Kent and Medway Safeguarding Adults Board

Annual Report

April 2019 – March 2020

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Section 1. Role of the Kent and Medway Safeguarding Adults Board (KMSAB)

About us

We are a statutory multi-agency partnership which assures adult safeguarding arrangements in Kent and Medway are in place and are effective. We do not provide frontline services but oversee how agencies co-ordinate services and work together to help keep adults who are, or may be, at risk, safe from harm. We promote wellbeing, work to prevent abuse, neglect and exploitation, and help to protect the rights of the residents of Kent and Medway. Our work also includes the development of multi-agency adult safeguarding policies and procedures, providing consistency and setting high safeguarding standards, which all our partner agencies sign up to.

For the purposes of this report the terms 'Board' and 'KMSAB' will be used interchangeably to refer to the Kent and Medway Safeguarding Adults Board.

Our Responsibilities

Our responsibilities include:

Developing and publishing a Strategic Plan to set out our priorities and how these will be met.

assuring safeguarding practice continuously improves, to bring about better outcomes for those experiencing, or at risk, of abuse.

assuring that we make safeguarding personal, person centred and outcome focused.

holding our partners to account, gaining assurance that effective safeguarding arrangements are in place.

producing multi-agency policies and procedures, and monitoring their impact .

undertaking Safeguarding Adults Reviews to establish what happened, and what we can learn.

producing an annual report to explain how we have achieved the priorities set out in our Strategic Plan.

working collaboratively and with effective governance to promote wellbeing and prevent abuse and neglect.

setting the strategic direction to protect and empower adults at risk across Kent and Medway.

Our Membership

In 2019-20 our Board was led by an Independent Chair, Deborah Stuart-Angus, who provided leadership, vision and support.

Our statutory partners are:

- Medway Council
- Kent County Council (KCC)
- Kent Police
- Kent and Medway NHS Clinical Commissioning Group

In addition to the statutory members, the Board and/or its Working Groups include representation from the following agencies:

- Advocacy People
- Dartford and Gravesham NHS Trust
- District and Borough Councils
- East Kent Hospitals University NHS Foundation Trust
- HM Prison Service
- Kent and Medway NHS and Social Care Partnership Trust
- Kent Autistic Trust
- Kent Community Health NHS Foundation Trust
- Kent Fire & Rescue Service
- Kent Integrated Care Alliance
- Kent Surrey and Sussex Community Rehabilitation Company
- Maidstone and Tunbridge Wells NHS Trust
- Medway Community Healthcare
- Medway NHS Foundation Trust
- National Probation Service
- NHS England
- Rapport Housing and Care
- South East Coast Ambulance NHS Foundation Trust
- Virgin Care

Engagement is not limited to the agencies listed above. We are committed to inviting contributions from other organisations and groups across Kent and Medway, such as faith groups and service user groups.

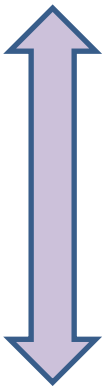
Our Structure

Our structure is set out on the next page. The terms of reference and membership for each group are reviewed annually, they can be found on the KMSAB Website.

We work closely with other strategic groups and partnerships, such as local Safeguarding Children Partnerships, Community Safety Partnerships and Health and Wellbeing Boards, to ensure key priorities are shared to promote efficiency, encourage joint working and to reduce duplication.

Our Board is supported by the KMSAB Business Unit, which comprises of a part time Board Manager, two full time equivalent Senior Administration Officers and a Business Development and Engagement Officer.

Kent and Medway Safeguarding Adults Board – Executive Group



Medway Safeguarding Adults Executive Group (MSAEG)

This group brings together senior representatives from the key agencies responsible for the effective delivery of adult safeguarding in Medway. MSAEG works collaboratively to deliver the strategic priorities of the Kent and Medway Safeguarding Adults Board, strengthening local delivery, oversight and governance.

KMSAB's Business Group is regularly updated on both Medway and Kent County Council's progress.

Kent and Medway Safeguarding Adults Board - Business Group

Responsibilities

- Hold the Working Groups to account for the delivery of the strategic plan, business plan and their annual work plans, by scrutinising update reports, monitoring progress and identifying and addressing gaps or risks.
- Accountable for decision making to implement the Strategic Plan and delivery plans.
- Receive update reports from partners and other Boards to share learning and identify development areas.
- Make recommendations to the Board where decisions require higher level scrutiny and or agreement, or if there are likely to be budget implications.

The Board's Working Groups	Responsibilities
Communications and Engagement (CEWG)	Co-ordinates activity to raise awareness within organisations and communities about the Board's work, and the need to safeguard adults at risk. Encourage participation and engagement to promote practice improvement, prevention of abuse and early intervention - to make Kent and Medway a safer place.
Learning and Development (LDWG)	Co-ordinates the commissioning, delivery and evaluation of the Board's multi-agency safeguarding adults training programme.
Practice, Policy and Procedures (PPPWG)	Reviews and updates the "Multi-agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway", and associated documents - maintaining a modern approach with a continuous review cycle.
Quality Assurance (QAWG)	Co-ordinates the delivery of quality assurance activity to evaluate and assess the effectiveness of safeguarding activities from our partner agencies.
Joint Exploitation Working group (JEG)	This is a joint group with Kent and Medway's Safeguarding Children Multi-Agency Partnerships. It oversees activity around; sexual exploitation, gangs/county lines, human trafficking/modern slavery, online safeguarding and radicalisation/extremism to understand current trends to protect and safeguarding the welfare of children and adults at risk.
Safeguarding Adults Review (SARWG)	Delivers our statutory responsibility to conduct Safeguarding Adults Reviews and hold agencies to account for improvement.

Section 2. Priorities and Achievements

This section details how we delivered against our priorities for 2019 – 2020. It is recognised that activity can cut across more than one priority. For example, Safeguarding Adults Awareness week met the priority for both Prevention and Awareness.

Priority One: PREVENTION

"I want to feel and be safe in the community where I live"

Our priority is to deliver a preventative approach in all that we do. We will:

- assure that agencies are clear about their obligation to deliver safeguarding and that they understand that this constitutes the prevention of abuse, crime, neglect and self-neglect;
- assure accountability of our partners;
- raise public awareness of the work of the KMSAB and of adult safeguarding; and
- listen to the voice of the adult at risk and make sure safeguarding is made personal, wherever possible.

What we have achieved

1. Continued to deliver our Strategic Plan

Our Strategic Plan, sets out our vision, our mission statement and our strategic priorities.

To support this high-level strategic plan, each Working Group is required to produce an 'annual delivery plan' which provides more detail about the tasks the Group will be undertaking to meet the strategic plan's three chosen priorities of Prevention, Awareness and Quality. Medway Safeguarding Adults Executive Group has also developed a delivery plan. The Chairs of each Working Group are required to provide a progress update at each Business Group meeting. The following ratings are used to measure progress against each action:

Blue	Action complete.
Green	Action on track and progressing to plan, no problems that will impact on schedule. No action required from KMSAB.
Amber	Some problems and or delays with the action but expected to recover. Highlighted to inform KMSAB, to be monitored and reviewed.
Red	Major problems and issues threatening the action, behind schedule and not expected to recover. Requires intervention from KMSAB.

If tasks are rated amber or red, Working Group Chairs must give reasons and advise on mitigation.

2. Delivery of our Training Offer

Between June 2017 and September 2019, we commissioned multi-agency safeguarding adults training, predominantly for staff from the statutory sector, supporting the effective delivery of their roles and responsibilities in relation to Section 42 Enquiries.

The programme comprised of the three workshops, focusing on the implementation of Section 42 of the Care Act, 2014:

- Policies, Procedures and Agency Responsibilities
- Undertaking and Managing s42 Enquiries
- Effective Contribution and Collaboration in Decision Making

Over this period the Board's multi-agency training offer was delivered to 1560 staff, attendance levels are detailed in the table below.

Table: KMSAB Multi Agency Safeguarding Adults Training June 2017 to September 2019 - Attendance Figures

Course Name	No of Workshops Held	Total Attendance	KCC	Medway Council	Health - KMPT	Health - Other	Police	KFRS	Probation	Other
Policies, Procedures and Agency Responsibilities (one day)	37	621	340	91	28	66	63	7	17	9
Undertaking and Managing Enquiries (one day)	39	591	325	89	56	56	50	6	1	8
Effective Contribution and Collaboration in Decision Making (two days)	21	348	190	59	23	27	39	5	2	3
Totals	**97**	**1560**	**855**	**239**	**107**	**149**	**152**	**18**	**20**	**20**

A set number of places per course are allocated to agencies according to the ratio of contribution to the Board budget and organisational need.

It is the responsibility of each agency to provide the introductory/foundation training, often referred to as level one and two training, which sits below this training. Agencies also supplement the Board offer with their own level three training programmes.

To ensure that the training offer remained reflective of the local issues, the training provider was notified of any policy updates and other relevant information, such as learning from Safeguarding Adults Reviews, so that training could be updated accordingly.

3. Delivery of Self-Neglect Training

As a response to safeguarding adult review (SAR) learning and to coincide with the launch of the new KMSAB self-neglect policy, we were also able to offer partners some workshops on "Working with Self Neglect", which used research evidence, SAR learning and local procedures to promote good practice. The sessions were led by Professors Suzy Bray and Michael Preston-Shoot, whose research was influential in the development of legislation and policy on self-neglect.

4. Development of a new Training Programme

The Kent and Medway Safeguarding Adults Board has six aims for its multi-agency training.

1. Ensure that the learning is accessible.
2. Ensure that multi-agency staff are legally literate in relation to safeguarding and their associated duties and responsibilities.
3. We will be pro-active in the delivery of learning to enhance early intervention and prevention.
4. Ensure that the delivery of learning and development is person centred following Making Safeguarding Personal protocols.
5. Ensure that collaborative working across agencies is enhanced.
6. Learning will be current, relevant and represent the local situation.

Learning and Development Working Group (LDWG) members continued to use the tools in the training evaluation framework to ensure training course content remained up to date and relevant to all partner agencies and reflective of; the Care Act and other key legislation; learning from best practice; and learning points from local Safeguarding Adults Reviews as well and relevant Domestic Homicide Reviews, Safeguarding Children Reviews and Learning Disabilities Mortality Reviews (LeDeR). The Framework was also used to seek views of attendees and their managers, about course content, delivery, relevance, and practice improvements.

Following analysis of information gathered, members agreed that, albeit the training programme was of a high standard and well regarded, after two years it was due for revision to support the delivery of our priorities and to further complement what agencies were delivering in-house.

Learning and Development Working members updated the training aims, as detailed above, and designed a new modular course programme, covering the following topics:

One day courses

- Adult safeguarding legal literacy
- Domestic abuse workshop, including a focus on stalking and harassment, harmful practices, female genital mutilation (FGM) and honour-based crime

Half day courses

- Collaborative working in multi-agency Section 42 Enquiries
- Self neglect and hoarding workshop
- Workshop on exploitation - including cuckooing, modern slavery, mate crime and county lines

Following a rigorous tender process, a considerable amount of work was undertaken with the successful training provider to prepare for delivery of the new courses from April 2020.

5. Kent and Medway Safeguarding Adults Board Policy and Procedures

The Practice Policy and Procedures Working Group (PPPWG) has a policy update schedule, which sets out when each policy is due to be reviewed and updated to ensure that they continue to incorporate relevant: legislative change; national advice; thematic learning from Safeguarding Adults Reviews, Complex Case Audits, Domestic Homicide Reviews and outcomes from Children's reviews.

During 2019/20, work to completely revise the Board's main policy document, "Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway" was finalised by members of the Practice, Policies and Procedures working group. This document sets out: legal responsibilities in relation to adult safeguarding; arrangements for working together across Kent and Medway; and provides guidance on how to recognise and respond to actual or suspected abuse against adults at risk. The main priorities for the update were to make the document more user friendly and to ensure that 'making safeguarding personal', hearing the voice of the adult, was a central theme throughout the whole document. The feedback received on the new document has been extremely positive.

The policy is supported by the following additional policies:

- When Adult(s) with Care and Support Needs or Care or Support Needs alone Abuse Each Other
- Multi-Agency Protocol for Dealing with Cases of Domestic Abuse to Safeguard Adults with Care and Support Needs - In accordance with the update schedule PPPWG members updated this policy in 2019/20
- Multi-Agency escalation policy for adult safeguarding - resolving practitioner differences - In accordance with the update schedule PPPWG members updated this policy in 2019/20
- Policy and Procedures to support people that self-neglect or demonstrate hoarding behaviour - In accordance with the update schedule PPPWG members updated this policy in 2019/20
- Protocols for Kent and Medway to safeguarding adults who are at risk of sexual exploitation, modern slavery and human trafficking
- Managing Concerns Around People in Position of Trust (PiPoT) (PPPWG members created this policy in July 2020)
- KMSAB Complaints and Compliments Procedure (PPPWG members developed this policy in 2019)

The quality assurance measures used to assure the dissemination and impact of these policies are set out under Priority Three.

Putting policy, training and learning from SARs into practice.
Anonymised case example.

"A fall was all it took to be found out, between five and seven years of not being able to control hoarding, waist high almost everywhere knowing I was doing it. In my mind coping with it, I must sort this out, leave it, and do it tomorrow. Oh what a relief along came X and her team. I was treated with so much respect, and kind words of support and encouragement. I admitted straight away that my life had got out of control. Five skips later and I've got my living space back. Help I needed desperately had arrived. First to give me a safe walk way then a de-clutter. I'm so grateful for X's continued support. If you have this issue/problem please seek help, I'm truly thankful to X and her team."

District Council in Kent

6. Prevent Duty across Kent and Medway

The Counter Terrorism and Security Act 2015 set out a legal duty for specified authorities, including Local Authorities and other organisations, which also have adult safeguarding responsibilities, in the exercise of their functions, to have due regard to the need to prevent people from being drawn into terrorism. The Prevent Duty Guidance for Local Authorities published in 2015 provides further guidance and sets out sector specific expectations, including; partnership working, risk assessment, Prevent action planning, and training. KCC as the upper tier authority for Kent are expected to lead and coordinate Prevent activity across the county, liaising with district local authorities as appropriate.

In April 2019 Kent and Medway received funding from the Home Office for local Prevent resources, bringing the addition of a Prevent Coordinator and Prevent Education Officer for Kent and Medway to support the KCC Prevent and Channel Strategic Manager. The team cover both KCC and Medway Unitary. Kent was also one of the original Dovetail pilot areas. The Dovetail pilot sought to test the efficacy and capability of local authorities taking responsibility for the administration and management of Prevent referrals suitable for Channel consideration and adopted Channel cases, which had previously been a police function. The Dovetail arrangements came into effect in KCC in September 2016 and have continued beyond the original 12-month pilot.

During 2019-20 Prevent training was delivered to a wide number of organisations and potentially as a result the number of Prevent referrals for those over 18 has increased from previous years.

The Kent and Medway Prevent Duty Delivery Board (PDDB) established in 2015 is the strategic partnership board that agrees levels of risk and co-ordinates Prevent activity across Kent and Medway. The PDDB connects to the KMSAB and other strategic partnership boards across Kent and Medway**.**

Some of our Partner Highlights

As part of our quality assurance framework, agencies report on how they are meeting our three strategic priorities. The next section reflects some of the good work taking place.

Case Study of collaborative working	
In March 2020, as part of the council's response to the Covid 19 crisis and the Government's "Everyone In" instruction, the Council procured accommodation within a local hotel. Officers compiled a detailed needs analysis for clients, identifying those believed to be at particular risk. One such person was X, a long-term rough sleeper who, prior to this project, had not wished to engage with services. X was known to have substance misuse issues and particular concerns were identified in relation to this. Outreach workers reached out to X, who chose to move into the recommended accommodation. As part of the move and virus prevention and control work, officers carried out a new assessment and identified significant concerns relating to self-neglect. X was found to be in need of medical attention, through working with X and involving colleagues from Health, Forward Trust (Drug & Alcohol Support Service) and Catching Lives (Voluntary Sector Organisation) a safeguarding referral was made and X was admitted to hospital. The project lead liaised with X and hospital staff to plan discharge. Progress was shared with partners through the Vulnerable Tasking Group.	
Canterbury City Council	This year front line staff have also attended additional training around County Lines, Cuckooing and Prevent and this has raised awareness of indicators of abuse, the impact on those most vulnerable and how to report and respond.
Canterbury City Council	The Council recognises that making safeguarding personal isn't purely about process and procedure but is about communication skills and practice. Skills based training for front line staff has included motivational interviewing and taking a trauma informed approach to working with vulnerable groups.
Canterbury City Council	A Vulnerability Tasking Group (VTG) is co-ordinated by the Council. This multi-agency tasking group addresses individual complex safeguarding issues which will have an impact on the wider community such as cuckooing & exploitation. As a result of meetings safeguarding referrals and action plans are co-ordinated and comprehensive. Rough Sleeper Forum is responsible for developing a joined up approach to tackling issues and informing future needs led strategies.
Dover District Council	We engage in multi-agency awareness training for example; Islamic Awareness training, Far Right Extremism Awareness training, Oasis Domestic Abuse training and Armed Forces Mental Health training.
Dover District Council	We work with minority groups to raise safeguarding awareness, for example, "controlling migration" funded project to build community cohesion.
Dartford Borough Council	We use a tiered approach to safeguarding training to ensure that all staff receive the most appropriate training that is proportionate and relevant to their roles and responsibilities. There are three categories of safeguarding training – A, B and C. These categories are based on specific roles and also on the level of contact staff have with children and adults at risk in their day-to-day job.
Dartford Borough Council	Additional training is also provided where there is a need identified. For example, in 2019, the Safeguarding Steering Group had monitored an increase in the level of concerns raised by staff regarding customers who were disclosing that they were at suicide risk. Staff were unsure of who to report their concerns to and of what action they should take to safeguard the individual from harm. Suicide Awareness Guidance was subsequently cascaded to all staff; and Suicide Prevention Training was also delivered to key members of staff.
East Kent Hospitals University Foundation Trust	In recognition of a growing number of patients who are homeless and self-neglecting, the Trust has just appointed a homeless lead Safeguarding Practitioner.
Folkestone & Hythe District Council	Two members of staff have undertaken Train the Trainer delivered by 'Stop the Traffik'. This will enable them to deliver Modern Day Slavery (MDS) Training to all staff across the council. All Designated Officers to be trained in MDS and act as a point of contact regarding any concerns once they have received training.

Gravesham Borough Council	Specific sessions delivered by external providers took place during this period, including a session on Modern Slavery delivered by Stop the Traffik, which Gravesham Borough Council hosted as a multi-agency event, inviting Police, local charities, etc.
Gravesham Borough Council	The Gravesham Vulnerability Panel (GVP) takes referrals from officers within the council, police, and partner agencies for vulnerable adults, with the following aims: • Provide an effective local response to issues related to areas of vulnerability in Gravesham; • Develop and implement multi-agency plans, specifically tailored to support and meet the needs of individuals, victims and communities affected by areas of vulnerability; • Raise awareness, amongst partner agencies and within local neighbourhoods, of the areas of vulnerability and the impact on individuals and communities; and • Carry out joint activity to develop techniques and identify interventions to deter people from being drawn into serious and organised criminality.
Kent County Council	Learning and Development provide a suite of e-learning and face to face training courses which are in-line with current legislation, guidance and reflect the themes highlighted within the Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs), such as an issue of adolescent to parent violence which had been highlighted within a review and was then incorporated within our Domestic Abuse training.
Kent County Council	The Kent and Medway Suicide Prevention Programme commissioned a range of suicide prevention training during 2019/20. The training identifies high-risk and vulnerable groups and individuals; and raises awareness and confidence about how they can be supported. 1478 individuals completed face to face suicide prevention training, and 588 completed suicide prevention e-learning. This Suicide Prevention Programme also continued to promote the 'Release the Pressure' campaign to raise awareness of the free wellbeing support available to everyone in Kent, 24 hours per day. 26,000 phone calls were received by the support-line. In addition, a new 24-hour mental wellbeing support service via text messaging was launched, as an alternative to speaking on the phone.
Kent Fire and Rescue Service	If a concern is identified at an incident or home visit, unless unsafe to do so, the concern will be discussed with the adult and see what support can be put in place to help. In addition, KFRS staff ask the customer what they would like to do moving forward to improve the situation. They build up a rapport with a customer, being open about the concern and suggesting ways to support the customer. There is a telephone line available to all staff 24 hours a day for designated safeguarding officer to triage information and offer support and guidance if concerns are identified.
Kent and Medway CCGs	The Kent and Medway CCGs introduced a new Kent and Medway CCG Community bulletin that highlights safeguarding as a regular item. This is updated on a monthly basis. Information is shared with GPs through a GP bulletin. This year, "7 minute reads" were introduced, providing briefings on key topics. These were shared across health economy, subjects covered have included domestic abuse and violence, exploitation, radicalisation and the Mental Capacity Act.
Kent and Medway NHS and Social Care Partnership (KMPT)	A 'Think Family' approach was introduced into all safeguarding training in 2019, and will continue to be embedded into training and practice in 2020/2021 to ensure that prevention, risks and resilience within the family unit are considered within care planning and assessment to ensure that KMPT clients and families have the right support and safeguards to enable safe care.
Kent Police	Officers and staff are instructed to consider the VOICE mnemonic when dealing with Children or Adults at Risk: V - Value and listen to the child or vulnerable adults' views, wishes, feelings and needs. O - Observe and record their presentation, environment, behaviour and experiences. I - Investigate what impact the incident and our actions have had. C - Check /obtain information from central referral unit / professionals / family members / carers. E - Evidence everything and ensure it is recorded / retrievable / referred.

	Compliance with this requirement is regularly checked by the newly formed Protecting Vulnerable People Governance and Scrutiny Team.
Kent Prisons (HMPPS)	We have Safer Custody, Isolator and Violence Reduction policies, all of which contribute to the identification of and structured support required for those at risk.
Kent Prisons (HMPPS)	For the wider staffing group including those not directly employed by HMPPS we provide Suicide and Self Harm (SASH) training which incorporates the identification of those who are vulnerable to exploitation from others.
Kent Prisons (HMPPS)	Mental Health Service providers are contracted to assist with Mental health provision. This provision includes intensive early days in custody supervision (at Elmley) so those residents new into the custodial system with specific mental health needs are identified and the appropriate referrals put into place at the earliest opportunity. Each resident is now allocated a Key Worker. This Key Worker is a Prison Officer who will spend 45 minutes per week speaking to the resident to identify and assist in referring on any specific needs.
Kent Surrey and Sussex Community Rehabilitation Company	A 'Focus on Practice Workshop' was delivered to practitioners in September 2019. This was led by Quality Development Officers and provided a space for staff to reflect on specific areas of practice. This session specifically had a section on learning from 'Serious Further Offence' investigations and access to adult safeguarding. It prompted questions for practitioners to ask and reflect on themselves with their cases, and guidance on what best practice is for working with service users.
Maidstone and Tunbridge Wells NHS Trust	The Trust Board has heard from patients and family members about their own patient experiences and are keen for this to continue. Not all are safeguarding issues but will have had elements of safeguarding within them.
Medway Community Healthcare	Patients receiving long term care from an Medway Community Healthcare (MCH) service have a "My Plan" in place which focusses on the patients' defined goals or in their Best Interests when assessed as lacking capacity to determine own goals.
Medway Community Healthcare	We have a Community Forum to facilitate patients and communities to input and provide opinion on new services and the review and development of services.
Medway Council	We use the '3 conversations', strength-based practice approach, which focuses on the goals and priorities of service users. The documentation to support this approach has specific areas to record the voice and experience of the adult. On our electronic recording system it is now mandatory to complete a personalised support plan before any support services can be commissioned, the exception being where a service is required in an emergency situation.
Medway Foundation Trust	Training has been developed in collaboration with the Named Nurse for Safeguarding Children and has been delivered jointly with Children's Safeguarding level 3, to embed the Think Family principles whilst meeting the level 3 criteria for both adult and children's intercollegiate (competency framework) documents. Safeguarding supervision is available to all staff and safeguarding support debriefing following incidents.
Medway Foundation Trust	During 2019 we attended regular safeguarding meetings at HMP Elmley Prison and liaised with our health colleagues at both HMP Swaleside and HMP Rochester Prison.
Sevenoaks District Council	Introduced a Safeguarding Policy and training for elected members.
Sevenoaks District Council	Our Licensing Team have undertaken training on vulnerability.
Swale Borough Council	Safeguarding Officers engage with the adults, for whom safeguarding concerns are raised to them, directly wherever possible. This may be through face to face visits or phone calls. This ensures that they fully understand the issues being faced by these individuals and responses can be tailored accordingly. An example of this is that we have a number of long running self-neglect cases that were first identified by our housing services teams. The safeguarding officers have worked directly with the vulnerable adults to seek to address their hoarding concerns in a way that is compatible with the needs of that individual. We also funded a hoarding counsellor through Mid Kent Mind that has worked with a number of individuals during 19/20.

Tonbridge and Malling Borough Council	Nominated Safeguarding Champions from across each Council service, receive Designated Officer training, which is refreshed every two years.
Tonbridge and Malling Borough Council	Certificated courses for taxi drivers take place monthly- this includes the completion of a safeguarding test.
Virgin Care	Nationally a new guidance was created in 2019- "Working with People Reluctant to Engage", this guidance is used alongside the North Kent personalised care plan (PCP) to support individuals with mental capacity to make decisions but reluctant to engaging with services, the PCP supports a person centred approach to quality care between individual and care professional, goals are reviewed to achieve positive outcome and individual's wishes are always in centre of care planning.
Virgin Care	New policy created 2019- "Colleagues Affected by Domestic Abuse"; this has been very effective in practice especially with the recent event of pandemic lockdown due to COVID-19. At the end of quarter 4, the Business Unit saw a rise in reported domestic abuse cases with colleagues who potentially use the workplace as a safe heaven. Managers and service leads used the policy as an additional document to support colleagues who are also victims of domestic abuse.

Priority Two: AWARENESS

"I know what abuse is and where to get help"

Our priority is to improve awareness of adults at risk and safeguarding within, and across, our partner agencies and communities. We will:

- improve awareness across Kent and Medway;
- improve engagement with local communities; and
- assess the effectiveness of the work we do, and review and share the learning.

What we have achieved

1. Safeguarding Adults Awareness Week 7 -11 October

To help share the message on how to recognise and report abuse and neglect and highlight the support and services available for those at risk or experiencing abuse, Board members arranged and held a safeguarding adults awareness raising campaign.

The focus of the 2019 campaign was to prevent adults at risk being abused by empowering individuals from local communities to take positive action if they felt concerned about someone's welfare. The strapline for the campaign was 'noticing is not nosiness' to reiterate the national focus that safeguarding is everyone's responsibility.

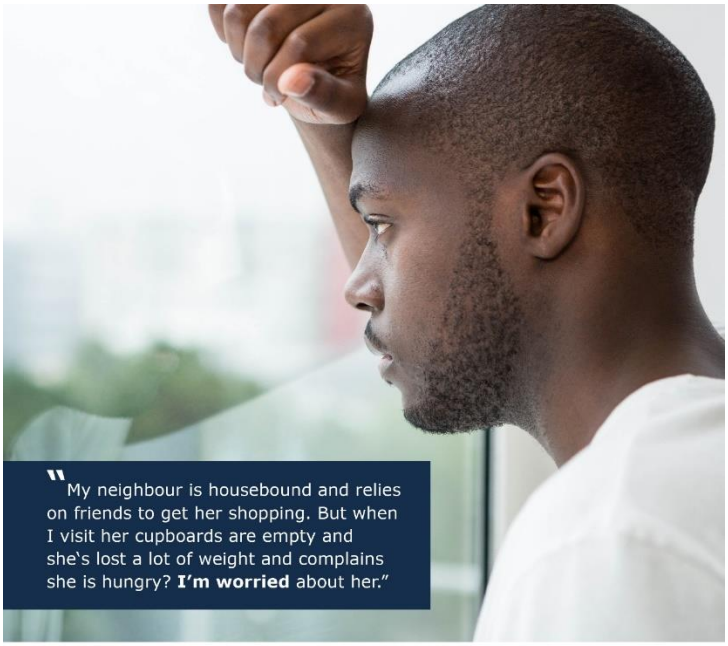
To promote the campaign and ensure people are aware of what the key indicators of abuse are, and how and when to report concerns, multi-agency partners hosted events and activities across both Kent and Medway to raise community awareness, such as dementia cafés, holding presentations, coffee mornings and home safety talks. Targeted correspondence was also sent to local businesses and community groups.

2. Development of Communication and Engagement Toolkit

To support safeguarding adult's awareness week and to enable agencies to raise awareness of adult safeguarding throughout the year, the Communications and Engagement Working Group created a Communications toolkit. This included:

- Posters –these were designed as 'conversational moments' to promote a more personal, everyday feel and to highlight that safeguarding is everyone's responsibility. The toolkit included copies which could be tailored to each organisation's specific needs.
- Social media graphics – in varying sizes, to accompany adult safeguarding related posts on each organisation's social media channels.
- Signature banners – to use in email signatures or on social media.
- Video files –short, 20 second graphics to be used on social media to catch attention.

Annual report readers please help us to raise awareness - if you would like to know more about the types of abuse or would like to receive the newsletter and/or communication toolkit to share within your networks, please email KMSAB@kent.gov.uk or visit our website -



Worried about an adult?

For more information about adult abuse
visit us: kent.gov.uk/safeguardingadultsweek

Noticing is not nosiness
#see it report it stop it

If you think someone is in imminent danger call **999** for the emergency services

Example of impact of social media campaign

A member of the public commented on a Facebook post placed by a local authority in Kent and Medway, they expressed concerns about being able to safeguard someone as they did not know their name. The media team picked up on this post, contacted the person privately and were able to establish sufficient information to provide the safeguarding team, who were then able to support the adult at risk.

3. Safeguarding Awareness Webpage

The toolkit provided links to the safeguarding awareness page on the Board's website. The website was updated to feature a sliding scale of concern for website visitors:

1. **Worried about someone** – Encourages people to speak with the individual they are worried about, if it is safe to do so.
2. **Concerned about someone's wellbeing and safety** – if people have information or strong suspicions that something is wrong, they are encouraged to contact social services and provide as much information as possible.
3. **Alarmed that someone is imminent danger** – call the emergency services.

4. Safeguarding Adults Awareness Conference

A safeguarding adults awareness conference, hosted by the Independent Chair of the Board, took place on 11 October 2019. The conference was aimed at non-partner organisations who work closely with their local communities (e.g. charities, faith organisations, sports groups, businesses). Again, the emphasis was on raising awareness about the types of abuse, channels for reporting concerns, and to encourage agencies, organisations and businesses to evaluate their internal processes to safeguard adults at risk. Those who attended the conference were provided with the communication toolkit to help them raise awareness within the groups they represent.

Speakers covered the following:

- Introduction to Adult Safeguarding and how to raise awareness;
- Adult Safeguarding and Homelessness;
- Self-Neglect and Hoarding;
- The work of the Sexual Assault Referral Centre; and
- Harmful Practices/Honour based abuse

The evaluation forms submitted, strongly indicated that conference attendees benefited from attending, with increased knowledge of the subject areas covered and through networking with others. They also expressed a commitment to take the learning back to their organisations.

Example feedback from safeguarding adults awareness week events

- "I have learnt a lot today, I did not know what cuckooing was all about but now I understand it better"
- 'I'm glad that this is happening now, I suffered domestic abuse for years and I couldn't do anything about it, but because of all these talks, I watch out and advise my grand daughters"
- "I would like to know more about what to look out for with different communities especially with a language barrier." – Harmful practices presentation.
- "very informative and thought provoking. Difficult not to make assumptions" – Harmful practices presentation.
- "Very informative and interesting presentation. Presenter very passionate and knowledgeable." – Homelessness presentation.
- "I'll invite KFRS to talk to our staff" – Self-neglect and hoarding presentation.
- "All presentations were informative and link with our clients".
- "Enjoyed the homeless and self-neglect talks. Working in Mental Health Service the Sexual Assault Referral Centre was also informative in terms of learning about a new service".

5. Communications and Engagement Working Group

The Kent and Medway Safeguarding Adults Board established a Communications and Engagement Working Group (CEWG) to coordinate the work of agencies working with service users, carers and the public, providing ways for them to influence the work of the Board and empower and enable them to contribute to safeguarding in Kent and Medway. The group is responsible for raising the profile of the work of the Board and of adult safeguarding to ensure that important messages and learning are shared and understood.

The overarching objective is to enable residents of Kent and Medway, partner agencies, and the private and voluntary sector to be able to recognise signs of adult abuse and neglect; be confident about what to do if they have concerns and be better informed about how they can help to ensure adults at risk stay safe.

The first meeting of the group was held in April 2019 when members developed terms of reference and an annual delivery plan setting out the work programme for the year. Activity undertaken by the group during 2019/20 includes:

- The Board's newsletter has been circulated monthly since May 2019, and now has a reach of over 500 members. It features safeguarding information, events, news and updates from the Board, partner agencies and key national information in relation to adult safeguarding.
- Analysis was undertaken to inform the development of the Board's communications strategy.
- Attendance at events and meetings throughout the year to raise awareness and encourage engagement.
- Establishing ways to evaluate the effectiveness of this work.
- Planning safeguarding awareness week and development of the toolkit.
- Increasing engagement with faith groups and community groups.

6. Some of our Partner Highlights

As part of our quality assurance framework, member agencies report on how they are meeting the Board's three delivery priorities. Below are some examples of the good work taking place.

Ashford Borough Council	All staff have been given small wallet/purse size cards with basic safeguarding information and useful contact numbers.
Ashford Borough Council	The authority has a Domestic Abuse co-ordinator and a weekly One-Stop-Shop based in one of our Children's Centres.
Canterbury City Council	We are proactive in raising awareness of safeguarding, and the contextual safeguarding issues that we are aware of in our District. We use our corporate social media channels to create and share multimedia content around safeguarding - For example, we have created a cuckooing awareness campaign that has been shared by other Kent Community Safety Units. It consisted of a video, social media graphic and postcard that detailed the signs of cuckooing and how to report anything suspicious. More recently, during Covid-19, we created and shared another video on domestic abuse detailing why vulnerable adults and children were at a higher risk during lockdown and to encourage neighbours and relatives to report any issues or for the victims themselves to seek refuge or advice from the police and domestic abuse helpline.
Dartford and Gravesham NHS trust	The safeguarding adults lead attends community lead meetings (Gravesham vulnerabilities forum and Dartford Vulnerabilities and organised crime meeting) This promotes sharing of concerns of individuals so that a whole person approach can be used. The trust also has a 'frequent attenders' Steering Group that is attended by external providers so that support, ideas and care planning can take place.
Dartford and Gravesham NHS trust	It is recognised that staff do not always feel confident in carrying out Mental Capacity Act (MCA) assessments. An MCA liaison nurse was employed and started in the Trust in February 2020 with the aim of improving staff skills/confidence and knowledge.
Dartford Borough Council (DBC)	Recently, the impact of COVID-19 has raised concerns that vulnerable people and people with limited contact with the outside world due to social distancing and self-isolation, may be at an increased risk of abuse. DBC has promoted national and Kent-wide campaigns, both internally through the Intranet and externally through posters and social media, in order to raise awareness of the risks of different types of abuse and the support available for victims – including for domestic abuse, radicalisation, modern slavery, and COVID-19 scams.
Dover District Council	We have a 'Keep Me Posted' Engagement Platform to be used to communicate safeguarding advice, notices and updates.

Dover District Council	Attend and engage in as many community engagement days offering advice and guidance, usually including property marking to get people talking in the first place.
East Kent Hospitals University Foundation Trust	The Trust holds annual Learning Disability and Dementia Tea parties, where families and the local community come together with the patients at the hospitals. These are supported by the People at Risk Team.
East Kent Hospitals University Foundation Trust	The Trust has the Barbara Machete award for the most proactive staff team relating to learning disability care, presented two yearly to staff at the Trust awards ceremony. The sister of the patient whose memory is honoured by the award helps select the winner.
Gravesham Borough Council	An annual conference has been held as part of a multi-agency project entitled Altogether Safer – Reducing Violence Against Women and Girls (VAWG) in North Kent. The project has been led by Gravesham Borough Council but in close collaboration with Choices (Domestic Abuse Services), Kent Equality Cohesion Council, Kent Police, Dartford Borough Council and Rethink Mental Illness. It has been funded by the Home Office VAWG Transformation Fund. The annual conference is targeted at local women and girls from a Black, Asian and Minority Ethnic background to raise awareness, help remove stigma and break down cultural barriers that may prevent victims of violence and exploitation from seeking help. The most recent conference was held in September 2019 and approximately 300 women and girls of all ages attended - approximately 95% of them being from a Black, Asian and Minority Ethnic background Presentations and discussions took place on the issue of modern slavery and human trafficking to raise awareness of these crimes and to develop an understanding of the kinds of behaviours resulting in domestic servitude and sexual and/or labour exploitation. Other potentially linked topics covered included forced marriage and honour-based violence.
Kent and Medway CCGs	Over the period of 2019-20, the team has delivered safeguarding training at practice development learning sessions to approximately 900 individual primary care colleagues. This has been supported by the recruitment of a Designated Doctor in the west of the county and the development of localised bespoke individual training sessions in surgeries, to promote a greater understanding and confidence in working with, and reporting of, safeguarding issues.
Kent and Medway NHS and Social Care Partnership	In March 2019 the KMPT Safeguarding Team formally introduced a new training package to reflect Royal College of Nursing's Adult Safeguarding: Roles and Competencies for Health Care Staff Intercollegiate Document (2018); and similarly, to the children's training. This included the re-mapping of training requirements for all health care staff to ensure role diversification was considered as part of the skills required to fully embed safeguarding activity in all areas of the

(KMPT)	Trust. Due to the introduction of the new safeguarding training in March 2019, the adult alerts made by KMPT into Local Authority adult social services increased significantly, evidencing quality and need.
Kent and Medway NHS and Social Care Partnership (KMPT)	The Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification Checklist (RIC) is a tool used to assess the immediate risk, threat, and danger a survivor is subject to. The KMPT Safeguarding Team, with support from the Learning and Development fund, supported the training and accreditation of the KMPT Domestic Abuse Lead to become a fully accredited DASH RIC trainer. DASH RIC training has been delivered to key teams and will continue to form part of the training delivery plan to ensure staff have the skills to identify high risk domestic abuse requiring referral in to the MARAC (Multi Agency Risk Assessment Conference). Domestic Abuse has been a key theme from DHRs, SARS and SCRs locally and nationally and as such KMPT are committed to increase the skills of the workforce to enable safe and timely support.
Kent and Medway NHS and Social Care Partnership (KMPT	The KMPT safeguarding team introduced the Home Office "Workshop to Raise Awareness of Prevent" (WRAP) training into all level of safeguarding training to support staff in identifying people at risk of radicalisation and Counter Terrorism. Following a zero-referral rate in 2018/2019 the introduction of this systemic and prolific quality training led to the Channel Panel and CCG commending KMPT staff due to the quality and increased referral rate. In 2019/2020 twelve clients were identified and supported via the Prevent and Channel process, a significant achievement for KMTP safeguarding.
Kent Community Health Foundation Trust (KCHFT)	In 2019/20 the KCHFT safeguarding team processed 472 referrals raised into the local safeguarding process, this is a 14% increase from 2018/19 from 414 to 472. The key categories were Neglect, followed by the category of Self-Neglect and Domestic Violence and Abuse.
Kent Community Health Foundation Trust (KCHFT)	In relation to self-neglect, consultations from staff to the safeguarding service have risen from 60 in 2016/17, to 112 in 2018/19 to 126 in 2019/20. This demonstrates an increase in staff recognising and acting upon concerns of self-neglect.
Kent County Council	Following on from the work KCC Public Protection began in 2018-19, the 'Connected Communities' project continues, it proposes a 'social prescribing plus' innovative solution to support older isolated people, or those at risk of being isolated, by improving their access to health and well-being facilities and services. The project began its development across Kent for the pilot and 'Connectors' (also known as link workers) were recruited and have started to undertake training.

Kent County Council	The Keeping Safe Delivery Group (which reports to the Kent Learning Disability Partnership Board) looks at community safety for people with learning disabilities. It works with police, transport providers and people with learning disabilities to make sure people feel safe in their communities.
Kent Integrated Care Alliance (KICA)	KICA keeps members informed of changes in Kent safeguarding by Board members attending meetings and then passing on the information to KICA members through newsletters and forums. KICA also opens its forums and website to non-members and seeks to engage with all providers in Kent
Kent Police	Kent Police also provide, free of charge, key speakers at events organised by other agencies, for example in 2019 a member of the Modern Slavery and Human Trafficking Team was involved in delivering training to over 300 GPs, organised by the NHS.
Kent Prisons (HMPPS)	Within prison establishments, self-neglect is often an indicator of undiagnosed or untreated mental health illness. When a resident displays self-neglect or poor personal hygiene they can be swiftly identified due to the intensity of staff supervision. A mental health referral is generated and action taken to address the underlying issues.
Kent Prisons (HMPPS)	In September 2019, we produced the 'Care Leavers and Care Experienced Strategy', highlighting to staff exactly who care leavers are and the importance of a coordinated and sustained effort from all parties to continue to improve service standards and everyday practices, whilst also giving an overview of the importance of significant others in a care leavers life. Monthly meetings, chaired by a senior manager, with groups consisting of no more than 15 attendees, have given care leavers a voice, they share experiences with like individuals and also ideas and suggestions for how we can continue to support them in feeling safe and moving forward.
Kent Surrey and Sussex Community Rehabilitation Company	The following 'Focus on Practice' workshops have been held this year: March/April 2019 'Domestic Abuse' - Entirely focused on child and adult safeguarding in relation to domestic abuse. What to be aware of, actions to take and reflections on practice. May/June 2019 'Professional Curiosity' - What professional curiosity is, how to use it, the importance of home visits, professional curiosity is a vital tool to safeguard others. August/Sept 2019 'Not this again!' (structured work) - Delivering structured work to facilitate behaviour change. This included the 121 domestic abuse pack and victim awareness work. Focus on behaviour change in general and harmful behaviours, in order to safeguard children and adults at risk. December 2019 – 'Should I be worried?' (identifying and assessing extreme

	behaviour) - The workshop explored different types of extreme behaviour including terrorism, hate crimes, domestic abuse, sexual abuse of children, human trafficking, cuckooing and numerous others. Looked at cases in the media across Kent Surrey and Sussex. How we identify extreme behaviour in our services users, underlying beliefs and how to work with them, to safeguard other adults and children).
Kent Surrey and Sussex Community Rehabilitation Company	KSS CRC has a well-developed and embedded Service User Council who are responsible for conducting surgeries to obtain service user feedback as part of an organisation service user engagement strategy.
Medway Foundation Trust	A wallet size card with Mental Capacity Act / Deprivation of Liberty Safeguards (DoLS) information was been produced to provide staff with prompts and safeguarding folders were distributed to all clinical areas.
National Probation Service	Kent has a dedicated Offender Personality Disorder (OPD) pathway and the service users referred and accepted on the pathway are engaged with the community through a local church group; where the group comes together in support of one another in a safe place. Other NPS Service Users are engaged with both charities, community groups and small businesses as part of unpaid work requirements and as part of licence conditions, where accessing services and community groups as part of their continued community support and rehabilitation are core to their successful reintegration into society and the communities in which they live and work.
National Probation Service	The Offender Personality Disorder pathway and in particular Intensive Intervention and Risk Management Service has a service user involvement strategy that advocates the need for co-production and co-delivery of work and training. NPS commission Windmill Training to recruit, support and develop trainers who are 'expert by experience'. We work closely with this group to deliver the OPD training programme for probation and prison staff.
Swale Borough Council	Swale BC is also a key partner in the delivery of the community safety partnership focus area project. This project seeks to identify 'focus areas' or neighbourhoods where there are higher levels of crime/antisocial behaviour, but as part of this work seek to identify vulnerable members of the community and put in place measures to support them.
Tonbridge and Malling Borough Council	The Council's "One You" health team run a number of campaigns to support mental health, including regular information stands at numerous community events, to signpost and support vulnerable members of the community The "One You" health team have undertaken Suicide Awareness training and Dementia training.

Virgin Care	District nurses, Community Therapists, Rehabilitation Assistants and Heath Care Assistants visiting housebound patients are supported by having open conversations about safeguarding and how to report abuse. Their hand-held electronic tablets have information and assessments to support immediate Mental Capacity Assessment and best interest decision checklist if needed.

Priority Three: QUALITY

"I am confident that professionals will work together and with me to achieve the best outcome for me"

Our priority is to quality assure our work, learn from experience and consequently improve practice. We will:

- ensure agencies are accountable for having competency and quality in practice;
- ask for feedback, learn from people's experiences and put learning into practice; and
- define our quality parameters and measure performance accordingly.

What we have achieved

1. <u>Continued to Implement our Quality Assurance Framework</u>

As a Board, one of our main responsibilities is to hold our partners to account. This involves gaining assurance that safeguarding arrangements are in place, that they are effective and they deliver the outcomes people want. It also involves respectfully challenging partners. During 2019/20 Quality Assurance Working Group (QAWG) members implemented the quality assurance framework, which sets out the measures and tools we use to measure effectiveness of partners' safeguarding activity.

The tools detailed in the framework include:

Annual Self-Assessment Framework (SAF)

All agencies represented on the Board are asked to complete an annual 'self-assessment framework', a series of questions to measure progress against key quality standards. The purpose is to enable them to evaluate the effectiveness of their internal safeguarding arrangements and identify and prioritise areas needing further development.

Agencies are required to assess and provide evidence to demonstrate how well their organisation is achieving each standard/requirement using the following RAG rating:

- Green (consistently meeting the standard)
- Amber (part meeting the standard)
- Red (not meeting the standard)
- Not applicable (with reasons why).

Agencies are required to complete a SAF action plan for any requirements graded red or amber, detailing how compliance will be achieved. These are monitored by the QAWG and shared at Kent and Medway Safeguarding Adults Board Business Group meetings.

The standards are informed by factors such as; learning from safeguarding adults reviews, any new legislation and guidance, policy and practice and feedback from service users and carers.

To help mitigate against different interpretation of requirements, to instil more rigor in the process and to ensure greater consistency, agency leads are required to present their completed SAF analyses and evidence to a panel of 'peer' reviewers.

Questions in the 2019 SAF included:

- **Making Safeguarding Personal -** Demonstrate how your agency involves the individual in safeguarding decision making and include details of how they are involved from the point of referral through to the investigation and conclusion.
- **Exploitation** - How does your agency identify and respond to potential exploitation of individuals in your area? This could involve gangs, county lines, modern slavery, sexual exploitation and 'Prevent'.
- **Loneliness and Isolation** - What has your agency put in place to promote the national theme of 'Isolation and Loneliness'? How are you working to decrease isolation and loneliness in your area – both individually and together with partner agencies?
- **Work of the Board and Policy** - Detail how your agency disseminates and promotes policy updates from the Board, including what form of media is used. How does your agency ensure that any changes made are understood and embedded? Who is responsible for identifying any problems with implementation? How does the agency introduce staff to the work of the Board and advise them about the website and information provided by the Board that is pertinent to their area of work?
- **Safeguarding Adult Reviews (SARs) -** How does your agency make the decision to submit a SAR? What opportunities are there for staff to discuss cases and decide whether a case meets the criteria for submission? Who makes the decision to refer? In light of the wide-ranging information contained in the published executive summaries following completion of a SAR, how does your agency ensure that 'lessons learnt' are taken on board and incorporated into the agency's policies where appropriate (regardless of whether the agency has been involved in the original SAR)?
- **Timeliness** - How does your agency monitor and seek to improve the time taken from initial referral to the resolution of safeguarding concerns raised?

Annual Agency Reports

All KMSAB partner agencies are required to complete an annual agency report to detail actions taken to improve effectiveness, identify good practice and issues for their organisation over the previous 12 months. The 2018/19 report also sought information on how agencies were delivering the three priorities of awareness, prevention and quality, as set out in the Board's strategic plan.

A total of 27 reports were submitted. These reports were presented at the quality assurance working group. Members reviewed the submissions, highlighting areas for clarification, good practice, and areas of concern to be raised to the Board.

Members were impressed with the good practice examples provided and these were included in the 2018/19 annual report. The report also identified two areas of concern which were escalated to the Board membership for discussion and resolution.

2. Monitoring of Safeguarding Adult Reviews (SAR) Action Plans

Following the completion of a Safeguarding Adults Review (SAR), agencies involved must detail the actions they will take to respond to any recommendations made for improvement. SAR Working Group members quality assure these action plans at every meeting, requesting remedial actions if required, and escalate concerns to the KMSAB Business Group. The SAR Working Group also monitors actions arising from out of area SARs that have involved KMSAB agencies.

It is important to note that the Board and its working groups do not wait until a SAR is complete to begin to make improvements identified as the review progresses. For example, current SAR referrals have identified issues with the application of making safeguarding personal and the self-neglect policy in practice, so each working group is addressing this as a matter of priority.

3. Sharing of Good Practice

Safeguarding Adult Reviews are a critical tool to help identify areas for improvements with multi-agency partnership working. It is helpful to balance the findings against examples of good practice as these can also be a powerful way of learning. Many of the quality assurance tools designed by the Board ask agencies to highlight this good practice so that it can be shared.

Example of 'professional curiosity' making a difference to an adult at risk

Kent Fire and Rescue Service was called to an incident whereby a person was in great distress. Firefighters were first on scene followed by Police. Great actions of the crews meant that they were able to talk to the individual involved and calmed the situation. The person was then detained under section136 of the Mental Health Act.

No internal safeguarding was raised for this person at the point of the incident and no details of the person were obtained by the crew. Details were picked up the following day from an incident log by a Safe and Well Supervisor who identified the need for a safeguarding case to be created and allocated to a Designated Safeguarding Officer (DSO).

The DSO contacted the Police to ascertain details and where the individual had been taken. It was ascertained that the person was at a specialist mental health provision. The DSO contacted the relevant team and was informed that they were discharging the person. The DSO challenged this and asked if they were considerations to refer to adult social services for more support but was informed that the individual had declined this and provided the DSO with contact details. Professional curiosity lead to the DSO calling the number and they spoke with the person involved, they were happy to engage and informed the DSO that they were sleeping rough with very little support in place. The DSO offered other methods of support which were accepted and appreciated. The DSO then completed a referral to local authority to request further support for this person and a referral to another specialist agency for homelessness support.

4. Evaluation of Level One and Two Safeguarding Adults Training

KMSAB partner agencies are required to deliver level one and two (foundation) adult safeguarding training which is aligned to their professional bodies' competency/capability framework, or should they not have one, the Board's competency framework. Whilst the Board does not hold responsibility for level one and two training, the Learning and Development Working Group (LDWG) does have a quality assurance function, as level one and two training should equip those attending subsequent KMSAB training with a sufficient and consistent knowledge base. In 2019/20 partner agencies completed a 'standards tool' to evaluate their level one and two training and presented their findings to the LDWG. Members found this helpful and highlighted the success of including case examples to support application of learning to practice.

5. Some of our Partner Highlights:

As part of our Quality Assurance Framework, agencies report on how they meet the Board's priorities some examples are set out below.

Ashford Borough Council	Ashford Borough Council takes an active role in internal audits. The 2019 safeguarding audit was awarded a 'sound' rating.
Canterbury City Council	The Council's Safeguarding Key Contacts Group has representatives from all services across the organisation. Learning from Safeguarding Adults Reviews, Domestic Homicide Reviews and SCRs (children's reviews) are a standing agenda item. Learning from cases is discussed and key contacts are responsible for disseminating the information throughout their service.
Dartford and Gravesham NHS trust	Due to Covid 19, patients have been unable to have visitors, which has left people feeling isolated and has had an impact on their mood and wellbeing. The Trust formed the Compassionate Care Team, offering video calls and telephone calls between patients and their relatives.
East Kent Hospitals University Foundation Trust	There are weekly 'hub' sessions at each acute hospital. A stand is taken at a 'Hub' session to promote a topic. Staff attend during their breaks, to see what issues are being raised. Safeguarding regularly has a stand at the sessions. It is a good way of interacting on a one to one basis with staff. Ward walks are another way of interacting and monitoring staff performance. Specific wards tend to be targeted if there is a particular issue to work through.
Kent and Medway CCGs	Designates also use triangulation of safeguarding data against; data from Serious Incident (SI) reporting; complaints involving safeguarding; alongside quality concerns identified from feedback via the local patient population; and the CCG System Quality Intelligence Meeting (different members of the quality team and commissioning teams) to validate provider data and identify where constructive challenge or additional monitoring, support and guidance may be required.
Kent Community Health Foundation Trust (KCHFT)	Meridian Patient Survey/Patient Feedback Survey shows percentage of patients who would recommend our services this figure is currently at 96%.
KCHFT	Safeguarding activity is captured using quality improvement tools to monitor peaks and trends of safeguarding activity, in relation to referrals and consultations, to identify emerging themes.

Kent Police	In 2019, Kent Police hosted its annual "Open Day" where the public was invited to attend an event that contained several stands from departments working with adults and risk and partners such as Dementia UK. It was attended by over 15,000 people across three days and was extremely well received.
Kent Surrey and Sussex Community Rehabilitation Company	Quality Development Officers (QDOs) have been utilised in KSS CRC to create 'space' for practitioners to develop professional curiosity and sound defensible decision-making around assessing and managing risk of harm. They also support our staff retention strategy by creating opportunities for advancement and development, and re-stimulating an enthusiasm for, and interest in, core practice
Medway Council	In January 2019, Early Help and Long Term support functions within the Adult Social Care structure were brought together under a single line of management to prevent unwanted handovers between teams, which was found to be having an adverse effect on safeguarding.
Medway Council	A safeguarding hub model was piloted in one locality from June 2019. This was a small, focused team of social workers, managed by a senior social worker and overseen by a Team Manager. The hub managed the safeguarding process from concern through enquiry to closure for all cases in that locality. It was evidenced through the pilot, in terms of performance and audit activity, that cases were appropriately responded to. An increased number of concerns were managed within the Medway timescale. There was improved decision making and timely enquiries. In February 2020 decisions were made to roll out the hub model to the other localities by April 2020
National Probation Service (NPS)	At a national level, the NPS produce a number of Practice improvement Tools (PITs) and QA Tools to promote quality in practice.
Tonbridge and Malling Borough Council	Feedback and discussions take place weekly at the Community Safety meetings, to ensure that the best support is available for vulnerable people. Work on safeguarding is regularly audited, with recommendations/actions for improvement highlighted and monitored. Loneliness and isolation - people have been supported directly by staff with telephone befriending or signposted to local agencies for longer term ongoing support.
Virgin Care	The clinical governance scorecard is another platform which is used in providing assurance within the operational services in North Kent. It includes safeguarding questions, which were reviewed by national safeguarding leads, to ensure clinical operations are constantly thinking of ways to improve their services. The scorecard is often jointly peer reviewed by Safeguarding Lead and the Quality Lead.

Section 3. Safeguarding Adults Reviews

1. Purpose of a Safeguarding Adults Review

The KMSAB is lawfully required to review what has happened in cases when an adult who needs care and support either dies, or suffers serious harm, when abuse or neglect is thought to have been a factor. This is called a Safeguarding Adults Review, or SAR for short. This is not an enquiry or investigation into how someone died or suffered injury and it does not allocate blame. It stands separately to any internal organisational investigation, or that from Police or a Coroner. The SAR scrutinises case and system findings and analyses whether lessons can be learned about how organisations worked together, or not, as the case may be, to support and protect the person.

2. Criteria for Conducting a Safeguarding Adults Review

KMSAB must arrange for there to be SAR for an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs), if:

- An adult at risk dies (including death by suicide), **and** abuse or neglect is known or suspected to be a factor in their death;
- An adult at risk has sustained any of the following:
    - A life threatening injury through abuse or neglect
    - Serious sexual abuse
    - Serious or permanent impairment of development through abuse or neglect;

Or

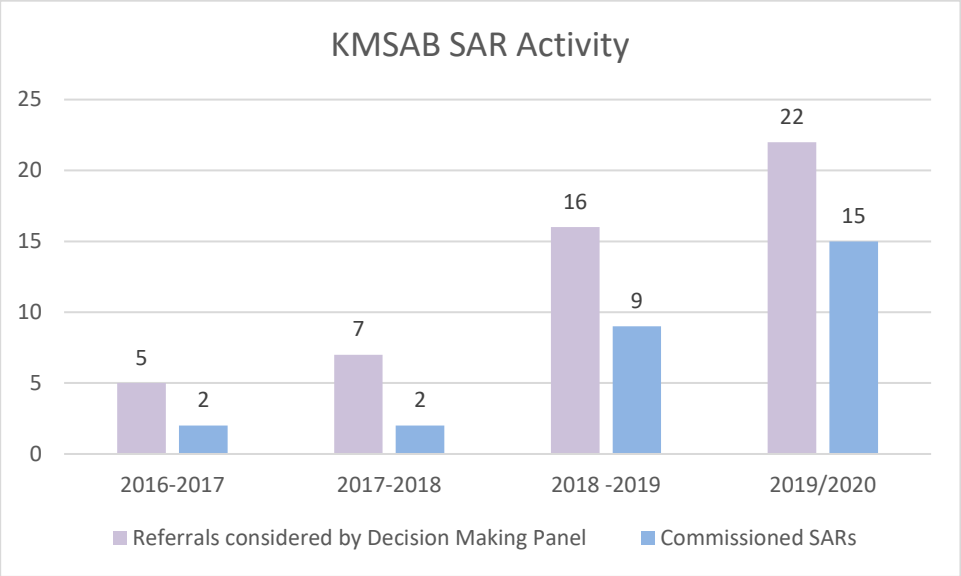
- Where there are multiple victims
- Where the abuse occurred in an institutional setting
- A culture of abuse was identified as a factor in the enquiry;

And
The case gives rise to concern about the way in which professionals and services worked together to protect and safeguard the adult(s) at risk.

KMSAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice. More information on the SAR process is available here.

3. Safeguarding Adults Review Activity

To ensure a robust and consistent process for determining whether a case referred for a Safeguarding Adults Review meets the criteria, a multiagency decision-making panel, chaired by a member of the SAR working group, is convened when a new referral is received. Each agency brings a summary of their involvement, these are considered to assess if the referral meets the criteria for a SAR or whether any other review or action is required. The recommendation of the panel is sent to the Independent Chair of the KMSAB for a final decision.



The KMSAB received 22 new SAR applications between April 2019 and March 2020, of these:

- 3 cases progressed using the case review methodology
- 12 cases progressed with traditional SAR methodology
- 7 cases did not meet the criteria and no further action for the Board was required

As highlighted above, the volume of SAR activity continued to increase during 2019-20 Whilst it is not possible to measure what led to this increase, it is hypothesised that this may in part be attributable to an increased awareness of SARs, in particular through the inclusion of a SAR measure in the Self-Assessment Framework, as detailed in the previous section of this report. This is an area that the Board is monitoring as a priority.

5. Completed Safeguarding Adults Reviews

Completed reviews are available on the KMSAB website. Since the last annual report, the following SAR has been published:

Charlotte Burton (pseudonymised name)

Charlotte Burton sadly passed away in 2018, aged 20 years. During her short life, Charlotte had been a looked after child and on reaching adulthood she led a transient lifestyle, living at addresses in various towns across Kent and Medway. She had repeated contact and involvement with numerous professionals, who worked in the organisations subject of the Review. The SAR considered information and facts, gathered from organisations that had safeguarding responsibilities to Charlotte during the period between 1 January 2015 and the date of her death.

As well as identifying some areas of good practice, the Safeguarding Adult Review established case specific and more systemic lessons to be learned for professionals, notably focused on:

- Transition from children's to adult social care and child and adolescent mental health services to adult mental health services
- Timely sharing of information
- How organisations that deliver services though locally based team manage to do this effectively and ensure continuity of services when a person moves regularly

- The use of section 136 of the Mental Health Act
- Professional curiosity
- Oversight and management of risk when multiple agencies are working with an individual.

A multi-agency action plan was developed to address the recommendations made in the report, at the time of writing 74 percent of the 43 actions identified have has been completed, members continue to monitor progress quarterly.

One of the measures used to share learning from SARs and DHRs is to circulate quick reference briefing documents on key themes identified. To accompany the publication of the Charlotte Burton review, a briefing on professional curiosity was shared, as this was both an area of good practice and area for development in the review. The briefing can be found on the KMSAB website.

In addition to the SARs commissioned by the KMSAB, Board members also met to consider and share the findings of a SAR commissioned by the Royal Borough of Greenwich Safeguarding Adults Board as some agencies represented on the KMSAB were involved in the SAR.

The SAR related to Mr C (pseudonymised name)

Mr C was born in China in 1934 and came to the UK in 1977 with his wife. He had three daughters and a son. Mr C made his living firstly as a chef and then opening his own business, he retired in 2004. Mr C first showed signs of Parkinson's and Dementia in 2012 and despite it progressing over the next few years Mr C was cared for by his family at home with no outside help. As Mr C's condition got worse the family strove to find a suitable permanent home for their father. He was becoming increasingly verbally and physically threatening, was falling repeatedly and required supervision 24 hrs a day. The family contacted numerous homes throughout the country to try and find the best home for their father until they finally found a care home, where Mr C became a resident in February 2016 until his death. In 2016 Mr C fell twice on the same day, after the second fall an ambulance was called as Mr C had become unresponsive. Sadly, he had suffered irreparable brain damage and he subsequently passed away.

The SAR established lessons to be learned in relation to the following:

- Making Safeguarding Personal – making sure that the voice of the individual is heard throughout and planning is centred around this.
- Undertaking a Mental Capacity Act assessment where appropriate, ensuring services such as advocates and interpreters are considered for support.
- Raising awareness of carers assessments and offering these where applicable.
- Effective information sharing between agencies
- Thorough risk assessments which are well documented and include actions to mitigate risks and contingency plan.

The overview report was published in August 2019. It is available on the following link:
https://www.greenwichsafeguardingadults.org.uk/wp-content/uploads/2019/08/Safeguarding-Adults-Review-3-Mr-C.pdf

Section 4. KMSAB Funding

The Kent and Medway Safeguarding Adults Board is funded by Kent County Council, Medway Council, Kent Police, Kent Fire & Rescue Service, Clinical Commissioning Groups and commissioned Health provider organisations. Each of these agencies made the following percentage contributions in 2019-20:

- Kent County Council – 40.4%
- Medway Council – 8.2%
- Kent Police – 14%
- Kent and Medway NHS – 35.8%
- Kent Fire & Rescue Service – 1.7%

The budget covers Board salaries for the Independent Chair, Safeguarding Adults Board Manager, Business Development and Engagement Officer and Senior Administration Officer posts. It also covers the administration costs for the multi-agency group meetings, Safeguarding Adults Reviews, including the commissioning of Independent Authors/Chairs, and covers the whole provision of the multi-agency training programme.

The table below sets out the budget contributions for the past three years

	2017-2018 Agreed contribution (£000's)	2018-2019 Agreed contribution (£000's)	2019-2020 Agreed contribution (£000's)
KCC	**82.0**	**105.6**	**111**
Medway Council	**16.7**	**21.6**	**22.6**
Local Health Commissioners and Providers	**72.5**	**93.6**	**98.2**
The Office of the Police and Crime Commissioner	**28.5**	**36.7**	**38.6**
Kent Fire & Rescue Service	**3.3**	**4.3**	**4.5**
Reserve	**20.0**	**0**	**9**
Total	**223.0**	**261.0**	**283.9**

In addition to the above, in 2019/20 HMPS Kent provided a one-off payment of £4,000.

Appendix 1 - Safeguarding Activity

Background to Data

The data for this report was extracted from the Kent County Council social care system (SWIFT prior to 16 October 2019, MOSAIC thereafter) and the Medway Council Adult Social Care Database Framework (Framework-I and MOSAIC from July 2020).

Data included in this report is consistent with the Department of Health statutory requirement return: NHS Digital Safeguarding Adults Collection (SAC) for 2017-18, 2018-19 and 2019-20.

The first part of the report looks at new adult safeguarding concerns, which is a sign of suspected abuse or neglect that is reported to the local authority or identified by the local authority, and new safeguarding enquiries. Safeguarding enquiries are defined as the action taken, or instigated, by the Local Authority in response to a concern that abuse or neglect may be taking place.

The second part of the report summarises the outcome of safeguarding enquiries in Kent and Medway

National comparator data has been included, it is also available on the NHS Digital website. To help interpret the data, NHS Digital has also developed an Interactive Power-BI Tool.

New Safeguarding Concerns and Enquiries

Number of Safeguarding Concerns

This section presents the number of safeguarding concerns that have been reported to each local authority. Anyone may report concerns regarding actual, alleged or suspected abuse or neglect and reports can be made by phone, e-mail or in writing. Safeguarding concerns can include all types of risk, including domestic abuse, sexual exploitation, modern slavery, and self-neglect. Each local authority will then need to engage with referrers to determine whether the concerns raised constitute the need to undertake a safeguarding enquiry.

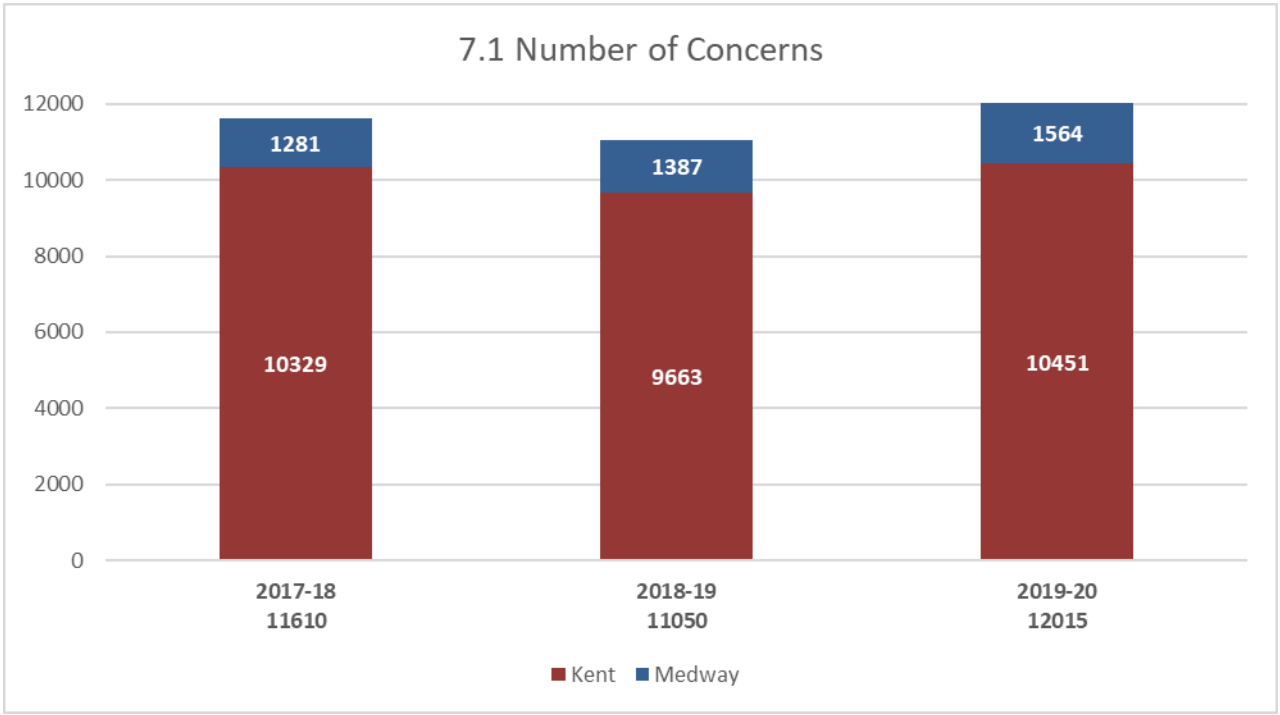


Fig 7.1: Number of Safeguarding Concerns received in Kent (red) and Medway (blue)

A total of 12,015 safeguarding concerns were raised across Kent and Medway during 2019-20, representing significant activity and an overall increase of 8.7%. Increases in the number of Concerns were observed in both Kent (up 8.2%) and Medway (up 12.8%).

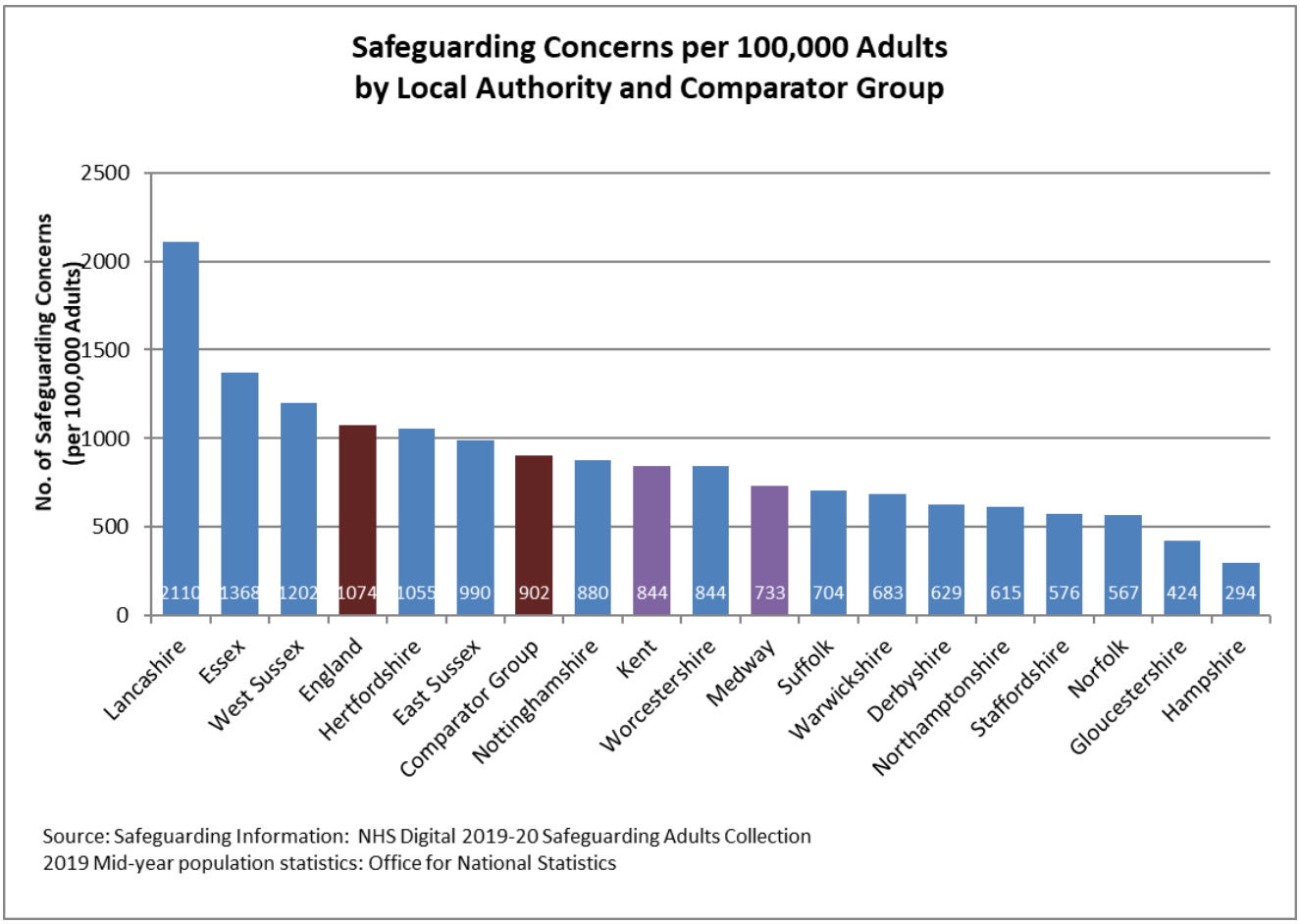


Fig 7.1a: Number of Safeguarding Concerns per 100,000 adults by Local Authority and Comparator Group (Kent and Medway are the purple columns)

Number of Safeguarding Enquiries and Rate of Change

7,373 new safeguarding enquiries were started in Kent and Medway during 2019-20, a 13% increase from the year before.

- Kent - the number of enquiries initiated during 2019-20 was up by 12% with 703 more than the year before.
- Medway - a 20.9% increase was observed in 2019-20, up 146 compared to the year before.

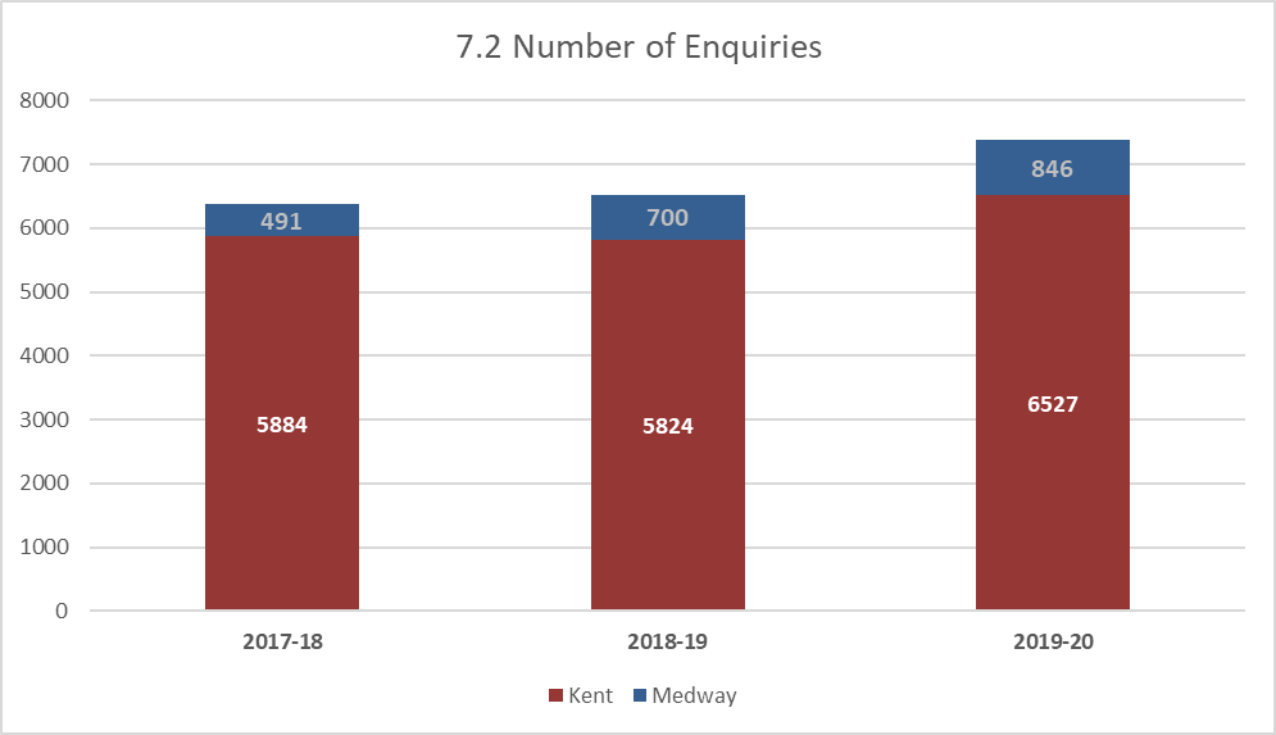


Fig 7.2: Number of enquiries 2017-18 to 2019-20

The conversion rate (i.e. the proportion of safeguarding concerns that progress to enquiries) has also increased, from 59% in 2018-19 to 61.4% in 2019-20. The conversion rate observed in Medway is 51.4% and in Kent it 62.5%.

National comparator:

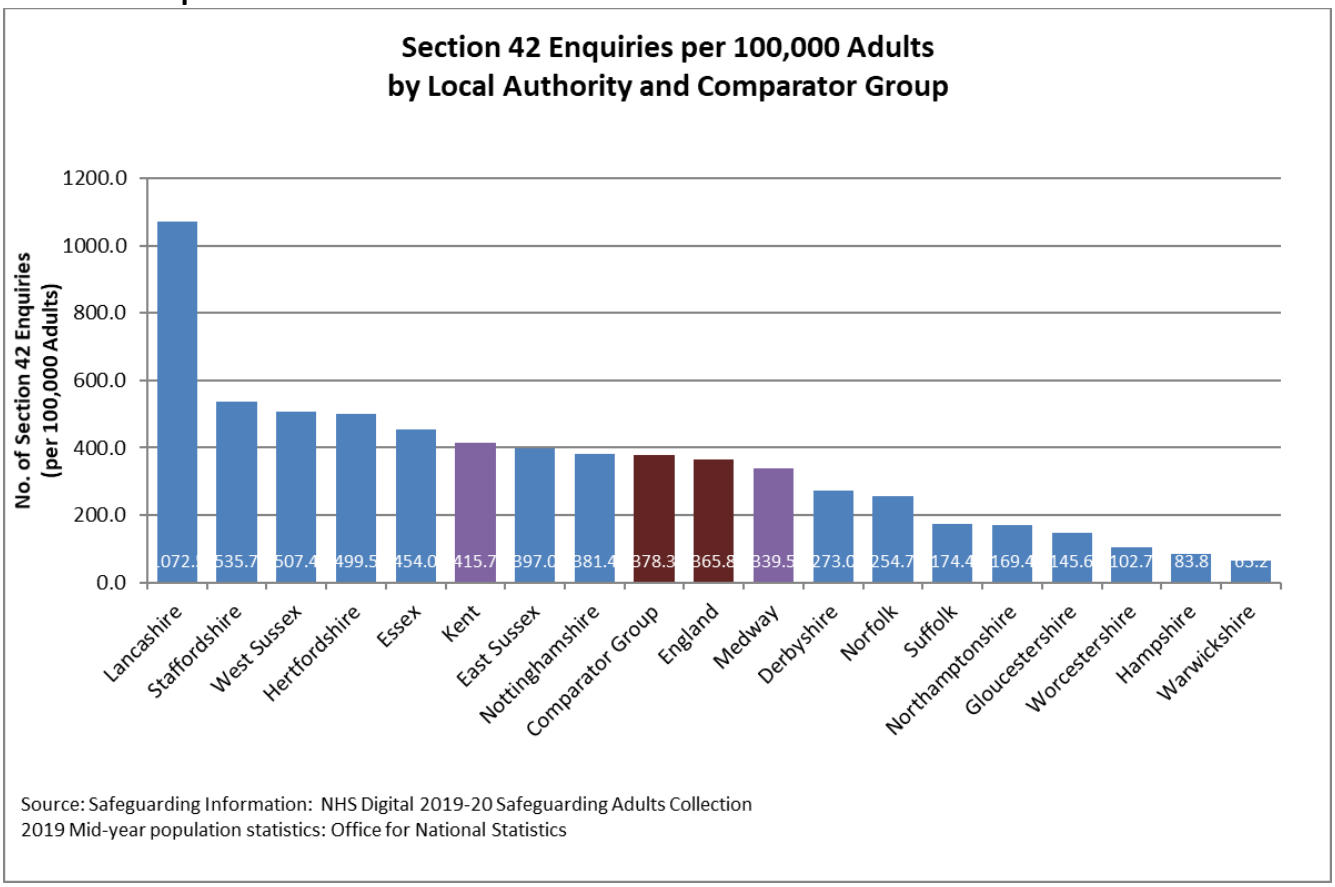


Fig 7.2a: Section 42 enquiries per 100,000 adults by Local Authority and comparator group.

Age of People at Risk of Harm

43.3% of individuals involved in safeguarding enquiries in the past year fell into the 18-64 age banding, up from 39% in 2018-19. Within this banding, the highest proportion in this age band relate to the 55-64 age group with 11.2% (666 individuals) represented here followed by the 45-54 age group at 9.2% (543), consistent with last year. The 18-24 age band accounts for 6.9% (350 individuals), reflecting a 1.6% increase; if equated with a 10-year age band this would represent 10.9% of individuals involved in a safeguarding enquiry.

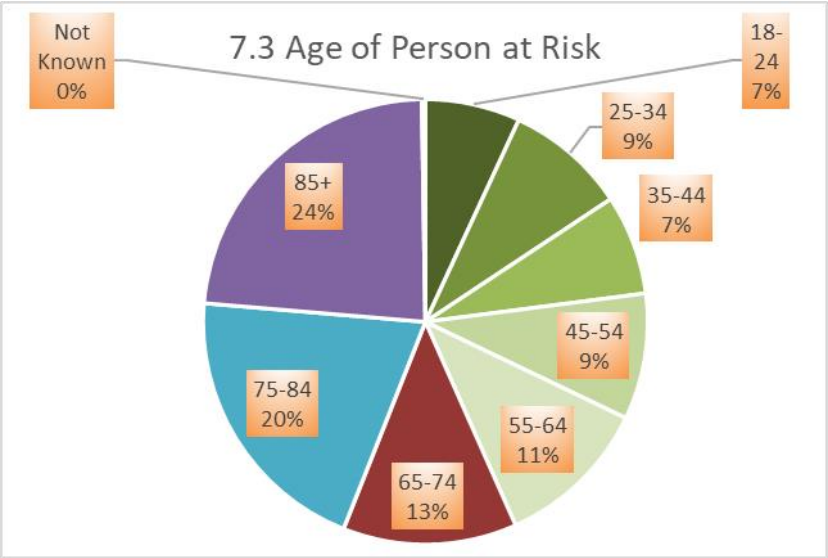


Fig 7.3: Age breakdown of people at risk of harm for 2019-20

***NB:** Caution should be taken if comparing the 18-24 age group, as this age group represents a smaller age band than all other age bands.*

The percentage of individuals aged over 65 has decreased by 4.3% compared to last year, distributed fairly evenly between the three age bandings 65-74 (12.7%, 750 individuals, down 1.2%), 75-84 (20.3%, 1,205 individuals, down 1.6%) and 85+ (23.4%, 1,387 individuals, down 1.5%). The percentage of enquiries where the age of the person at risk of harm is unknown has remained level at 0.3% for the third consecutive year.

Gender of People at Risk of Harm

In 2019-20 the highest proportion of people at risk of harm remains female, with a fractional of 0.6% observed (3,556) and corresponding rise in the male category (2,352). As with 2018-19, 0.3% of individuals had a 'not known' gender value recorded (including *indeterminate gender*).

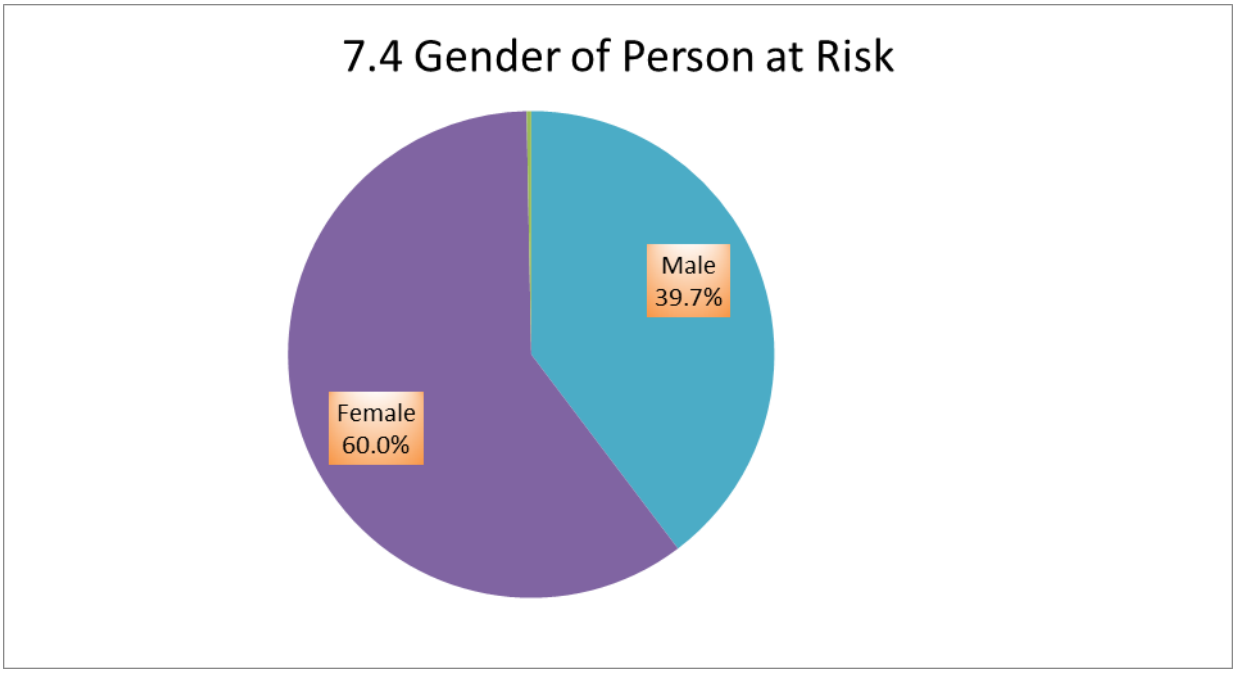


Fig 7.4 Gender of people at risk of harm 2019-20

Ethnicity of People at Risk of Harm

Of all safeguarding enquiries initiated during 2019-20, 79.8% related to people from a white ethnic background, down 0.5% from 2018-19 and the fourth consecutive drop for this group. For the fifth year running an increase has been observed in the percentage of enquiries relating to people from a black and minority ethnic background, increasing 0.5% to 4.5% (figures in the table below), however there remains a substantial cohort of enquiries where ethnicity data was unavailable. In some instances, the client may have declined to supply the information, but in most circumstances this information has not been sought and/or recorded. Efforts are being made by both authorities to promote the recording of this data, and with the introduction of MOSAIC in Kent there is an expectation that recording will improve here.

Ethnic Group	2017-18		2018-19		2019-20	
	Num	%	Num	%	Num	%
White*	5,291	83.0%	4,658	80.3%	4,729	79.8%
BME **	265	4.2%	232	4%	268	4.5%
Not obtained	819	12.8%	911	15.7%	929	15.7%
Total	**6,375**		**5,801**		**5,926**	

Table 7.5: Breakdown of Ethnic Group for the periods 2017-18 to 2019-20

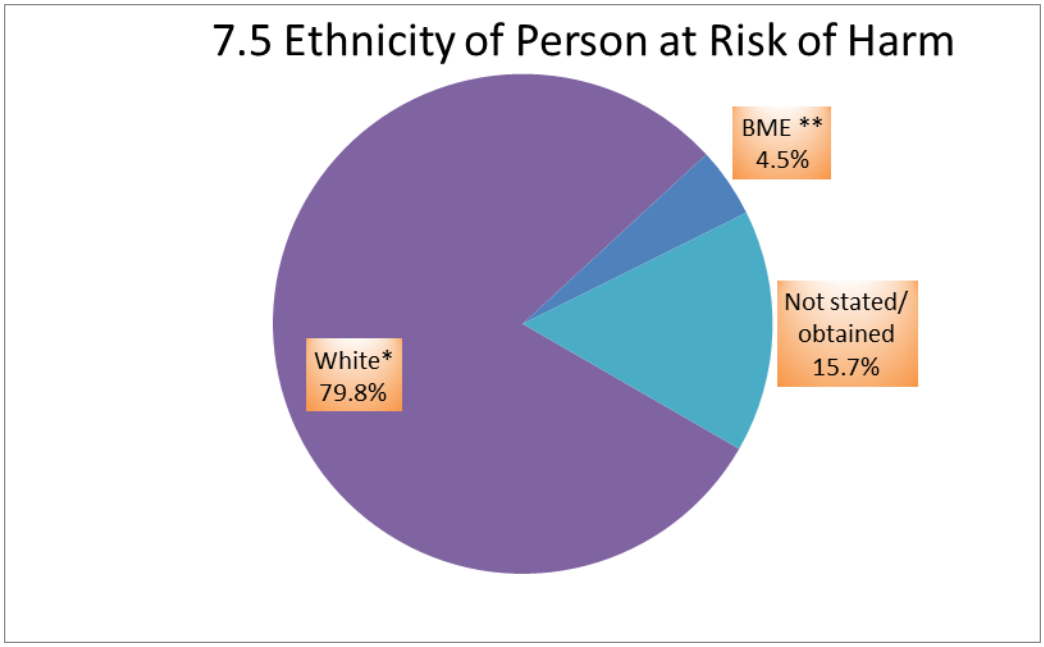


Fig 7.5: Breakdown of Ethnic Group 2019-20

** 'White' contains the DoH ethnic groups of White British, White Irish, Traveller of Irish Heritage, Gypsy/Roma, Other White Background*

*** 'BME' includes all Asian or Asian British, Black or Black British, Mixed and Other groups*

Primary Support Reason of Person at Risk of Harm

As in previous annual reports, in both Kent and Medway, the most prevalent support reason remains *Physical Support*. This is then followed by *No Support Reason* at the time of the alleged incident, with Kent and Medway reflecting 36.6% (1,895) and 43.5% (342) of cases respectively. The category '*no support reason* is likely to relate to instances where the investigating authority is not providing direct support to the person at risk of harm and information on support needs is not captured; this category does represent a notable increase for both authorities when compared to 2018-19, highlighting a need to ensure that support needs of vulnerable individuals is captured.

Primary Support Reason	Kent	Kent %	Medway	Medway %	Aggregated
Physical Support	1,716	33.2%	335	42.6%	34.4%
No Support Reason	1,895	36.6%	342	43.5%	37.5%
Learning Disability Support	460	8.9%	42	5.3%	8.4%
Mental Health Support	651	12.6%	35	4.4%	11.5%
Support with Memory & Cognition	297	5.7%	20	2.5%	5.3%
Social Support	83	1.6%	11	1.4%	1.6%
Sensory Support	69	1.3%	2	0.3%	1.2%
Total	**5,171**	**100%**	**787**	**100%**	**100%**

Table 7.6 Breakdown of Primary Support Reason (PSR) for the period 2019-20

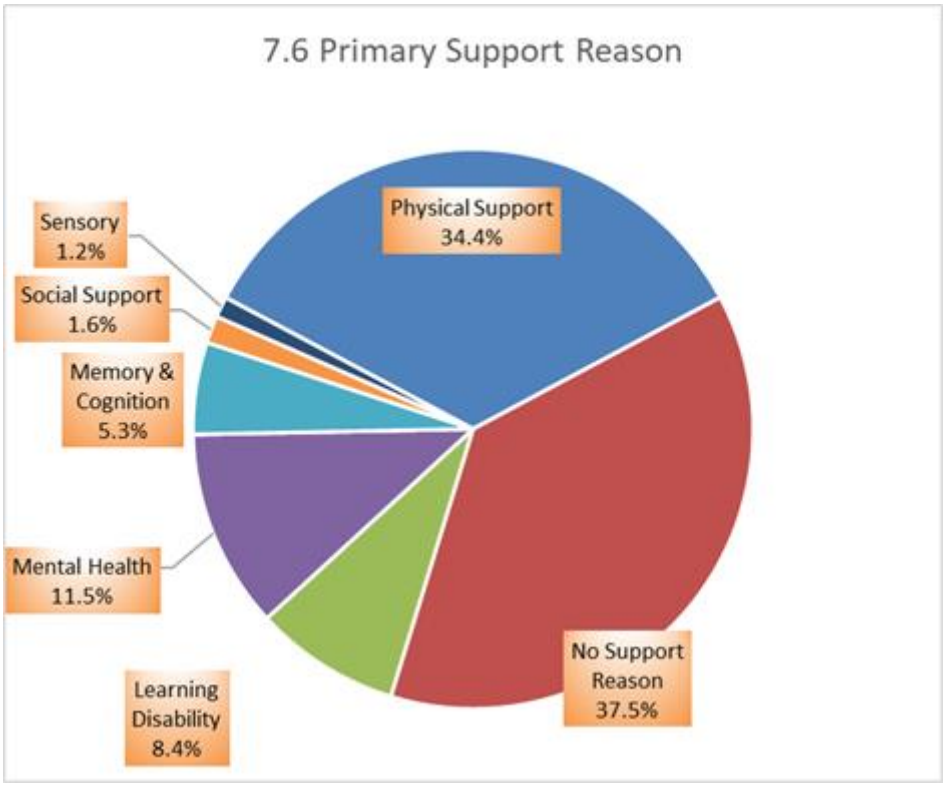


Fig 7.6 Breakdown of Primary Support Reason (PSR) for the period 2019-20 (aggregated)

Location of Alleged Abuse

Please note that the method of calculating the location of alleged abuse is based on closed enquiries in the reporting year. Therefore, the total number of enquiries will not correlate with earlier sections of the report which detail number of enquiries received within the reporting period.

In 2019-20 the most prominent location for incidents of alleged abuse remained within the alleged victim's own home, representing 40.4% of all incident locations (2,908). This represents a decrease of 3.5% percentage points compared to 2018-19. The care home setting is also a main setting of alleged incidences of abuse at 26.8% (1,925), however this has seen a sharper 4.3% percentage point decrease compared to last year.

The category *Hospital – Mental Health* has increased significantly and this is thought to be related to improved recording and reporting – the low figure reported in 2018-19 is attributable to cases being misaligned to the *Hospital – Acute* and *Other Health Setting* locations.

Location of Alleged Abuse	2017-18		2018-19		2019-20	
	Number	%	Number	%	Number	%
Own Home	**3,145**	**42.8%**	**3,424**	**43.9%**	**2,908**	**40.4%**
In the community (exc. community services)	**248**	**3.4%**	**257**	**3.3%**	**278**	**3.9%**
In a community service	**258**	**3.5%**	**261**	**3.3%**	**310**	**4.3%**
Care Home*	**2,481**	**33.8%**	**2,423**	**31.1%**	**1,925**	**26.8%**
Care Home - Nursing	615	8.4%	623	8.0%	412	5.7%
Care Home - Residential	1,866	25.4%	1,800	23.1%	1,513	21.0%
Hospital**	**655**	**8.9%**	**450**	**5.8%**	**697**	**9.7%**
Hospital - Acute	422	5.7%	384	4.9%	398	5.5%
Hospital - Mental Health	151	2.1%	4	0.1%	252	3.5%
Hospital - Community	82	1.1%	62	0.8%	47	0.7%
Other***	**554**	**8.3%**	**979**	**8.3%**	**1,076**	**15.0%**
Not Known	**-**	**-**	**-**	**-**	-	**-**

Table 7.7: Location of alleged abuse for the periods 2017-18 to 2019-20

The following conventions apply to table 7.7 above:

- Care home location is broken down into residential and nursing settings
- Hospital settings are broken down by acute, mental health hospital and community hospital locations
- The location of public place has been recoded under the setting of "*In the community (excluding community services)*".

National comparator:

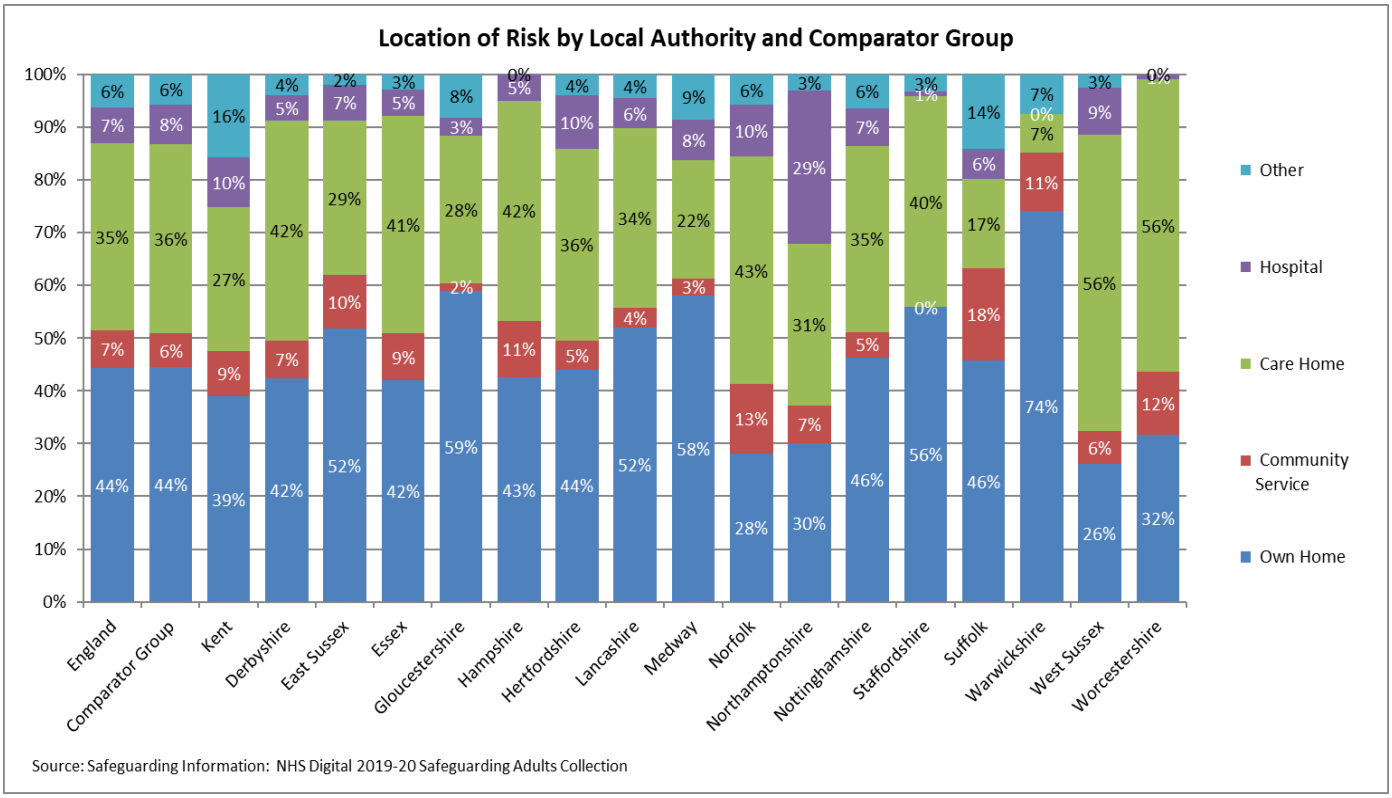


Fig 7.7a Location of risk by Local Authority and comparator Group

Category of Alleged Abuse

Based on concluded safeguarding enquiries, the most predominant type of risk has remained *physical abuse* over the past five reporting years, however this has been proportionally decreasing since 2015-16 (40.8%) culminating in a further 3.1% fall in 2019-20 to 31%, almost 10% lower than five years ago. This is primarily driven by enquiries in Kent.

Neglect and acts of omission has remained the second most prevalent type of risk but has also decreased in comparison to last year, falling 3.4%. *Neglect and acts of omission* has consistently been the most predominant type of risk in enquiries conducted by Medway and was reflected in a third (227) of all concluded Medway enquiries during 2019-20.

There has been a notable increase in the recording of domestic abuse, more than doubling as a proportion of safeguarding enquiries. This is likely to be attributable in part to increased awareness among staff of domestic abuse as a safeguarding issue, and to the improved recording of the embedded forms within the new MOSAIC system, meaning that this domestic abuse recording is more prominent, and recording has improved as a result. Increases in domestic abuse recording have been observed particularly in older people with physical disabilities (OPPD) and levels of recording here are comparable to mental health, where domestic abuse recording levels have been consistently good.

Categories of alleged abuse	2017-18		2018-19		2019-20	
	Number	%	Number	%	Number	%
Physical Abuse	2,687	36.6%	2,661	34.1%	2,230	31.0%
Neglect and Acts of Omission	2,040	27.8%	2,092	26.8%	1,688	23.5%
Psychological Abuse	1,383	18.8%	1,470	18.9%	1,430	19.9%
Financial or Material Abuse	1,151	15.7%	1,407	18.1%	1,162	16.2%
Sexual Abuse	366	5.0%	397	5.1%	324	4.5%
Organisational Abuse	155	2.1%	187	2.4%	225	3.1%
Domestic Abuse	238	3.2%	244	3.1%	523	7.3%
Self-Neglect	683	9.3%	700	9.0%	393	5.5%
Discriminatory Abuse	81	1.1%	67	0.9%	55	0.8%
Sexual Exploitation	63	0.9%	54	0.7%	77	1.1%
Modern Slavery	16	0.2%	11	0.1%	10	0.1%

Table 7.8: Category of alleged abuse for the periods 2017-18 to 2019-20

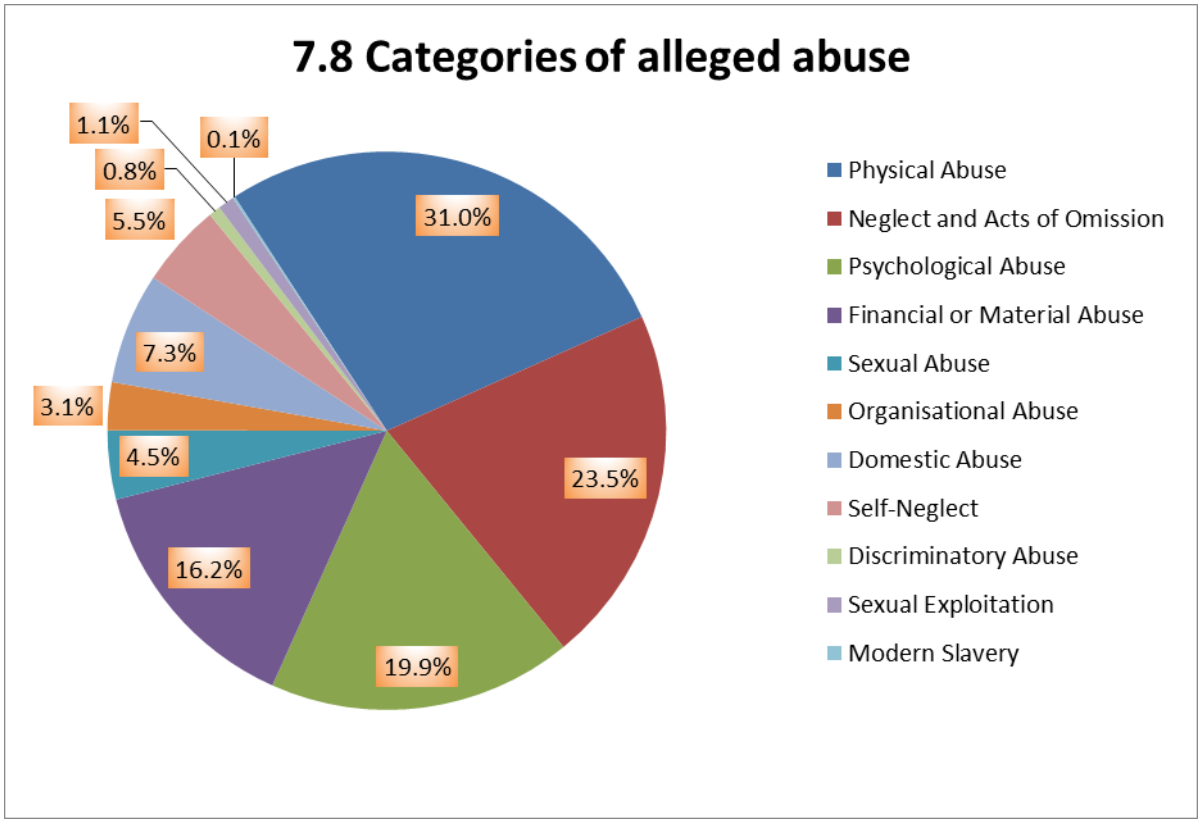


Fig 7.8: Category of alleged abuse, 2019-20

***NB:** An enquiry may have multiple categories of alleged abuse recorded; as the percentage figures relate to the proportion of all concluded Safeguarding Enquiries, columns may therefore sum to more than 100%*

National comparator:

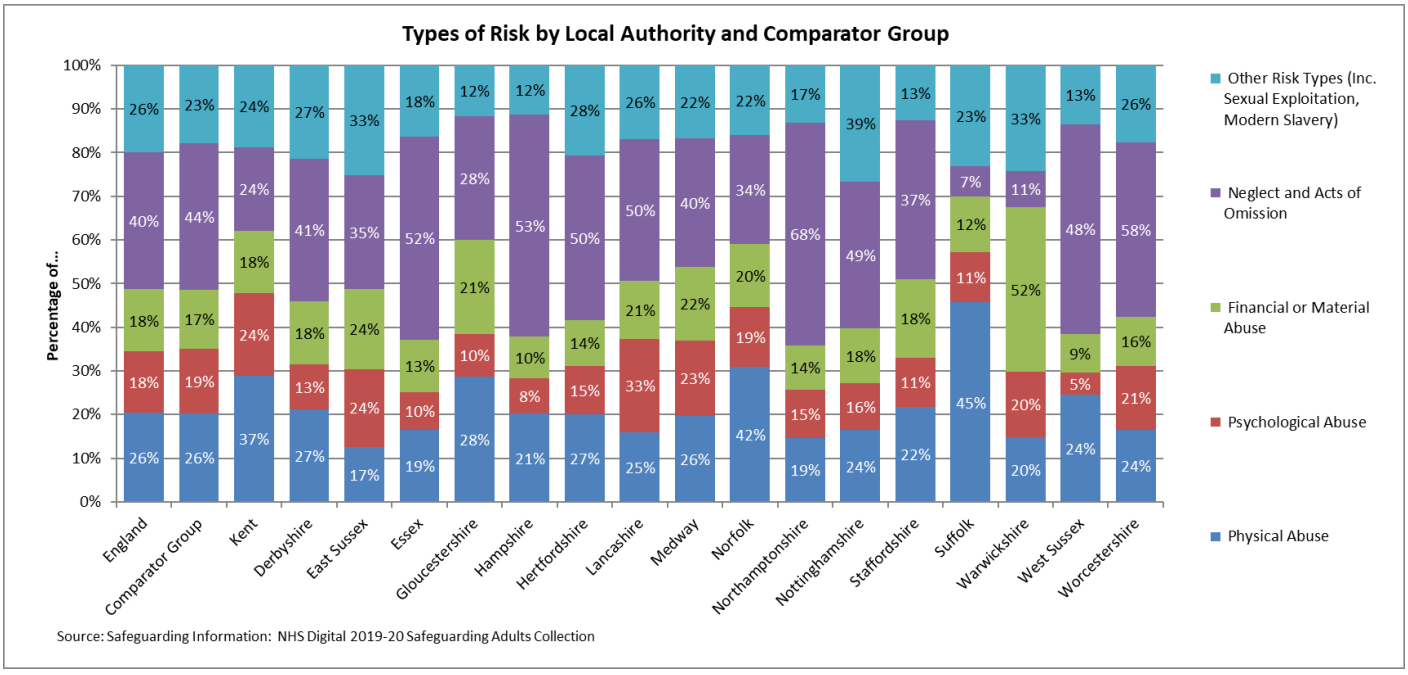


Fig 7.8a: Category of alleged abuse, by Local Authority and Comparator Group

Source of Safeguarding Concern Leading to Safeguarding Enquiry

Table 7.9 below shows the comparison of the sources of safeguarding concerns leading to safeguarding enquiries over the past four years. Most concerns leading to enquiries continue to come from social care staff, consistent with previous annual reports; however, there has been a further 4.4% percentage point decrease from 2017-18 in the reporting. Health staff form the next group where a majority of referrals come from, though this also sees a proportional decrease from 2017-18.

Both Kent and Medway have safeguarding information available on their local authority websites and marketing materials accessible to members of the public. Safeguarding adults awareness week is key to increasing safeguarding awareness amongst members of the public.

Source of Safeguarding Concern leading to Enquiry	2017-18		2018-19		2019-20		2018-19 to 2019-20
	No.	%	No.	%	No.	%	% point change
Social Care staff	2,680	42.0%	2,456	37.6%	2,720	38.9%	1.3%
Health Staff	1,892	29.7%	1,735	26.6%	1,755	25.1%	-1.5%
Other	879	13.8%	951	14.6%	591	8.5%	-6.1%
Police	301	4.7%	377	5.8%	254	3.6%	-2.1%
Family member	131	2.1%	174	2.7%	443	6.3%	3.7%
Care Quality Commission	119	1.9%	85	1.3%	75	1.1%	-0.2%
Self-Referral	17	0.3%	29	0.4%	31	0.4%	0.0%
Housing	162	2.5%	190	2.9%	141	2.0%	-0.9%
Friend/Neighbour	20	0.3%	39	0.6%	65	0.9%	0.3%
Education/Training/ Workplace	11	0.2%	13	0.2%	11	0.2%	0.0%
Other Service User	5 or less	<1%	5 or less	<1%	10	0.1%	0.1%
Unknown	163	2.6%	473	7.3%	888	12.7%	5.5%
Total	**6375**	**100%**	**6,524**	**100%**	**6,984**	**100%**	-

Table 7.9 Source of Safeguarding Concern leading to Enquiry - for the periods 2017-18to 2019-20

Closed Referrals

Risk Outcomes for Closed Enquiries

This section looks at where a risk was identified and what happened to the risk following action being taken. Action can include anything that has been done as a result of the safeguarding concern or enquiry, for example, disciplinary action for the source of risk or increased monitoring of the individual at risk.

Area	Risk Remained		Risk Reduced		Risk Removed	
	No.	%	No.	%	No.	%
Kent	93	2.9%	2,756	86.1%	351	11.0%
Last Year:	*149*	*4.2%*	*2,969*	*83.8%*	*426*	*12.0%*
Medway	78	11.4%	315	46.1%	291	42.5%
Last Year:	*49*	*17.1%*	*157*	*54.7%*	*81*	*28.2%*
Total	**171**	**4.4%**	**3,071**	**79.1%**	**642**	**16.5%**
Last Year:	*198*	*5.2%*	*3,126*	*81.6%*	*507*	*13.2%*

Table 7.10: Risk Outcomes for closed Safeguarding Enquiries 2019-20
Note: Only presents information for cases where a risk was identified.

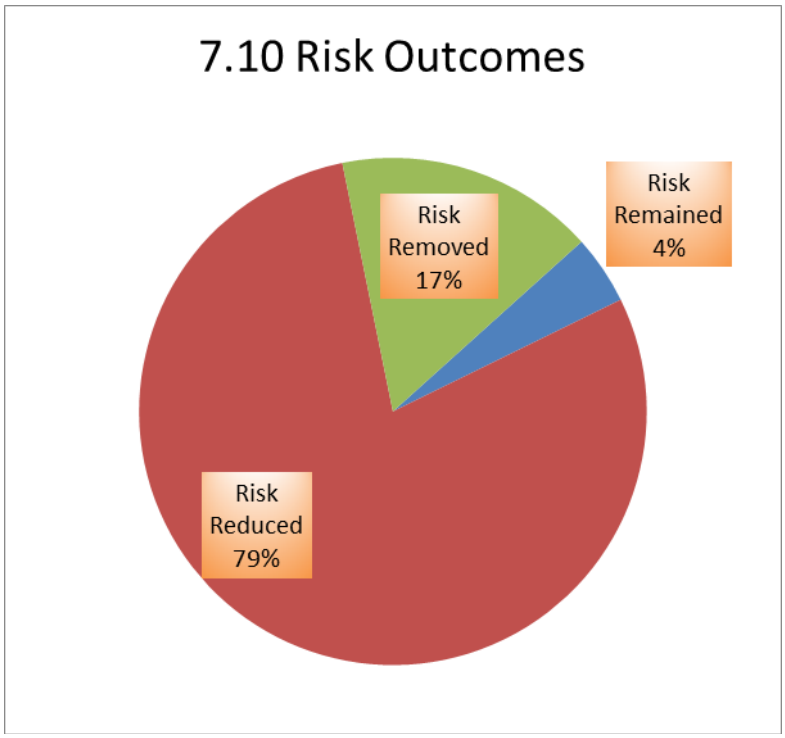


Fig 7.10: Risk Outcomes for closed Safeguarding Enquiries 2019-20

Overall, in 4.4% of concluded enquiries the circumstances causing the risk were unchanged and the same degree of risk remained, a fall of 0.8% from last year. In Kent this represented 2.9% of concluded enquiries (93) and in Medway this risk outcome represents 11.4%. It should be acknowledged that there are circumstances that a risk could remain; for example, in the case of an individual wanting to maintain contact with a family member who was the source of the risk (in such an example action could still be taken to refer a person to an alternative provision, such as counselling, should they wish it).

Glossary

Abuse Includes physical, sexual, emotional, psychological, financial, material, neglect and acts of omission, self-neglect, modern slavery, sexual exploitation, discriminatory and institutional abuse.

Advocacy Is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

CEWG Communication and Engagement Working Group**.** This Working Group of the Board has responsibility for raising awareness of the Board and adult safeguarding issues, both within organisations and with the residents of Kent and Medway to incite change, encourage engagement, improve practice and prevent abuse.

DHR A Domestic Homicide Review is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —

(a) a person to whom they were related or with whom they were or had been in an intimate personal relationship, or

(b) a member of the same household as them,

held with a view to identifying the lessons to be learnt from the death.

Intercollegiate document. Adult Safeguarding Adult Safeguarding: Roles and Competencies for Health Care Staff. This intercollegiate document has been designed to guide professionals and the teams they work with to identify the competencies they need in order to support individuals to receive personalised and culturally sensitive safeguarding. It sets out minimum training requirements along with education and training principles.

LDWG Learning and Development Working Group. This Group is responsible for the co-ordination, commissioning, delivery and evaluation of the KMSAB multi-agency safeguarding adults training programme.

LeDeR Learning Disabilities Mortality Review Programme aims to improve the standard and quality of care for people with learning disabilities by reviewing premature deaths.

MSP Making Safeguarding Personal (MSP) is about professionals working with adults at risk to ensure that they are making a difference to their lives. Considering, with them, what matters to them so that the interventions are personal and meaningful. It should empower, engage and inform individuals so that they can prevent and resolve abuse and neglect in their own lives and build their personal resilience. It must enhance their involvement, choice and control as well as improving quality of life, wellbeing and safety. It is not "just another process", it underpins all interactions and involvement with the adult at risk.

MCA Statutory Principles of the Mental Capacity Act (MCA) 2005 are underpinned by five key points which are explained in the MCA Code of Practice:

- a presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;

- the right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;
- that individuals must retain the right to make what might be seen as eccentric or unwise decisions;
- best interests - anything done for or on behalf of people without capacity must be in their best interests; and
- least restrictive intervention - anything done for or on behalf of people without capacity should be an option that is less restrictive of their basic - as long as it is still in their best interests.

MSAEG Medway Safeguarding Adults Executive Group brings together senior representatives from the key agencies responsible for the effective delivery of Adult Safeguarding in Medway. The MSAEG works collaboratively to deliver the strategic priorities of the Kent and Medway Safeguarding Adults Board, strengthening local delivery, oversight and governance.

MSP The Making Safeguarding Personal programme has been running since 2010. It emphasises that safeguarding adults should be person centred and outcomes focused and advocates a move away from being 'process' driven.

Policy KMSAB policy documents deal with legal responsibilities that everyone has under the Care Act 2014 and other associated legislation with regards to safeguarding adults at risk.

PPPWG Practice, Policy and Procedures Working Group. This Group reviews and updates the multi-agency safeguarding adults Policy, Protocols and Guidance for Kent and Medway, and associated documents.

Practice The actual application or use of an idea or method, as opposed to the theories relating to it.

Procedure An established or official way of doing something via a series of actions conducted in a certain order or manner.

Protocol KMSAB protocol documents detail how organisations and people work together to achieve the best outcomes for safeguarding adults at risk.

Professional **Curiosity** is the capacity to consider, explore and understand what is happening within a scenario, with a person or within a family unit rather than making assumptions or accepting things at face value.

QAWG Quality Assurance Working Group. This Group co-ordinates quality assurance activity and evaluates the effectiveness of the work of all KMSAB's partner agencies, to safeguard and promote the welfare of adults at risk of abuse or neglect.

SAAW Safeguarding Adults Awareness Week. An annual event where the Board and partner agencies seek to promote awareness of types of abuse, how to seek help and report abuse within Kent and Medway.

SAF Self-Assessment Framework. An annual set of questions posed to agencies by the Board to measure progress against key quality standards.

Safeguarding Concern is a sign of suspected abuse or neglect, that is reported to the local authority or identified by the local authority.

Safeguarding Enquiry is defined as the action taken, or instigated, by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry is triggered when the safeguarding threshold is met, which is when someone who has care and support needs, is being or suspected of being abused or neglected, and cannot protect themselves due to those care and support needs.

SAR The criteria for a Safeguarding Adults Review is detailed in section 3. Safeguarding Adults Reviews look at any lessons to be learnt about the way all local professionals and agencies worked together.

SARWG Safeguarding Adults Review Working Group. This Group ensures that KMSAB carries out its statutory responsibilities in respect of Safeguarding Adults Reviews and other learning reviews, such as case audits, and monitors action plans resulting from these reviews.

SCR Children's Serious Case Review takes place when a child has died or sustained serious abuse, and investigates the involvement of organisations and professionals to determine any lessons to be learnt. Following the enactment of the Children and Social Work Act 2017, Serious Case Reviews (SCRs) were replaced by Local Learning Inquiries (LLIs) and National Serious Case Inquiries (NSCIs).

Substantiated Where evidence has been provided to support or prove the truth of an allegation.

3 Conversations Approach Model of practice used in Medway Adult Social Care
Conversation 1, Listen and Connect, (Initial Response & Prevention)
Conversation 2, Work intensively with people in crisis, (Early Help & Prevention)
Conversation 3, Build a good life for people needing long term care.