Portsmouth Safeguarding Adults Board

Annual Report

PSAB

2018 - 2019

Statement from the Independent Chair

I am pleased to be able to introduce the Portsmouth Safeguarding Adults Board's Annual Report for 2018-19.

This year, we have taken steps to develop a new three-year business plan which sets out our priority areas of work for the coming years. A particular focus of our partnership working over the last year has been maintaining oversight of the quality of care across the city, and taking a multi-agency approach to supporting continuous improvement.

With all partners working in an increasingly challenging context, it has been a priority to ensure that joint working across organisations in the Hampshire and Isle of Wight region is effective. We have been able to embed pan-Hampshire/Isle of Wight working in the areas of quality assurance and workforce development through new sub-groups, and this year we have also launched joint policies on Hoarding and Escalation. With the imminent introduction of the new safeguarding arrangements for children,[1] we have also been working increasingly closely with our local Safeguarding Children Boards, to ensure that our services take a family approach to safeguarding.

One of the Board's key priorities is to ensure system-wide learning. Following the publication of the Independent Panel's report into deaths at Gosport War Memorial Hospital,[2] the Board has been reviewing oversight and governance processes to ensure that unexpected deaths are identified and scrutinised, and that our services listen and respond to the concerns of adults at risk and their families.

Finally, I would like to thank our partners for their contribution to the work of the Board over the last year, and their firm commitment to ensuring that adults at risk of abuse or neglect are safeguarded effectively and empowered to make their own decisions.

[1] *Working Together to Safeguard Children (July 2018)* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

[2] Gosport Independent Panel, *The Panel Report,* https://www.gosportpanel.independent.gov.uk/panel-report/

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?

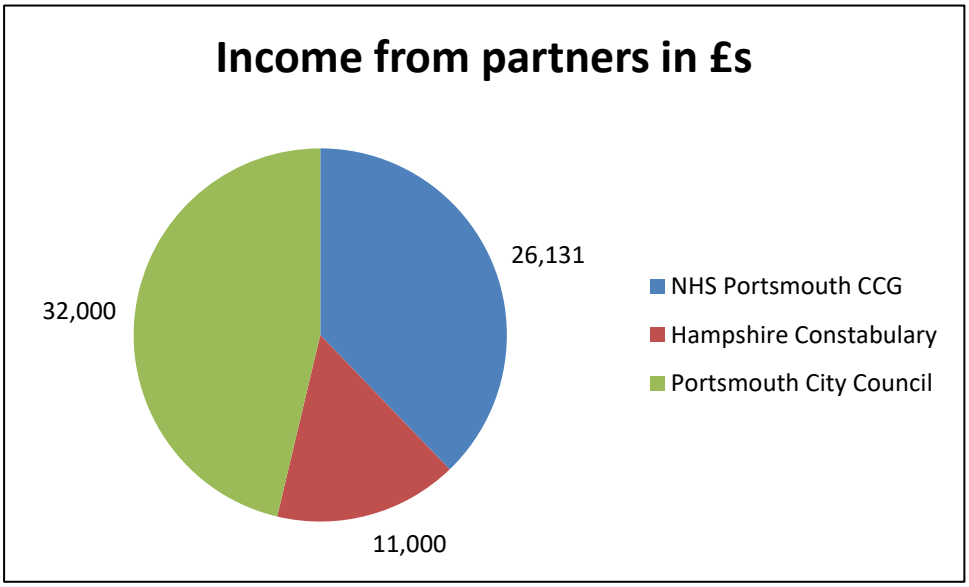
The Portsmouth Safeguarding Adults Board (PSAB) is a partnership of key organisations in Portsmouth who work together to keep adults safe from abuse and neglect. These include:

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

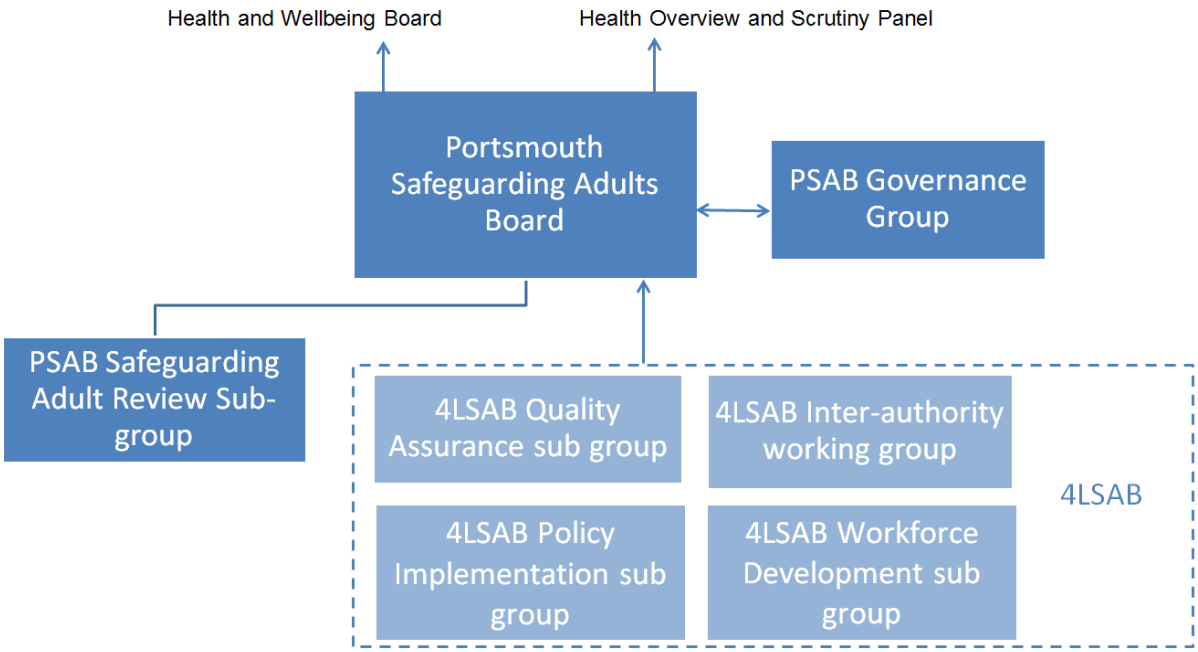
The Board has an independent chair that can provide some independence from the local authority and other partners. This is especially important in terms of:

- offering constructive challenge
- holding member agencies to account
- acting as a spokesperson for the PSAB.

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 sub-groups is shown in the diagram below. In the areas of Policy Implementation, Workforce Development and Quality Assurance, 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.



Our Vision

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

Our Strategic Priorities

During 2018 the Board reviewed its approach to strategic planning. Retaining the priorities identified for 2018-19, a business plan for a three year planning cycle from 2019-20 to 2021-22 was developed, with progress to be reviewed on an annual basis. The Board's strategic planning is firmly underpinned by a multi-agency assessment of key risks to keeping people safe across the City.

All actions set out within our priorities will be underpinned by the principles of 'Making Safeguarding Personal' (MSP), an approach which enables safeguarding to be done with, not to, people – 'no decision about me, without me'. MSP principles ensure that safeguarding is person-centred and outcome focussed.

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

Adults at risk are empowered to make decisions where they have the mental capacity to do so. Adults at risk who do not have mental capacity are supported to ensure decisions are made in their best interests and that legal safeguards are in place.

The Board endorsed and promoted a revised MCA toolkit (produced by Hampshire County Council) to assist staff with assessing mental capacity and carrying out Best Interests assessments.

In December 2018 Board members were invited to observe (and take part in) innovative simulation training developed by Portsmouth Hospitals Trust. More information about improvements in this area are outlined in the following case study.

Case Study: Safeguarding Improvement Board and MCA/DoLs improvements at Portsmouth Hospitals Trust

During 2017-18 two inspection reports from the Care Quality Commission (CQC) were published regarding the quality of health provision in Portsmouth:

- CQC Portsmouth Hospitals NHS Trust, Queen Alexandra Hospital Quality Report (publication date 24th August 2017).
- CQC Review of health services for Children Looked After and Safeguarding in Portsmouth (publication date 19th September 2017).

These reports both identified areas of good practice as well as some areas concern relating to safeguarding of both adults and children in Portsmouth's health services.

To ensure that both the PSAB and the Portsmouth Safeguarding Children Board (PSCB) had sufficient oversight of the improvement activity in partner agencies, whilst not overly burdening them with duplication of reporting, a Joint Safeguarding Improvement Board was convened. This Board was constituted as a sub-group of both PSAB and PSCB on a task-and-finish basis and had agreed terms of reference. As two-thirds of the patients attending Portsmouth Hospitals Trust live in Hampshire, the Safeguarding Improvement Board has also sought to work in partnership with the Hampshire Safeguarding Adults Board and the Hampshire Safeguarding Children Board.

This Board was jointly chaired by the Independent Chairs of the PSAB and PSCB and the membership was made up of:

- Chief of Health and Care Portsmouth, NHS Portsmouth CCG/Portsmouth City Council
- Deputy Director of Quality and Safeguarding, NHS Portsmouth CCG
- Head of Safeguarding, Portsmouth Hospitals NHS Trust
- Associate Director of Quality and Governance, Portsmouth Hospitals NHS Trust
- Public Health Consultant, Public Health
- Director of Children's Services, Portsmouth City Council
- Head of Health and Wellbeing Partnerships, Healthwatch Portsmouth
- Associate Director Quality and Nursing, South Eastern Hampshire/Fareham and Gosport Hampshire CCG Partnership
- District Manager for Hampshire Children’s Services, Hampshire County Council
- Chief Superintendent, Head of Prevention and Neighbourhood Command Hampshire Constabulary

- Board Manager, Portsmouth Safeguarding Adults Board
- Safeguarding Partnerships Manager, Portsmouth Safeguarding Children Board
- Strategic Partnerships Manager, Hampshire Safeguarding Children Board
- Strategic Partnerships Manager, Hampshire Safeguarding Adults Board

The objectives of the Safeguarding Improvement Board were:

a. To ensure appropriate actions have been identified and undertaken to address the areas of concern
b. To provide a direct line of reporting and accountability for the actions / work streams being undertaken by providers
c. To provide an accessible escalation route to address any areas that may prevent or hinder the necessary actions being taken
d. To provide strategic support to providers as required.

The PSAB commissioned independent consultants CPEA to produce a report and recommendations to initiate the work and detailed action plans were developed in response to the recommendations in these reports.

The Improvement Board met for the final time in November 2018. The majority of recommendations had been completed and the remaining outstanding actions were in hand. The following improvements were noted:

- The adults and children's safeguarding teams are now co-located and there is a single contact number. There is now increased capacity within adult safeguarding.
- Reporting mechanisms are now clear and include reporting to the Trust Board.
- The backlog of DoLS notifications to CQC has been cleared and there is a process in place for managing these.
- Data on safeguarding alerts, S42 safeguarding enquiries and DoLS are collected and monitored on a weekly basis, and any anomalies are addressed.
- Policies are now integrated and a new MCA/DoLS policy has been developed.
- Training has been reviewed and extended, and 100 staff have been trained using simulation training. This has produced demonstrable outcomes for staff at all levels.
- Support was being received from a Best Interests Assessor from Hampshire County Council, and external agencies had offered support and training.

PHT indicated that plans for future improvement work include:

- Work on MCA/DoLS, addressing the enforcement notices from CQC.
- Embedding the training strategy.
- Embedding the Hampshire MCA toolkit.
- Further work on domestic abuse.

It was decided that the work of the Improvement Board should conclude and monitoring would become part of business as usual for the PSAB and PSCB. A final

report and evaluation of the process were produced and distributed to partners and the Local Quality Surveillance Group.

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

Service users experience high quality and safe care in all care settings in Portsmouth.

Case Study: Quality Improvement Team

The Quality Improvement Team was established in April 2018 to work proactively with all Portsmouth care homes and domiciliary care providers in a positive and supportive manner to enhance the quality of care provision and to prevent low level concerns escalating. The team was established due to the concerns about the quality of care in Portsmouth, with a need for improvement in Care Quality Commission (CQC) ratings and coordination of approaches to support providers. The team is hosted by Portsmouth CCG and is funded jointly with Portsmouth City Council Adult Social Care. The small team is an integrated health and social care team which includes both nurses and social workers. The team's remit is to support providers to meet the quality standards and requirements of CQC, and to sustain and continuously improve the quality of services by:

- Offering advice and signposting to resources and development opportunities to support best practice.
- Working with care home / domiciliary care staff to audit quality of care as a means to showcase excellence across the sector, to identify unmet need or unacceptable variation in care, and to drive improvement where necessary.
- Encouraging reporting of incidents and concerns, and supporting action planning, risk assessment and positive risk taking.
- Designing bespoke support for individual providers and managers through action planning as part of the quality audit process, which may include training, group workshops and/or one-to-one guidance.
- Developing sustainable initiatives to support the sector as a whole to ensure most appropriate and effective provision to enable care homes and domiciliary care providers to deliver the best possible person -centred care.

The Quality Improvement Team maintains a dataset and regularly reports to the new Quality Improvement Board, which includes senior managers from Portsmouth CCG and Portsmouth City Council and provides oversight of the quality of care provision within the city.

Priority 3: Pan-Hampshire working

Adults at risk will experience a consistency of approach across all agencies working in Portsmouth, Southampton, Hampshire and the Isle of Wight. Additional staff training will improve how adults at risk are identified and supported. Areas we will improve on are:

- *Supporting the whole family in a joined-up way*
- *Supporting people who self-neglect through hoarding*

- *Early signposting to sources of support for people who are vulnerable*

We will also work with partners on a pan-Hampshire basis to:

- *Reduce fire deaths by supporting adults at risk to improve fire safety*
- *Monitor and learn from deaths, and ensure that any failures in the system are identified and addressed effectively*

Through the 4LSAB Policy Implementation sub-group, a number of pan-Hampshire policies and protocols have been agreed to help staff support adults at risk.

In August 2018 the World Health Organisation categorised Hoarding as a standalone medical disorder for the first time. With key input from Housing services in the various local authorities and Hampshire Fire and Rescue Service, Hoarding Guidance was developed to help staff to identify when to raise concerns regarding poor self care or lack of care for living conditions, and identify agencies who can provide support.

Based on learning from Safeguarding Adults Reviews across the region, it was identified that it would be helpful to have a formal process in place for situations where staff need to challenge the professional practice or delivery of services in another agency. In response, the Escalation Protocol was developed to enable professionals to challenge effectively and resolve issues in a timely way. The protocol ensures that the risks to the adult concerned are minimised and their wishes and preferences are taken into account, in line with the principles of 'Making Safeguarding Personal'.

Hampshire Constabulary held a workshop for partners in January 2019 to scope the development of a toolkit to help frontline practitioners on visits to look beyond the issue they are there to address and consider the wider indicators and symptoms of vulnerability, and associated risks. Identifying that frontline staff can often be overwhelmed by the amount of information available, Hampshire Constabulary are now leading on work to draw together key information so that practitioners will be able to signpost more effectively to appropriate services.

Following the publication of the Independent Panel's report into deaths at Gosport War Memorial Hospital,[3] a new 4LSAB 'Learning from Deaths' meeting was convened in September 2018. This group has undertaken work to map out the mechanisms in place to respond to unexpected deaths and to provide ‘early warning’ of emerging systemic issues, across the pan-Hampshire health and social care system. The group also reviewed actions taken in response to the Gosport War Memorial Hospital, and the findings from other reviews such as Safeguarding Adults Reviews and the Learning Disabilities Mortality Review Programme (LeDeR).

Case Study: Learning from fatal fires

Hampshire Fire and Rescue Service (HFRS) led a piece of work analysing all fire deaths across Portsmouth, Southampton, Hampshire and Isle of Wight between

[3] Gosport Independent Panel, *The Panel Report,* https://www.gosportpanel.independent.gov.uk/panel-report/

2015 and 2017. Most of the cases were known to the relevant local authority and 16 cases (out of 26) had care and support needs with long term care and support in place. A standardised audit tool was developed to collate the information and this will be used for future work. The work identified a range of risk factors: environmental (such as living alone); behavioural (such as smoking, hoarding); and health-related (such as dementia, poor mobility). Areas for further work identified as a result of the project included:

- Fire safety and prevention needs to be an integral part of the support offered by partners, and in particular domiciliary care providers.
- Guidance needed on signs and indicators of fire safety risk, guidance relating specifically to ignition sources, smoking.
- Targeted work in mental health services.
- Awareness training to increase referrals to HFRS for Safe and Well visits.
- Use of the Multi-Agency Risk Management process to manage on-going risk.

These recommendations will be led and coordinated through a new 4LSAB Fire Safety Development Group.

Priority 4: Improve the quality of transition

Service users moving between Children's Services and Adult Services receive timely, effective and coordinated support to help them stay safe and plan for adulthood.

Families are supported in a holistic and joined-up way by all professionals.

Alongside the 4LSAB and the four Local Safeguarding Children Boards (4LSCB), a 'Family Approach' protocol was developed. The Family Approach secures better outcomes for children (including unborn babies), adults with care and support needs, children and their families by co-ordinating the support they receive from Adult and Children and Family Services. The protocol was launched at the HSAB/HSCB conference in January 2019 and a toolkit to assist professionals is under development. Training for practitioners on the use of the new toolkit is planned across the four local authority areas for 2019-20.

Portsmouth City Council has also begun work on revising its transition policy.

Priority 5: Ensure PSAB decision making is underpinned by robust data

Service users and carers are assured that Board priorities and plans are shaped by evidence, and that resources are allocated where they are most needed.

The Board now receives regular data at each meeting from the Adult Multi-Agency Safeguarding Hub (MASH), Hampshire Constabulary, and Hampshire Fire and Rescue Service.

The MASH reviewed the way it collects and records data on safeguarding concerns and has made some changes so that the data provided to the Board is more useful in making comparisons and identifying trends.

Through the 4LSAB Quality Assurance sub-group, a dataset has been agreed which will enable data collection from a wider range of agencies, including NHS partners and Trading Standards. It is planned that the use of the dataset will be rolled out in 2019-20.

Priority 6: Improve safeguarding adults practice within Portsmouth

Adults at risk will receive a high quality response if referred to safeguarding services, in line with 'Making Safeguarding Personal' principles. If they do not meet the threshold for safeguarding, agencies will work together effectively to ensure that risks are documented and managed.

The 4LSAB Workforce Development sub-group has begun a review of the 4LSAB learning and development framework, following the publication of a new NHS Intercollegiate document setting out the required competencies in adult safeguarding for staff in different roles. In response to a request by Healthwatch Portsmouth for e-learning resources which could be accessed by the voluntary sector, the sub-group also developed a list of adult safeguarding e-learning opportunities.

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

Service users, carers and the public understand that safeguarding is everybody's business. They have access to information about safeguarding, including how to raise a concern and how to keep safe. There are mechanisms for service users, carers and the public to engage with the Board.

The Board conducted a review of its membership to ensure that relevant partners are involved and that its reach is maximised. As a result, the Board has recruited a representative from the voluntary sector and from the University of Portsmouth.

Working with members, the Board is in the process of conducting a review of its website.

Jointly with the other three LSABs, the Board has commissioned an 'animation scribe' video to help explain to service users and the public what safeguarding is and the process of raising a concern. It is planned that this will be completed in 2019-20.

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 PSAB has a SAR sub-group which is chaired by the Deputy Director for Quality and Safeguarding from NHS Portsmouth Clinical Commissioning Group. The group is a multi-agency group with members who have a specialist role or experience in safeguarding adults. The group met monthly during 2018-19 and part of each meeting is conducted jointly with the Portsmouth Safeguarding Children Board's (PSCB) Case Review Committee (CRC) to work together on cases which might involve both children's and adult services.

Summary of SAR activity during 2018-19

Two new SAR referrals were received in 2018-19. One of these referrals was not considered to have met the criteria for a SAR, but it was identified that there may be learning for substance misuse services within the city for cases when a client is discharged following detoxification treatment. A learning event has been planned with all the agencies involved in the case to explore this issue further. For a second case, scoping has been initiated to identify whether or not the criteria for a SAR have been met.

Further work has been undertaken on the SAR which had been commissioned as a result of a referral from 2017-18. An independent author has been engaged to write a report on the case, working under the oversight of a SAR panel. This review is close to concluding and will be published early in 2019-20.

One SAR referral was carried forward from 2017-18. The case was referred by Hampshire Fire and Rescue Service (HFRS) after they attended a house fire in which a death occurred. After scoping the case, it was decided that the criteria for commissioning a SAR had not been met. Although the coroner found that the death was due to a medical cause and that the fire started subsequent to death, both HFRS and Solent NHS Trust reviewed their processes for working with clients who need home oxygen for their medical condition and introduced some improvements as a result. These include:

- Information about home oxygen users is shared with HFRS by the supplier, who then offer all users a Safe and Well visit. Home oxygen information is shared to responders at incidents.
- The safety information advice and guidance provided to home oxygen users by clinicians has been reviewed and standardised by the supplier and HFRS.
- The supplier completes direct referrals for people who have been refused home oxygen installation because the risks are too high.
- There are regular review meetings with NHS Home Oxygen and the supplier.
- Online training is available for practitioners.
- There is improved training about home oxygen use for operational firefighters in partnership with the supplier.
- HFRS is also working on a Fire Fatality Thematic Review across Hampshire in partnership with the Safeguarding Boards, and a Fire Safety Development Group has been established to oversee the work emerging from the findings.

Additional learning and review work undertaken by the SAR sub-group

The Hampshire Safeguarding Adults Board undertook a thematic review of their SARs related to Learning Disability and physical health care.[4] The PSAB SAR sub-group reviewed the recommendations and action plan from this review to assure itself that the learning has also been embedded within organisations working in Portsmouth. Following on from this, in February 2019, PSAB collaborated with the other Safeguarding Adults Boards to host a 4LSAB workshop to develop the Health

[4] http://www.hampshiresab.org.uk/wp-content/uploads/HSAB-Thematic-Review-1.pdf

Sector response to learning from local Safeguarding Adults Reviews relating to meeting the physical health needs of people with learning disabilities.

Similarly, in response to Southampton Safeguarding Adults Board's publication of a learning review of the case of Adult H,[5] the SAR sub-group reviewed the findings in relation to Portsmouth. As a result, the sub-group scrutinised the data on the take-up of Annual Health Checks for people with a learning disability, and satisfied itself that the take-up is good and improving within Portsmouth. The sub-group also recommended to the PSAB that assurance is sought from its members that the new Escalation Protocol has been fully embedded within their organisations.

The Government's Rough Sleeping Strategy[6] was published in August 2018, and included a recommendation that Safeguarding Adults Boards should conduct SARs into the deaths of rough sleepers where abuse or neglect is suspected. The SAR sub-group was concerned that there was no mechanism for identifying the deaths of rough sleepers so they could be considered for SARs, so undertook some work to review the processes so that all such deaths would be reported to them, with a standing item on the agenda. Portsmouth Hospitals NHS Trust (PHT) reviewed their mortality review process to help identify rough sleeper deaths, and figures are now being reported to the SAR sub-group by the Police, South Central Ambulance Service NHS Foundation Trust (SCAS), and PHT. No such deaths were identified in 2018-19. As a result of this work data is also now being gathered and monitored on the reasons why rough sleepers have contact with SCAS, and processes have been clarified whereby SCAS can refer rough sleepers to the MASH if safeguarding concerns are identified.

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.

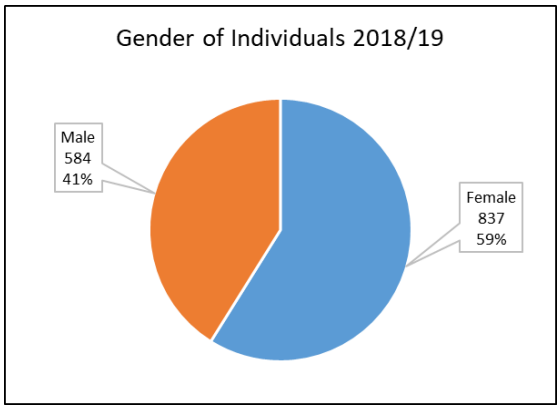
Data collected by the MASH gives further information about who has experienced abuse or neglect in Portsmouth, where abuse has taken place, and the types of risk they have experienced. The information below is taken from the NHS Digital Safeguarding Adults Collection end of year return.

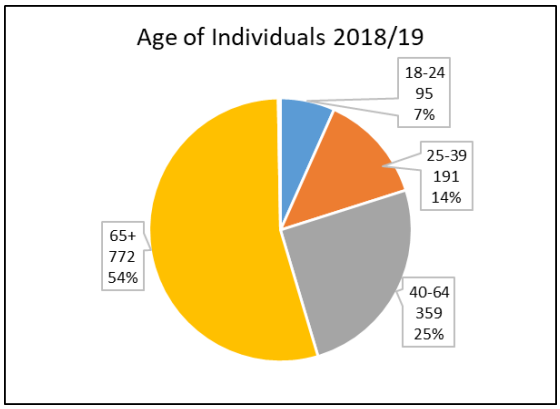
[5] http://southamptonlsab.org.uk/wp-content/uploads/Southampton-LSAB-Adult-H-6-step-briefing.pdf
[6] https://www.gov.uk/government/publications/the-rough-sleeping-strategy

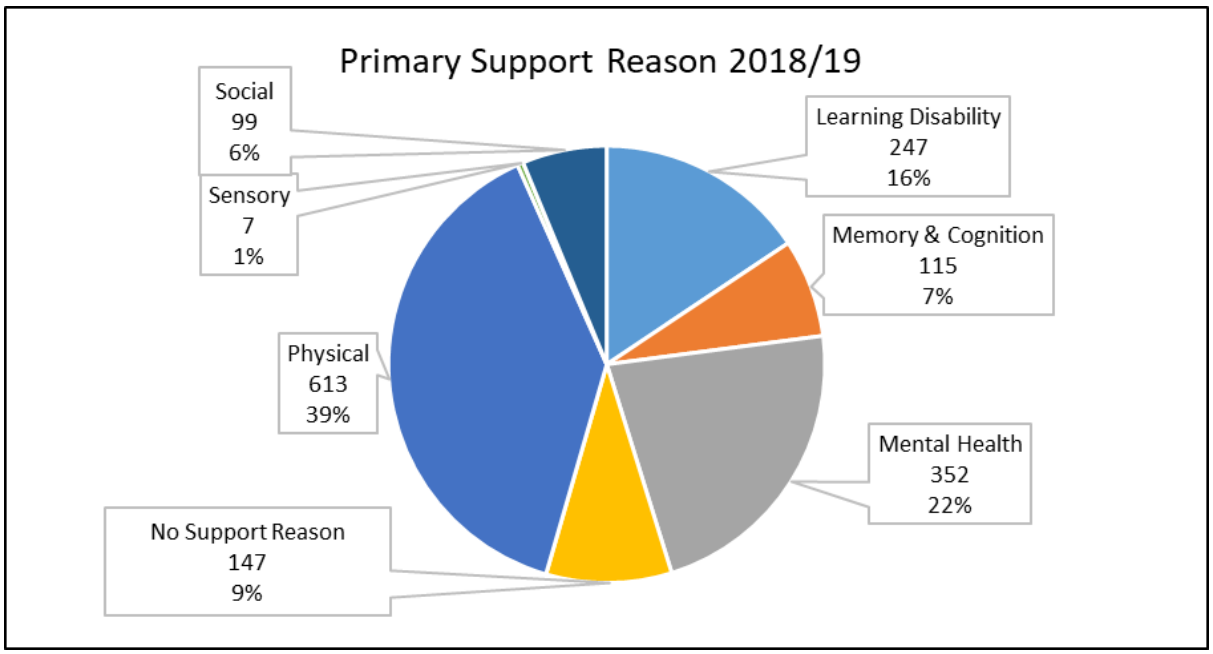
If an issue about an adult safety or welfare is raised with the MASH, this is categorized as a *Safeguarding Concern*. The MASH will then assess the concern and take appropriate action.

There were 2064 concerns raised in 2018-19 about 1421 individuals.

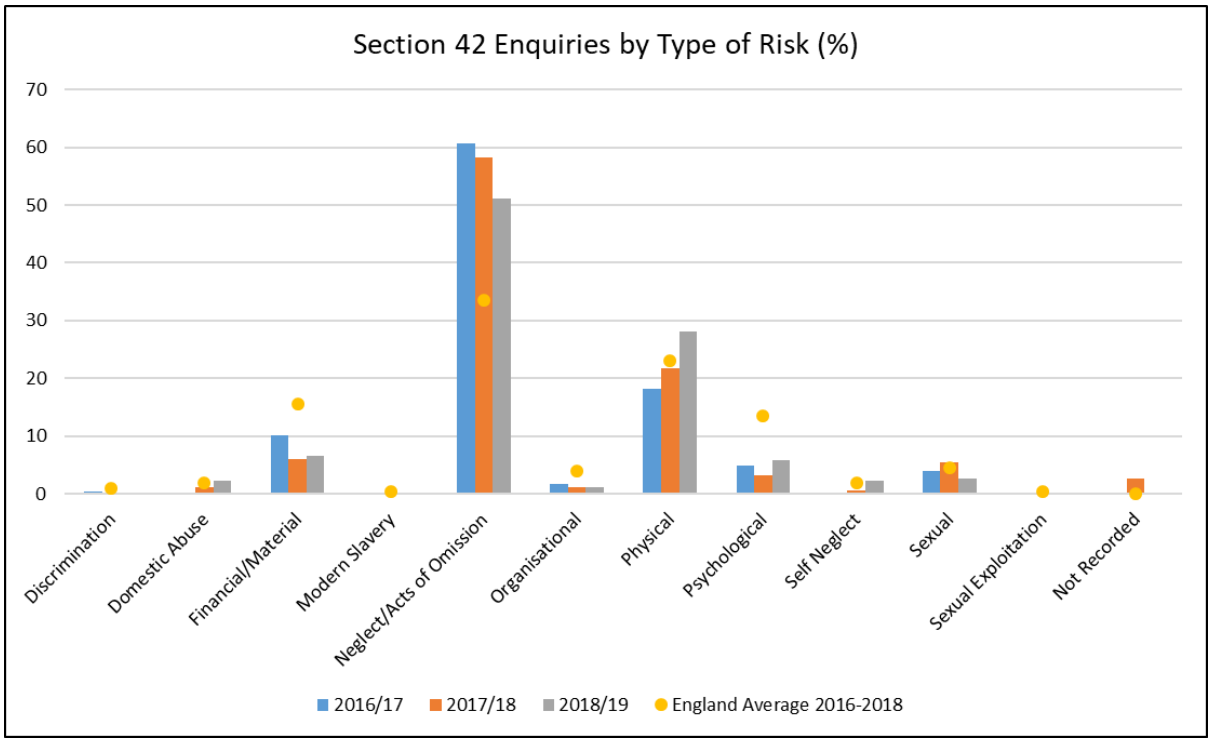
More information about the individuals involved in safeguarding concerns is shown below.

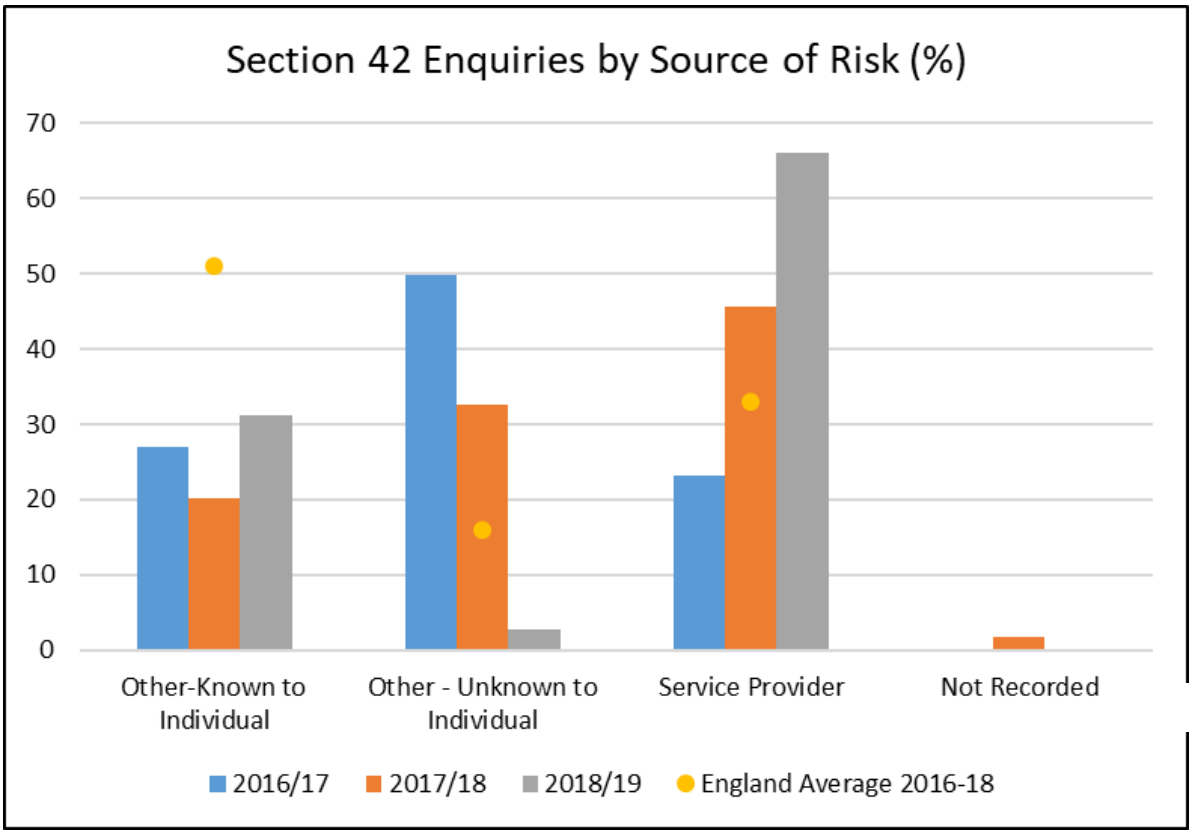


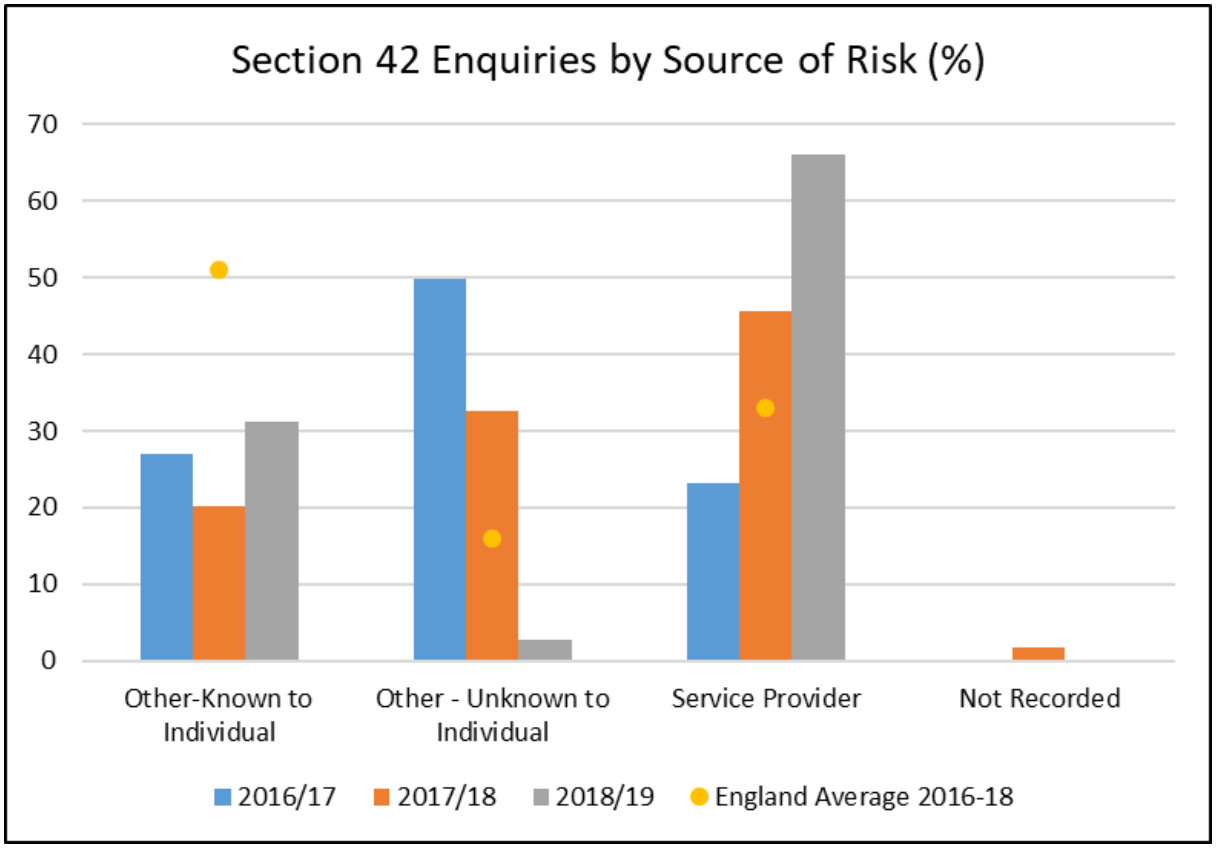




260 safeguarding concerns were taken forward as formal *Safeguarding Enquiries* under Section 42 of the Care Act.







The Board also receives data regularly from Hampshire Constabulary and Hampshire Fire and Rescue Service.

In 2018-19 Hampshire Constabulary reported:

- 10 incidents of Honour Based Violence where the victim was over 18.
- 6 incidents of trafficking of a person over 18.
- 782 high risk domestic crimes
- 607 incidents of hate crime

HFRS carried out 641 Safe and Well visits in Portsmouth in 2018-19.

There were 0 domestic homicides in Portsmouth in 2018-19.

There were 0 fire deaths in Portsmouth in 2018-19.

Contact us

02392 841786

Portsmouth City Council
Floor 5, Core 5,
Civic Offices
Guildhall Square
PO1 2AL

psab@portsmouthcc.gov.uk

@portsmouthsab

Glossary

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

4LSCB - The Portsmouth, Southampton, Hampshire and Isle of Wight Safeguarding Children 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.

CPEA - specialist social care consultants.

CRC - Case Review Committee (a committee of the Portsmouth Safeguarding Children Board, which also meets jointly with the Safeguarding Adults Review sub-group of the Portsmouth Safeguarding Adults Board).

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.

HFRS - Hampshire Fire and Rescue Service.

LeDeR - Learning Disabilities Mortality Review programme. A national programme funded by the NHS to review the deaths of people with a learning disability. It aims to reduce premature deaths and health inequalities for people with learning disabilities.

LSAB - Local Safeguarding Adults Board.

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, not to, people.

NHS - National Health Service.

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

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

PSCB - Portsmouth Safeguarding Children Board. 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.

SCAS - South Central Ambulance Service NHS Foundation Trust.