Portsmouth Safeguarding Adults Board

Annual Report

PSAB

2022 - 2023

Statement from the Independent Chair

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

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

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

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

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

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

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

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

David Goosey

Independent Chair

Our vision

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

Our strategic priorities

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

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

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

We have made progress in relation to these priorities by:

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

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

Other key achievements in 2022-23

This year, the Board has:

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

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

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

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

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

*Name changed to protect identity

Peer review

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

Some of the key messages included:

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

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

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

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

The suggested actions included:

Portsmouth Safeguarding Adults Board:

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

Portsmouth City Council:

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

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

PSAB Conference and Training Programme

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

Our multi-agency training offer included:

- Safeguarding concerns online training

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

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

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

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

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

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

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

Learning from Safeguarding Adults Reviews

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

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

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

Summary of SAR activity during 2022-23

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

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

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

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

Mrs E - Safeguarding Adults Review

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

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

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

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

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

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

Mr F - Safeguarding Adults Review

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

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

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

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

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

Actions planned or carried out include:

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

Thematic Safeguarding Adults Review

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

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

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

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

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

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

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

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

4LSAB Fire Safety Development Subgroup

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

4LSAB System Improvement and Learning Framework (SILF)

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

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

Safeguarding activity in Portsmouth

Safeguarding Duty

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

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

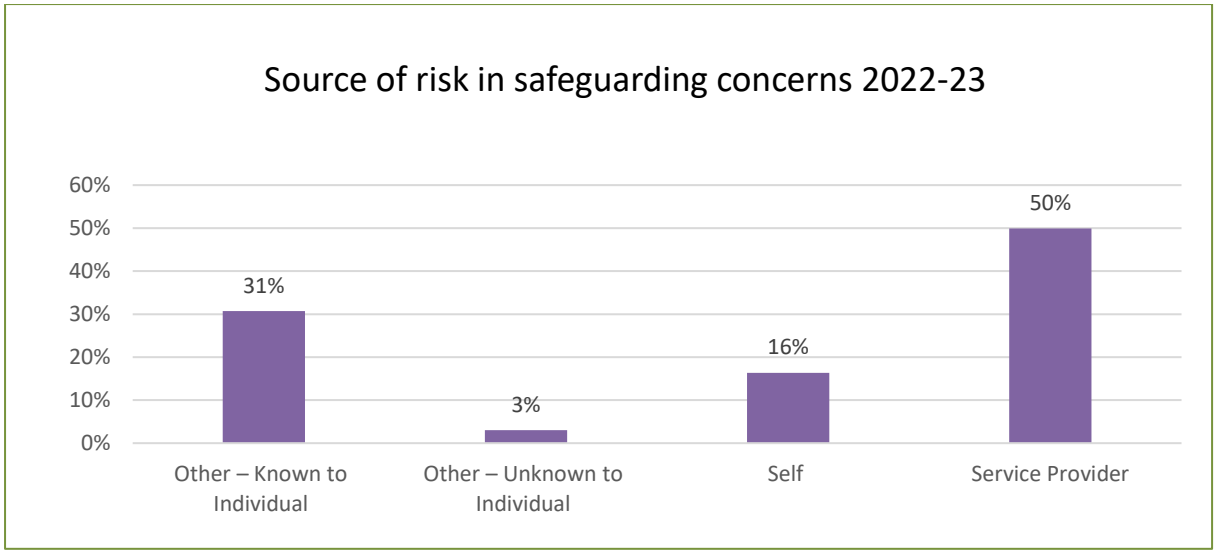
Portsmouth has an Adult Multi-Agency Safeguarding Hub (MASH) with a team of social workers and police officers working together who have direct links with colleagues in areas such as health, trading standards, and children's safeguarding. The MASH manages a high volume of referrals.

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

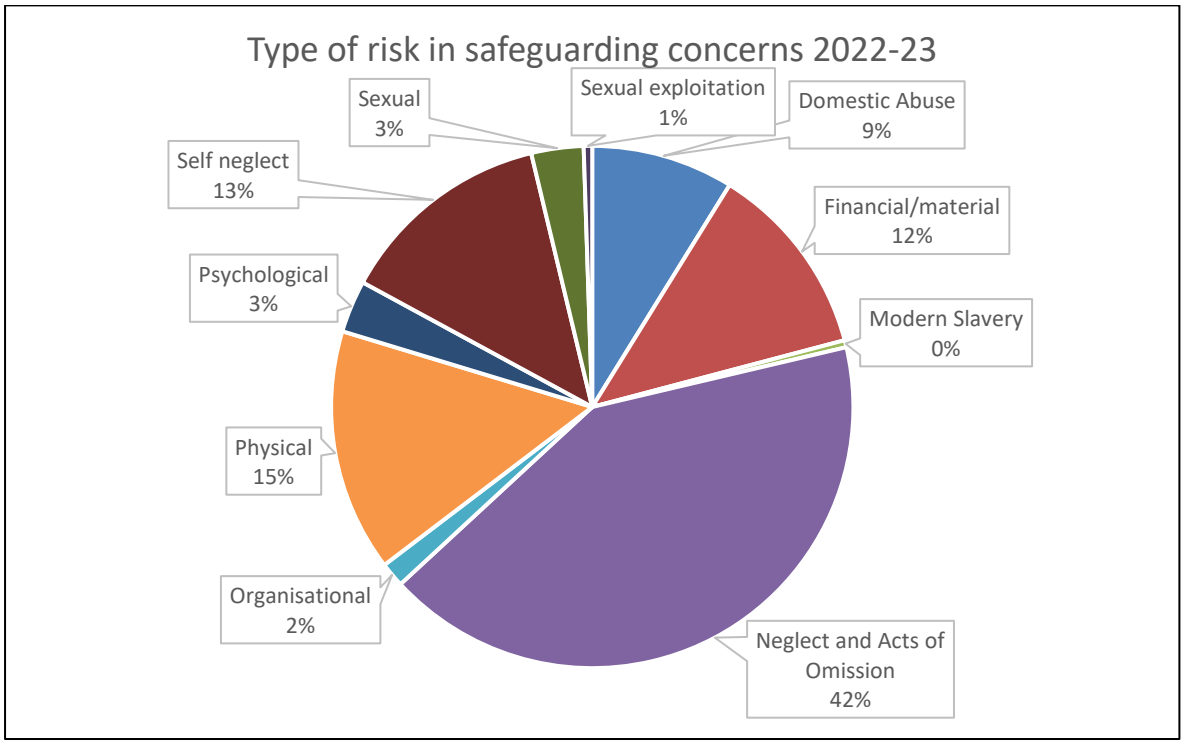
If an issue about an adult's safety or welfare is raised with the MASH, it is called a safeguarding concern. The MASH will assess the concern and take appropriate action.

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

More information about the safeguarding concerns is shown below.



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



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

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

842 formal Safeguarding Enquiries were concluded in 2022-23.

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

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

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

In 2022-23 Hampshire Constabulary reported:

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

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

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

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

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Glossary

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

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

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

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

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

LSAB - Local Safeguarding Adults Board

MARM - Multi-Agency Risk Management

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

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

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

NHS - National Health Service

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

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

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

SAB - Safeguarding Adults Board

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

SILF - 4LSAB System Improvement and Learning Framework

Appendix

What is Safeguarding?

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

Who are we?

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

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

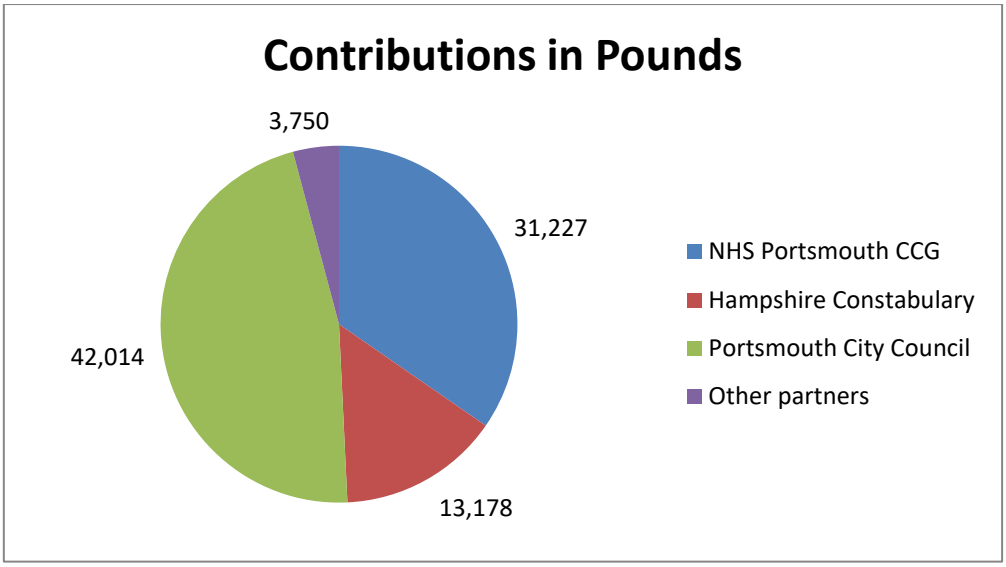
The Board has an independent chair that can provide some independence from the local authority and other partners. This is especially important in terms of:

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

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

The contributions received in 2022-23 were:

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



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

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