HAMPSHIRE SAFEGUARDING ADULTS BOARD

SSAB SOUTHAMPTON SAFEGUARDING ADULTS BOARD

Isle of Wight Safeguarding Adults Board

PSAB

Spotlight on Safeguarding Concerns

27 January 2026
09.30 – 1pm

Welcome

Welcome to today's session

Turn off

Please turn off your mic and camera

Use

Please use the chat function for any questions

Slides

Slides will be shared with you following the session

4LSAB Safeguarding Concerns Guidance Agenda

	Item	Item Lead
09:30 – 09:40	Welcome, introductions and why this matters	Jason Brandon
09:40 – 10:00	Navigating the Guidance	Ruth Goncalves
10:00 – 10:20	Pathways & Alternative Routes	Laura Rice
10:20 – 10:40	SAR Learning (Anne)	Alison Lawrence
10:40 – 10:55	BREAK	
10:55 – 11:10	Spotlight on… Domestic Abuse	Joanna Bassham
11:10 – 11:25	Spotlight on… Medication Incidents	Sue C and Emma P
11:25 – 11:40	Spotlight on… Homelessness	Becky Nurmahi
11:40 – 11:55	Spotlight on… Incidents between Adults in a Service	Sue C and Emma P
11:55 – 12:10	Spotlight on… Pressure Ulcers	Katie M and Claire M
12:10 – 12:25	Spotlight on… Falls	Sue C and Emma P
12:25 – 12:40	Spotlight on… Substance Use	Carley Goodson
12:40 – 12:55	Spotlight on… Suicide / Self Harm	Ruth G and Colin B
12:55 – 13:00	Close	

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Welcome and Introductions

Jason Brandon

Navigating the Guidance

Ruth Goncalves

NAVIGATING THE GUIDANCE

A SAFEGUARDING CONCERN IS:

Where there is reasonable cause to suspect that an adult who has or may have needs for care and support and is at risk of or experiencing of abuse or neglect. Care Act 2014 Section 42 (1) (a) and (b).

This definition directs us to all work together to improve our understanding of the risks and experiences of adults who have needs for care and support:

- it will improve our ability to prevent or intervene early when there are concerns of abuse or neglect
- it will enhance joint working to prevent, reduce or delay the risk of harm to the adult
- it will ensure that safeguarding concerns are identified and reported to support the adult
- it will ensure that those who have a statutory duty to enquire, act in a timely, person centered and coordinated way.

Reasonable cause to suspect

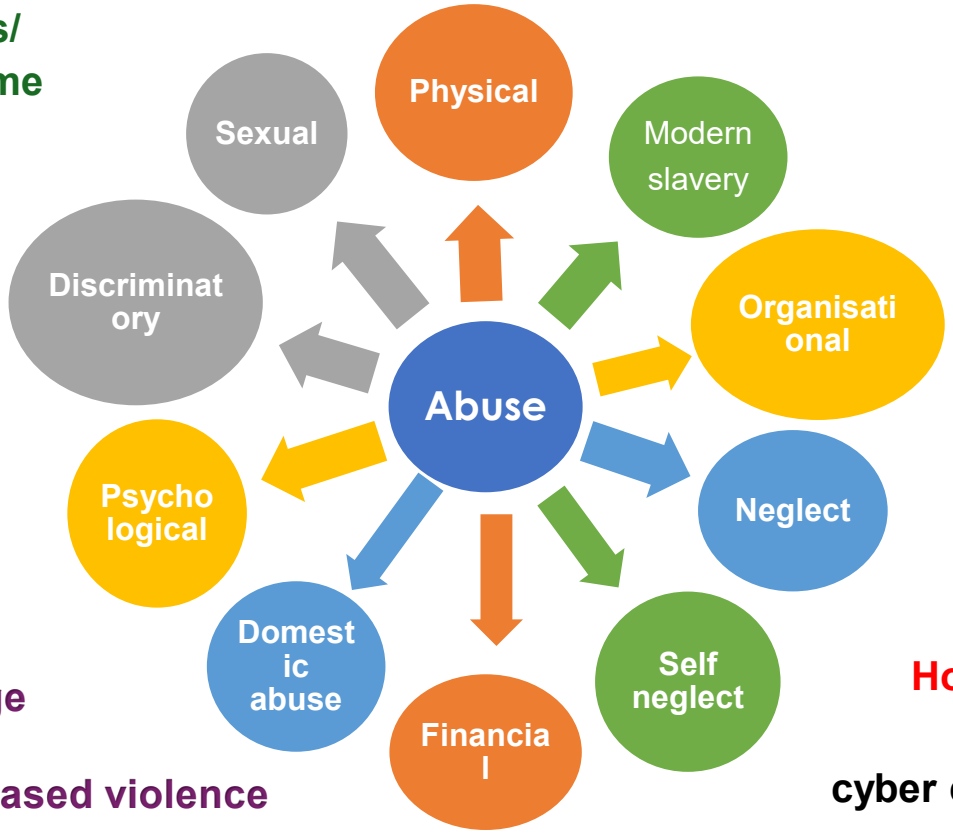
S42 (1) (a) adult with/or may have care and support needs

S42 (1) (b) at risk of or experiencing abuse or neglect. **Care Act 2014**

Raise a safeguarding concern to the local authority in your area.

- Only the LA can apply the S42 duty if it meets the criteria and there is cause to suspect that the three statutory criteria are met.

10 types of abuse named in the Care Act and others to be aware of



county lines/ organized crime

cuckooing

mate crime

hate crime

female genital mutilation

Forced marriage

honour based violence

human trafficking

sexual exploitation

professional abuse / abuse of trust

radical groups promoting violence

Hoarding

AI based abuse/crime

cyber crime

Empowerment
People being supported and encouraged to make their own decisions and informed consent

Protection
Support and representation for those in greatest need.

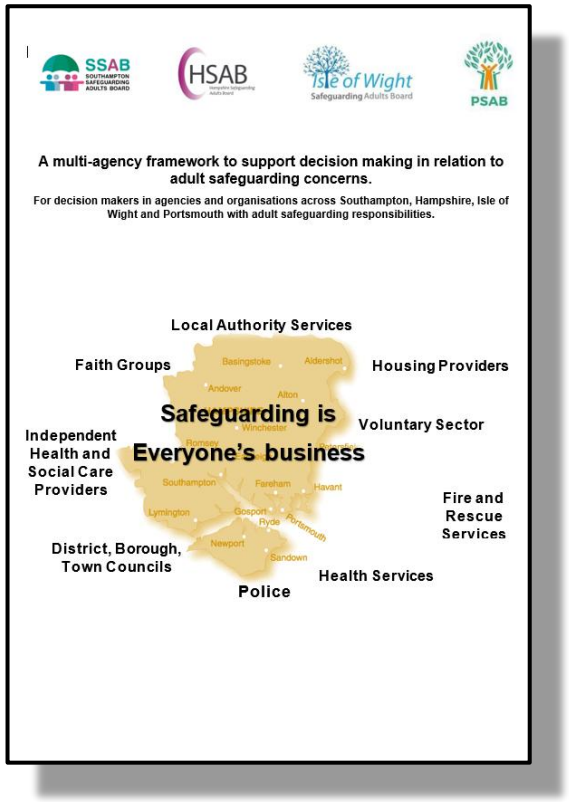
Prevention
It is better to take action before harm occurs.

Partnership
Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability
Accountability and transparency in safeguarding practice.

Proportionality
The least intrusive response appropriate to the risk presented.

SAFEGUARDING CONCERNS - A multi agency framework to support professionals to make decisions about when to raise safeguarding concerns



Why was it developed?

- In response to feedback from professionals - we often hear that people are unsure when to refer to safeguarding and would welcome more support and guidance
- To ensure that concerns are addressed in the most appropriate way
- To ensure a more consistent approach to what is referred to safeguarding
- **To improve the quality of concerns**
- **To improve legal literacy**
- **Basis for quality assurance/audit and escalation**

SCOPE OF REVIEW

This review is not a complete re-write of the previous guidance. We have only made changes where:

- There have been changes to legislation/statutory guidance since the last review
- There have been changes to local or national policy since the last review
- Errors or inconsistencies in the previous version
- Changes required as a result of good or poor practice noted in SARs/audits
- Feedback from previous staff training sessions
- In response to feedback from staff/providers as part of our pre-review consultation process.
- Independent review of guidance commissioned and Board Chair/Scrutineer input.

CONSULTATION

Positive feedback themes

- Simple and easy to use and follow
- Structured approach
- Useful for staff training and induction
- Helps facilitate consistent decision making
- Easy to understand
- Supports with audits and KPIs
- Helps work through complex cases
- Good as a quick reference guide
- Can word search topics
- Helps empower the team and allay fears about safeguarding
- Examples of what isn't safeguarding - particularly the judgement calls over risk and seriousness

Negative feedback themes

- Too long
- majority of the guidance appears to be repetitive
- too many core messages.

KEY AREAS THAT HAVE BEEN CHANGED OR REWRITTEN

- Reduction in number of core messages (now key messages).
- Consistency in terminology.
- Alignment of section on consent with wording aligned to other 4LSAB Policy, Processes and Guidance
- Rewrite of multi-agency tools including addition of 'requires consultation' section, links to policy/guidance, and other actions to take.
- Addition of multi-agency tools covering behaviours/contexts/ situations which are not types of abuse/neglect (eg homelessness, self-harm).
- Removal of case studies.
- Addition of flowchart covering what happens when local authority receives concern.

TOOLS TO SUPPORT DECISION MAKING

- A series of tables giving pointers on:

When to **RAISE AS A SAFEGUARDING CONCERN**, when the issue **REQUIRES CONSULTATION** and when it **SHOULD NOT BE RAISED AS A SAFEGUARDING CONCERN**.

- Include types of abuse/neglect from the statutory guidance and other contexts/behaviours practitioners find challenging eg self-harm, homelessness.
- These do not replace **professional judgement.**

Neglect				
Isolated missed home care visit where no harm occurs.	Adult is not assisted with a meal/drink on one occasion and no harm occurs.	Temporary environment restrictions, but action to resolve in place.	Pressure ulcers with no risk assessment or risk management plan in place.	**PROBABLY NOT A SAFEGUARDING CONCERN**
Ongoing lack of care to the extent that health and wellbeing deteriorate significantly, e.g., dehydration, malnutrition, loss of independence or confidence.	Mismanagement of pressure ulcer by profession[illegible]id carers.	Gross neglect resulting in serious injury[illegible]ath.	Carers or paid staff wilfully ignoring or preventing access to care.	**REPORT AS A SAFEGUARDING CONCERN**
Inappropriate or incomplete DNAR (do not attempt to resuscitate).	Occasionally not hav[illegible] access to aids to independence N.B. I[illegible] may be restraint	[illegible]g with [illegible]o is failing	Occasional inadequacies in care from informal carers. No significant harm.	
Recurrent missed care visits where risk of harm escalates, or one missed visit where harm occurs.	Poor transfers[illegible] services, e.g[illegible] discharge with[illegible] planning and ha[illegible]	[illegible]ov[illegible] discom[illegible] inconvenie[illegible]o significant ha[illegible]curs e.g. Being left wet occasionally.	Hospital discharge, no adequate planning and harm is likely to occur or harm has occurred.	
Failure to arrange access to life saving services or medical care.	Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk.	Access to aids for independence is being denied.	Serious injury or death as a result of consequences of avoidable pressure ulcer development e.g. septicaemia.	

EXAMPLE PAGE FROM TOOLS

Type of abuse	Non-reportable	Requires consultation	Reportable
PSYCHOLOGICAL ABUSE **Ongoing psychological or emotional maltreatment including:** • emotional abuse • threats of harm or abandonment • deprivation of contact • humiliation • blaming • controlling • intimidation • coercion • harassment • verbal abuse • cyber bullying • isolation • unreasonable and unjustified withdrawal of services or supportive networks (as per statutory guidance 14.17)	Lower-level concern where it would be unlikely to meet the definition of a safeguarding concern. Internal policies and procedures should be followed and an internal written record of what happened and what action was taken should be kept. **Where there are several low-level concerns, consideration should be given as to whether the criteria may be met for a safeguarding concern due to increased risk and therefore should be reported as the local authority have the statutory duty to make this decision.**	All appropriate action should be taken to reduce risk and internal policies and procedures followed. Consultation should be undertaken internally, refer to your local 4LSAB Safeguarding Adults Policy and Procedures and consider if consultation is needed with the local authority. Incidents at all levels should be recorded. **Following consultation, consideration should be given as to whether the criteria may be met for a safeguarding concern and therefore a referral into the local authority or whether other referral pathways need to be considered.**	Incidents at this level should be raised as a safeguarding concern with the local authority. **Consideration should also be given as to whether the police or other emergency services need to be contacted. Ensure whole family approach if children or other adults may be impacted.**
Links to Policy and Guidance: 4LSAB Adult Safeguarding Policy Process and Guidance July 2023 Home Office Statutory Prevent Guidance Mate Crime Good Practice Guidance 4LSAB Multi-Agency Domestic Abuse Guidance National Referral Mechanism Guidance	**Examples:** • Not committed by a Person in a Position of Trust (e.g., a professional), **AND:** • Incident where a person is spoken to in a rude or inappropriate way – respect is undermined but no significant distress is caused. • Occasional taunts or outbursts between two people using a service that do not cause impact or distress, that is managed within a care plan.	**Examples:** • Treatment that undermines dignity and damages esteem. • Repeated incidents of documented denying or failing to recognise an adult's opinions, views, and choices, particularly in relation to their care and support needs as part of their care plan. • Withholding of information from a person that disempowers them but there is a minor impact, and reasons documented.	**Examples:** • Any concerns about a Person in a Position of Trust. • Denial of basic human rights/civil liberties. • Intentional intimidation or humiliation. • Emotional blackmail, e.g., threats of abandonment/harm. • Withholding of information to dis-empower that has a significant impact. • Producing and distributing inappropriate photos via any social media. • Concerns that the adult is being radicalised. • Intentional befriending in order to benefit from adult, including cuckooing.
Alternative actions to consider at every stage	• Information and education around expected standards of conduct, respect, and dignity. • Use of behavioral charts. • Input from mediation services. • Training around de-escalation and/or other risk management processes.	• Share information with local Police teams via a Community Partnership Information Form • Referral to the Local Authority, carers assessment, or review of existing arrangements.	**RAISE SAFEGUARDING CONCERN** If there is an indication a criminal act has occurred, the police **MUST** be informed. Immediate safety plans must be implemented.

Points to Consider:

- This document is there to support your professional decision making, this is not meant to be used in isolation.
- Keep talking to colleagues, managers and other professionals involved in the cases.
- What are the policies/procedures within your own organisation
- What's already in place
- Key areas to remember:

Professional Curiosity this means not taking things at face value, asking questions to understand why and how situations have developed, looking for evidence of what people tell you, and working effectively with other agencies.

Trauma Informed Approach past trauma (including trauma experienced in childhood) working in a way that will prevent re-traumatisation. The five key principles of a trauma informed approach are: safety, trustworthiness, collaboration, empowerment and choice.

Making Safeguarding Personal (MSP) an approach to adult safeguarding that puts the adult at the centre of the process, focusing on their wishes, views, and desired outcomes to improve their quality of life, wellbeing, and safety. Instead of a process-driven approach.

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Pathways & Alternative Routes

Laura Rice

Safeguarding Pathways & Alternative Routes

Safeguarding pathways are about choosing the right response at the right time, with the right partners.

Why do pathways matter?

Timely person-centered responses

Safeguarding should improve outcomes, not delay support through inappropriate routes

Professional judgment, not fixed thresholds

Safeguarding requires flexible approaches and professional judgment, different risks need different responses, not every concern meets the S42 criteria

Multi-Agency responsibility

Safeguarding is everyone's responsibility, not just adult social care

Balancing empowerment and protection

Adult's wishes matter, even when risk is present

Section 42 Criteria & Duties

S42 Criteria

All three criteria must be met:

a) care and support needs,

b) risk of abuse or neglect,

c) and inability to protect oneself.

Local Authority decision-making role

Only the Local Authority can initiate a Section 42 enquiry but may ask other agencies to undertake enquiries on their behalf

Person-centered & outcome focused

Enquiries must reflect the adult's views, wishes, capacity and advocacy needs

Understanding the threshold supports good referrals

Knowing the criteria helps ensure clarity, not gatekeeping

When S42 criteria are not met

Safeguarding is a continuum

Prevention, early intervention and alternative routes are all safeguarding activities

Alternative pathways may be more effective

Health, housing, regulatory, legal or community responses may better need the need of the adult

Proportionality is key

Responses should address risk without unnecessarily overriding autonomy

Recording matters

Decisions and rational must be clearly documented.

MULTI AGENCY RESPONSE

- It is recognised that adults can present with many complexities and that a variety of agencies may come into contact with the same person.
- Often the response can be to advise the relevant agencies involved to co-ordinate the Multi-agency risk management framework (MARM).
- This framework is designed to support adults where there is a high level of risk, but the circumstances may sit outside of the statutory adult safeguarding framework (S42) but for which a multi-agency approach would be beneficial.

Multi-Agency Risk Management (MARM)

Structured Risk Management

MARM coordinates multi-agency activity where risks persists

Step-up and step-down approach

Can be used either side of the S42 process, but not at the same time

Responding to complexity

Particularly relevant for concerns relating to self-neglect and homelessness

Shared accountability

Risk is managed collectively, not held by one agency

Adults *without* care & support needs

Other statutory and non-statutory routes exist:

- Referral for advocacy support
- Domestic Abuse services
- Multi-agency risk assessment conference (MARAC)
- High-Risk Domestic Abuse (HRDA)
- Police may consider a multi-agency public protection arrangement (MAPPA)
- A contract monitoring or commissioning response to issues in a health or care provider setting
- A regulatory response (Trading Standards, Environmental Health)
- Review of a person's care and support or health care plan.
- Referral for a Home Fire Safety Visit from the Fire and Rescue service
- The National Referral Mechanism for victims of modern slavery
- Consider a referral to PREVENT where concerns are related to radicalisation
- Referral to community and voluntary sector organisations including Citizens Advice Bureau
- Organisations complaints procedures, including Care Quality Commission or Ombudsman
- Registered Housing Provider, including tenancy support or Anti-Social Behaviour policies
- Multi-Agency Risk Management Framework (MARM)

Adults *with* care & support needs but *no abuse or neglect*

Not all concerns are safeguarding concerns

Where there is no abuse or neglect, the response should focus on wellbeing, presentation and early intervention.

The Care Act

Section 9 relates to care and support assessments, Section 10 relates to carer assessments. These can help identify needs early and prevent escalation

Advocacy and community support

Access to advocacy, community groups and voluntary sector services support inclusion, reduces isolation and enhances resilience.

Early actions prevents future safeguarding risk

Addressing unmet needs early reduces the likelihood that concerns will later escalate into safeguarding situations.

Key principles for decision making

Principle of proportionality

Response should match the level of risk and avoid unnecessarily restricting an adult's rights or autonomy.

Empowerment in safeguarding

Adults should be supported to understand risks, express their wishes and shape the response wherever possible.

Importance of recording

Clear documentation and evidence of risk assessments ensures transparency and accountability

Duty to act

Professionals must take action to reduce risk, even where concerns do not meet statutory safeguarding criteria.

Support and advice

Safeguarding leads and LA teams should be used as a source of consultation, not only referral

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Anne SAR

Alison Lawrence

What is a Safeguarding Adults Review?

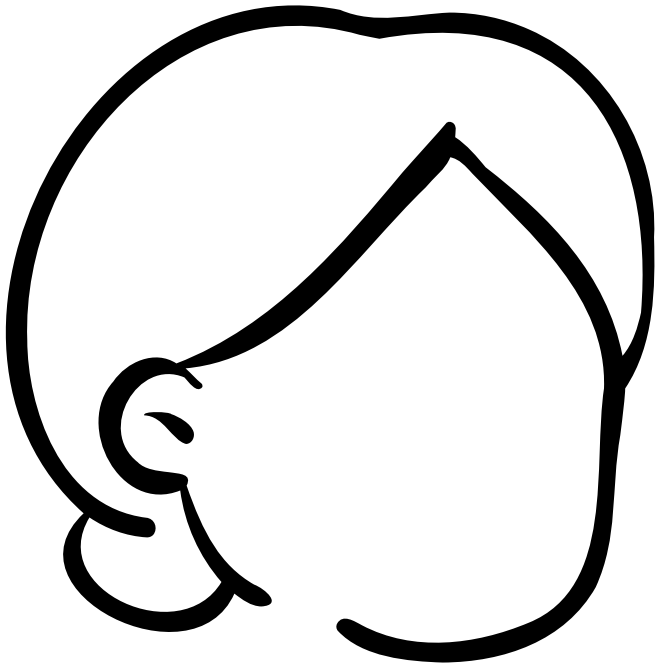
- The Care Act s44 requires Safeguarding Adults Boards to arrange a review when adults with care and support needs die or are seriously harmed in certain circumstances.
- The Care Act also gives us the power to review other cases where there may be learning.

The reviews help us:

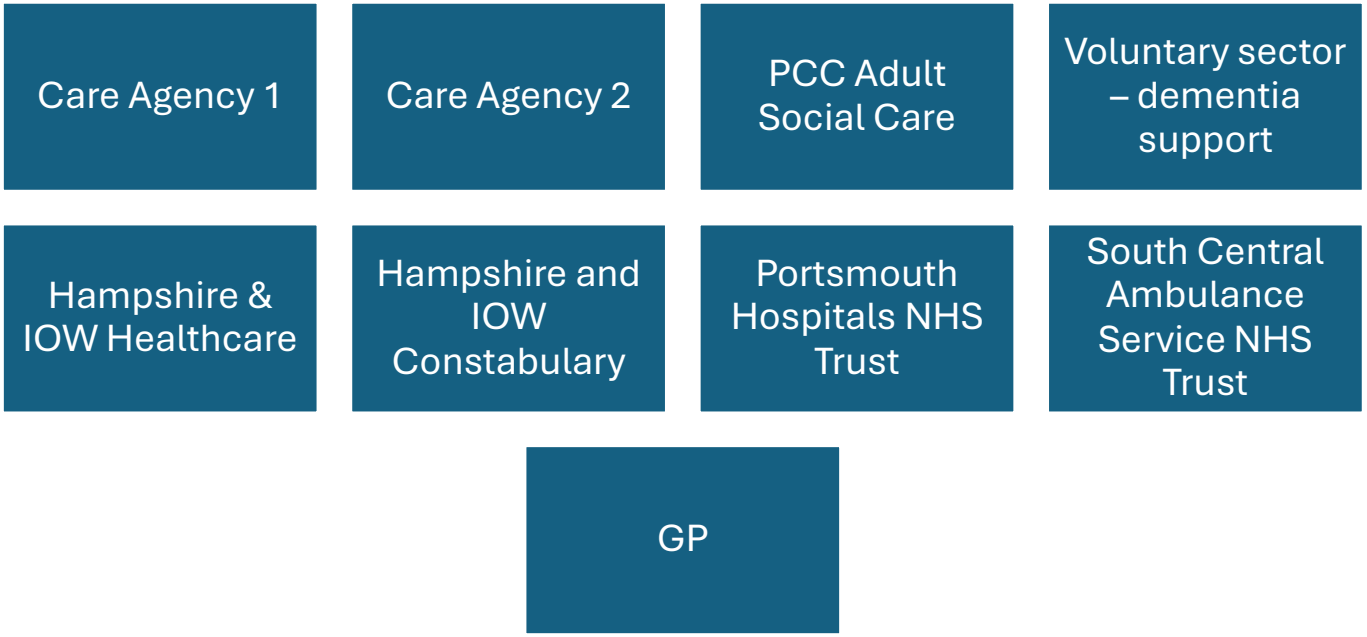
- learn from good practice
- learn lessons from what went wrong, so that services and practice can be improved to reduce the risk of future harm

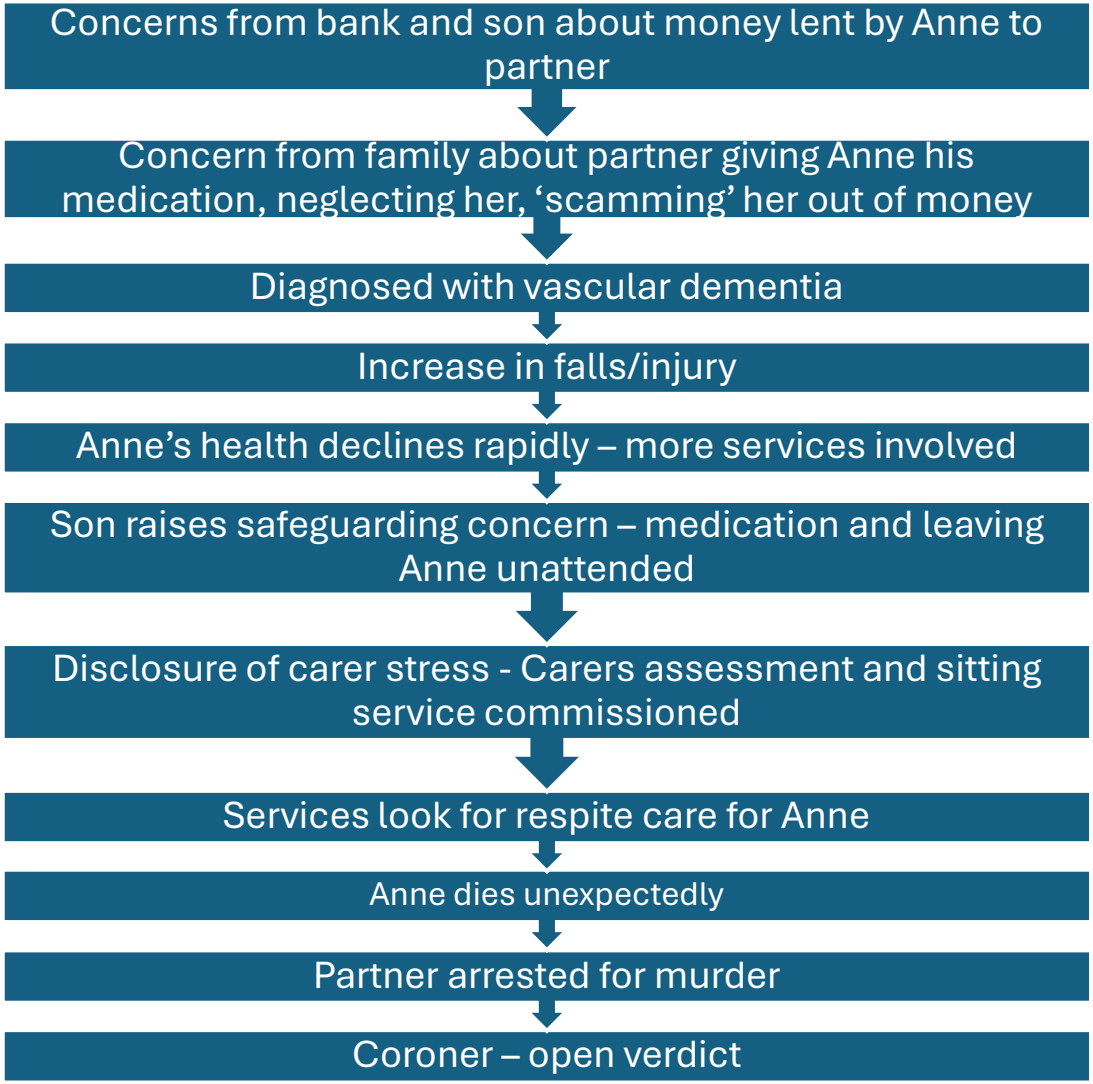
Who was Anne?

Age: 82
Background: White British woman, former auxiliary nurse in maternity services
Family: Widowed, mother of three, with two children living abroad. One son lived locally and visited/phoned regularly.
Relationship: In a 16-year relationship with a significantly younger partner
Health: Diagnosed with vascular dementia 15 months before her death
Living Situation: Cared for at home by her partner, with limited professional involvement until late in her illness



Who knew Anne?





What happened to Anne?

Key finding - using a safeguarding lens

Spotting signs of abuse or neglect

WHAT TYPES OF ABUSE OR NEGLECT MIGHT ANNE HAVE EXPERIENCED?

PUT YOUR THOUGHTS IN THE CHAT

Spotting signs of abuse or neglect

Neglect and Acts of Omission

Physical abuse

Financial abuse

Domestic abuse including coercive/controlling behaviour

Neglect and Acts of Omission

- Partner declined to use equipment provided or take advice from professionals eg to prevent Anne's falls
- Agencies concerned about management of medications
- Partner did not wait for ambulance when Anne fell and suffered a head injury
- Son's concerns that partner was leaving Anne alone while partner visited his own mother

(see also Medications Errors tool)

Physical Abuse

- Partner disclosed slapping Anne round the face to calm her
- Anne had unexplained bruising
- Partner may have given Anne morphine that she was not prescribed

(see also Medications Errors tool)

Financial Abuse

- Bank/family raised concerns about Anne giving large sums of money to her partner
- Anne said she would stay with the partner to get her money back
- Partner asked for bail money – claimed he was in prison
- No money left on Anne's death

Domestic Abuse

Domestic Abuse can include physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse, psychological, emotional abuse or other abuse.

- Partner supervised access by carers, spoke on Anne's behalf
- Threats of abandonment – partner said he had cancer and MS
- At time of bank's concerns, Anne disclosed coercion/control to Police
- Isolation from family/friends

What were the findings?

Good practice

- Services (sitting, dementia support, GP) mobilised quickly as needs escalated
- Practitioners responded promptly and showed strong commitment
- Carer's assessment completed under Care Act 2014; respite support provided
- Assessment consistent across carers centre and social work
- Carer stress identified and addressed via referrals and support
- GP referred death to Police and Coroner; triggered safeguarding review

What were the findings?

Areas for improvement

- Voice of the Adult - Practitioners relied heavily on her partner's account, even when Anne retained some decision-making capacity.
- Understanding relationship dynamics - Practitioners lacked full awareness of Anne's relationship history and its impact.
- Balancing Carer and Care Recipient Needs - Anne's partner was both caregiver and person of concern.

What were the findings?

Areas for improvement

- Safeguarding practice and legal literacy – Delays in safeguarding triage and lack of Section 42 enquiries limited risk assessment.
- Advocacy should be sought when the primary caregiver is implicated in safeguarding concerns.
- Interagency coordination - No multi-agency meeting was convened to share concerns and historical context.
- Understanding dementia - Practitioners were not consistently informed about vascular dementia progression.
- Professional curiosity - practitioners need to dig deeper when concerns arise, especially with complex histories.
- Professional curiosity - A safeguarding lens should be applied even when care appears adequate on the surface.

More information and resources:

Anne SAR (full report, learning briefing, and video)

4LSAB Safeguarding Concerns Guidance and tools

Professional Curiosity Resource pack

4LSAB Domestic Abuse guidance

4LSAB One Minute Guide to Advocacy

4LSAB Quick Guide to Financial Abuse

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Break

1030 - 1045

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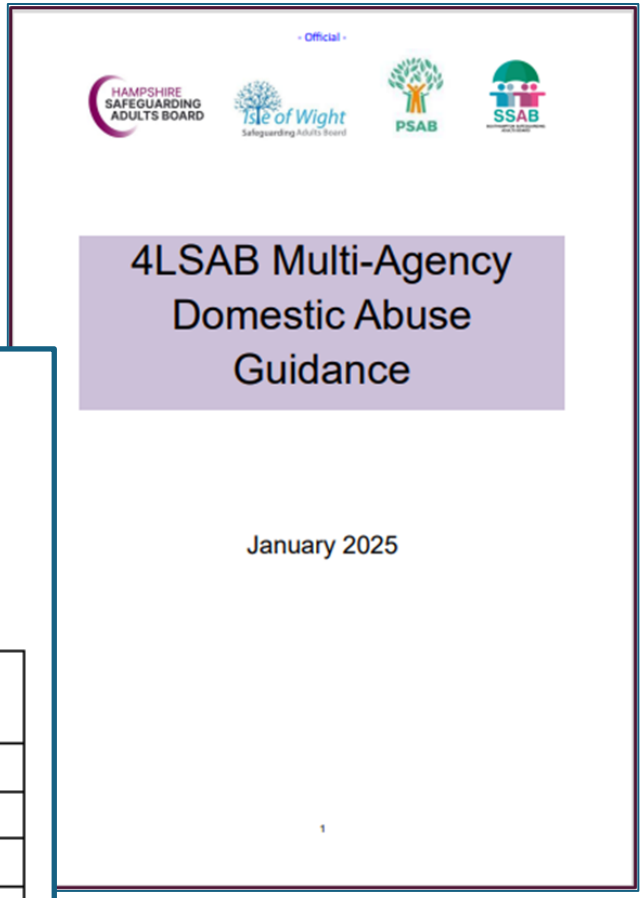
Spotlight on Domestic Abuse

A collaborative, multi-agency approach to domestic abuse:

- Raise awareness
- Support practitioners
- Promote responsibility
- Signpost to resources



Definition of Domestic Abuse

Sections 1-3, Domestic Abuse Act 2021

Behaviour of a person 'A' towards another person 'B' is "domestic abuse" if:

A and B are each aged 16 or over and are personally connected to each other

and

the behaviour is abusive

The abuse can be a single incident or a course of conduct.

Behaviour is considered 'abusive' if it consists of any of the following:

physical or sexual abuse

violent or threatening behaviour

controlling or coercive behaviour

psychological, emotional abuse

economic abuse

Economic abuse includes behaviour that has a "substantial adverse effect" on B's ability to: acquire, use or maintain money or other property, or obtain goods or services.

Children (under 18 years of age) who see, hear or ***experience the effects of*** domestic abuse towards their parent, guardian or relative are now treated as victims/ survivors of domestic abuse in their own right.

Prevalence and Impact

Impact on Survivors:

- physical injury
- harm to basic life functioning
- emotional and mental wellbeing
- trauma
- financial/ debt
- housing instability
- coping strategies
- harm to child

Domestic abuse is widespread, can affect anyone across all walks of life in many ways.

Challenges include:

- under reporting
- isolation of survivors
- barriers to accessing support
- not recognising that the behaviour is abuse

Signs & Indicators: Barriers

- fear of the person who is abusive
- fear that they may not be believed
- pressures from family or the community: in particular victims in rural or closed communities
- negative past experiences with the police/services
- a desire to make the relationship work
- economic barriers
- communication difficulties
- not wanting to uproot the children or fear that the children will be taken into care
- fear related to insecure immigration status

Responding to Domestic Abuse

Recognise the signs

Create a safe environment

Respect the victim's autonomy

Immediate safety planning

Signpost to support services

Follow safeguarding procedures

By remaining empathetic, supportive, and informed, professionals can offer crucial assistance to victims of domestic abuse.

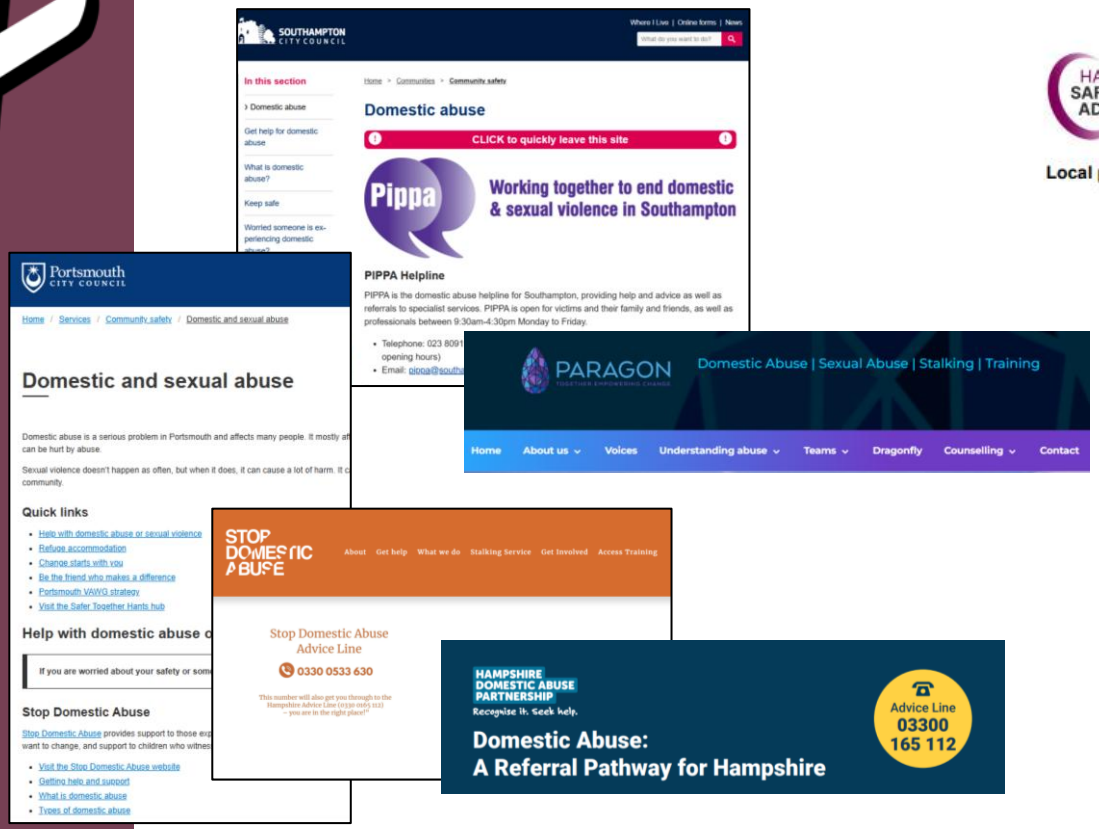
Adults Who Use Abusive Behaviours

- recognition of domestic abuse
- understanding risks and impacts
- multi-agency response
- economic barriers
- challenges for practitioners
- complexity of relationships
- disclosure and non-disclosure
- no direct contact

Pathways & Referrals

- identification of domestic abuse
- care act (2014) safeguarding criteria
- carers
- framework for MARM
- specialist domestic abuse services
- mental capacity
- families with children

Local DA Pathways & Referrals



- Official -

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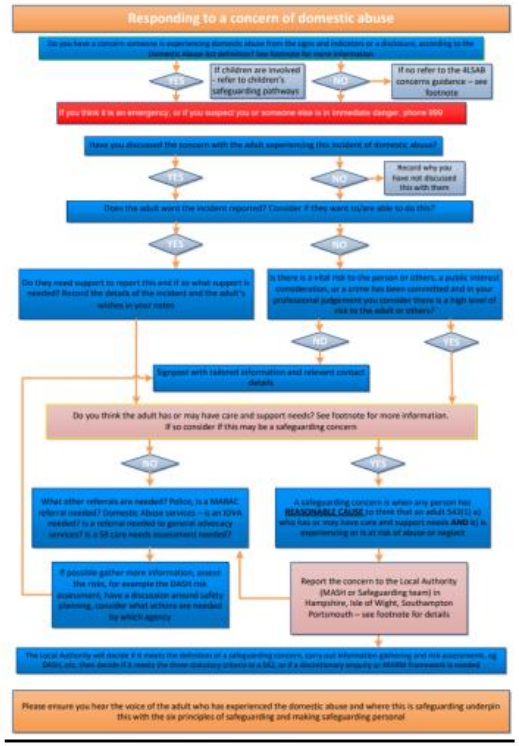
Local pathways

Flowchart - Responding to a concern of domestic abuse[2]



[2] Domestic Abuse Act definition
4LSAB Concerns Guidance
Report the concern to the Local Authority – Hampshire, Isle of Wight, Southampton, Portsmouth

The referral pathways for each local area are linked below:

- Portsmouth
- Southampton
- Isle of Wight
- Hampshire

Responding to Domestic Abuse

Domestic Abuse Disclosure Scheme (DVDS) – Clare's Law

Domestic Abuse Protection Orders

Domestic Abuse Related Death Reviews (DARDR)

DA in Non-intimate Relationships

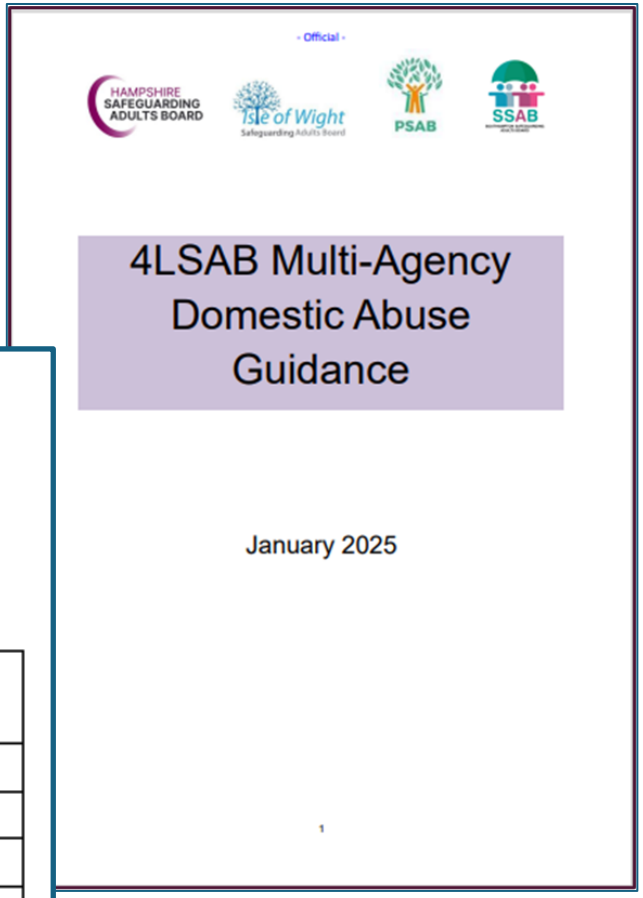
Protected Characteristics

Harmful Practices

A collaborative, multi-agency approach to domestic abuse:

- Raise awareness
- Support practitioners
- Promote responsibility
- Signpost to resources

By remaining **empathetic, supportive, and informed,** professionals can offer crucial assistance to victims of domestic abuse.



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Spotlight on - Medication Incidents

4LSAB Safeguarding Concerns guidance – Medication Incidents

The National Patient Safety Agency (NPSA) 2001 defines a medication error as ‘an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred’. Errors may result in an incident or an adverse event or where averted, they can be classified as a ‘near miss’.

The nature of the medication error will determine what category of abuse it falls under i.e. neglect, physical or organisational.

All medication errors require a proportionate response, but not all will require a safeguarding referral.

Incidents requiring referral

- The medication error involves administration of a critical medication by a provider or informal carer
- The medication error (critical medication or any other) has caused harm or had an adverse effect on the adults physical or mental health
- Any medication error requiring urgent or significant medical intervention (paramedic attendance, attendance at A&E, or escalation to relevant medical staff)
- If there has been repeated medication errors in the same service.
- The medication error was a deliberate act (i.e. intended to cause harm, given to control behaviour or restrict an individual, administer or neglect to administer medication contrary to the directions of the prescriber or inappropriate use of as required, PRN, medication*)*
- Where there is a concern that the controlled medication management processes have not been followed.

Incidents requiring referral

- Medication is administered covertly where there is no medically approved best interest decision recorded or specific approved covert medication protocol in place.
- If you identify that the medication error originated outside of your organisation (e.g. delay in prescribing or where stock has not been or could not be delivered)
- There is ongoing failure to provide appropriate medication reviews.
- Where the adult is continually or significantly mismanaging their medication, regardless of their capacity.
- A Safeguarding adult concern referral will always need to be raised where the medication error triggers a notification to CQC and/or a report to the Police.

Ensure all medication errors are looked at individually to decide if there has been any harm caused/impact on the adult and if a safeguarding concern needs reporting.

Time critical medications

Movement disorders medication (Parkinson's / myasthenia medication),

Immunomodulators including HIV meds

Sugar—diabetes medication

Steroids—Addison's & adrenal insufficiency

Epilepsy—anticonvulsants

Direct Oral Anti Coagulants (DOACs) & warfarin

Any medication can be critical depending on the person for whom it is prescribed and there should be professional curiosity around what the missed medication may mean for the induvial.

Organisational response to medication errors

As soon as the error is discovered organisations should have clear policies and procedures in place to ensure that the adult receives the appropriate response including, when required, access to emergency and primary care services to ensure the immediate safety of the individual.

Every organisation is responsible for monitoring themes and trends related to medication errors through robust governance mechanisms and for reporting any systems weaknesses.

Organisations should:

- Review each incident to decide whether further action and /or investigation is required and/or if an adult safeguarding referral needs to be made
- Ensure the safety and ongoing support needs of the adult. What was the actual effect on the individual? What actions were taken at the time
- Discuss with the adult the concerns, explain what has happened/needs to happen and when, ascertain the views, wishes and outcomes of the adult and/or where appropriate the family or advocate

Organisational response to medication errors

- Consider issues of mental capacity and consent
- Consider what the contributary factors were
- Consider what went well and what could have been done better
- Consider the risk issues identified including for near miss events
- Generate other appropriate responses, i.e. undertake Duty of Candour, incident reporting, CQC notification
- Consider lessons learned and what actions need to be taken to minimise any reoccurrence


QUESTIONS

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Spotlight on Homelessness

brief overview of homelessness legislation in the UK

- **Core Legislation**
- **Housing Act 1996:** Sets statutory homelessness duties.
- **Homelessness Act 2002:** Requires homelessness strategies; expands priority-need groups.
- **Homelessness Reduction Act 2017:**
  - 56-day prevention and relief duties
  - Personalised Housing Plans
- **Domestic Abuse Act 2021:** Automatic priority need for survivors; broader definition of abuse.

- **Local Authority Duties**
- Provide free homelessness advice
- Assess homelessness and eligibility
- Deliver **Prevention Duty** (56 days)
- Deliver **Relief Duty** (56 days)
- Provide interim accommodation where required
- Apply the **Main Housing Duty** to eligible, priority-need households

- **Responsibilities**
- **Local Authorities:** Deliver statutory duties
- **Central Government:** Legislation and funding
- **Public Bodies:** Duty to Refer individuals at risk within 56 days

- **Safeguarding Links**
- Automatic priority need for domestic abuse survivors
- Alignment with Care Act 2014 and Working Together to Safeguard Children

Adult safeguarding and homelessness

People experiencing homelessness are at heightened risk of abuse, neglect, and exploitation, often due to poor health, trauma, and lack of stable support. Effective safeguarding requires a person-centred, trauma-informed approach, thorough risk assessments, and collaboration among housing, health, and social care services. Key practices include:

Why Homelessness Increases Safeguarding Risk
Vulnerability: Homelessness worsens physical and mental health, increasing susceptibility to abuse.
Complex Needs: Linked with issues like substance misuse, trauma, and mental illness, raising risks.
Barriers to Help: Stigma and past negative experiences can hinder access to support.

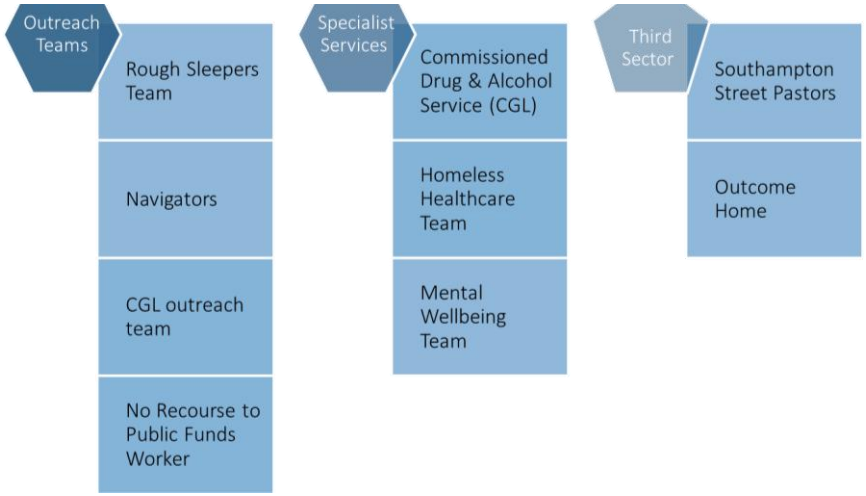
Key Safeguarding Principles for Homeless Individuals
Person-Centred & Trauma-Informed: Address root causes and trauma, not just surface behaviours.
Concerned Curiosity: Seek to understand non-engagement and behavioural patterns.
Thorough Assessments: Avoid assumptions; conduct comprehensive health, capacity, and risk evaluations.
Thinking Family/Networks: Involve supportive networks when appropriate.
Managing Transitions: Plan transitions from hospitals or prisons to reduce further vulnerability.
Advocacy: Provide advocates to ensure needs are understood and addressed

Safeguarding and Homelessness – Key Considerations

- **Key Consideration**
- **Details**
- Care and Support Needs
- Mental health conditions (trauma, psychosis, depression), physical health issues, unmanaged long-term conditions, substance misuse, cognitive or learning needs (ABI, learning disabilities, autism), barriers to accessing services (unstable accommodation, limited trust in professionals)
- Risk of Abuse
- Financial exploitation (coercion around benefits), criminal exploitation (cuckooing, forced criminal activity), sexual exploitation (exchange of sex for safety or shelter), physical assault, emotional or psychological abuse, survival needs may lead to unsafe or exploitative situations
- Risk of Neglect
- Self-neglect (lack of personal care, medication management), unsafe living environments (rough sleeping, squats), hoarding, chaotic living, untreated physical or mental health needs
- Trauma and Vulnerability
- History of trauma (domestic abuse, childhood adversity, bereavement), affects engagement with services, trust in professionals, capacity to make safe decisions, ongoing safeguarding needs
- Modern Slavery Risks
- Forced labour, domestic servitude, sexual exploitation, forced criminality, may require immediate action and referral through National Referral Mechanism (NRM)
- Duty to Refer (Homelessness Reduction Act 2017)
- Professionals must refer to local housing authority if homeless or at risk within 56 days, consent must be obtained, safeguarding referrals separate and can be made alongside Duty to Refer, can be completed alongside MARAC, NRM, or other risk processes
- When to Raise a Safeguarding Concern
- Adult has care and support needs, is experiencing or at risk of abuse or neglect, cannot protect themselves due to those needs, many adults' experiencing homelessness meet all three criteria

Reducing Rough Sleeping Through Person Centered Approach

Reducing rough sleeping thorough Multi agency working



Overview of Commissioned Services

- **Commissioned Homelessness Services – Executive Summary**
- Commissioned homelessness services, led by local councils and supported by specialist third-sector providers, form a critical part of the system response to rough sleeping and housing vulnerability. Provision focuses on single adults, young people, families, and those experiencing domestic abuse.
- **Core Functions**
- **Prevention & Early Intervention:** Targeted support to prevent tenancy loss, including floating support, legal/mediation services, and youth-focused interventions.
- **Emergency & Temporary Provision:** Hostels, assessment hubs, and rapid-response schemes such as RSI, SWEP, and “A Bed Every Night.”
- **Specialist Interventions:** Housing First, domestic abuse services, street outreach, and clinical support for complex needs.
- **Resettlement & Sustainment:** Move-on pathways and tenancy sustainment teams to reduce repeat homelessness.
- **Strategic Contribution**
- Commissioned services deliver measurable system benefits by:
- **Reducing rough sleeping** and breaking cycles of repeat homelessness.
- **Improving cross-agency efficiency** using shared data systems and coordinated care.
- **Embedding lived experience** in service design and evaluation.
- **Lowering demand on high-cost services**, including emergency healthcare, policing, and criminal justice.

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Spotlight on Incidents between Adults in a Service

4LSAB Safeguarding Concerns guidance – incidents between adults in a service

Incidents between people using a service, where there is reasonable cause to suspect that an adult may be experiencing or at risk of abuse or neglect

Incidents requiring consultation:

- Any incident between people using a service in which medical attention or attendance at hospital is required.
- There have been other similar incidents involving the same perpetrator.
- Concerns over escalation of behaviours between identified individuals.
- The care plan has not been implemented, reviewed or is not reducing risk.
- It is not clear that professional advice or support has been sought at the appropriate time.

Incidents requiring referral

- Any incident resulting in intentional or intended harm or risk of harm to the person, including hate crimes.
- Any incident where a weapon or other object is used with the intention to cause injury.
- Repeated incidents where the person lacks capacity and is unable to protect themselves.
- The person alleged to have been harmed is, or appears, fearful in the presence of the other person or is adapting their behaviour to pacify or avoid the other person.

Organisational response to incidents between adults in a service

Organisations should:

- Appropriate medical advice is sought as required
- Is there a need to report this to the Police
- Review each incident to decide whether further action and /or investigation is required and/or if an adult safeguarding referral needs to be made
- Ensure the safety and ongoing support needs of the adult. What was the actual effect on the individual? What actions were taken at the time
- Discuss with the adult the concerns, explain what has happened/needs to happen and when, ascertain the views, wishes and outcomes of the adult and/or where appropriate the family or advocate

Organisational response to incidents between adults in a service

- Some incidents will require mandatory reporting
- Generate other appropriate responses, i.e. undertake Duty of Candour, incident reporting, CQC notification
- The incident must be recorded within the daily care record and the care plan and risk assessment for both parties reviewed and updated as required
- Consider issues of mental capacity and consent
- Consider what the contributary factors were
- Appropriate medical advice is sought as required
- Consider lessons learned and what actions need to be taken to minimise any reoccurrence


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Spotlight on Pressure Ulcers

Pressure Ulcer Guidance

What is a Pressure Ulcer and why do they matter?

- Pressure ulcers (pressure sores or bed sores) are areas of damage to the skin and the tissue underneath.
- Pressure ulcers usually form on bony parts of the body, such as the heels, elbows, hips and tailbone.
- Pressure ulcers are caused by pressure on the skin, including pressure associated with shear. This might be for example, from body on furniture, or medical devices putting pressure on skin, or because of an individual sliding down a bed when in a semi-recumbent sitting position.
- Pressure Ulcers can happen to anyone, but certain factors place some individuals at higher risk
- Symptoms of a pressure ulcer can include pain or itchiness, discoloured skin or skin that appears or feels different, and they can develop into open wounds that can become infected.
- Treatments for pressure ulcers varies depending on the severity of the ulcer

Pressure Ulcer Guidance

Refer to the DHSC's Safeguarding Adults Protocol for Pressure Ulcers

Key Changes in Approach:

Clinical Focus: The guidance emphasizes that most pressure ulcers are clinical issues requiring health practitioner leadership, not automatic safeguarding enquiries by local authorities.

Safeguarding Trigger: A safeguarding concern is raised if the ulcer suggests neglect or abuse, using a decision guide to determine when a Care Act 2014 response is needed.

National Alignment: The guidance integrates recommendations from the National Wound Care Strategy Programme (NWCSP).

The 4LSAB Multi-Agency Pressure Ulcer Guidance was updated recently. The appendices include a flowchart to follow once severe skin damage is identified, the DHSC protocol and guidance for completing this, body maps and referral information.

Incidents requiring referral

- Multiple category 3 or 4, unstageable, or suspected deep tissue injury ulcers with considerable impact on the individual
- Adult Safeguarding Decision Guide score 15+ or score is under 15 but professional judgement determines safeguarding concern.
- Concern that pressure damage occurred as a result of informal carer wilfully ignoring or preventing access to care services.
- Concern that pressure damage occurred as a result of neglect/acts of omission by care staff (in care agency or residential home.)
- There is no evidence of risk assessment or care plans having been completed, or if present the completion and documentation is poor.
- Evidence demonstrates that this is part of a trend.

Organisational response to pressure ulcers

- Review each pressure ulcer(s) to decide whether further action and /or investigation is required and/or if an adult safeguarding referral needs to be made
- Appropriate clinical advice is sought as required
- Does the DHSC's safeguarding decision tool need to be used?
- Some incidents will require mandatory reporting
- The incident must be recorded within the daily care record and the care plan and risk assessment reviewed and updated as required

- **Organisational response to pressure ulcers**
- Consider issues of mental capacity and consent
- Consider what the contributary factors were
- Ensure the safety and ongoing support needs of the adult. What was the actual effect on the individual? What actions were taken at the time
- Discuss with the adult the concerns, explain what has happened/needs to happen and when, ascertain the views, wishes and outcomes of the adult and/or where appropriate the family or advocate
- Generate other appropriate responses, i.e. undertake Duty of Candour, incident reporting, CQC notification
- Consider lessons learned and what actions need to be taken to minimise any reoccurrence


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Spotlight on Falls

4LSAB Safeguarding Concerns guidance – Falls

'A fall is defined as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard.' (PHE, 2018).

Not all falls are preventable however we should take a preventative approach to the delivery of high-quality care, underpinned by appropriate risk assessment, individualised care planning and good team communication.

All falls require a proportionate response; however not all will require a safeguarding referral.

https://www.portsmouthsab.uk/wp-content/uploads/2026/01/4LSAB-Multi-Agency-Protocol-for-Falls-and-Adult-Safeguarding-Jul-2025-vFINAL.pdf

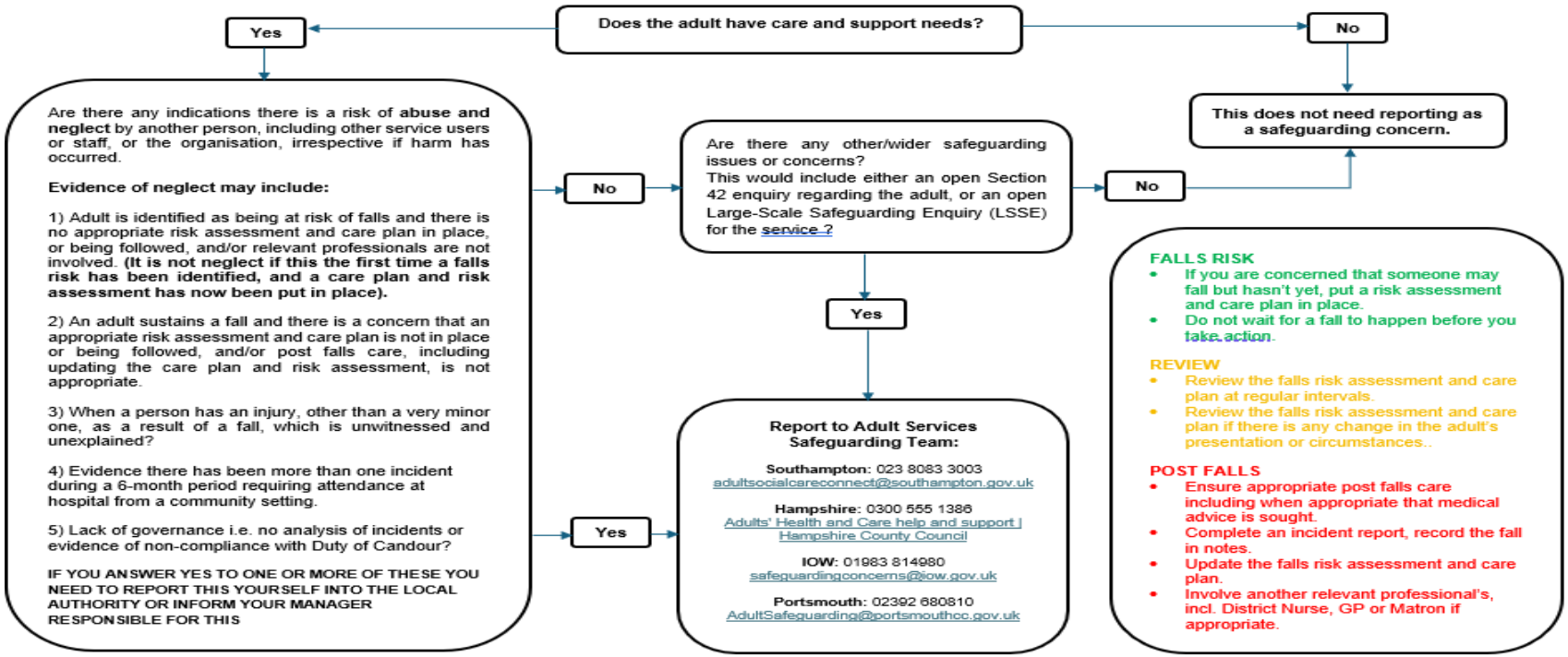
Incidents requiring referral

- When there is a concern about possible abuse or neglect by another person, including other service users or staff, or the organisation
- When a person is identified as being at risk of falls and there is concern that an appropriate risk assessment and care plan is not in place or is not being followed, or that the care plan is not updated after a fall.
- Staff are not following the relevant policies and procedures.
- When a person has an injury, other than a very minor, which is unwitnessed and unexplained.
- When appropriate medical attention has not been sought following a fall.
- When appropriate measures have not been taken to maximise the safety of the person from an environmental perspective, including avoiding harm from other clients / service users.

Incidents requiring referral

- Where there has been more than one incident during a 6-month period requiring attendance at hospital.
- Multiple incidents where it is not clear that professional advice or support has been sought at the appropriate time.
- Where there have been other similar incidents or areas of concern.
- Where there is an open Section 42 enquiry regarding the person.
- Where there is an open Large-Scale Safeguarding Enquiry (LSSE) regarding the service.

Flowchart Adult Safeguarding Decision Guide for Individuals Identified as Being at Risk of Falls



A person at risk of falls may be described as: A person who has had 2 or more falls in the past 12 months, or who demonstrates abnormalities of gait or balance, or who has risk factors for falling e.g. dementia, visual impairment, fear of falling, diabetes, incontinence (not an exhaustive list)

IF YOU ARE CONCERNED THAT SOMEONE MAY FALL BUT HASN'T YET, PUT A RISK ASSESSMENT IN PLACE. DO NOT WAIT FOR A FALL TO HAPPEN BEFORE YOU TAKE ACTION

Organisational response to falls

Organisations should:

- Review each incident to decide whether further action and /or investigation is required and/or if an adult safeguarding referral needs to be made
- Ensure the safety and ongoing support needs of the adult. What was the actual effect on the individual? What actions were taken at the time
- Discuss with the adult the concerns, explain what has happened/needs to happen and when, ascertain the views, wishes and outcomes of the adult and/or where appropriate the family or advocate

In the event of a fall occurring,

- The fall must be recorded within the daily care record and the care plan and risk assessment reviewed and updated as required. Documentation should include the circumstances of the fall, assessment of any injury and actions taken.
- Consider issues of mental capacity and consent
- Consider what the contributary factors were
- Consider what went well and what could have been done better
- Consider the risk issues identified including for near miss events
- Generate other appropriate responses, i.e. undertake Duty of Candour, incident reporting, CQC notification
- Consider lessons learned and what actions need to be taken to minimise any reoccurrence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Spotlight on Substance Use

4LSAB Safeguarding Concerns guidance – Substance Use

The use of psychoactive substances (including illegal drugs, alcohol, and misused prescription medicines) in a way that is harmful, hazardous, or causes dependency - OHID (Office for Health Improvement and Disparities)

Many people use substances do not experience harm. However, people who use substances at increasing amounts will have more likelihood of having complex needs, be at increased risk of harm and have care and support needs relating to…

- Physical health
- Mental health
- Self neglect
- Housing
- Domestic violence
- Other complex Vulnerabilities – eg risk of home takeover, financial abuse, Modern day slavery

Recognising Concerns – Substance Use

- Change in substance use - increase in frequency, changes of substance or method of use, presenting as more substance affected.
- Personal presentation – change in self care, change in weight, having less or more ‘nice things’ eg clothing, phone etc.
- Deterioration in physical and mental health – increased presentations at ED/calls to SCAS
- Engagement – missing appointments, someone else waiting outside or accompanying to appointments.
- Change at home environment – clutter, evidence of increased alcohol use or equipment relating to substance use, inadequate temperature, lack of food, no electric, living in one room.
- New ‘friends’ or people coming and going at address
- Finances – unable to pay rent and bills, owing money, having access to ‘unusual’ amount of money.

Actions

- Consult with organisation's Safeguarding Lead
- Consider referral to ASC, use of MARM, referral to Safeguarding involving the person with care and support needs at each stage to ensure their voice is heard.
- Always being mindful that sharing information can at times place an individual at increased risk so ensuring strategies are put in place to mitigate this.
- Use Community Partnership Information Sharing Forms Practice Guidance and Resources - Hampshire Safeguarding Adults Board

Contact your local Community Drug and Alcohol Service - Support, consultative advice and training

- Hampshire – Inclusion Recovery Hampshire - Home - Inclusion Hants
- Portsmouth Recovery Service – Society of St James - Portsmouth Drug & Alcohol Treatment Service – SSJ
- Southampton – Change Grow Live - Change Grow Live Southampton - drug and alcohol service info

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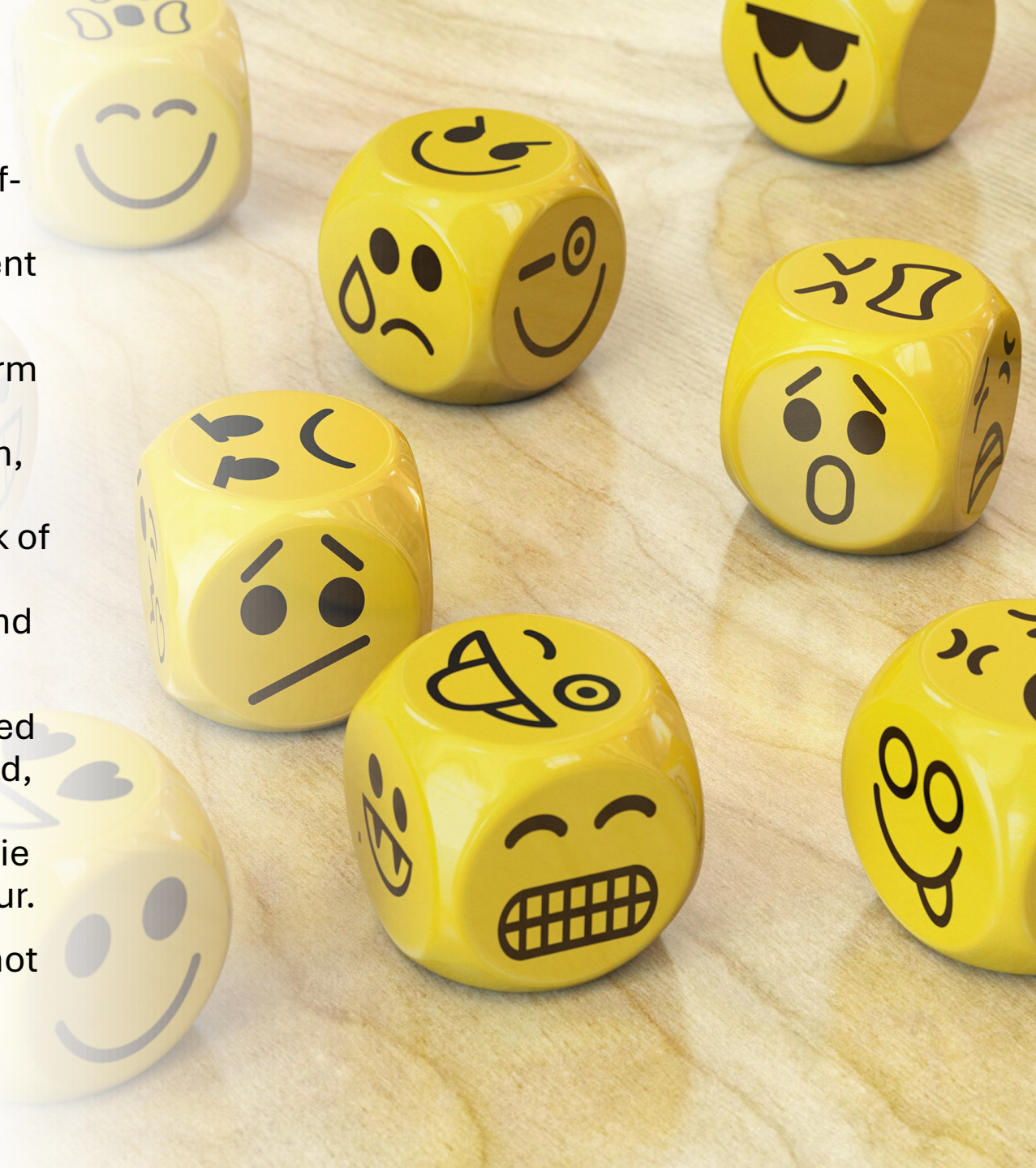
Spotlight on Suicide / Self Harm

- Self-harm “self-harm is defined as intentional self-poisoning or injury, irrespective of the apparent purpose.” (NICE, 2022
- For some people, self-harm is a one-off episode, but repetition is also common, Self-harm could be an indicator of increased risk of suicide, but self-harm is often not an attempt to end one’s life.
- Non-fatal suicide is defined as attempted self-directed, potentially injurious behaviour with intent to die as a result of the behaviour.
- A suicide attempt might not result in injury.



4LSAB Safeguarding Concerns guidance – Suicide and Self Harm

There is a National Suicide Prevention Plan which all areas have based their Strategy on:

Suicide prevention strategy for England: 2023 to 2028 - GOV.UK

Hampshire and Isle of Wight: Hampshire Suicide Prevention Plan

Southampton: Enc. 1 for Southampton Suicide Prevention Plan.pdf

Portsmouth: Suicide prevention action plan for Portsmouth 2022-2025

Suicide Prevention Plan

1. **Living experiences:** Actions will be co-designed and developed alongside Hampshire Voices: A collective of people with living experiences of suicide.
2. **Adopt a lifecourse approach:** Consider how all ages and key transitions are managed and supported by actions.
3. **System Ownership:** Partners recognise their roles and responsibilities in implementing actions identified within this plan; working closely with other suicide prevention forum members.
4. **Data-led decision making:** Actions must make best use of available insight, intelligence and evidence to maximise effectiveness.
5. **Language:** All partners and actions promote appropriate and de-stigmatising language when discussing suicide and suicidality.

Six Areas for Action Nationally and Locally:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

Information Sharing

Consensus statement for information sharing and suicide prevention - GOV.UK

Suicide and Self Harm Prevention: Guidance for Workers

- Complete the free training available to all
- Use this training to support you to have conversations with someone who maybe showing signs of suicidal thoughts
- Don’t feel you have to make decisions on your own, talk to colleagues, suicide prevention leads and your manager

Why is suicide important to talk about?

- Talking about suicide not only reduces stigma but also allows a person to open up about how they are feeling.
- People who have felt suicidal often report feeling a huge relief after opening up to someone about how they are feeling, and evidence shows asking someone if they’re suicidal could protect them.
- It is a myth that talking to someone about suicide puts the idea in their heads; talking to someone about suicide does not make it more likely to happen.
- One in five people have thought about suicide at some time in their life and not all people who die by suicide have mental health problems at the time they die. That is why it is important to ask the question if you know someone is struggling, even if they have not historically struggled with their mental health.

Cruse Bereavement Support

Support After Suicide Service (Southampton, Hampshire, Isle of Wight & Portsmouth) - Cruse Bereavement Support

Voices
People with Living Experience of Suicide

About us

We are a collective of People with Living Experience of Suicide. We believe our shared knowledge is fundamental in steering decision-making on suicide prevention and bereavement support.

We work collaboratively with you to offer strong guidance, advice and signposting on suicide related action.

> "Voices' perspective allows us to think differently and ensure the sensitivities around those who have lost someone to suicide are respected and built into aspects of our work."
>
> **SANDRA O'HAGAN**
> **PUBLIC HEALTH CONSULTANT**

Introduction

Voices came together as a collective in 2018, with the aim that fewer lives are lost to suicide, and anyone affected by suicide receives the best possible support. We are striving for quality initiatives in suicide prevention, postvention* and bereavement by suicide across the Hampshire, Isle of Wight, Portsmouth and Southampton area.

A unique perspective

Our valuable insights contribute to a tailored approach to suicide prevention and bereavement support work that better meets the needs of those who rely on it:

- Our stories break down the barriers of stigma, judgment and discrimination
- Our passion and drive create a positive impact on professionals
- We advocate for services designed with insight, compassion, and empathy at their heart
- We serve as models of hope and sources of comfort for others who are at risk of suicide or who have lost someone to suicide

*Postvention is the term given to activities and programmes that are intended to assist those who have been bereaved or impacted by suicide to cope with what has happened. Suicide prevention and postvention are closely related in that postvention can also prevent further deaths.


Zero Suicide Alliance
Because ONE life lost is ONE too many
SAVE A LIFE...
TAKE THE TRAINING
zerosuicidealliance.com

111 Help us help you

NHS

Support for your mental health

Looking after yourself

There are little things you can do to look after your mental health.
Just a few simple changes can help improve your mood and cope with life's challenges.

With the Every Mind Matters online platform, you can get free expert advice and practical tips to help you look after your mental health and wellbeing.

Talking therapy

If you feel stressed, anxious or depressed, you might struggle with work, life or relationships.
NHS Talking Therapies can help.
Search **nhs.uk/talk**

Your GP can refer you to your local NHS Talking Therapies service - or you can refer yourself online.

Crisis

If you are experiencing significant emotional or mental distress, call NHS 111 and select the mental health option.

The service offers 24/7 advice and support if you are:

- Experiencing worry, anxiety or fear that you can't control
- Hearing voices and seeing things that others can't
- Considering harming yourself
- Find yourself withdrawing from your friends or family.

If someone's life is at risk, call 999 or go to A&E.

NHS
Hampshire and
Isle of Wight Healthcare
NHS Foundation Trust

111 Mental Health Triage Service

Performance Pack Includes;

1. Mental Health Triage Service Overview
2. Activity and Demand Overview
3. Children and Young People's MH Overview
4. Mental Health Rapid Response Vehicle

HIOW Mental Health Triage Service

December 2025

NHS
Hampshire and
Isle of Wight Healthcare
NHS Foundation Trust

Hampshire and Isle Of Wight Healthcare Foundation Trust deliver an 'all age' 24/7 Mental Health Triage Service that is co-located in the Southern Central Ambulance Service Foundation Trust control room across NHS 111.

This service covers the entirety of Hampshire and the Isle Of Wight, supporting the population size of approx. 2 million.

This is a truly integrated partnership approach to urgent and emergency mental health care which incorporates seamless referrals, signposting and appropriate advice and support.

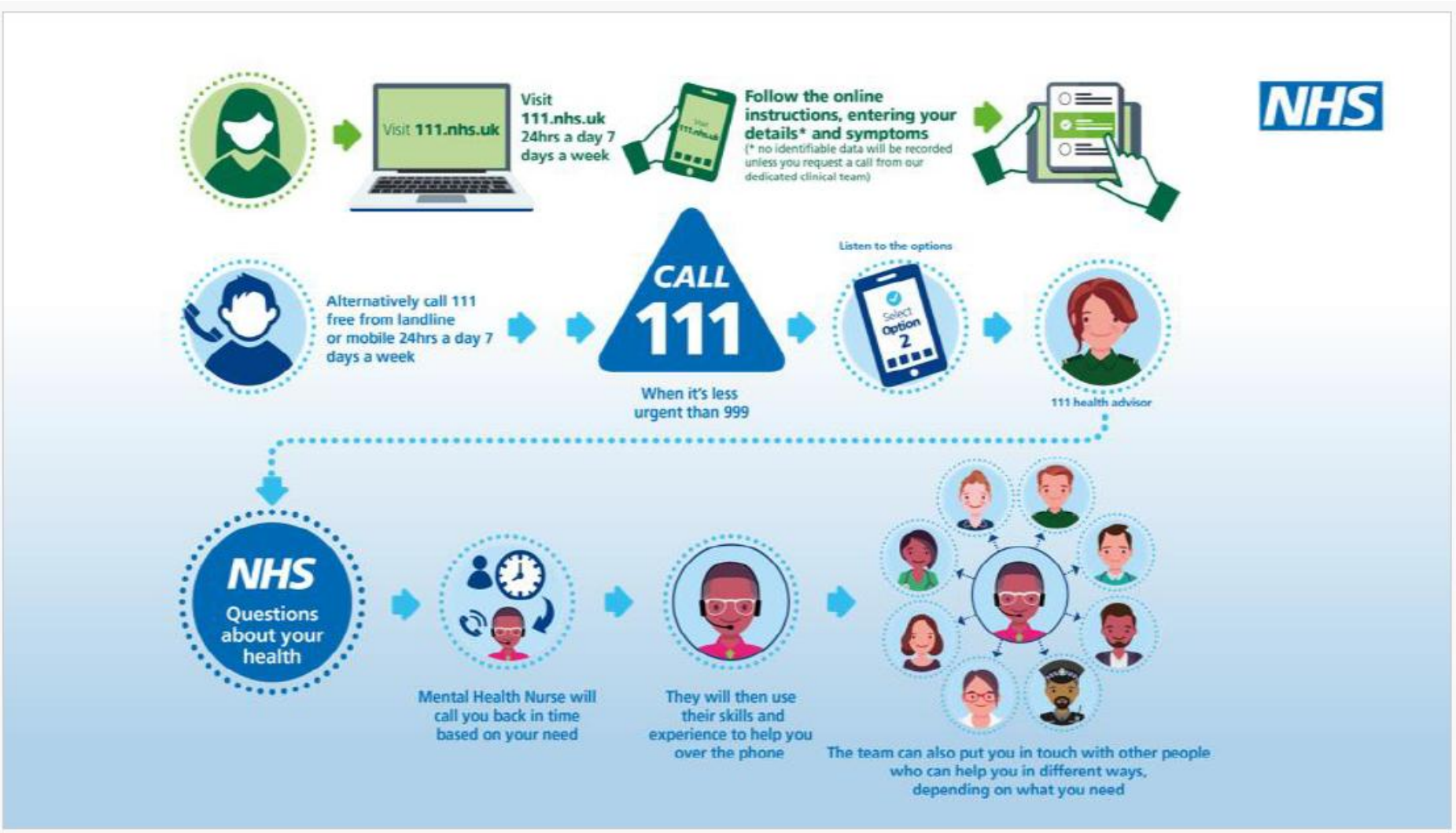
The mental health practitioners work on a call queuing system from SCAS 111 and make prioritised callbacks to patients calling into 111 with urgent mental health issues.

This is about achieving a more clinically focussed and patient-based set of outcome standards, an improved experience for all patients. The mental health triage service, by taking a little more time to triage the call, validate and understand patient needs to enable an effective triage. This results in an increase of the use of 'hear and treat' (over the phone support) rather than the dispatch of an ambulance resulting in an ED attendance.

This service provides 24/7 (365 day) access to Mental Health practitioners to ensure a consistent, reliable and sustainable service across Hampshire and Isle of Wight. The Mental Health Triage Service also supports a dedicated Mental Health Response Vehicle which is in partnership with SCAS to provide urgent and emergency mental health triage to people who are in their own home or in the community.

The 111 mental health triage service is supported by No Limits. Which offers a timely social prescribing capability to all callers under 25.

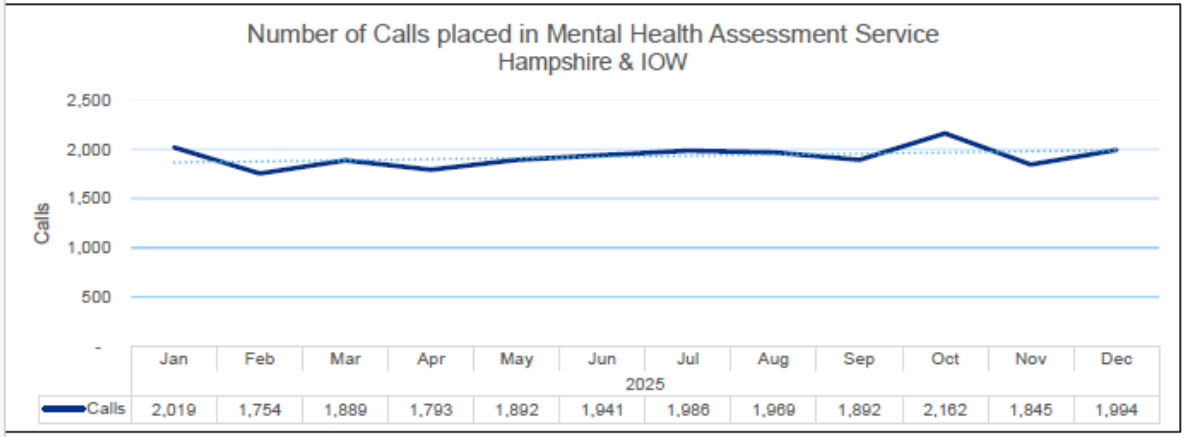
We actively support healthcare professionals and Hampshire Constabulary / British Transport Police on scene with expert mental health telephone advice and support when they are with a person who is presenting with mental health needs.

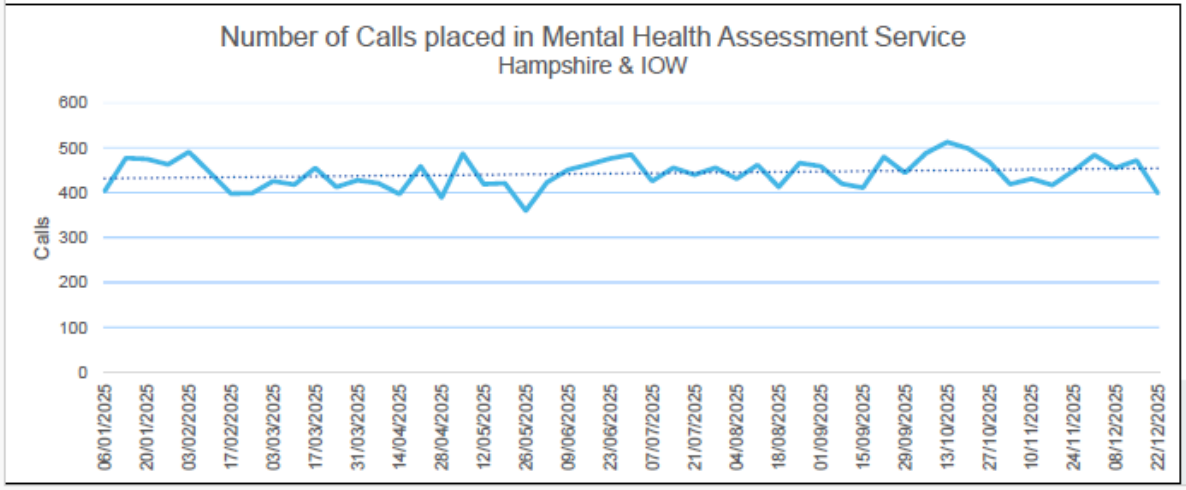

Visit 111.nhs.uk
Visit 111.nhs.uk 24hrs a day 7 days a week
Follow the online instructions, entering your details* and symptoms
(* no identifiable data will be recorded unless you request a call from our dedicated clinical team)
NHS
Alternatively call 111 free from landline or mobile 24hrs a day 7 days a week
CALL 111
When it's less urgent than 999
Listen to the options
Select Option 2
111 health advisor
NHS Questions about your health
Mental Health Nurse will call you back in time based on your need
They will then use their skills and experience to help you over the phone
The team can also put you in touch with other people who can help you in different ways, depending on what you need

NHS Mental Health Triage Service – December 2025

There was an 8.1% increase in the number of calls placed in the service in December compared to November. Compared to December-24, there was a 3.6% increase.

Hampshire and Isle of Wight Healthcare NHS Foundation Trust





Year	Month	Calls
2025	Jan	2,019
	Feb	1,754
	Mar	1,889
	Apr	1,793
	May	1,892
	Jun	1,941
	Jul	1,986
	Aug	1,969
	Sep	1,892
	Oct	2,162
	Nov	1,845
	Dec	1,994

NHS Mental Health Triage Service

Hour of Day Heat Map

Fridays were busiest. Peak periods for calls placed in the queue were from 10:00 to 02:00 but especially in the afternoon from 17.00 to 19.00.

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ALL PATIENTS																								
Dec-25																								
Hour of day																								
Weekday	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Grand Total
Monday	11	14	8	6	1	3	2	8	11	13	12	11	17	18	18	19	18	21	20	11	13	16	8	22	301
Tuesday	17	21	12	10	8	5	2	7	5	10	16	16	18	21	17	19	20	22	15	14	12	11	17	17	332
Wednesday	15	7	9	4	2	5	2	16	11	11	14	21	16	17	21	14	13	24	16	14	26	10	10	10	308
Thursday	12	12	9	1	4	3	5	10	4	10	11	10	18	10	10	13	14	16	18	9	12	10	11	12	244
Friday	15	10	9	9	5	5	2	11	8	10	14	11	10	11	12	13	10	19	17	11	10	18	12	22	274
Saturday	19	15	3	9	11	7	5	2	9	8	10	11	13	11	13	14	14	16	18	16	12	2	15	13	266
Sunday	10	7	6	4	7	5	2	5	7	14	13	14	15	27	10	5	9	11	18	20	15	16	16	13	269
Grand Total	99	86	56	43	38	33	20	59	55	76	90	94	107	115	101	97	98	129	122	95	100	83	89	109	1994

ALL PATIENTS																								
Nov-25																								
Hour of day																								
Weekday	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Grand Total
Monday	3	7	2	1	2	8	2	3	11	17	11	10	8	9	7	13	6	10	5	2	7	16	12	10	182
Tuesday	5	2	5	4	4	1	1	5	10	13	9	14	15	19	21	15	19	8	8	8	11	11	5	2	215
Wednesday	1	5	15	5	3	7	3	5	12	17	9	7	8	8	16	13	14	14	20	17	17	7	10	13	246
Thursday	4	5	12	2	2	3	3	5	4	12	14	13	13	20	10	11	18	32	15	12	13	24	16	14	277
Friday	11	16	2	4	3	1	1	4	9	11	13	19	9	13	14	15	14	22	20	19	18	17	7	13	275
Saturday	24	16	3	8	1	2	2	7	17	13	8	21	19	23	24	20	24	16	22	20	24	19	8	15	356
Sunday	10	10	9	15	5	11	7	13	4	7	18	22	16	13	19	14	18	18	7	18	13	9	9	9	294
Grand Total	58	61	48	39	20	33	19	42	67	90	82	106	88	105	111	101	113	120	97	96	103	103	67	76	1845

NHS Mental Health Triage Service

Demand By Place

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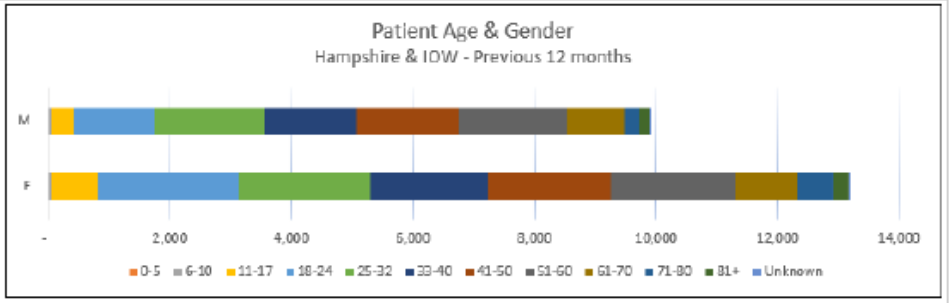
Division	2025												Grand
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
SHFT Portsmouth and South East Hampshire	466	344	432	412	510	477	478	487	403	490	429	421	5,349
SHFT Southampton City	421	349	393	331	306	395	401	391	380	466	443	420	4,696
SHFT South West Hampshire	405	367	383	424	412	385	412	384	371	373	298	329	4,543
Solent NHS	309	271	290	247	254	274	294	272	341	359	275	311	3,497
SHFT Mid and North Hampshire	215	214	168	172	207	186	176	178	165	183	176	214	2,254
IOW	127	149	143	119	135	161	148	175	158	194	167	227	1,903
Surrey and Borders	76	58	79	86	65	59	76	79	73	92	52	71	866
Unknown		1	1	1	1	1	1	1	1	2	1	1	12
OOA		1			2	2		1		3	2		11
OXFORDSHIRE CCG				1				1			2		4
BUCKINGHAMSHIRE CCG						1							1
Grand Total	**2,019**	**1,754**	**1,889**	**1,793**	**1,892**	**1,941**	**1,986**	**1,969**	**1,892**	**2,162**	**1,845**	**1,994**	**23,136**

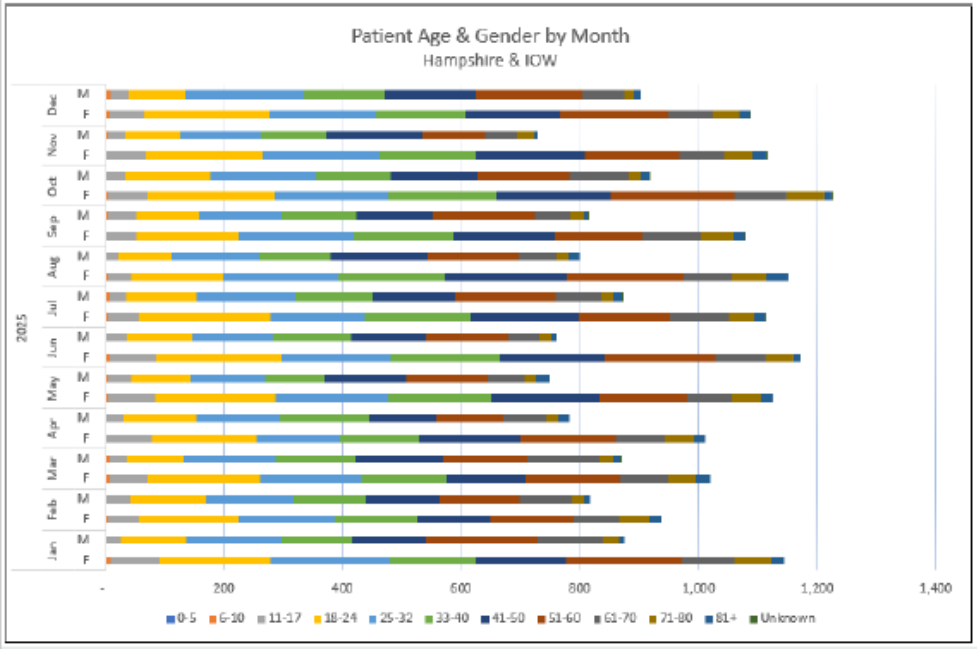
NHS Mental Health Triage Service

Mental Health by Age & Gender

Average time for Mental Health Triage and Assessment:
Under 18 Age Range – *Average – 51:21 (Average 49:02)*

18 + Age Range – *Average – 42:55 (Average 38:15)*

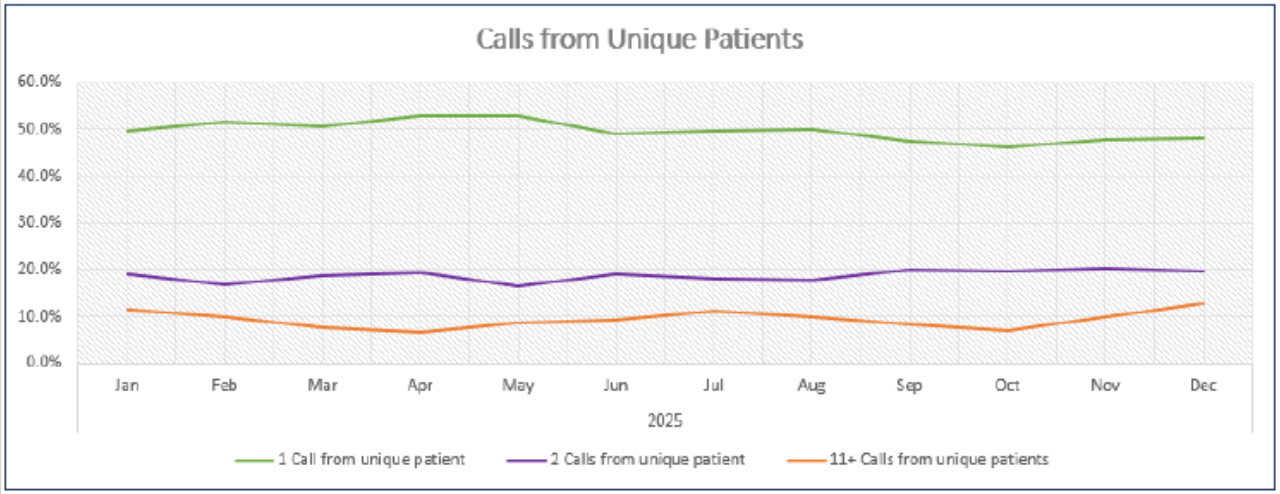




In the previous 12 months, the highest volume of calls has come from female patients in the 18-24 age range measuring 10%, followed by patients aged between 25-32, measuring 9.4%.

For male patients, in the previous 12 months, the highest volume of calls has come from patients in the 25-32 age range (7.9%), followed by patients aged 51-60 (measuring 7.7%).

NHS Mental Health Triage Service



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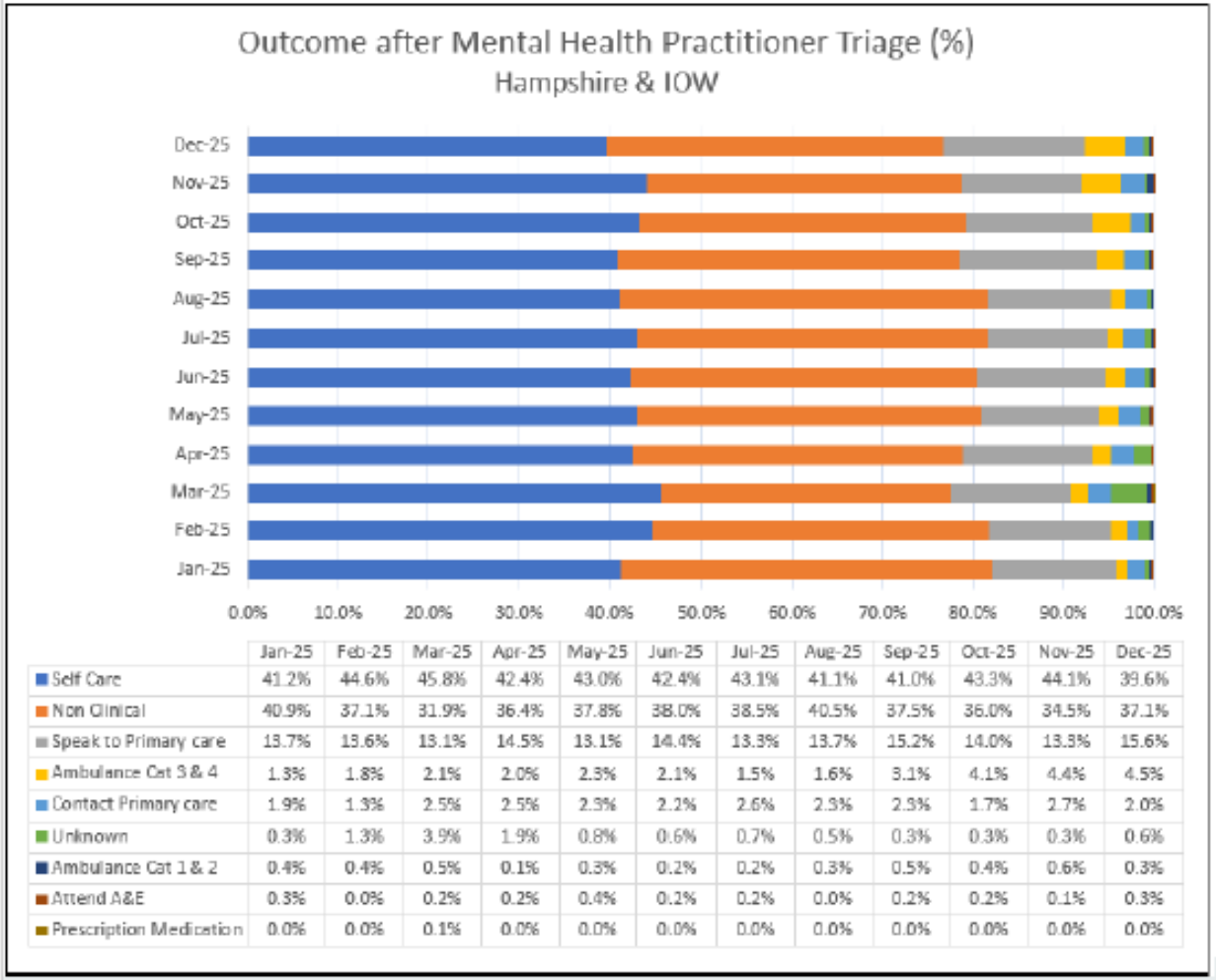
Unique callers into 111

	Oct-25		Nov-25		Dec-25		Previous 12 Months	
	No of Patients	% of Calls	No of Patients	% of Calls	No of Patients	% of Calls	No of Patients	% of Calls
1 Call from unique patient	999	46.2%	884	47.9%	956	47.9%	7,568	32.7%
2 Calls from unique patient	213	19.7%	186	20.2%	196	19.7%	1,794	15.5%
3 Calls from unique patient	66	9.2%	57	9.3%	49	7.4%	642	8.3%
4 Calls from unique patient	31	5.7%	20	4.3%	19	3.8%	284	4.9%
5-10 Calls from unique patients	37	11.9%	22	7.4%	26	8.2%	442	12.4%
11+ Calls from unique patients	8	6.9%	8	10.0%	13	12.6%	200	25.8%
Calls from Patients with Unknown NHS Number	9	0.4%	16	0.9%	8	0.4%	88	0.4%
	1,354	2,162	1,178	1,845	1,259	1,994		23,136

NHS Mental Health Triage Service

Patient Outcomes

- **76.7% (1,530)** of overall demand supported with Home Management/Self Care
- **17.6% (351)** Primary Care Outcomes
- **0.3% (5)** Recommended to attend A&E outcomes
- **4.8% (96)** Emergency Ambulance response



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Self Care	41.2%	44.6%	45.8%	42.4%	43.0%	42.4%	43.1%	41.1%	41.0%	43.3%	44.1%	39.6%
Non Clinical	40.9%	37.1%	31.9%	36.4%	37.8%	38.0%	38.5%	40.5%	37.5%	36.0%	34.5%	37.1%
Speak to Primary care	13.7%	13.6%	13.1%	14.5%	13.1%	14.4%	13.3%	13.7%	15.2%	14.0%	13.3%	15.6%
Ambulance Cat 3 & 4	1.3%	1.8%	2.1%	2.0%	2.3%	2.1%	1.5%	1.6%	3.1%	4.1%	4.4%	4.5%
Contact Primary care	1.9%	1.3%	2.5%	2.5%	2.3%	2.2%	2.6%	2.3%	2.3%	1.7%	2.7%	2.0%
Unknown	0.3%	1.3%	3.9%	1.9%	0.8%	0.6%	0.7%	0.5%	0.3%	0.3%	0.3%	0.6%
Ambulance Cat 1 & 2	0.4%	0.4%	0.5%	0.1%	0.3%	0.2%	0.2%	0.3%	0.5%	0.4%	0.6%	0.3%
Attend A&E	0.3%	0.0%	0.2%	0.2%	0.4%	0.2%	0.2%	0.0%	0.2%	0.2%	0.1%	0.3%
Prescription Medication	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Unknown outcome needs to be assigned a DX code which forms part of Home Management/ Self Care.

Demand for U25s

77.3% (316) of overall demand supported with Home Management/Self Care
17.6% (72) Primary Care Outcomes
0.5% (2) Recommended to attend A&E outcomes
4.4% (18) Emergency Ambulance response Cat 3 & 4 Response
0.0% (0) Required Emergency Ambulance Cat 1 & 2 response

Year	Month	Calls
2025	Jan	414
	Feb	393
	Mar	391
	Apr	408
	May	429
	Jun	443
	Jul	431
	Aug	312
	Sep	381
	Oct	462
	Nov	389
	Dec	409
Grand Total		**4862**

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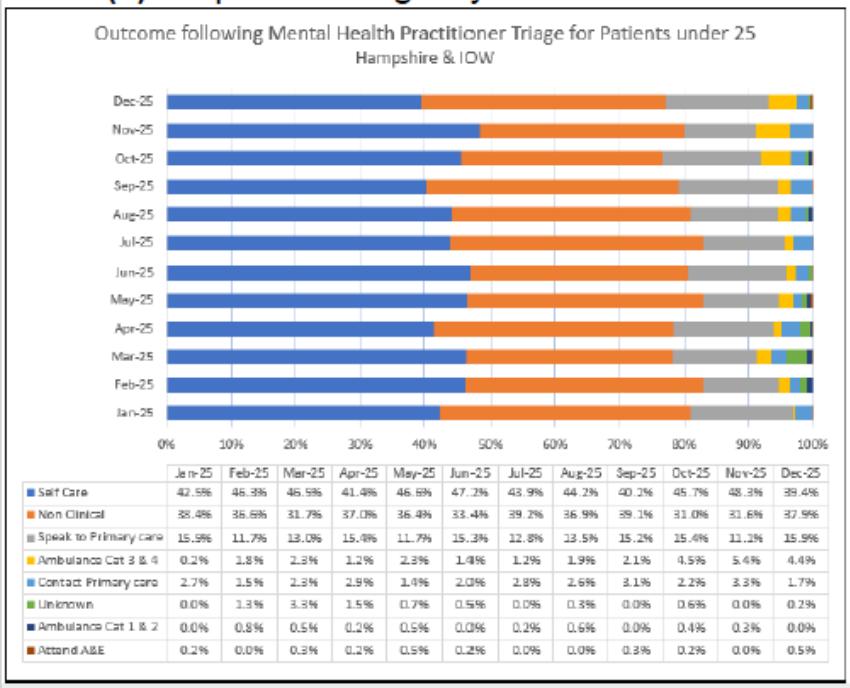
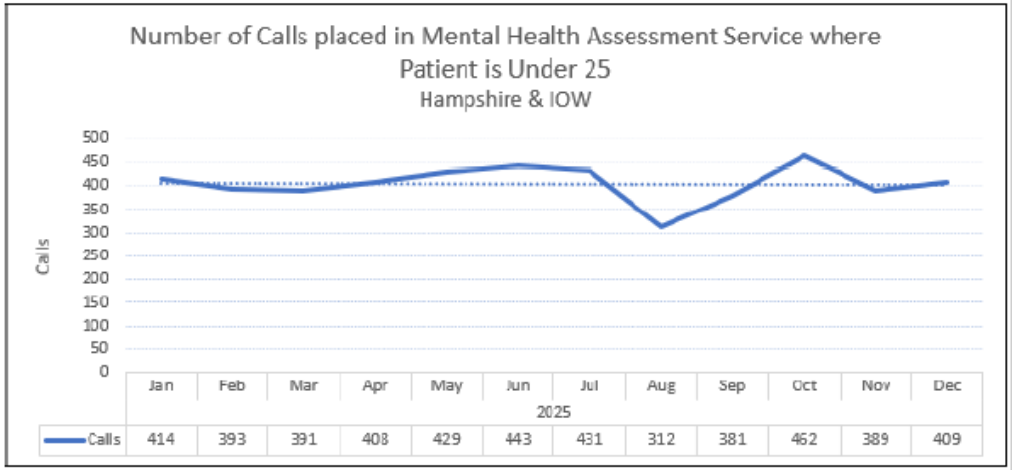


	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Self Care	42.5%	46.3%	46.5%	41.4%	46.6%	47.2%	43.9%	44.2%	40.2%	45.7%	48.3%	39.4%
Non Clinical	38.4%	36.6%	31.7%	37.0%	36.4%	33.4%	39.2%	36.9%	39.1%	31.0%	31.6%	37.9%
Speak to Primary care	15.5%	11.7%	13.0%	15.4%	11.7%	15.3%	12.8%	13.5%	15.2%	15.4%	11.1%	15.9%
Ambulance Cat 3 & 4	0.2%	1.8%	2.3%	1.2%	2.3%	1.4%	1.2%	1.9%	2.1%	4.5%	5.4%	4.4%
Contact Primary care	2.7%	1.5%	2.3%	2.9%	1.4%	2.0%	2.8%	2.6%	3.1%	2.2%	3.3%	1.7%
Unknown	0.0%	1.3%	3.3%	1.5%	0.7%	0.5%	0.0%	0.3%	0.0%	0.6%	0.0%	0.2%
Ambulance Cat 1 & 2	0.0%	0.8%	0.5%	0.2%	0.5%	0.0%	0.2%	0.6%	0.0%	0.4%	0.3%	0.0%
Attend A&E	0.2%	0.0%	0.3%	0.2%	0.5%	0.2%	0.0%	0.0%	0.3%	0.2%	0.0%	0.5%



NHS Mental Health Triage Service

Healthcare Professional Calls

The service provides a dedicated response to Hampshire Police, British Transport Police, paramedics and other approved healthcare professional where they can talk directly to a mental health nurse with a 30min response time.

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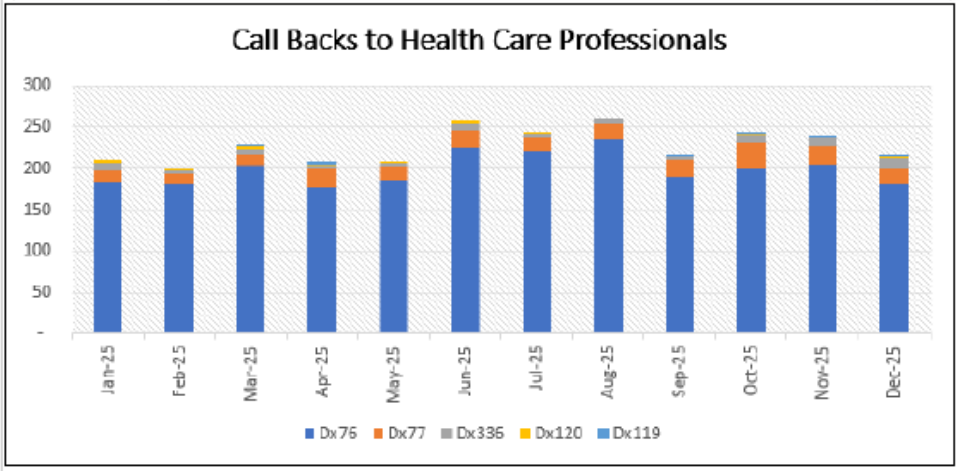
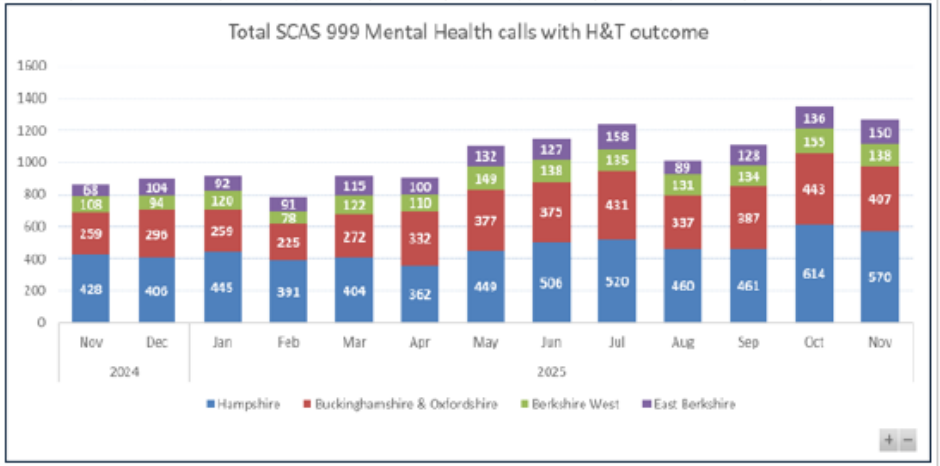
Total 111 Calls from Paramedic /Health Care Professional that were dealt with by Hampshire & IOW Mental Health Practitioner Assessment Service

Final Dx Code	Final Dx Desc	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Grand Total
Dx76	Callback by Healthcare Professional within 30 minutes	182	181	204	177	184	226	220	235	191	200	206	181	2,387
Dx77	Callback by Healthcare Professional within 60 minutes	15	12	12	22	18	20	17	18	20	31	22	18	225
Dx336	Paramedic requesting callback from Healthcare Professional within 30mins	10	5	8	5	5	8	6	8	4	10	9	14	92
Dx120	Callback by Healthcare Professional within 4 hours	4	1	3	2	1	3	1			1		1	17
Dx119	Callback by Healthcare Professional within 2 hours			3	3					2	1	1	1	11
Grand Total		**211**	**199**	**230**	**209**	**208**	**257**	**244**	**261**	**217**	**243**	**238**	**215**	**2,732**





Mental Health Response Vehicle Service Overview

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The team consists of a Paramedic from SCAS999 and a Mental Health Nurse from the 111 Mental Health Triage Service delivering an integrated partnership approach to blue light urgent and emergency mental health care for our population (excluding IOW).

The team operates 7 days a week. On late shifts which run from 12:30 – 23:00pm (everyday) and from 16:00-02:00 hours (Wednesday – Sunday).

The MHRV team, work with Hampshire Police and British Transport Police to promote the utilisation of the mental health nurses prior to detaining under S136 of the MHA.

More urgent help/Help in a crisis


QUESTIONS

Contact Information:

Important contact information:

In an emergency, contact the police by dialling 999. For non-urgent matters, call 101.

If you are worried about an adult, please telephone the correct number below for your area:

Southampton:

Phone: 023 8083 3003 (out of hours: 0300 555 1373)

Email: adultsocialcareconnect@southampton.gov.uk

Health and Social Care – 023 8083 3003 (023 8023 3344 for Out of Hours)

Contact Information:

Hampshire:

Phone: 0300 555 1386 (out of hours: 0300 555 1373)

Online: https://www.hants.gov.uk/socialcareandhealth/adultsocialcare/contact/start-a-referral

Adult Health and Care – 0300 555 1386 (0300 555 1373 for Out of Hours)

Contact Information:

IOW:

Phone: 01983 814980 (out of hours: 01983 821105)

Online: Making a Safeguarding Referral – Isle of Wight Safeguarding Adults Board (IOWSAB)

Portsmouth:

Phone: 023 9268 0810 (out of hours: 0300 555 1373)

Email: AdultSafeguarding@portsmouthcc.gov.uk