 fire deaths in Portsmouth in 2020-21.

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Glossary

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

ADASS - Association of Directors of Adult Social Services. A charity working to promote higher standards of social care services, influence policies and decision-makers to transform the lives of people needing and providing care.

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.

CQC - Care Quality Commission. The independent regulator of all health and social care services in England.

DoLs - Deprivation of Liberty Safeguards. Part of the Mental Capacity Act 2005. A set of checks that aims to make sure that any care that restricts a person's liberty is both appropriate and in their best interests.

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

PHUT - Portsmouth Hospitals University NHS Trust. A large district general hospital providing comprehensive acute and specialist services. The main site is Queen Alexandra Hospital in Portsmouth.

PPE - Personal Protective Equipment

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.

SEND - Special Educational Needs and Disability

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?

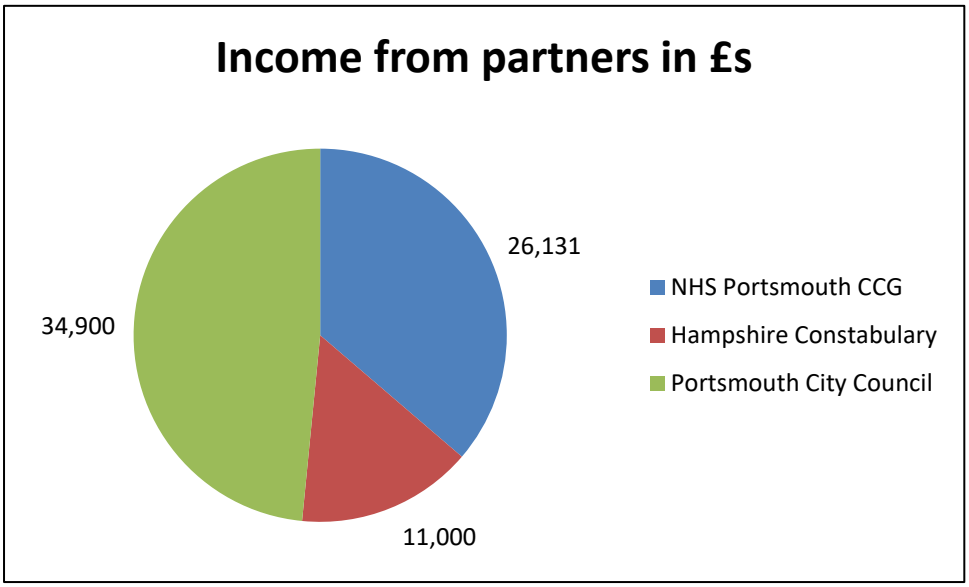
The Portsmouth Safeguarding Adults Board (PSAB) is a partnership of key organisations in Portsmouth who work together to keep adults safe from abuse and neglect. These include:

- 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 agreed contributions are:



The structure of our Board and its subgroups is shown in the diagram below. In the areas of Policy Implementation, Workforce Development, Quality Assurance 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.