Appendix A

Kent and Medway Safeguarding Adults Board

Annual Report

April 2022 – March 2023

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

About us

The Kent and Medway Safeguarding Adults Board (KMSAB) is 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, who have a responsibility for adult safeguarding, coordinate 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 three core duties

The Care Act 2014 requires that the Board:

- Develop and publish a Strategic Plan to set out our priorities and how these will be achieved.
- Undertake Safeguarding Adults Reviews, where the criteria is met, to establish what happened and what we can learn.
- Produce an Annual Report to detail how we achieved the priorities set out in our Strategic Plan.

Our responsibilities

In addition to our core duties, our other responsibilities include:

- Identifying the role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of adults.
- Assuring safeguarding practice continuously improves, to bring about better outcomes for those experiencing, or at risk of, abuse, ensuring that we make safeguarding person centred and outcome focused.
- Promoting multi-agency training, considering any specialist training that may be required, and identifying mechanisms for monitoring and reviewing the implementation and impact of training.
- Holding partners to account to gain assurance that effective safeguarding arrangements are in place.
- Producing multi-agency policies, procedures and strategies for protecting adults and monitoring their impact.
- Working collaboratively, and with effective governance, to promote wellbeing and prevent abuse and neglect.
- Establishing ways to analyse and interrogate data on safeguarding notifications to increase our understanding of prevalence of abuse and neglect.

- Identifying circumstances that give grounds for concern and deciding when they should be considered as an enquiry to the local authority.
- Developing strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect.
- Formulating guidance about the arrangements for managing adult safeguarding, and dealing with complaints, grievances and professional and administrative malpractice in relation to safeguarding adults.
- Evidencing how KMSAB members have challenged one another and held other boards to account.
- Balancing the requirements of confidentiality with the consideration that, to protect adults, it may be necessary to share information on a 'need-to-know basis'.
- Determining arrangements for peer review and self-audit.

Board membership

Independent Chair:	Andrew Rabey
Statutory Partners:	Kent County Council Medway Council Kent and Medway Integrated Care System Kent Police
Other partner agencies:	Advocacy People Dartford and Gravesham NHS Trust Department of Work and Pensions 12 District and Borough Councils across Kent East Kent Hospitals University NHS Foundation Trust HM Prison Service Kent and Medway NHS and Social Care Partnership Trust Kent and Medway Healthwatch Kent Community Health NHS Foundation Trust Kent Fire & Rescue Service Kent Integrated Care Alliance Maidstone and Tunbridge Wells NHS Trust Medway Community Healthcare Medway NHS Foundation Trust Probation Service NHS England Rapport Housing and Care (now Town and Country Housing) South East Coast Ambulance Service NHS Foundation Trust HCRG Care Group (formerly Virgin Health 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 groups for people with lived experience.

Board structure

Kent and Medway Safeguarding Adults Board – **Executive Group**
Delivers the responsibilities as set out on page 3 and 4.

Kent and Medway Safeguarding Adults Board – **Business Group**
Responsibilities: • Hold the Working Groups to account for the delivery of the strategic 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 work plans. • Receive update reports from other 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.

Kent and Medway Safeguarding Adults Board – **Working Groups (WG)**	
Communications and Engagement (CEWG)	Develops and updates the Board's communication strategy, for partner organisations to implement. The purpose is to raise awareness of the work of the Board, and wider adult safeguarding issues, both within organisations and with the residents of Kent and Medway, to incite change, improve practice and prevent abuse.
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)	Develops, reviews, and updates the Board's policies and procedures, in line with changes in legislation, guidance and good practice identified through safeguarding adult reviews, research, audit, practice, performance monitoring and feedback from practitioners or those with lived experience.
Quality Assurance (QAWG)	Designs and co-ordinates quality assurance activity to evaluate 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.
Joint Exploitation (JEG)	This is a joint group with Kent's 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 and to protect and safeguard the welfare of children and adults at risk.
Safeguarding Adults Review (SARWG)	Delivers the Board's statutory responsibility to conduct Safeguarding Adults Reviews and holds agencies to account for improvement in practice.

The terms of reference and membership for each group are reviewed annually, and 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 reduce duplication.

Our Board is supported by the KMSAB Business Unit

Section 2 – 2022 -2025 Strategic Plan

Development of the strategic plan

In accordance with the Care Act 2014, Safeguarding Adults Board's must produce a Strategic Plan which sets out how the Board and partner agencies will prevent adults with care and support needs from the risk of abuse, or neglect and support and promote their wellbeing.

During 2022 Members of the Kent and Medway Safeguarding Adults Board drafted the Strategic Plan 2022 - 2025, having used evidence and intelligence to identify the key priorities. The Board then sought to consult on the Strategic Plan to ensure that it fulfilled the statutory duty, met the needs and expectations of Kent and Medway residents, and promoted a partnership approach to the delivery of the Plan.

Public Consultation

Prior to the consultation starting, the Board's communication and engagement working group was consulted, and the Board Business Unit worked closely with the KCC consultation team, to identify and develop appropriate tools to support the consultation.

The key stakeholders identified were:
All residents of Kent and Medway, in particular:

- people with a lived experience of adult safeguarding
- Carers groups and organisations
- Voluntary and community sector
- Faith groups
- Groups supporting people with physical and mental health disabilities.
- Board partner agencies

The following tools were developed to support the consultation:

Resource	Detail
Strategic Plan 2022 – 2025 Consultation document	The KMSAB Strategic Plan for 2022 – 2025 and supporting documentation were made available online and as a Word document.

Easy read KMSAB Strategic Plan 2022 – 2025	An easy read version of the plan and supporting questionnaire were developed by a specialist organisation, this included testing of the document by user groups.
Large print	All consultation material was made available in large print versions.
Social media content plan and graphics	A social media content plan and assisting graphics were developed to raise awareness of the consultation on agencies' social media channels.
Guided discussion document	The guided discussion tool was developed for partner organisations to use in meetings, public engagement events, advisory groups and user forums, to facilitate a discussion and gather feedback on the Strategic Plan. Board members were asked to add the KMSAB strategic plan to the agenda of relevant meetings taking place during the consultation period and utilise the tool to collate feedback.
Posters	Posters promoting the consultation were designed for partner organisations to print and display in public facing spaces, in accordance with their agencies' policies on this, such as infection control.
Introductory video by the Independent Chair of the KMSAB	The Independent Chair of the Board, Andy Rabey, produced a brief video message to introduce the Strategic Plan and encourage people to complete the consultation questionnaire.

The consultation was live for a period of eight weeks, taking place between 26 April to 20 June 2022. All consultation material was shared with partner agencies for onward dissemination. Regular reminders were circulated by email as well as at Board and working group meetings. Additionally, details of the consultation were included in the Board's newsletter, which has a distribution list of approximately 350 individuals. The newsletter is also further disseminated by those receiving it. Other promotional activity included:

- An invite to engage with the consultation was sent to individuals registered with the engagement platform, who expressed an interest in Adult Social Care, Community Safety, Public Health and Wellbeing and General interest (6,309 individuals)
- A press release
- A promotional banner on kent.gov and Let's talk Kent homepage.

It was identified that the subject matter could be difficult and emotionally triggering for some people to talk about and that some individuals may not be able to access documents online. To help counter this, partner agencies were asked to identify and facilitate discussions with individuals/groups that they work with, and/or their staff groups. A guided discussion document was developed to support these conversations and to provide consistency.

There were 973 total visits to the consultation webpage with 747 of these being unique visitors to the webpage. There were 409 document downloads from the consultation webpage in total. The table below highlights the number of downloads of each resource from Let's talk Kent.

Table 1. Downloads of each resource

Engagement Tool	Visitors	Downloads/views
Strategic Plan Document	260	364
Consultation Questionnaire - Word version	15	21
Equality Impact Assessment	9	9
Equality Impact Assessment Supporting information	6	8
KMSAB draft Strategic Plan - Easy Read	3	3
Equality Impact Assessment Supporting information - Large Print	2	4
Andy Rabey introducing the KMSAB Strategic Plan Consultation	48	48
Total	343	457

A total of 67 consultation responses were received. In addition, four completed guided discussion documents were submitted, with a total number of 60 individuals consulted by this method. Bringing the total number of respondents to 127. The full consultation report is available on this link. For comparison, the consultation on the 2019-2021 Strategic plan elicited 28 responses.

The Final KMSAB Strategic Plan 2022 – 2025

The final strategic plan, and easy read version are available here. The plan includes:

The operating environment

This section sets out the national and local context which influences and impacts on the work of the Kent and Medway Safeguarding Adults Board and its partner agencies. These include, legal, regulatory, policy and financial factors.

Our vision

The agreed vision is to "Protect and prevent adults with care and support needs from the risk of abuse, or neglect; supporting and promoting their wellbeing, with all partners working together effectively, ensuring that the safeguarding system is always improving through learning".

The Board at a glance.

This section sets out the Board arrangements, including the purpose, membership and working groups.

Approach to partnership working

This section sets out the 'three lines of defence model' which the Board works to. It places an emphasis on the organisational operational management responsibilities, as distinct from the strategic multi-agency safeguarding accountabilities.

- **Tier 1 – Operational** – The operational delivery of safeguarding activity sits with each organisation, as the 1st tier. That is, the expectation that each organisation will meet the various requirements placed on them by relevant laws, regulations, guidance, and professional standards connected with the exercise of their own responsibilities and accountabilities, alongside their own assurance arrangements.

- **Tier 2 – Board/System** - The effectiveness of the overall safeguarding system in protecting adults at risk of abuse or neglect, is the collective responsibility of all partners through the Board, informed by the principle of collaborative working.

- **Tier 3 – Independent Assurance** –scrutiny from relevant independent regulatory or statutory bodies (such as the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services' (HMICFRS), Office for Standard in Education (OFSTED), Healthwatch, NHS England NHS Improvement).

Top three priorities

1. Promoting Person Centred Safeguarding – putting adults at the centre of our work
2. Strengthening system assurance – checking that organisations are working well together to support adults
3. Embedding improvements and shaping future practice – helping the organisations we work with to keep getting better

Objectives

The strategic plan lists 14 objectives which detail how the Board plans to deliver the three priorities between 2022-2025.

Promoting Person Centred Safeguarding	1. Raise awareness of adult safeguarding to ensure that people understand what abuse is, how to recognise the signs and how to seek help. 2. Enable residents of Kent and Medway to voice their opinions on the work of the Board. 3. Ensure the voice of the person (or their representative) who has been involved with our safeguarding system is heard in respect of their safeguarding experience. 4. Seek assurance that each partner agency's workforce demonstrates 'professional curiosity and has processes in place to allow them to reflect on their practice and receive appropriate supervision.
Strengthening system assurance	5. Establish a mechanism to identify system issues and risks to provide assurance to Kent and Medway residents that effective safeguarding arrangements are in place. 6. Improving public understanding of the roles and responsibilities of partners.

	7. Improving interagency understanding of the roles and responsibilities of other partner organisations. 8. Agencies discharging their respective responsibilities to safeguard people. 9. Ensure effective Board to Board/Partnership arrangements. 10. Ensure an effective functioning Board with appropriate support structures.
Embedding improvements and shaping future practice	11. The voice of the person is listened to, and there is evidence their wishes are respected. 12. Learn from experience and have a workforce that is knowledgeable and confident in the application of their safeguarding adults roles and responsibilities. 13. Develop the right balance between support and challenge, aimed at system improvement. 14. Partners will be able to contribute to safeguarding at regional and national level.

Included in the strategic plan is a list of the actions that will be taken, over the coming years, to meet the objectives and key indicators of success and impact.

The final section sets out the Board's communication and engagement principles.

Section 3. Priorities and Achievements

This section details how we delivered against our new strategic priorities for 2022 – 2023. It is recognised that activity can cut across more than one priority.

Promote Person Centred Safeguarding – What we achieved:

National Safeguarding Adults Awareness Week	• Kent and Medway Safeguarding Adults Board members supported National Safeguarding Adults' Awareness Week, established by the Ann Craft Trust. The purpose of the week was to share messages with the public on how to recognise and report abuse and neglect, and to highlight the support and services available for those at risk or experiencing abuse.
	• The safeguarding issues highlighted through the week were:
	  ○ Exploitation and county lines
	  ○ Self-neglect
	  ○ Creating safer organisational cultures
	  ○ Elder abuse
	  ○ Domestic abuse in a 'tech-society'
	  ○ Safeguarding in everyday life
	More information on these themes is available here.
	
	• To support agencies in promoting the week, the Board's communication and engagement working group developed a social media package and a toolkit of awareness raising materials.
	• KMSAB partner agencies participated in the week by sharing the social media messaging and hosting events within their agencies.
	• The Kent Community Safety team hosted an online seminar exploring the theme of harmful practices and cultural competency, over 160 people attended with 96% of respondents rating it as excellent, very good or good.
	• Public facing events included attendance at coffee mornings, one stop shops, community centres and information stands at supermarkets and shopping centres.
	• There were 3524 visits to the KMSAB webpages during the week, with 1147 clicks to the "worried about and adult?' pages for the public. This included 191 views to the 'report abuse' page and 956 visits to the 'useful resources for the public' page. 896 views were received on Tuesday 22 November, the theme of this day was 'self-neglect'. This was the highest number of views per day, of the week.

KMSAB Open Session on Predatory Marriage	• As part of Safeguarding Adults Awareness Week, the KMSAB hosted an open session on Predatory Marriage, led by Daphne Franks, who has lived experience of the issue. Attendance included representatives from the Kent and Medway registrar services. • Feedback included: *"I just wanted to say how interesting and thought provoking the event for Predatory Marriage was yesterday evening. The work that Daphne Franks has undertaken is inspirational and I would like to promote further within KCC to continue to raise awareness*." "Just a quick email to say thanks to you and the Board for the event last night

	regarding “Predatory Marriage”. The lived experience of Daphne and her family was heart-breaking to hear, and I am glad to know that the law has moved on a little in the last 10 years and the knowledge around complex capacity questions is spoken about more often. I will be looking to produce a small information precis of the event for internal circulation.” • Following the event, the Board shared a 7 minute briefing on the subject, and added the information to the newsletter, to support agencies in disseminating the message. • The Manager of the KCC Registrar service advised that Daphne’s presentation has been shared with the Kent registrars and is now embedded within their training.
Response to Homes for Ukraine Scheme	• We commissioned a translation of our ‘Adult abuse and what to do about it’ leaflet into Ukrainian. This was completed and made available on the KMSAB website in April 2022. In addition, hard copies of the leaflet were printed so that these could be shared at events and with agencies who requested them. Activity to promote the leaflet was listed in the KMSAB Annual report for 2021/2022. • Additionally, the leaflet was used and adapted by other Boards and partnerships such as Oldham SAB and Shropshire Safeguarding Community Partnership. • The Communication and Engagement working group developed a social media content plan to share messaging, in Ukrainian, on how to recognise and report abuse. An example post:  • The KMSAB Business Unit attended an information event, hosted by the charity 'Medway Help for Ukrainians', where the Ukrainian KMSAB leaflet was shared to provide information on how to recognise and report abuse to Ukrainian nationals and their hosts.

Translated leaflets	• The KMSAB is committed to having its information leaflet, on how to recognise and respond to abuse, available in all the languages which are most commonly spoken in Kent and Medway. • During 2022-2023, agencies were consulted and advised that the following languages were required: ○ Dari, Pashto, Lithuanian, Arabic, Tamil, Albanian and Kurdish • Translations were commissioned and the leaflets were shared with partners, made available on the KMSAB website and promoted through the newsletter and at events. • The leaflet is currently available in English, Easy Read, British Sign Language Accessible and 26 other languages.

Engagement with local communities	• During 2022/2023, a brief article, titled "*Are you concerned about an adult*?", continued to be included in every edition of *Medway Matters*, a community magazine delivered to 120,000 homes across Medway.
	• Members of KMSAB and the Business Unit hosted a stand at the Kent Police Open Day on 3 July, where 10,000 members of the public were in attendance. The aim was to speak to members of the public, share safeguarding resources and raise awareness of how to recognise and respond to adult safeguarding concerns. Approximately 1000 people visited the stand and engaged with the facilitators. Highlights of the website data, following the event, include:
	  ○ 241% increase in views to the KMSAB website during July
	  ○ All pages received an increase in visits
	  ○ 175% increase in visits to the 'useful resources for the public page' (435 from 158)
	  ○ Report abuse for public saw 249**%** increase for the rest of July (412 from 118)
	• As part of their work, the Independent Chair of the Board, Board Manager and the Board's Business Development and Engagement Officer, continued to hold introductory sessions with charities, voluntary sector and other community leads. This also includes meetings with advocacy leads, faith leaders, homeless services, the prison service and organisations representing people with lived experience.
	• The Independent Chair of the Board volunteers as a member of the diocese safeguarding advisory panel, their role is to support and advise the diocese of Rochester on safeguarding for their congregation and wider membership.
	• Safety in Action Day - The Medway Task Force held a Safety in Action Day on Sunday 24th July at the Chatham Dockyard in Medway. The event was aimed at members of the public to share the work that agencies are doing to protect the community. The Kent Fraud Protect and Prevent team attended a stall to share advice on how to protect themselves from fraud, along with information on how to recognise the signs of abuse and how to report concerns.
	• Members of the KMSAB Communications and Engagement Working Group and the Business Unit occupied a stand at the Ashford College Freshers Fayre, to speak to young adults about the signs of abuse and how they can report it. During this time, information was shared with trainee nurses, social workers and people from Ukraine who are now living in Kent

Meetings with Healthwatch	• In addition to attending Board meetings, Healthwatch leads met with the Independent Chair of the Board and the Board Manager regularly throughout the year. These meetings provide the opportunity for Healthwatch to provide insights into information that they have received on key areas of safeguarding. • It was agreed that Healthwatch would analyse feedback in relation to specific themes identified in SARs, and emerging issues. The first thematic analysis was in relation to people's experiences of NHS hospital discharge from 1 December 2021 to 30 November 2022.
Promotion of Communication and Engagement Toolkit	• To support Safeguarding Adults Awareness Week, and to enable agencies to raise awareness of adult safeguarding throughout the year, the Communications and Engagement Working Group continued to update and promote their Communications toolkit. This included posters, social media graphics, signature banners and video files (short graphics used on social media to catch attention). The toolkit was added to the KMSAB website to enable all agencies and stakeholders to access the content.
Support for Carers Week	• As support for carers and carers stress was identified as a theme in Safeguarding Adults Reviews and Domestic Homicide Reviews, the Communication and Engagement Working Group produced materials to support the 'national carers week' campaign. These were shared by KMSAB partner agencies. Following the campaign, there was an increase in visits to the KMSAB webpages: Carers Week 2022 (6-12 June 2022) ○ The 'support for young carers' page saw a 109% increase from May-June ○ The 'support for carers' page saw a 54% increase from May – June ○ The 'useful links and resources for carers' page saw a decrease of 70% in views from May-June but a 55% increase from June to July. ○ Although there was a decrease to the 'useful links and resources for carers' page from May-June, there was a 2206% increase to the Carers Week 2022 information during the same time frame, with a total of 1314 views.
Consultation on the Board's Strategic Plan	• As detailed in section 2 of this report, the KMSAB ran a 6 week consultation, seeking feedback on the Board's Strategic Plan to ensure that it fulfilled the statutory duty, met the needs and expectations of Kent and Medway residents, and promoted a partnership approach to the delivery of the Plan.
Family Involvement in Safeguarding Adults Reviews	• The KMSAB is committed to involving individuals, their representatives, family members and friends when undertaking safeguarding adults reviews, to gain an understanding of their experiences and views of safeguarding. At each terms of reference meeting, SAR panel members will determine who should be contacted to be involved in the review, how to facilitate this contact, and what support may be required to enable them to contribute. It is only in exceptional circumstances, for example, where there are no next of kin details, where no contact is attempted. Of the SARs published

	since the last annual report, detailed in section 4, 50% included the views of the individual or those close to them. It is important to recognise that whilst every effort is made to approach the subject sensitively and supportively, some individuals indicate that they do not want to be involved, and their wishes are respected. • The SAR information leaflet for individuals, families, friends and carers, which details the review process, was updated during 2022, to incorporate different SAR methodologies.
Tricky friends Animation	• The KMSAB adapted Norfolk's Tricky Friends animation which was designed to help people to understand what good friendships are, when they might be harmful, and what action they can take if they have concerns. The animation is also available in British sign Language.
Advocacy People – development of a citizens panel	• The Advocacy People launched a campaign to find people with lived experience of adult safeguarding, to share their stories, and contribute to creating a new approach to safeguarding. The aim of the project was to draw on individual's experiences and use this to inform the work of the Board. Unfortunately, despite much promotion, no individuals offered to take part in the panel. Subsequently, the KMSAB members agreed to continue to make use of existing forums to seek the views of people with lived experience of safeguarding.
Culturally Competent Practice	• Members of the KMSAB raised awareness of culturally competent practice. This was supported by the training provider, who ensured that this was reflected in training modules. • The update of the KMSAB's main policy document included a new section on culturally competent practice, which referenced supporting resources.
Small Concertina Awareness Raising Leaflets	• Practitioners advised that they would benefit from a credit card sized concertina leaflet setting out how to respond to adult safeguarding concerns, which they could share with members of the public. The communications and engagement working group members agreed the content for the leaflet. The Board business unit sought funding, from the KCC Community Safety Unit, for the design and printing of 2000 copies.

Strengthen System Assurance

What we achieved:

Quality assurance framework	• During 2022-2023, Quality Assurance Working Group (QAWG) members continued to implement the quality assurance framework, which sets out the methods and tools used to measure effectiveness of partners' safeguarding activity.

Self-Assessment Framework	• One of the quality assurance tools is the 'self-assessment framework' (SAF). All agencies represented on the Board are asked to complete an annual SAF, 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. • To allow agencies time to undertake any improvement activity to meet any standards rated red or amber, it was agreed that the 'full SAF', which was last issued in 2021, would be completed every two years. A shorter, thematic SAF would be completed in the intervening years, with a focus on measuring the impact of learning from safeguarding adult reviews and other priorities identified by the Board. • The 2022 thematic SAF focused on the following priority standards: ○ **Legal literacy** ▪ The agency/organisation ensures that staff are aware of their legal responsibilities and powers to safeguard adults. ▪ Relevant staff working with adults at risk are aware of the legal powers of intervention (as referenced in the KMSAB self-neglect policy) and how and when to apply them. This includes Inherent Jurisdiction. ▪ Consent is sought from the individual (where it is safe to do so) before a referral is made to adult safeguarding. Decisions on consent are well documented. ▪ Relevant staff working with adults at risk are aware of the Mental Capacity Act and how and when to apply it. Decision making is recorded appropriately. ▪ Decision making in relation to adult safeguarding is clearly recorded, justified and proportionate. ○ **Self-Neglect** ▪ The agency / organisation raises awareness of the 'Kent and Medway Multi Agency Policy and Procedures to Support People that Self-Neglect or Demonstrate Hoarding Behaviour', to relevant staff. ▪ Employees/Staff /Volunteers within the agency/ organisation are implementing the 'Kent and Medway Multi Agency Policy and Procedures to Support People that Self-Neglect or Demonstrate Hoarding Behaviour' appropriately, effectively and in a timely manner. ▪ The organisation provides clear information to those at risk of self-neglect and/or hoarding regarding the support that can be provided. ▪ The communication needs of individuals are taken into account when engaging with them. ○ **Person centred Practice** ▪ Making Safeguarding Personal is understood and applied within safeguarding practice. The individual or

	their advocate is involved throughout. If this has not been possible, the reasons are clearly documented. ▪ The 'think family' approach is applied when working with individuals. Think Family is an approach to help practitioners consider the parent, the child and the family as a whole when assessing the needs of individuals and when planning care packages and or/support. ○ **Embedding learning from safeguarding adults reviews** ▪ Learning from relevant reviews is shared with staff and there is a mechanism in place to measure the impact of this on practice/increase in knowledge. ▪ For agencies involved in hospital discharge arrangements. Discharge pathways (including discharge to assess) ensure the safe transition between inpatient hospital settings and community or care home settings for adults with social care needs. Due consideration is given to adult safeguarding within this. There are means of assessing whether the plan is being delivered or whether a review is required. ▪ Staff are aware of the legal basis for sharing information and are confident in applying this to safeguarding adults. • To support the launch of the SAF, the Board manager hosted a briefing session for agencies. The session covered how to complete the SAF, the rationale for the standards, and provided an opportunity for questions and peer support. • Agencies were required to assess how well their organisation was achieving each standard/requirement, using a red, amber, green (RAG) rating. They were also required to provide supporting evidence and complete an action plan for any requirements graded red or amber, detailing how compliance would be achieved. Outstanding actions were monitored by the QAWG, with regular reporting to the Business Group. • To help mitigate against different interpretation of requirements, to instil more rigor in the process and to ensure greater consistency, agency leads were required to present their completed SAF analyses and evidence to a panel of 'peer' reviewers. • Of the 406 standards (29[1] agencies x 14 standards) initial returns indicated a 76% achievement rating (green), with 23% rated amber and 1% red. Following the peer-review, there was a 73% achievement rating (green), with 27% rated amber and .2% rated red. • The difference between agency's gradings and peer review ratings can mostly be attributed to; differing thresholds, the peer review panel requiring more evidence, or agencies considering a standard was not applicable, which the panel felt was applicable.

[1] Although 30 agencies were asked to complete the SAF, one submission was delayed and therefore is not included in these figures.

	• By June 2023[2] there was an 87% completion rate, with 13% (54) requirements remaining amber. Members of the QAWG will continue to receive updates until the standards are met. If the standards are not met after 18 months, the Independent Chair of the Board will escalate with the relevant agency leads.
Roles and responsibilities	• A referral is the gateway into a service that a professional or the individual has identified that they need. A referral without the right information can result in time wasted, health and/or social care needs deterioration, reactive escalation and most importantly the right support not being offered. In response to learning from SAR referrals and reviews, members of the Safeguarding Adults Review Working Group developed a guide for practitioners, setting out what makes a good referral and the key points that need to be considered when completing a referral for a service. • The KMSAB partnered with the training provider, DCC-I, to create an introductory e-learning module. The module provided a basic introduction to topics such as the Care Act 2014, safeguarding principles, the well-being principle, and the Mental Capacity Act. The training was publicised and made available on the KMSAB website. • The KMSAB promoted and raised awareness of the "Safeguarding Adults, roles and responsibilities in health and care services" guide. The guide was created by the Directors of Adult Social Services (ADASS), the Local Government Association, NHS England, the Care Quality Commission and the Association of Chief Police Officers. The document provides clarity on the roles and responsibilities of the key agencies involved in adult safeguarding. The aim is to ensure that the right things are done by the right people at the right time, by working within their own agency and with partners. • The need for robust record keeping, to evidence defensible decision making, is a feature of many safeguarding adults reviews, without this it can be hard for those involved in the review to evidence what actions were taken and the rationale for these. The KMSAB continued to raise awareness of the significance of good record keeping, including sharing this document produced by the social care institute of excellence. As detailed in the section above, defensible decision making formed part of the 2022 SAF, to measure how agencies were embedding this learning. • During 2022, Kent County Council ended their consultation process for adult safeguarding, which offered partner agencies the opportunity to discuss safeguarding concerns and issues with the local authority to assist them in making the decision on whether to submit a safeguarding concern form. Instead, agencies were encouraged to consult with their safeguarding leads, as was the established process in Medway. To support the change, the KMSAB promoted the national guidance on "Understanding what constitutes a safeguarding concern". The aims of this framework are to support a whole range of sectors and organisations in making appropriate referrals of concerns to adult social care, by promoting a consistent and shared understanding of what constitutes a safeguarding adults concern. Legal literacy was measured in the 2022 SAF.

[2] All 30 agencies had completed their SAF by this time.

	• Analysis of the 2021 self-assessment framework responses identified that not all agencies were clear on the different types of statutory advocacy services available to support individuals across Kent and Medway. In response to this, the Advocacy People developed a flowchart setting out the process for statutory advocacy for Independent Mental Capacity Advocates (IMCA), Independent Care Act Advocates (ICAA) and Independent Mental Health Advocates (IMHA). An open session was also arranged by the Board business unit, offering an introduction to the advocacy offer and the opportunity to ask questions. Subsequently, there was an increase in the number of agencies that were able to demonstrate that they had achieved a green rating for this standard.

Agency Audits	• As part of the Board's Quality Assurance Framework, agencies are asked to present relevant audit activity and findings to the quality assurance working group, to provide assurance and inform future KMSAB activity. During 2022-2023 the following audits were presented:
	  ○ Medway Community Healthcare – Mental Capacity Assessment Audit
	  ○ Medway Foundation Trust –LeDeR audit

Joint SARs and DHRs	• Within Kent and Medway, the responsibility for undertaking Domestic Homicide reviews, where the criteria is met, sits with the community safety partnership (CSP). Where it is expected that a referral may meet the criteria for both a SAR and a DHR, the KMSAB business unit and the CSP team liaise closely with each other. If the criteria is met for both reviews then a joint SAR/DHR is commissioned. To date, 3 joint reviews have been commissioned, of these, the Board led two reviews and the CSP led one. • The commissioning of joint reviews is not only cost effective, but also facilitates stronger partnership working and understanding. • Where a safeguarding adults review involves an individual who was known to children's services, then the children's partnerships (Kent or Medway) in addition to the respective agencies, will be invited to contribute to the review. This allows for a holistic, person centred review and for learning to be shared across the partnerships in a timely way.
Legal basis for sharing information	• To support agencies in delivering their statutory duties, and to address findings from safeguarding adults reviews, the KMSAB produced and promoted a short guide on "the legal basis for sharing information". This was an extract of guidance developed by London ADASS. • To ensure that this information was embedded, the 2022 self-assessment framework included the following standard, "Staff are aware of the legal basis for sharing information and are confident in applying this to safeguarding adults."
Annual Agency reports	• All KMSAB partner agencies are required to complete an annual agency report to provide examples of how they have delivered the Board's three priorities over the previous 12 months. The report also provides the opportunity to highlight safeguarding priorities and any areas of challenge.

	• A total of 28 responses were submitted. These reports were peer reviewed by the quality assurance working group. Members reviewed the submissions, highlighting areas for clarification, good practice, and any areas of concern to be raised to the Board. Appendix 2 provides some examples of good practice from the responses received.

Effective Board to Board/Partnership arrangements	• Monthly meetings take place between the Managers of the following partnerships:
	  ○ Community Safety Partnership
	  ○ Kent Safeguarding Children Multi-Agency Partnership
	  ○ Medway Safeguarding Children Partnership
	  ○ Domestic Abuse Partnership
	  ○ KMSAB
	• The meetings provide an opportunity for peer support and to share good practice, priorities, key learning, and intelligence. This information is then triangulated to identify areas for joint working. It allows for the sharing of resources and messages across the partnerships, to ensure consistency and reduce duplication.
	• Update reports from the Kent and Medway Health and Wellbeing Boards, Community Safety Partnerships and Safeguarding children's partnerships are received by the Business Group. The purpose of this is to share learning and identify areas for joint working and development.
	• The Joint Exploitation Working Group is a joint subgroup of the Medway Safeguarding Children Partnership (MSCP) and the Kent and Medway Safeguarding Adults Board (KMSAB). Both Kent and Medway Community Safety Partnerships (CSPs) and the Kent Safeguarding Children Multi Agency Partnership (KSCMP) are also part of the group. It is a well-attended meeting, the areas of work overseen by the group are set out in section 1 of this report.
	• In 2022, the JEG introduced a quarterly contextual safeguarding report, covering both Kent and Medway, which informs partners of any patterns and trends covering issues such as emotional well-being, domestic abuse, missing children, county lines and serious youth violence. Members provide updates on how they use this information to keep practitioners informed on the changing picture of contextual risks and to understand how partners are mitigating these.

Escalation policy	• Members of the Kent and Medway Safeguarding Adults Board are clear that whenever a practitioner, agency or service has a concern about the action or inaction of another, this must be addressed, and any challenges conducted in a professional and respectful manner. • During 2022 the Board's escalation policy was reviewed, updated, and shared with practitioners. The 2023 SAF will include a standard to measure how this has been embedded in practice.
KMSAB Executive Meetings	• The Board Executive Membership met on 4 occasions in 2022-2023. In addition to the standard business items, under their responsibility to ensure that safeguarding adults arrangements and governance across agencies are fit for purpose, and to

	share good practice, the Board received presentations in relation to: ○ Tackling violence against women and girls strategy ○ Review of safeguarding processes – East Kent Hospitals University Foundation Trust ○ Section 42 referral process and adult social care restructure – KCC ○ NHS safe and wellbeing review programme ○ Impact of cost of living pressures and safeguarding ○ ICB strategic plan ○ Suicide thematic review ○ Roles and responsibilities ○ Serious violence duty ○ Care Quality Commission – Assessment framework for local authority assurance • In addition to the executive meetings, the statutory members of the Board met on 2 occasions to discuss resourcing and KMSAB priorities.
New SAR policy	• The Board's safeguarding adults review (SAR) policy was completely re-drafted to incorporate different methodologies for undertaking reviews. The revised document followed the format of the Board's main policy document, with sections for policy, protocols and guidance, it was also cross referenced against the national SAR quality markers. The updated policy has been well received by all agencies and adds greater consistency and rigor to all stages of the SAR process. • Supporting documents, such as the SAR referral form and summary of agency involvement forms were also revised to ensure that they provided the most relevant information to support decision making and to identify key learning. • The revised policy and supporting documents are available on the Board's website.
Prevent Duty	• The KCC and Medway Prevent team deal with Prevent/Channel referrals and deliver extensive work to prevent radicalisation across Kent and Medway as part of the UK counter terrorism strategy CONTEST. Innovative work is being delivered in relation to the threat of online extremism, providing support to adults, parents, carers and individuals who have been identified as being vulnerable to radicalisation. This includes delivering Prevent training to KMSAB partners, ensuring that organisations understand new and emerging threats. • The Kent and Medway Prevent Duty Delivery Board provides the strategic oversight across our area. Work is focused on promoting person centred safeguarding, ensuring appropriate and timely support is provided to those at risk of radicalisation. In February 2023, a hybrid conference on tackling Hateful Extremism across Kent and Medway was held and over 250 in person or online delegates attended. A further conference will be held in February 2024. All KMSAB partners have a Prevent duty as outlined in the Counter Terrorism and Security Act 2015.

Embed Improvement and Shape Future Practice

What we achieved:

Delivered our Training Offer	• The Board offers multi-agency training, predominantly for staff from the statutory sector. In response to feedback, learning from SARs and a course content review, all half-day courses were increased to full day courses with the modules focusing on the following priority areas:
	  • Adult safeguarding legal literacy
	  • Domestic abuse, including a focus on stalking and harassment, harmful practices, female genital mutilation (FGM) and honour-based crime
	  • Collaborative working in multi-agency Section 42 Enquiries
	  • Self neglect and hoarding workshop
	  • Types of Adult Exploitation - including cuckooing, modern slavery, 'mate' crime and county lines
	• Between April 2022 – March 2023, 57 workshops were held, with 703 delegates participating.
	• The training providers, DCCi, increased the number of places available on each course from 15 to 22. This enabled the learning and development working group to extend the learning offer more widely, to GPs, local councils and charities.

Evaluation of training	• In line with the KMSAB Training Evaluation Framework, delegates were asked to provide immediate feedback on the day of the training, with an opportunity to provide more reflective comments six weeks later. • Analysis of feedback presented a positive picture in relation to people's experiences of the course and the reported increase in their knowledge and skills.

Kent and Medway Safeguarding Adults Board Policy and Procedures	• Members of the Practice, Policies and Procedures Working Group reviewed and significantly updated the Board's main policy document, "Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway" , which all Board members and relevant partners are required to work to.
	• The policy is supported by a number of additional policies, which are updated in accordance with a policy update schedule.
	• During 2022/23, Members completed their review and revision of the following documents:
	  ○ Kent and Medway Multi-Agency Resolving Practitioner Differences; Escalation Policy for Referrals and Adult Safeguarding
	  ○ Kent and Medway Multi Agency Policy and Procedures to Support People that Self-Neglect or Demonstrate Hoarding Behaviour

	○ Managing Concerns around People in Positions of Trust (PiPoT) • As part of the policy update process, working group members are asked to consult with members of frontline staff. An item is also added to the KMSAB newsletter to ask for views and comments, so that these can be incorporated where appropriate.
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, requesting remedial actions if required, and escalating concerns to the KMSAB Business Group. • The Board and its Working Groups do not wait until a SAR is completed to begin to make improvements identified as the review progresses. • To improve how the Board responds to learning from SARs, Board members agreed to work to a thematic approach for action plans. The actions to address each theme were determined by members of the SARWG, co-opting other practitioners with subject matter experience/expertise where required. This approach enabled reviews to build on already established learning and allowed time for previously identified actions to embed in practice. They key themes are shared with the Board's working groups, so that these can be incorporated into their work programmes.
Sharing of Good Practice	• Safeguarding Adults Reviews are a critical tool to help identify areas for improvements. 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 good practice examples so that these can be shared.
SAR Video and Reflective Learning Briefings	• It is acknowledged that individuals have different learning styles and preferences. To accommodate this, the Board piloted a video approach to sharing learning from SARs. The author of the Elizabeth Eastly review created and presented a 10 minute summary of the review process and findings. • Members of the Communication and Engagement working group will undertake analysis to measure the effectiveness of this approach. If the findings are positive, more videos to accompany SAR reports will be produced. • In addition to the full overview report, Independent SAR Chairs produce a reflective summary briefing. This briefing distils the key learning from the review and poses reflective questions for practitioners to consider themselves, or in team meetings/other training.
KMSAB Open Sessions	• The Board Business Unit continued to deliver quarterly 'KMSAB open forum sessions', providing an opportunity for anyone with an interest in adult safeguarding to hear from people with a lived experience of safeguarding, and other subject matter experts. The following sessions were held in 2022-2023: ○ Deaf awareness and adult safeguarding ○ Adult safeguarding where chronic alcohol dependency is a factor

	○ Advocacy and adult safeguarding ○ Preparation for safeguarding adults awareness week, briefing sessions ○ Predatory Marriage.
KMSAB Newsletter	• The Board Business Unit continued to produce and circulate a monthly newsletter sharing updates in relation to: Board activity; learning from safeguarding adults reviews; guidance and support; and relevant local and national safeguarding information. • Over 350 people/agencies subscribe to the KMSAB newsletter (a 20% increase from 2021/2022), with many cascading it further within their organisations.
Regional and National Forums	• The Independent SAR Chair attends the national SAR Independent Chair Network and Chairs the regional meeting of Independent SAR Chairs and Safeguarding Adults Board (SAB) Managers. • The Board Manager attends the regional meeting and also attends the national SAB Manager's network. • These network meetings are extremely beneficial and provide the opportunity to share information, best practice, learning and work on joint projects. They also provide the Boards with a stronger national voice, should they wish to escalate concerns to relevant government departments.
Theft and Fraud within Families	• Members of the quality assurance working group received a presentation on the "all parliamentary report on theft and fraud within families", which aims to prompt discussion of financial abuse within families and the need to work more effectively together to prevent the abuse and harm that it causes. • The report was also shared in the newsletter, with a request to spread awareness amongst safeguarding partners, and others, about the issue and prompt greater collaboration.
Safeguarding Adults Review Learning Events	• The Board, in collaboration with the training provider DCCi, delivered the following workshops to share the learning from safeguarding adults reviews: ○ Improving partnership working – managing complexity and capacity – 180 delegates attended this session. ○ Understanding Self-Neglect and Supporting Good Practice. 2 sessions were delivered on this topic to coincide with the launch of the revised self-neglect and hoarding procedures. 181 delegates attended in total. ○ Overcoming Barriers to Engagement. 144 delegates attended this session. • The sessions encouraged attendees to work collaboratively, reflect on good practice and develop a solution focussed approach. • Through engagement in the sessions, members co-produced a guide to working with complexity, self-neglect, substance misuse and mental capacity. Which is available on the Board's website. • Feedback received indicated that the sessions were valuable, both in terms of content and in providing multi-agency

	networking opportunities.
Work with SAR Chairs	• The Board Business Unit, and the Chair of the LDWG met with the Independent SAR Chairs to discuss emerging themes within SARs/SAR applications. These themes included homelessness and the commissioning of specialist placements. • Independent SAR Chairs provided intelligence that the issues surrounding homelessness, including the lack of appropriate supported housing, social housing and the concerns around hospital discharges when someone is identified as homeless, are also common themes in other areas they are completing reviews for. • The Chairs found the joint meeting beneficial. To enable them to continue to provide peer support and share themes, a secure Microsoft Teams page was set up. To maintain confidentiality, case specific details are not shared or discussed.
Multi-agency risk management framework (MARM)	• In response to SAR findings and recommendations, a task and finish group was established to provide assurance that current practice and procedures are sufficient in relation to co-ordination of a multiagency response to adults as risk, or whether an additional tool/process, such as the MARM framework would be beneficial.

Section 4. Safeguarding Adults Reviews

4.1. Criteria for Conducting a Safeguarding Adults Review

Mandatory SAR

Provision 44 of the Care Act 2014 sets out the criteria for Safeguarding Adults Reviews as follows:

An SAB must arrange for there to be a review of a case involving 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—

> (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, **and**
>
> (b) condition 1 or 2 is met.

Condition 1 is met if—

> (a) the adult has died, **and**
>
> (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

> (a) the adult is still alive, and
>
> (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect

Discretionary SAR

An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs)[3]

More information on the SAR process is available here.

4.2. Purpose of a Safeguarding Adults Review

A Safeguarding Adults Review (SAR) 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. It also identifies and highlights good practice.

[3] Care Act 2014 (legislation.gov.uk) section 44.

As detailed in section 3 of this report, the Safeguarding Adults Review policy was completely redrafted and relaunched during 2022/3. The new policy was designed to ensure greater clarity, consistency, and a focus on establishing the lessons in a timely and rigorous way, without compromising on quality. In line with national findings and best practice, the intention is to build upon any previous learning in a systematic way and focus on the delivery of improvement outcomes and measuring the impact of changes. As part of this, the document distinguishes between single agency practice learning and system learning.

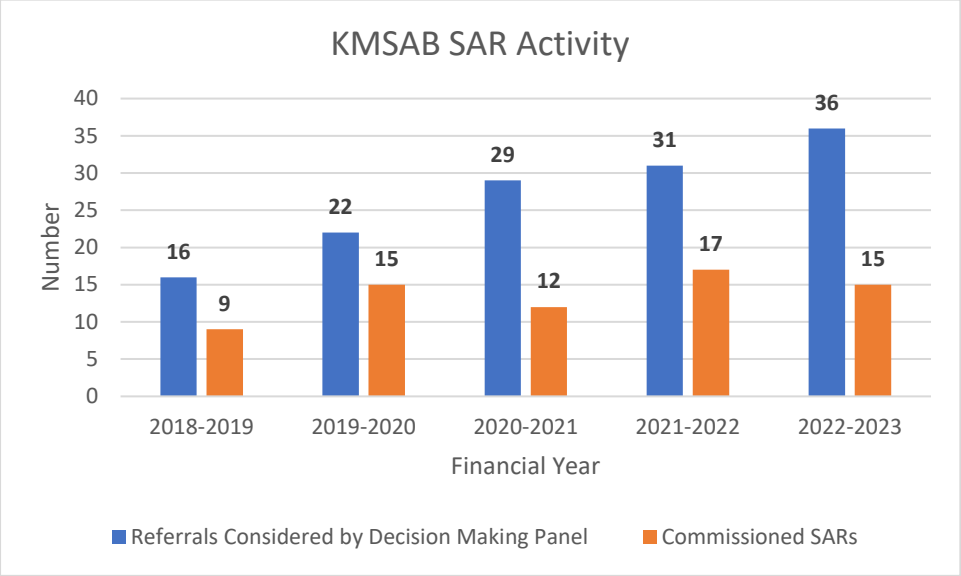
4.3. Safeguarding Adults Review Activity

To ensure a robust and consistent process for determining whether a referral/application for a Safeguarding Adults Review meets the criteria, a multi-agency decision-making panel, chaired by a member of the SAR Working Group, is convened. Prior to the meeting, agencies who worked with the adult, are asked to complete a summary of agency involvement form, detailing relevant and proportionate information to inform the discussion and decision on whether the criteria for a SAR is met. The SAR decision making group consider the agency involvement returns and the initial referral and assess whether the referral meets the criteria for a SAR, or whether any other review or action is required. The options for the panel are as follows:

- Commission a mandatory SAR (as detailed in 3.1)
- Commission a discretionary SAR (as detailed in 3.1)
- Criteria not met- should the panel members agree that a situation does not meet the criteria, but consider there to be single agency learning, they can recommend that the relevant agency conduct an internal review. At the end of the review, the agency will be asked to share relevant findings with the Safeguarding Adults Review Working Group.

The recommendation of the panel is sent to the Independent Chair of the KMSAB for a final decision.

The number of SAR referrals received by the KMSAB continues to increase year on year.



The KMSAB received 36 new SAR referrals between April 2021 and March 2022, of these:

- 15 SARs were commissioned.
- 21 did not meet the criteria and no further action for the Board was required.

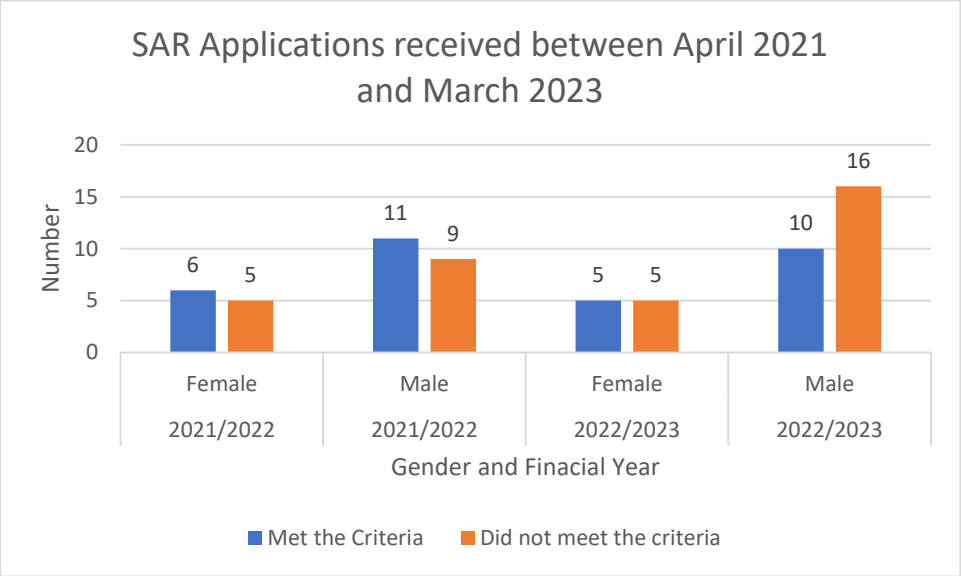
The summary of agency involvement returns allow members to consider information that may not have been available to the person who made the SAR referral, and, in many cases, the additional information evidenced that agencies did work together, so the criteria was not met.

Gender - SAR applications received between April 2021 and March 2023[4]

There continues to be more SAR referrals for males, including people who identified as male. Of the 36 SAR referrals received between April 2022 and March 2023, 72% were for males and 28% for females. In 2021/2022 the proportion was 35% female to 65% male.

The gender breakdown of SARs commissioned remains consistent, with approximately a third of commissioned reviews relating to females and two-thirds to males.

2022/23	Referrals (Number)	Referrals (Percentage)	SARs commissioned (Number)	SARs Commissioned (Percentage)
Male	26	72%	10	67%
Female	10	28%	5	33%
2021/2022				
Male	20	65%	11	65%
Female	11	35%	6	35%



[4] These figures reflect the individuals chosen gender identity.

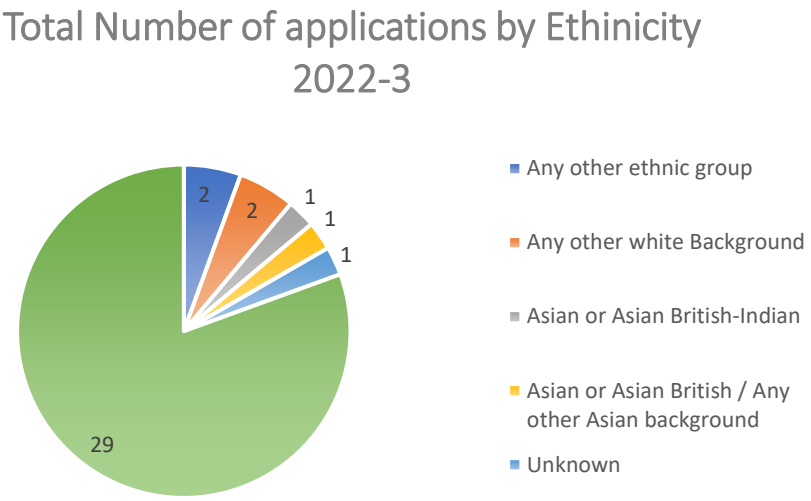
In 2021 – 2022, the conversion rate of referrals to commissioned SARs was 55% for both males and females. In 2022-2023 the conversion rate was 50% for females and 38% for males.

Ethnicity - applications received between April 2022 and March 2023

The SAR referral form contains a field for ethnicity information. Under the revised SAR procedure, the SAR core panel is asked to validate this information when reviewing the summary of agency returns, to ensure that information is recorded and that it is accurate.

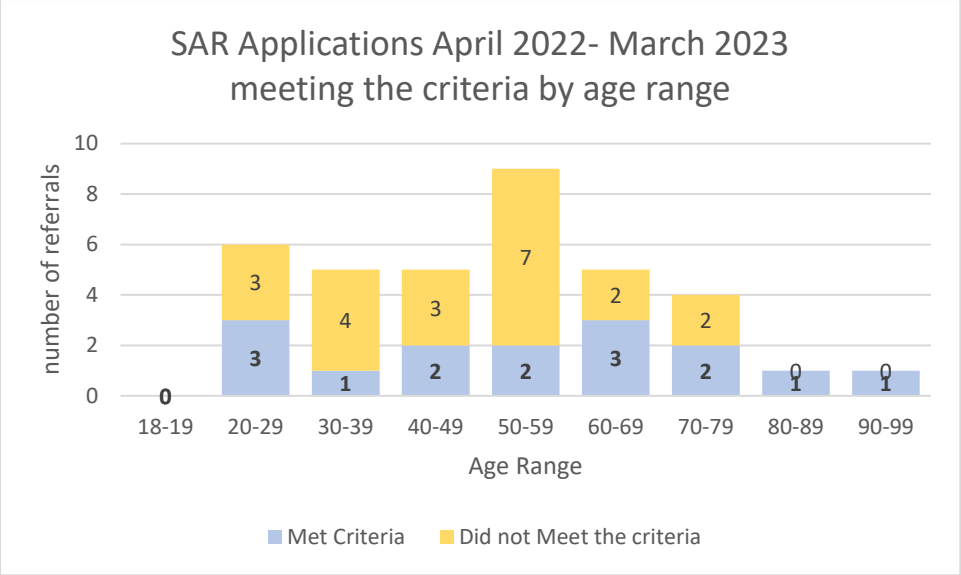
Of the 36 referrals received, 80.5% of the individuals were 'White British-English', 5.5% 'Any other white background', 5.5% 'Any other ethnic group', 3% 'Asian or Asian British – Indian', 3% Asian or Asian British / Any other Asian background, and 3% 'unknown'. 93% of the SARs commissioned were in relation to individuals who were white British/English.

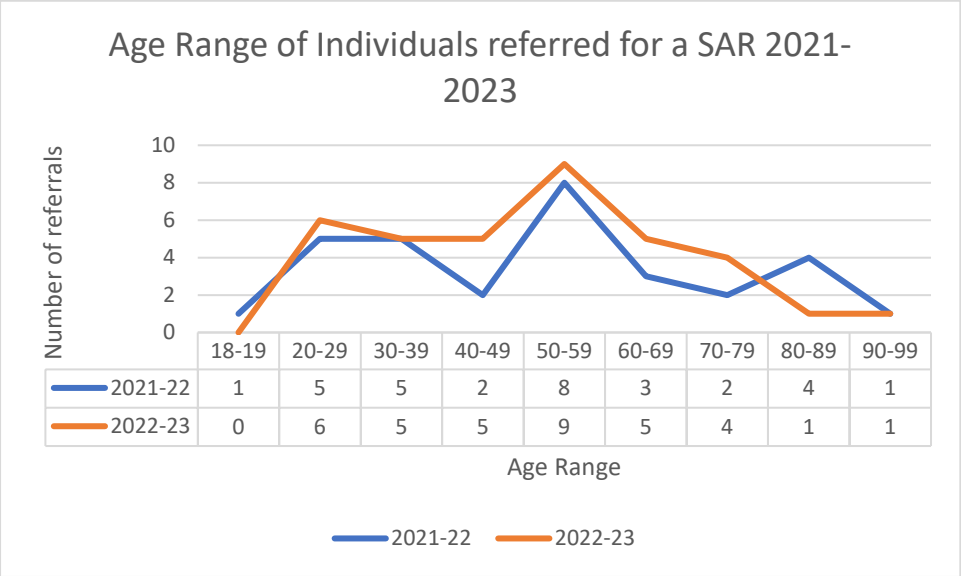
Ethnicity	Total Number of applications	Number of referrals meeting the criteria	Percentage of referrals meeting the criteria
Any other ethnic group	2	1	50%
Any other white background	2	0	0%
Asian or Asian British-Indian	1	0	0%
Asian or Asian British / Any other Asian background	1	0	0%
Unknown	1	0	0%
White British/English	29	14	48%



Age – SAR applications received between April 2022 and March 2023

Of the SAR referrals received, as with the previous year, the most frequent category was the 50-59 age range. Possibly due to the low numbers, there is little variation in age for the SARs commissioned during this reporting period.


SAR Applications April 2022- March 2023 meeting the criteria by age range
number of referrals
10
8
6
4
2
0
0
3
3
4
1
3
2
7
2
2
3
2
2
0
1
0
1
18-19
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90-99
Age Range
Met Criteria
Did not Meet the criteria


Age Range of Individuals referred for a SAR 2021-2023
Number of referrals
10
8
6
4
2
0
18-19
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90-99
2021-22
1
5
5
2
8
3
2
4
1
2022-23
0
6
5
5
9
5
4
1
1
Age Range
2021-22
2022-23

4.4. Completed Safeguarding Adults Reviews

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

All names are pseudonyms to protect the identity of those concerned.

Individual and Methodology	Background	Findings/Recommendations
Rosie and Emma Published: 19 July 2023 **Traditional review**	Rosie, a white British female, was 24 when she died by suicide. Between 2011 and 2013 she had been looked after by the local authority on three occasions, following this, she was supported by the 18+ care leavers service. Her personal advisor described her as always beautifully presented and like a "little Amy Winehouse". Significantly, in January 2020, Rosie experienced the loss of her partner to suicide. A number of agencies reflect the impact of this loss on Rosie, and she was informally admitted to an inpatient unit for 4 days, having attempted to take her own life. In addition to the emotional trauma of this loss, Rosie also lost her home and went to live with a friend on discharge from hospital. Following her inpatient stay, Rosie was discharged to the Community Mental Health Team (CMHT) and met with a consultant psychiatrist who diagnosed her with Emotional Unstable Personality Disorder (EUPD), Post-Traumatic Stress Disorder (PTSD) and social anxiety. Rosie attempted suicide on 24 May 2020 and died as a result of this on 25 May 2020. Rosie's last recorded contact with services was on 21 May 2020. Emma, a white British female was 21 when she died by	Learning related to: • **Suicide prevention** - KMSAB should work with public health teams in Kent and Medway to ensure that the Kent and Medway Suicide and Self-harm Prevention Strategy 2021-2025 includes key findings from this Safeguarding Adults Review including understanding of suicide risk on a population-wide as well as an individual basis for people who: • have survived adverse childhood experiences • are using drugs and alcohol and have co-occurring mental health needs. • live nomadic lives with few fixed points and had little stability, economically, socially, or of accommodation • have experienced recent and ongoing trauma through loss of loved ones and friends, relationship breakups, homelessness and physical and sexual assaults. • **Think family -** Agencies involved in this review should introduce a "Think Family" approach and support

	suicide. Emma first became known to KCC Specialist Children's Services in 2004 when she was aged 5 years, having experienced abuse and neglect from her biological family. Emma and her siblings were made subject of a Child Protection Plan. They were placed in foster care together, where she remained until she was 18. Emma's personal advisor described her as 'very spiritual, creative, colourful, bubbly and independent". In May 2019, aged 20, Emma abandoned her tenancy, the reason for this is not clear. Following her leaving her tenancy Emma experienced frequent housing instability. The day before Emma's PA learned about the tenancy being abandoned, Emma was detained for her safety under section 136 of the Mental Health Act, having told her GP that she was actively suicidal. This followed an attendance at Accident and Emergency, eight days before having taken an overdose of paracetamol. Emma described herself to professionals as a 'sex worker'. During the period covered by the review, Emma was known to services following overdoses, self-harm and suicide attempts. Emma died by suicide on 2 July 2020. Her last recorded contact with services was on 1 July 2020. The rationale for a joint review was that it allowed a focus on similarities and differences and the approaches taken by services to engage and support Rosie and Emma. In this way, themes, patterns, systemic factors and processes could be identified. Agencies who knew Rosie and Emma were required to write separate Independent Management Reports and chronologies for each, to ensure that the focus remained on them as individuals.	practitioners to consider, for instance, how background information can be obtained from family members or friends that will help to identify risk and approaches to take to increase engagement; how to identify whether family or friends are protective factors or not, and how to work with family or friends in protection planning and providing ongoing support. • **Multi-Agency working -** KMSAB partners should examine the Camden Core Team model, the Plymouth and Bristol practice models and the work by Sandwell Metropolitan Borough Council, which provide examples of system change approaches for working with people like Rosie and Emma.

Pablo Published: 8 June 2023 **Day review**	*"Pablo was unique and passionate – he felt different to other people and wanted acceptance" (Pablo's mother)* Pablo, a white British male, was a musician and an artist. Growing up, Pablo and his mother were subjected to domestic abuse. Pablo's mother reported that this affected him deeply. Records indicate that Pablo had a diagnosis of bipolar affective disorder, paranoid schizophrenia and schizoaffective disorder – along with a history of drug and alcohol abuse. Mental health services were involved with Pablo from 2011 until his death. There are numerous reports of Pablo self-harming, which resulted in Emergency Department attendances. He was reported as being non-compliant with medication prescribed for his mental health and had poor concordance with his mental health needs. During periods of psychosis Pablo did not trust anyone, however he was never violent or confrontational – he preferred not to be around anyone due to the paranoia. His family also argued that he was not suicidal, but rather was experiencing delusions which led him to take actions which endangered his life. Pablo was in his early thirties when he went missing from a hospital in Town A, Kent. On the day he went missing, Pablo had left the hospital's Emergency Department whilst he was under supervision, due to being in an acute psychotic episode. Pablo's body was recovered some months later having been found on the coastline of the English Channel.	Learning related to: • **Safeguarding and Managing Risk Tool (SMaRT plus) -** The review has raised questions about the use of SMaRT tools, which require analysis. The need for learning around these tools is not unique to Hospital Trust 1. Other Trusts in Kent and Medway have been developing processes to aid the use of SMaRT tools. It is recommended that Hospital Trust 1 link in with these Trusts to share learning. • **Self-discharge/absconding from hospital -** All Safeguarding Adult Reviews in Kent and Medway which involve patients self-discharging or absconding from hospital will be collated, along with data from each Hospital Trust – to be shared with the Kent and Medway Integrated Care Board, to highlight the issue across Kent and Medway Hospital Trusts. • **Quality of Referrals -** Staff must be reminded of the importance of including pertinent points and using suitable language when making interagency referrals – this was also identified in SAR Elizabeth Eastley. Referrers must state clearly what the issue is and what they require of the agency they are referring to. • **Documenting defensible decision making** - Staff from all agencies should be reminded that decisions and the rationale behind decisions must be recorded clearly. • **Co-occurring conditions** – The findings from this review are to be used to inform the work of the Board's co-occurring conditions task and finish group.

Brian Published: 22 May 2023 **Traditional review**	Brian was a 49 year old single white male who lived alone in a coastal resort town in Kent. He was a tenant in District Council accommodation at the time of his death. Brian lived with mental health issues, including anxiety and preoccupied thoughts. Brian had a history of self-neglect when he increased his intake of alcohol and/or non prescribed drugs. Brian was found dead in his flat on 22 September 2021 by the police. It was evident he had been dead for some time. A Coroners' Inquest recorded an open verdict as it was not possible to determine the cause of death.	Learning related to: • **Practice/defensible decision making-** Adult social care was asked to ensure that parameters be set in relation to what the expectation for delivering, or meeting, an action that is deemed "urgent" are. As a guide, responding to an "urgent" action should whenever possible be measured in days, rather than weeks. • **Multi-Agency working /Information sharing** - KMICB should clarify the procedure and protocol for "just to let you know" correspondence sent by Health and Social Care Organisations. Relevant and contextual information should be included. Specifically, where there is an expectation the GP will take some form of action, this should be made explicit. KMPT and KCC Adult Social Care should consider introducing a working protocol that before services are withdrawn because there is a belief the other organisation is now taking the lead; the relevant organisation should obtain this confirmation before the withdrawal of services is approved. All Health and Social Care agencies should view Housing Authorities as key safeguarding partners and should be encouraged to involve them when individuals are tenants of their properties. (Subject to the permission of the individual). • **Safe-Discharge** - The NHS Hospital Trust should continue to explore their current initiative to review hospital

		discharge procedures for vulnerable patients into potentially unsafe home environments, with social care partners and other relevant agencies. • **Self-Neglect -** All Safeguarding agencies should publicise and implement a training and awareness programme for their staff now the new multi-agency self-neglect protocol is approved. KMSAB have been proactive in this regard and have self-neglect as part of their multi-agency training offer.
Brett Published: 18 May 2023 **Traditional review**	Brett, a white British male was 49 years when he died. His bother said that, when he was well, Brett was a fun loving person who loved a laugh and was easy going. Brett was a scout leader. His brother said that Brett loved being a leader in the scouts but when his mental illness started, he had to give it up. Brett's brother stated that after this Brett's depression got worse and he could see him shrinking as a person and that it was very sad to watch. Brett had a long history of psychotic illness, diabetes and self-neglect when unwell. Brett was referred to the Kent and Medway NHS and Social Care Partnership Trust (KMPT), in September 2020 by his brother, due to concerns that Brett's mental state was deteriorating, and as a result his ability to take care of himself was diminishing. Brett was also an insulin dependent diabetic and there were concerns that he was not managing this well. Brett was under the care of his local Community Healthcare	Learning related to: • **Self-Neglect -** The Kent and Medway Safeguarding self-neglect and escalation policy have both undergone a recent extensive and robust review. It is recommended that the KMSAB carries out a qualitative review with partner agencies to provide assurance that their staff are working towards the policy. This can be evidenced in the Board's Self-Assessment framework**.** • **Escalation -** The Kent and Medway Safeguarding Adults Board to consider carrying out an audit of practitioners in relation to their use of the self-neglect policy to identify if the escalation policy is being utilised when the self-neglect policy isn't working. • **Multi-Agency working** - Following the completion of this SAR a practice note guidance is to be produced highlighting the importance of recognising the complex needs of patients, both physical and mentally, and the

	Trust for his diabetes management. Brett was known to various services and issues of self-neglect were mentioned by services, however limited safeguarding referrals were made, and none in relation to possible self-neglect, until Brett was admitted into hospital for the last time. In October 2020, Brett was found unresponsive by his brother at his home address. An ambulance was called, and he was admitted to hospital. Sadly, Brett later died in hospital.	need for a multi-agency response through pre-established Multi-disciplinary meetings**.** There has been an identified need to strengthen communication between services to reduce gaps with regards to ownership and the utilisation of the escalation process. Assurance is to be gained that the communication between primary care and secondary care services is clear with regards to ownership and responsibilities. Agencies to raise awareness around the understanding of when a person has serious health conditions that the practitioner knows where they can refer the individual to, ensuring that the right agency is involved with that individual, including making use of GP MDT meetings. • **Diabetes management** - The SAB to commission a leaflet for adults, families and carers of adults with diabetes to identify the significant impact of mismanagement of diabetes care and the linkage with mental ill-health. Agencies are to highlight the link between certain serious medical conditions, such as diabetes, and the associated mental health problems and also the impact of managing mental health conditions can have on an adult's physical health. • **Carers** - A review is to take place regarding referrals for Carer's assessments to identify gaps within the system.

		• **Person centred/strength based practice** – Adult Social Care to roll out the new core skills framework/training (new practice framework) for staff which has been set up based on a strength-based approach, using families, friends and networks to support the person. • **Domestic Abuse** - A reminder learning bulletin/ information graphic is to be sent out to all agencies highlighting sibling on sibling domestic abuse and the appropriate referral and support mechanisms available.
Peter Published: 2 May 2023 **Practitioner Event**	Peter was a 74-year-old white British man. He was known to be living between his own home and that of his neighbour and friend, Susan. Professionals visiting him only saw him at Susan's home. Little is known of Peter's history. He appears to have been a private individual who developed a co-dependent relationship with Susan. During the review it was identified that their relationship was recorded as neighbours, friends, partners or as a married couple. In February 2021, Peter was admitted to hospital. On this occasion an ambulance attended Peter at Susan's address following an NHS 111 call for chest pain. When the ambulance clinicians arrived, they found Peter barely conscious with an ongoing chest infection and likely sepsis and possible Covid-19. He was noted to have numerous abrasions, swelling, infected wounds, cellulitis, and oedema to both legs. He was unable to speak properly with crew due to symptoms, was unkempt in old clothes, no personal hygiene maintained and unable to mobilise without help. Peter was conveyed to	Learning related to: • **Self-Neglect and Hoarding -** There were early indicators of potential self-neglect identified by single agencies. This would have been strengthened had there been images shared to enable interagency assessment. Therefore, it is recommended that the clutter image rating, with a full description of the room where the individual is mainly living, is shared with relevant agencies to underpin the assessment of risk for the individual. • There is evidence that Kent Fire and Rescue Service demonstrate good practice in this area, and it is recommended that they share their training across agencies. • **Multi-Agency working -** There was a multidisciplinary team meeting (MDT) to share concerns about Peter. This would have been improved by the inclusion of voluntary agencies and if it had been achieved earlier. It is

	hospital and an ambulance concern form was submitted to KCC Adult Social Care stating that it was unclear what the patient's home state was, but due to his appearance it was clear he was unable to care for himself effectively and the crew were unsure if his home environment was safe for him to return to. He was admitted to hospital for three days. When he was discharged home, there was no social care support set up as Peter declined a care package. There was community health input established. However, G4S (patient transport) made a safeguarding referral as Peter's house was found to be uninhabitable when they transported him home. He was noted to be unkempt and went to Susan's as he said he was waiting for his house to be cleaned. The community nursing team visited Peter weekly, at Susan's home, to provide wound care to his leg. They also made a referral for a short-term community nursing team to provide personal care, and meals twice a day for Peter and Susan. It is reported that they both declined personal care which led to a delay in support being delivered. The safeguarding referrals made in February did not meet the threshold for statutory safeguarding involvement, however, a referral to KCC Kent Enablement at Home Service (KEAH) was made. Once this was in place, Peter was discharged from the *short term* community nursing team. The community nursing team continued to provide wound care. During this time the GP visited the home and saw Peter to be unkempt and made a referral to the Community Trust for assessment. Kent Fire and Rescue Service (KFRS) conducted a safe and well visit for Susan. There were reports of declining KEAH support on occasions, saying he was	recommended that there is a review of how the Integrated Care System Primary Care Network Multi-Disciplinary Team Framework is monitored to ensure that primary care led MDTs include all relevant agencies. • **Safe-Discharge** - The discharge planning included the offer of a care package and the referral to community nurses. This would have been strengthened if the information about the concerns had been considered to enable a home visit to be undertaken to assess where Peter would be living. • **Referral Forms -** It is recommended that SECAmb review how their crews can make safeguarding referrals in line with the KMSAB policy procedures and practitioners guidance. There should be an audit of the outcomes for SECAmb concerns shared to identify further learning and this should be presented as a report to KMSAB. • **Carers -** It was known by some agencies that Peter was a carer, but often either he or Susan would refuse support. This would have been improved if there had been a consistent understanding of the needs of Peter both for himself and as a carer. It is recommended that the KMSAB review what guidance there is for all agencies to be able to identify those who are in a caring role but have specific needs of their own.

	not happy with the service and that he had a friend who was able to shop for him. By April 2021, there were increasing concerns that Peter was not coping. Prior to his hospital admission in February, he had been independent and was able to provide care for Susan. A multidisciplinary meeting was held on 22 April 2021. On 23 April 2021, SECAmb attended a 999 call for Peter and conveyed him to hospital, they contacted adult social care with concerns. Peter died in hospital on 2 May 2021	
Robin Published: 19 April 2023 **Traditional review**	Robin, a white British male, was 27 years old when he died, in August 2020. Robin's family reported that Robin was diagnosed, at the age of six years old, with Autistic Spectrum Disorder. When he was a teenager his family report that his self-care was poor, and he began to severely neglect himself. They reported that when Robin was 15 years old, he received a diagnosis of schizophrenia. As a young adult, Robin was moved to an intensive supported residential adult setting following a period in Psychiatric hospital, which was arranged by Mental Health Services, and then was moved to supported living accommodation. Robin lived alone at the time of his death and had a wish to be independent, Robin's mother tried to maintain contact with Robin, but he struggled to access help from his family or other agencies, most likely as a result of his mental ill health. In late August 2020, during an unrelated Police call to a property in the area, a large quantity of milk bottles was noticed on Robin's kitchen table and there were a large	Learning related to: • **Section 117 Aftercare - legal literacy and information sharing -** There is a need to ensure that section 117 aftercare and support responsibilities are recorded accurately on ICB, KMPT and Local Authority computer recording systems, where individuals are transferred back to Kent following an out of county mental health hospital admission. System checks need to be in place to ensure that individuals are accurately registered so that legal responsibilities for aftercare services to the individual are clear. When an individual is discharged to the care of their GP the risk of not engaging with medication/treatment plans should be carefully noted and informed, along with the status of section 117 arrangements. Where the responsibility for section 117 is to be handed over to the GP, this should be pre-agreed within a Care Programme Approach (where a CPA is required and deemed to be

	number of flies noticed within the property. Neighbours advised that Robin had not been seen for over a week. Enquiries through the Housing Association revealed that they had not been able to contact Robin for a matter of months. The next morning, entry was gained to the property by Kent Fire and Rescue Service (KFRS) and sadly Robin was found to have died, his body being in an advanced state of decomposition. Milk cartons, drinking vessels and alcohol bottles were found in the property. Unopened mail was found dated June and August 2020. The Coroner's inquest report states that 'post mortem decomposition has inhibited any conclusions as to the medical cause of death'. The conclusion remains an open one.	appropriate). This should include the likely relapse indicators, as well as there being an agreed plan to ensure that any mental health deterioration is accurately assessed. • **Not taking medicine** - GP practices to review persons who are not engaging with their medication for any mental health conditions so that relapse indicators can be considered and assessed. This is to include careful consideration of any individuals entitled to section 117 status. • **Specific actions for housing provider/association** - The Housing Association to ensure that staff are equipped, through training and support, to use their professional curiosity at all times in practice to safeguard their tenants. The housing provider needs to be aware and competent in their care and support responsibilities. Workers need ongoing support and training about how to be vigilant about adult safeguarding including self-neglect and hoarding behaviours when observed. • **Self- neglect and hoarding** – Good practice and awareness was demonstrated by the Central Referral Unit of KCC who would not initially authorise the safeguarding closure due to concerns for Robin's welfare and wanting to ensure that the operational team followed the self-neglect policy and arranged a multi-agency professionals meeting. There remained a recommendation for all agencies to

		ensure that staff are competent in using the self-neglect protocols and when a multi-agency meeting should be convened. • **Barriers to engagement -** Agencies to robustly consider how to better engage with hard to reach individuals and evaluate themselves on how they communicate with such individuals, reflecting on a) How flexible is your service provision to individuals with autism, learning difficulties and mental health issues? b) How aware is your service/ agency of what other services do to support individuals with ASD, learning difficulties etc? • **Multi – Agency working -** The Safeguarding Adult Board to seek assurance that there is consistency in Kent and Medway about the role and functioning of Community Safety Partnership meetings, with clear terms of reference and governance arrangements understood by partner agencies regarding the discussion of vulnerable adults, and how this fits into Kent and Medway safeguarding procedures.
Thomas Published: 12 April 2023 **Traditional review**	Thomas, a white British male, was aged 27 when he died. Thomas experienced a difficult early life and was taken into care at the age of 5 years old, due to significant concerns within the family unit, including substance misuse and domestic abuse. Thomas had a diagnosis of borderline personality disorder, bi-polar disorder, features of anxiety disorder and Emotionally Unstable Personality Disorder. His mental ill health was believed to be exacerbated by the use of drugs and other	Learning related to: • **Safe Discharge -** The discharge of patients from mental health hospitals as well as acute hospitals needs to be carefully considered in each case, drawing on all the relevant and proportionate knowledge of historical risks known. Multi-agency working is essential in cases of complexity where an individual is known to a number of agencies. and the hospital needs to ensure that the appropriate agencies are invited to the discharge planning

	psychoactive substances. Thomas had been known to Mental Health services since 2012. His history documents a number of challenges including drug and alcohol misuse, suicidal ideation, mental health hospitalisation, self-discharge from hospital, self-neglect, housing crises and periods of non-engagement with services. Thomas had been a victim of violence and also had offences for assault, burglary, public order, shoplifting, vehicle crime, dating back to 2011 which included serving a prison sentence for 2 years. Thomas also suffered with a leg injury which had been ongoing and unresolved for a number of years for which he was taking pain killers on an ongoing basis. When Thomas was found by the Police, drug paraphernalia was also found at the scene which, when examined later, revealed traces of cocaine, heroin, cannabis and spice (synthetic cannabinoid). There was some medication (Diazepam) on the bedside table, which still had some tablets in the foil wrapping. The Record of Inquest revealed the cause of death to be drug related; specifically Multiple Drug Toxicity.	meeting. KCC adult social care need to be included at an early stage in discharge planning where it is likely that there will be an ongoing role for support going forward. • **Information sharing** - Greater information sharing is required as currently there continues to be complexities due to different recording databases being used across agencies as well as uncertainty around information sharing protocols between them, regarding vulnerable adults. The KMPT Independent Management Report has highlighted ongoing concerns around KMPT's inability to promote the use of community safety partnership meetings due to requiring clarity on information sharing and governance agreements. The SAB need to clarify these information sharing arrangements for all agencies in order for community contextual safeguarding approaches to be enabled in a transparent way**.** • **Homelessness and housing options** - Housing options and needs for adults who are homeless or at risk of being homeless following discharge from mental health units requires more careful and critical evaluation in all cases in order to ensure that the right support is linked to the accommodation type. It is acknowledged that this is a national challenge. Where a vulnerable adult requires alternative housing in the community, this needs to be sought in a proactive,

		timely way in order to avoid unnecessary stress and uncertainty to the individual concerned. Building strong links with community housing teams and support services is essential for professionals. • **Multiagency working** - Professionals need also to make the most of technology to enable remote meetings in a timely manner, as highlighted from the pandemic practices, in order to avoid meetings being unnecessarily cancelled as occurred in this case. Multi-agency meetings could be made easier in this way, which should assist in professionals coming together to discuss complex cases like Thomas also. • **Transition** - Transfer of services between areas e.g., Community Mental Health Teams, Adult Social Care, GP practices, based on residence needs to be carefully considered, and transitions to be planned to avoid unnecessarily destabilising of an individual's mental health further. Clearly there are resource implications for agencies in considering possible delays in transfers and it would require flexibility amongst services to best meet an individual's needs.
Alice Published: 12 April 2023 **Traditional Review**	Alice, a white British female, was aged 84 when she sadly took her own life by drowning in the river just outside her home. Alice had lived with her husband, Fred, in sheltered accommodation. The couple had some friends, and were well known in the housing complex, but there was no known wider family. The housing manager was invited to contribute to the review, he advised that Alice and Fred were pleasant and friendly to others. He described Fred as having adored Alice,	Learning related to: • **Wellbeing Principle and impact of loss -** All agencies to reinforce the importance of wellbeing, and the impact of wellbeing on mental and physical health. For Alice her husband's dementia, her feelings of loss and concerns about her own health led her to take her own life. Listening and understanding the concerns of the individual to ensure that they are heard and understood

	he would "wait on her hand and foot". When he became ill with dementia, she apparently found it hard that their roles were, effectively, reversed. She became the carer and he the cared-for and she struggled with this. They were popular in the building and other residents became increasingly concerned for Alice and tried to assist by inviting her to join in activities. For whatever reason, she rarely did and became increasingly isolated. In early 2019 Alice received a scam telephone call. This was the start of a number of such calls that led to Alice being defrauded of some £5000 over the following year. The scam knocked Alice's confidence. Up until a few months before her death, she and Fred had managed to go out for drives and for coffee. They had a dog which Alice used to walk regularly around their home. Her isolation became more profound when the Covid pandemic began, in March 2020. Several agencies were involved in supporting the couple, but over the period of Covid this was more difficult than usual. It is also notable that the situation for both Alice and Fred deteriorated very rapidly over the few weeks prior to her death.	can be invaluable. • **Impact of financial abuse -** Agencies to promote awareness of the impact of financial Abuse and scamming with the emphasis on the effects on the mental health and confidence of the victim. • **Carers -** Those caring for others in their own homes should have their own care and support needs considered to ensure that they are given as much support as possible in their; sometimes, new, unfamiliar and developing roles.
Folade and Bola **Traditional review**	The SAR in respect of Folade and Bola was not published for reasons of anonymity.	Learning related to: • **Barriers to engagement** • **Referral Forms** - KMSAB partners to review the various safeguarding referral forms used across Kent and Medway. The review is to consider the content, format and language of the forms with a view to moving forward towards a consistent approach**.** • **Multi-agency working -** That the Integrated Locality

		Review role in relation to people with complex mental health is reviewed to ensure its effectiveness.
Ken Published: 21 March 2023 **Day review**	Ken, a white British male was aged 63 when he died. A SAR referral was submitted following the outcome of the inquest into Ken's death. The Coroner concluded that Ken "died at [hospital] on 4 March 2019 of 1a pneumonia with abscesses 1b cellulitis with ulceration 1c peripheral vascular disease. This could be natural causes, but it is rendered unnatural by issues in relation to omissions and failure of care. There were two admissions to hospital when he had hypernatremia and sepsis but on 10 February, he was discharged home alone with leg ulcers and no home assessment and no Community Nurse which, together with a lack of nutrition on his second admission, probably accelerated his death." Ken had a father, brother, a daughter, and he had named an ex-partner as his next of kin when he was admitted to hospital. Ken had cared for his father from 2017 until June 2018, when his father was placed in a care home. According to the GP records, there were intermittent issues between 2013 until August 2017. It was noted that Ken was unable to work, due to epileptic fits, poor compliance with medication and drinking alcohol. In 2017, Ken had his first presentation with the GP regarding the eventual diagnosis of Peripheral Vascular Disease (reduced circulation of blood to a body part other than the brain or heart, caused by a narrow or blocked blood vessel). In January 2018 Ken was seen by the vascular team, they undertook scans and tests and diagnosed extensive stenosis. In January 2019 Ken attended a minor	Learning related to: • **Self-Neglect** - Review the self-neglect training package to reflect learning from SARs and the research in practice report (2020). This should include GP Practice Nurse training. Consider running a multi-agency update day, focusing on self-neglect to support practitioners to work together through the challenges. Build on the work done following other SARs in relation to how the self-neglect policy sets out who can lead a multi-agency discussion to ensure that the responsibilities for self-neglect are accepted across the multi-agency network. KMSAB should seek assurance from system leaders about how they are ensuring there is the capacity within their services to address the growing demands in relation to self-neglect. • **Person centred approach/barriers to engagement** - The KMSAB should ask Healthwatch for support in gaining feedback from the community about the use of holistic assessments within short appointments/episodes of care and how services gain feedback from those who do not 'engage' with services. • **Specific Action for GP/Barriers to engagement -** GP practice staff must be literate about access to funds or services for individuals in need of financial support,

	injuries unit and was found to have necrosis of wounds. He was referred and admitted to hospital with sepsis, hypernatremia and encephalopathy. He was discharged home on 10 February. The referral to the community nurses was not completed. It was noted in the hospital records that his friend would be supporting him. When he arrived home, there was no-one there. The family was contacted for a key. G4S (hospital transport) were concerned the home was not habitable, there was no bed. They reported to the hospital and were advised that Ken would need to go to A&E. G4S made a safeguarding referral and Ken was left at the property. 5 days later, Ken's daughter found him on the floor of the property and called an ambulance. The ambulance crew attended the home, made a safeguarding referral due to the state of the environment and Ken's condition. They conveyed him to hospital where he was diagnosed with sepsis, assessed as malnourished and unable to care for himself. Ken died in hospital on 3 March 2019.	including circumstances in which people can access free prescriptions. The CCG/ICS should ensure that Primary Care Networks/Integrated Care Partnerships have plans in place to demonstrate how they address the wider issues in their practice populations that impact on health. GP Practices should be able to explore why patients, known to have specific care and treatment needs, are not engaging with the service**.** • **Information Sharing -** Between services run by different organisations there must be an agreed approach to how clinical information can be shared effectively to benefit the care and treatment of the patient accessing the different services. • **Safe – Discharge -** KMSAB should receive reports about the impact of the Integrated Discharge System to ensure that there is evidence of improved outcomes for patients being discharged from hospital. This should include consideration of how poor transfer of care concerns can be raised by non-health staff where they do not amount to a safeguarding concern. • **Specific recommendation in relation to patient transport services -** Patient transport services need to have safeguarding policies that enable their workers to make rapid decisions about risks identified when transporting patients. • **Carers -** How do staff access supervision in identifying, and providing support, to address the needs of carers? How does the KMSAB gain assurance about this?

Laurence Published: 15 February 2023 **Traditional review**	Laurence was a white male, born outside the United Kingdom (UK) but who had been a resident in the UK for approximately 10 years. Laurence passed away at the age of 45 years old, in a Kent hospital. Laurence is described by his mother as having been a 'wonderful guy' who had a 'heart of gold' and would 'do anything for anyone'. She described how Laurence was outgoing and had a strong work ethic. He was always in work or searching for work if he was not employed. At the age of 18 years old he was involved in a serious road accident in his birth country which resulted in him being in hospital for a 6-month period. As a result of this accident, he lost the hearing in one of his ears and suffered a frontal lobe brain injury. The SAR referral raised concerns about physical as well as financial abuse, experienced by Laurence over a significant period of time, by a non-related resident living in the same property. The referral also raised concerns regarding self-neglect, as a result, primarily, of chronic alcohol dependency. The referral highlighted Laurence as a vulnerable individual who had multi-faceted health complexities which included; a significant brain injury following an assault in 2011 where he suffered life changing issues; epilepsy, Type 2 diabetes and significant alcohol dependency. In the years prior to Laurence passing away he was, on occasions, living on the streets, due to being fearful to return to his own rental property. Laurence was admitted to hospital at the beginning of February 2020, in a very poor physical state. The hospital	Learning related to: • **Multi-agency working/Information sharing** - There is a need for more robust proactive thinking and action in convening multi- agency meetings to avoid complex multi-faceted cases falling through the net of adult safeguarding procedures. Housing providers have a key safeguarding role to play, alongside their colleagues in social care, health and the Police, in keeping people safe. They are well placed to identify people with care and support needs at risk of abuse, share information and work in partnership to coordinate responses. A more co-ordinated approach between housing and other agencies to share information would have been very useful in this case and would have brought to light previous historic concerns raised by neighbours over a period of time, which in turn would have influenced the action taken by agencies and led to better practice in safeguarding. • In cases where information is being shared across separate Police departments/teams, as well as cross-agency, officers need to ensure that they are not overly reliant on limited recorded information of an incident to assess the risk of the situation. The Police to be mindful, where they were not individually present at an incident, that this may mean that details about a visit to a property are lost or not extensively recorded, resulting in the severity of the risk being potentially diluted in communications. Furthermore, historical information

	raised concern regarding self-neglect and the 'emaciated' physical condition that Laurence was in at the time of admission. Laurence passed away in hospital one month later, on the 8 March 2020, having never recovered following his admission. The cause of his death is recorded as Aspiration Pneumonia, Liver Cirrhosis (alcohol related) and Type 2 Diabetes as a contributory factor.	used may mask the emergence of new issues and risk related to the individual, impacting the effectiveness of information sharing, and hampering efforts to establish a better understanding of the individual's vulnerability. • **Self-Neglect** - KMSAB to monitor the application of the Kent and Medway Self-Neglect Policy and Procedures to ensure that this is being applied and utilised appropriately and consistently, as it was intended. • **Person centred practice** - Professional practice needs to be 'effective' with more consideration to the efficacy of signposting and referring individuals on to services. Agencies to avoid over-ambitious signposting when working with vulnerable persons and consider whether advocacy is required. Consideration needs to be more in line with 'walking with people' to a service (Preston-Shoot (ADASS report), 2020, p.16) and more follow–up put in place by agencies, compared to simply 'referring on' and 'signposting'. • **Legal Literacy** - There is a need to ensure ongoing safeguarding literacy through training amongst all agencies. Professionals need to be competent in knowing when and how to raise a safeguarding alert, and a referral for a Care and Support needs assessment, as well as when to consider and instigate multi-agency self-neglect policy and procedures. Housing authorities and associations need to be clear and

		competent with statutory guidance on how and when to seek advice regarding adults at risk and ensure that all staff have sufficient training on how to recognise vulnerability in tenants. • **Contextual Safeguarding** - the need to ensure a greater contextual safeguarding approach in working with adults who are vulnerable that can look to incorporate all community contacts who could contribute to safeguarding and supporting individuals in the community. This is to be inclusive of working with charities, drop-in services and such like, as well as family members and friends. Training for homeless drop-in centres to be made available and kept up to date, possibly through the local housing authority. • **Documenting Defensible Decision Making** - Record keeping and decision making needs to be defensible by all agencies. Recording needs to be in line with individual agency policies and procedures. Managerial supervision should also be documented, where sought. • **Carers** - multi-agency partners must review how assessments of carer needs are undertaken and raise wider awareness of the need to refer for formal carer assessments. • **Alcohol/substance dependency** - In cases where alcohol or substance related vulnerabilities are evident, the police should be alive to the fact that individuals who are

		regularly intoxicated should not be considered less at risk purely because of the frequency of their intoxication. Any immediate risks associated with their intoxication, including when and how best they can be interviewed, should be factored into decisions made about their care and safety. • Kent Police to consider and be mindful to best practice guidance (e.g. College of Policing) which allows for the taking of initial accounts and statements from individuals, who allege being the subject of a crime but who are intoxicated at the point of contact. • **Referral Forms -** The KMSAB to consider the use of a more unified Safeguarding Referral multi-agency form to be used by all agencies, when raising adult safeguarding concerns.
Elizabeth Eastley Published: 9 January 2023 **Traditional Review**	Elizabeth Eastley was a 72-year-old, white British female. She was resident in self-contained sheltered accommodation. On 17 June 2019, Elizabeth was found deceased in her flat by the accommodation's Scheme Manager. It is believed she had been deceased for some days. She had lived in the accommodation for just over a year and had been allocated the property following an application from housing via the homelessness process. Very little was known about Elizabeth when she applied for housing, she was not registered with a GP. Her previous settled address had been in another county, decades before. She had been using a post office box address for post in a third	Learning related to: • **Legal Literacy** - It is recommended that all agencies responding to people at risk are aware of the available legislation and are confident of their own decision-making protocols and procedures. Including how to escalate concerns when a partner agency's response does not appear to be proportionate to the individual's needs. • **Specific action for housing provider** (legal literacy and KMSAB policies and procedures)- Housing provider staff to receive training on Mental Capacity Act awareness and on Kent & Medway Safeguarding Adult Boards Self-Neglect and Escalation policy and procedures.

	county for many years. Most of the questions about her past and how and why she came to be in Kent remain unknown. The review found that Elizabeth had lived in a hotel for over eight years, when this was sold, she was re-housed temporarily in another hotel by the local housing team, whilst her application for housing was progressed. She remained in this hotel for 18 months. The hotel manager, and the scheme manager where her postal address was, described Elizabeth to be well educated, well-spoken and very secretive. During the 18 months that Elizabeth was resident at the hotel she wrote regularly to the homeless and housing options teams. The letters became increasingly confused in nature. She also wrote to the hotel manager, indicating that she thought she needed to pay for the accommodation and that she would be returning to the previous hotel once it had been renovated. When offered a place in sheltered accommodation, Elizabeth wrote to the homeless officer, stating that she would not be staying for long, so didn't want to take up a property that someone else could have. No safeguarding concerns were raised about Elizabeth's state of mind and wellbeing. Elizabeth was reluctant to move to a new placement which had been identified for her and allocated by home choice. After the placement had been made, Elizabeth wrote a letter of a very concerning nature. As she had already been accommodated, the letter was scanned and saved on file. It has been confirmed that had this been seen by an officer, a safeguarding concern would have been raised. Elizabeth wrote daily to the new scheme manager, she	• **Specific action for local council** (person centred practice and embedding of policy and procedures) - Town A staff to follow their safeguarding policy and employ a person-centred approach, particularly when responding to homeless applications.

	wrote that she was expecting money from her solicitor and believed she was living in a hotel. Enquiries found that the solicitor did not represent Elizabeth, they had also received letters and were concerned. At the housing scheme Elizabeth slept in the communal living room, her belongings remained in boxes in her sparce room. She took food from the communal fridge and left notes for the cost to be added to her hotel bill. Elizabeth declined help and to register with a GP. The scheme manager made a referral to adult social care, which led to a referral to Kent and Medway NHS and Social Care Partnership Trust's (KMPT) community mental health team. Elizabeth had been known to these teams for less than three months prior to her death.	
Leon Published: 12 December 2022 **Practitioner event**	Leon was a 31-year-old white British man. He had lived alone since 2016, following a period of four years when he lived with his mother as he had struggled to live alone due to his drug and alcohol misuse. He had a dependency to drugs since his early teenage years, when he had been subject to a child protection plan. In 2014, his GP records showed he had a diagnosis of mental and behavioural disorders due to multiple drug use and use of psychoactive substances. Leon also experienced physical illness, with a persistent abscess. He reported to professionals that he had an eating disorder. In 2018 Leon stopped taking his antipsychotic medication, without seeking clinical advice, due to weight increase and he reported feeling better not taking them. In early 2019, Leon was in contact with addiction support services, his GP and other agencies. He was having 4 week reviews of his methadone prescription. By August 2019, there were increasing concerns about Leon's	Learning related to**:** • **Self-neglect** - It is recommended that all relevant agencies completing the KMSAB annual agency report, include how they have acted in relation to their initial response to self-neglect situations. • **Alcohol/substance dependency and legal literacy -** It is recommended that agencies must have arrangements in place, e.g., guidance, to support frontline workers in supporting individuals, who have long term addictions, specifically in relation to MCA and Advanced Care Planning**.** • **Multi-Agency working** - It is recommended that additional guidance for the multi-agency safeguarding adult policy and procedures is developed in terms of the wider legal frameworks available to support early interagency intervention for those with care and support needs due to addiction or self-neglect.

	wellbeing. The Pharmacy reported to the Addiction Support Service recovery worker that Leon appeared unwell. Leon also reported to his recovery worker that he was unwell and needed to be in hospital. He reported that he was not eating. The outcome was for a home visit planned for 3 September 2019. On 3 September 2019, the Addiction Support Service worker found no answer at the flat. Leon later contacted the worker and reported that he had no food for 14 days and was asking for medical attention. Leon's father visited and called 999 as Leon was not able to move, was jaundiced and very poorly. The ambulance crew, in consultation with the Single Point of Access assessed that Leon had the capacity to refuse to go into hospital. The plan was for a follow up within 72 hours and a safeguarding referral. The following day, Leon agreed to be admitted to hospital. He was assessed as self-neglecting, had not eaten for 20 days, had an abscess and pressure ulcers. His flat was deemed uninhabitable. Consideration was given to admission to hospital for a mental health act assessment. Subsequently it was deemed that he did not require an admission and had insight into his self-neglect. Leon had returned to his flat by the latter part of September 2019. The local authority attempted a home visit to complete a care needs assessment, Leon was found unresponsive and was admitted to hospital. Whilst in hospital Leon expressed concern about being discharged, due to the state of his flat, managing stairs and shopping. His family reported that he could not cope. During this period there were several services involved in attempting to support Leon. In	It is recommended that a multi-agency meeting is held to assess the risks for the individual themselves when they have been removed from a GP practice due to violence.

	November 2019, Leon became more aggressive when in contact with his GP. This resulted in him being de-registered and placed, by NHS England Primary Care Support, to a new practice. At this time the Local District Council Housing Team followed up their safeguarding concern with KCC adult social care and were informed that the concern had been assessed as not meeting the Section 42 criteria. This led to the Local District Council Housing Team making a second safeguarding referral in relation to poor mobility, not eating and utilities turned off. The outcome was a plan for a joint assessment between mental health and KCC. In December 2019, Leon self-referred to the Emergency Department where he was seen as pale and limping. He had a wound to his heel which was cleaned, dressed and he was given antibiotics. However, Leon did not attend the follow up appointment at the Urgent Treatment Centre. This was not looked into as he was deemed to have capacity. Later that month, Leon was found to have missed 3 days of methadone. It was considered unusual for him not to attend the pharmacy. This resulted in communication between the pharmacist, recovery worker, GP, and Leon's father. The recovery worker visited the home but there was no answer. They contacted Leon's father who had a key but when he visited, he found the flat was locked from inside. He contacted the police who entered the flat and found Leon deceased.	
Phyllis **Traditional Review**	The SAR in respect of Phyliss was not published for reasons of anonymity.	**Multiagency Working -** To review the Multi-disciplinary team process and consider keeping cases open if the risk to an individual has not decreased as a result of the actions agreed in the MDT**.**

		Alcohol dependency - Kent and Medway SAB to consider the roll out of training/awareness with regard to functional capacity and alcohol use. **Self neglect** - Remind agencies to use the Self-neglect policy and to ensure that there is awareness that this applies to people who can't, or won't, care for themselves. **Fire Safety** - Agencies should support Kent Fire and Rescue Service (KFRS) where a safe and well visit has taken place and equipment has been provided. There should be interagency communication to ensure that the equipment is being used. If circumstances change and/or the equipment needs to be re-issued then agencies must contact KFRS to report this. Where equipment is refused, agencies should work together to determine best support arrangements.

The Board is reliant on partner agencies to share the learning from reviews and incorporate these into practice. To measure the effectiveness of this, the Board's 2022 Self-Assessment Framework included a requirement for agencies to evidence how learning from reviews is shared with staff and the mechanisms in place to measure the impact of this in practice/increase in knowledge.

It is acknowledged that, due to the covid pandemic and other factors, some of the reviews published over this reporting period relate to more historic incidents. However, the KMSAB does not wait until a report is concluded to share and act upon themes and findings. The inter-relationships between the working groups and the role of the business group enables themes to be raised from SAR decision making stage onwards. These are then addressed in each working groups' work programmes. Previous annual reports have identified the work that has taken place to address the recommendations made in the SARs listed above.

The table below provides a summary of some of the actions taken by the Board to address the recommendations made in SAR reviews, or measure the impact of learning. These are in addition to activity that individual agencies undertake.

Recommendation/Theme	Actions taken by the Board
Multi-agency working and information sharing This theme was a feature in (11) 79% of the SARs published during this period. In addition, it is acknowledged that this will be a theme in all reviews as for a mandatory Safeguarding Adults Review (SAR) to be commissioned, it must meet the criteria set out in the Care Act 2014, this includes the condition that *"there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult*".	• KMSAB policy and protocols have been strengthened to provide clear guidance on multi-agency working and how to escalate concerns, including the self-neglect policy. The self-assessment framework seeks assurance from agencies that these policies are shared and understood by relevant staff. • Relevant agencies have commenced work to map multi-agency risk management forums/panels including governance, referral criteria and pathways, and how actions are progressed, so that gaps and areas for improvement can be identified and addressed. • The PPPWG produced a practitioner guide document, to outline the legal basis for sharing information. • A feature of effective multi-agency working is understanding each other's roles and responsibilities, to assist with this the LGA document on Safeguarding Adults - Roles and Responsibilities has been shared widely. • The Board's training offer included a specific module on collaborative working in multi-agency Section 42 Enquiries. The importance of effective multi-agency working is featured in all other courses. • Although outside of this reporting period, the KMSAB has agreed to develop a Multi-Agency Risk Management Framework, as these have been identified as good practice in other areas.

Identifying and responding to self-neglect and hoarding
 	
This theme was a feature in (8) 57% of the SARs published during this period.
	• The 2022 SAF included the following standards:
	  ○ The agency / organisation raises awareness of the Kent and Medway Multi Agency Policy and Procedures to Support People that Self Neglect or Demonstrate Hoarding Behaviour, to relevant staff
	  ○ Employees/Staff /Volunteers within the agency/ organisation are implementing the Kent and Medway Multi Agency Policy and Procedures to Support People that Self Neglect or Demonstrate Hoarding Behaviour appropriately, effectively and in a timely manner
	  ○ The organisation provides clear information to those at risk of self-neglect and/or hoarding regarding the support that can be provided.
	• The KMSAB Training Programme included a module on self-neglect and hoarding, the module was extended from half a day to a full day's training.
	• The Kent and Medway Multi-agency policy and procedures to support people that self-neglect or demonstrate hoarding behaviour was reviewed in relation to the 'lead agency' procedure and was launched in September 2022. Although after the reporting period for this annual report, the accompanying quick guide was reviewed and updated, to reflect the changes made to the main document.
	• The Board hosted two safeguarding adult review learning events which focused on self-neglect and hoarding.
	• National safeguarding adult awareness week included a dedicated day for self-neglect – Tuesday 22 November 2022.
	• The annual agency report included the following requirement: *all agencies to include how they have acted in relation to their initial response to self-neglect situations.*

Safe-discharge from hospitals This theme was a feature in (5) 36% of the SARs published during this period	Board members are aware of the national and local pressures in relation to hospital discharge and have sought updates through related meetings. In addition, safe discharge falls under priority 5 of the Kent and Medway Integrated Care Strategy**.** • In February 2021, representatives from 4 acute hospital trusts, 3 community trusts and the Director of Adult Social Services, for both Kent County Council and Medway Council attended an Extraordinary Meeting of the KMSAB to provide assurance and to detail any improvement activity in

	relation to safe-discharge from hospital. • Following this meeting, relevant agencies have been required to provide updates on progress. • The ICB commissioned improvement activity through their System Quality Group. The Chief Nurse met with the Chair of the Board, to provide assurance. • Improvement activity was measured through the 2022 self-assessment framework, which included the following standard: ○ Discharge pathways (including discharge to assess) ensure the safe transition between inpatient hospital settings and community or care home settings for adults with social care needs. Due consideration is given to adult safeguarding within this. There are means of assessing whether the plan is being delivered or whether a review is required. • Healthwatch Kent and Medway conducted a thematic analysis of all feedback received by Healthwatch Kent and Healthwatch Medway concerning people's experiences of NHS hospital discharge from 1 December 2021 to 30 November 2022. As this was mostly from people who contacted Healthwatch proactively, there was a bias towards the negative, accounting for 31 of the 32 pieces of feedback received. • In addition, Healthwatch spoke to ten carers with recent experiences of their loved one being discharged from hospital and 15 professionals from the NHS, social care and the voluntary sector who work with carers or could influence changes in their support. They produced this report and accompanying actions. What happens when the person you care for is discharged from hospital? | Healthwatch Kent
Carers, including raising awareness of a carers right to a formal carer's assessment. This theme was a feature in (5) 36% of the SARs published during this period	• Communication relating to carer's assessment has been sent to agencies and promoted using different media. • The KMSAB Business Unit developed and promoted a specific webpage for carers, which can be found here. The page includes useful links and resources. • As a quality assurance measure, the 2021 SAF included the following question: ○ How does your agency assure that it meets its legal obligations under the Care Act so that carers are referred for a Carer's Assessment, or the need for a Carer's Assessments is highlighted to the Local Authority? This measure will also be included in the 2023 SAF. • As the theme of carers has also been a feature within Domestic Homicide Reviews, the Kent and Medway Safeguarding Adults Board and the Kent Community Safety Partnership hosted a joint

	learning event. A further joint event is planned for November 2023, to coincide with National Safeguarding Adults Awareness Week. • Communication and Engagement Working Group has supported and raised awareness of 'carers week' June 2023 and produced a social media content plan for all agencies to utilise.
Legal literacy This theme was a feature in (4) 29% of the SARs published during this period.	• The KMSAB training offer includes a module on legal literacy. • Practice Policies and Procedures working group members updated the multi-agency policy document to include situational incapacity and inherent jurisdiction. • Practice, Policies and Procedures working group produced a practitioner guide to outline the legal basis for sharing information. • The Board reviewed and further updated the escalation policy and raised awareness. • The Board Business Unit hosted an open session on the application of the Mental Capacity Act 2005. • The Board Business Unit hosted a SAR Learning event on "Improving Partnership Working – Managing Complexity and Capacity". • To measure how learning has been shared and embedded, the 2022 Self-assessment framework included the following standards: o The agency/organisation ensures that staff are aware of their legal responsibilities and powers to safeguard adults o Relevant staff working with adults at risk are aware of the legal powers of intervention (as referenced in the KMSAB self-neglect policy) and how and when to apply them. This includes Inherent Jurisdiction. o Consent is sought from the individual (where it is safe to do so) before a referral is made to adult safeguarding. Decisions on consent are well documented. o Relevant staff working with adults at risk are aware of the Mental Capacity Act and how and when to apply it. Decision making is recorded appropriately. o Decision making in relation to adult safeguarding is clearly recorded, justified and proportionate. o Staff are aware of the legal basis for sharing information and are confident in applying this to safeguarding adults.

Working with individuals who are dependent on alcohol or substances. Including co-occurring conditions This theme was a feature in (4) 29% of the SARs published during this period.	• SAR findings were shared with Kent and Medway Public Health teams, to inform their work in this area. • Presentations on SAR findings have been delivered to relevant meetings, such as those concerning co-occurring conditions (mental ill health and substance dependency). • Alcohol Change's research documents; "Learning from Tragedies – an analysis of alcohol related safeguarding adults reviews" ; "The Blue Light Approach: Identifying and addressing cognitive impairment in dependent drinkers", and "How to use legal powers to safeguard highly vulnerable dependent drinkers", were circulated to all KMSAB and working group members, and included in the newsletter and KMSAB webpages, to reach a wider audience. • In October 2022, Mike Ward from Alcohol Change delivered an open session on alcohol dependency, providing more information on the research listed above. • The Board has commissioned a thematic review of SARs where alcohol dependency is a factor. • The Practice Policies and Procedures Working Group has established a co-occurring conditions task and finish group. • The Communications and Engagement Working Group helped to promote alcohol awareness week 2023. • The 2023 SAF will include the following measure: ○ The organisation promotes awareness of co-occurring conditions (mental health and substance/misuse) and demonstrates processes and person centred practice to overcome any potential barriers to engagement.
Barriers to engagement - how to work with individuals at risk of harm who decline services This theme was a feature in (3) 21% of the SARs published during this period. **Person Centred – Strength based**	• As part of the Board's work to address the theme of barriers to engagement, working groups have also focused on ways to increase engagement, such as making safeguarding personal and making information accessible. For example, the Practice, Policies and Procedures Working Group members developed a dedicated page on the KMSAB website. The Board's how to recognise and report abuse literature has been translated into 26 different languages, in addition to a British Sign Language version, as well as an easy read guide. • The Board hosted a safeguarding adult review learning event on barriers to engagement, as part of this event, delegates co-produced a good practice guide, which was shared with agencies.

practice.
This theme was a feature in (4) 29% of the SARs published during this period
	• The quality assurance working group asked member agencies, through their self-assessment framework return, to evidence the following:
	  ○ The communication needs of individuals are taken into account when engaging with them
	  ○ Making safeguarding personal is understood and applied within safeguarding practice and that the individual and/or their advocate is involved throughout
	  ○ The 'think family' approach is applied when working with individuals
	  ○ Relevant staff working with adults at risk are aware of the legal powers of intervention (as referenced in the KMSAB self neglect policy) and how and when to apply them. This includes Inherent Jurisdiction
	• The KMSAB facilitated open sessions which included 'deaf awareness and safeguarding' and 'working with people with alcohol dependency'.
	• The new KMSAB strategic plan made "promoting person centred safeguarding" a priority area.
	• As part of the annual agency report 2022-2023, agencies were asked to describe what they have done to achieve priority 1, of the previous strategic plan, which includes to listen to the voice of the adult and make sure that safeguarding is personal wherever possible. Good practice examples are included in Appendix 2.

Quality of referrals **referral mechanisms** - the different ways in which concerns are reported to the local authority and the consequences of this. This theme was a feature in (4) 29% of the SARs published during this period.	• In February 2022, the Independent Chair of the Board convened a meeting with relevant partners to discuss this theme. He requested that the statutory agencies and South East Coast Ambulance Service work together to develop a consistent approach or an agreeable compromise which mitigated against the risks. • This theme has been raised nationally. • The Safeguarding Adult Review Working Group developed a one page guide on what makes a good referral and why the content of a referral is so important, this was promoted through communication and engagement activity Why the content of any Referral is so important (kmsab.org.uk)

Defensible decision making This theme was a feature in (3) 21% of the SARs published during this period.	• All KMSAB training modules cover defensible decision making and the importance of accurate recording. • When reviewing and updating policies and procedures, the Practice, Policies and Procedures Working Group ensure that defensible decision making is included. • The 2022 Self-Assessment framework included the following standard: ○ Decision making in relation to adult safeguarding is clearly recorded, justified and proportionate.

Glossary of terms

Autistic Spectrum Disorder	Autism is a lifelong developmental disability which affects how people communicate and interact with the world. Autistic people may: • find it hard to communicate and interact with other people • find it hard to understand how other people think or feel • find things like bright lights or loud noises overwhelming, stressful or uncomfortable • get anxious or upset about unfamiliar situations and social events • take longer to understand information • do or think the same things over and over Autism is known as a "spectrum" disorder because there is wide variation in the type and severity of symptoms people experience. More information is available here.
Aspiration Pneumonia	Pneumonia is swelling (inflammation) of the tissue in one or both lungs. It's usually caused by a bacterial infection or a virus. As well as bacterial pneumonia, there are other types of pneumonia, including aspiration pneumonia– caused by breathing in vomit, a foreign object, such as a peanut, or a harmful substance, such as smoke or a chemical. More information is available here.
Bipolar affective disorder	www.nhs.uk "Bipolar disorder is a mental health condition that affects your moods, which can swing from one extreme to another. It used to be known as manic depression." More information is available here.
Care Programme Approach	The term Care Programme Approach (CPA) describes the framework that supports and co-ordinates effective mental health care for people with severe mental health problems in secondary mental health services. In 2008 the Department of Health issued national guidance in the form of documentation entitled 'Refocusing the Care Programme Approach' with the aim of providing a wider focus for all service users which ensures consistency and ensuring that the focus is centred upon a good quality of care. More information is available here.
Care Quality Commission (CQC)	The CQC is the independent regulator of health and social care in England. They monitor, inspect and regulate health care providers to make sure they meet fundamental standards of quality and safety, ensuring the best possible care for patients, service users and their family and friends. More information is available here
Cirrhosis	Cirrhosis is scarring (fibrosis) of the liver caused by long-term liver damage. The scar tissue prevents the liver working properly. More information is available here.

Clutter Score/Clutter Image Rating	the Clutter Image Rating has been developed to assist in identifying and sharing hording concerns. The images can be found here. More information on how to respond to self-neglect and hoarding concerns can be found here.
CONTEST Counter-terrorism strategy	The aim of CONTEST is to reduce the risk from terrorism to the UK, its citizens and interests overseas, so people can live freely and with confidence. More information is available here.
Emotionally Unstable Personality Disorder	Emotionally unstable personality disorder (EUPD) is also known as borderline personality disorder. It is commonly characterised by pervasive instability of interpersonal relationships, self-image and mood and impulsive behaviour. More information is available here.
Integrated Care Board (ICB)	A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the Integrated Care System area.
Integrated Care System	Integrated care systems (ICS) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. More information is available here.
Kent Enablement at Home (KEAH)	Kent Enablement at Home (KEAH) is managed by Kent County Council. It is for people who need support to regain their independence after a medical or social crisis. The service helps adults to do more for themselves at home, by learning or re-learning skills that make them feel safe and happy in their own home. Enablement is a time limited service which is provided free of charge, for up to 6 weeks.
Kent and Medway NHS and Social Care Partnership (KMPT)	KMPT provide secondary mental health services across Kent and Medway, both in the community and within inpatient settings. More information is available here
LeDeR	Research has shown that on average, people with a learning disability and autistic people die earlier than the general public, and do not receive the same quality of care as people without a learning disability or who are not autistic. LeDeR reviews deaths to find areas of learning, opportunities to improve, and examples of excellent practice. This information is then used to improve services for people living with a learning disability and autistic people. More information is available here.
Making Safeguarding Personal	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.

Mental Capacity Act 2005 (MCA)	The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The MCA is designed to protect and restore power to those vulnerable people who lack capacity. Capacity should also be assumed unless there is a reason to suggest otherwise, in which the MCA applies.
Multi-Disciplinary Team (MDT) – Primary Care	A multidisciplinary team (MDT) is a group of health and care staff who are members of different organisations and professions (e.g., GPs, social workers, nurses), that work together to discuss the care and treatment of individual patients. MDTs are used in both health and care settings.
Necrosis of wounds	This is where the wound tissue has died and is no longer viable so cannot heal, this tissue is normally cut away until viable tissue is exposed to allow healing.
Personality disorder	A person with a personality disorder thinks, feels, behaves or relates to others very differently from the average person. There are several different types of personality disorder and symptoms vary depending on the type of personality disorder. Mixed personality disorder refers to a type of personality disorder that does not fall into the ten recognised personality disorders. More information is available here.
Peripheral Vascular Disease	Peripheral Vascular Disease, also known as Peripheral Arterial Disease (PAD), refers to the development of narrowing and blockage of the arteries of the limbs and can lead to pain the legs when walking or foot sores. In severe cases it can lead to infection and ultimately amputation.
Prevent	The aim of the Prevent Strategy is to stop people becoming terrorists or supporting terrorism. Prevent tackles all forms of extremism – including both Islamist extremism and far right threats. Prevent has 3 key objectives: • respond to the ideological challenge of terrorism • support vulnerable people and prevent people from being drawn into terrorism • work with key sectors and institutions to address the risks of radicalisation.
Psychosis	www.nhs.uk "Psychosis is when people lose some contact with reality. This might involve seeing or hearing things that other people cannot see or hear (hallucinations) and believing things that are not actually true (delusions)". More information is available here
Schizophrenia	Schizophrenia is a severe long-term mental health condition. It causes a range of different psychological symptoms. Doctors often describe schizophrenia as a type of psychosis. This means the person may not always be able to distinguish their own thoughts and ideas from reality. More information is available here.

Section 117 "Aftercare"	s117 of the Mental Health Act 1983 (Amended 2007) imposes a joint duty on the Local Social Services and the Integrated Care Board (ICB) to plan and provide after-care services, free of charge, to those who have been detained under applicable sections of Mental Health Act (MHA) The ultimate aim of s117 is to enable the individual to remain in the community, with as few restrictions as are necessary, wherever possible. More information is available here.
Section 42 Enquiry	An enquiry is any action taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.
Section 136	Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.
Sepsis	Sepsis is a life-threatening reaction to an infection. It happens when the immune system overreacts to an infection and starts to damage the body's own tissues and organs. More information is available here.
South East Coast Ambulance Service NHS Foundation Trust (SECAmb)	Respond to 999 calls from the public, urgent calls from healthcare professionals and provide NHS 111 services across the region. More information is available here.
Spinal stenosis.	Spinal stenosis is a term used to describe the narrowing of the spinal canal, which may progress to cause compression of the spinal nerves and can cause back pain and/or leg pain.

Kent and Medway Safeguarding Adults Annual Report 2022-2023. Appendix One – Safeguarding Data

Contents

Medway Council Data

1. Background to the data

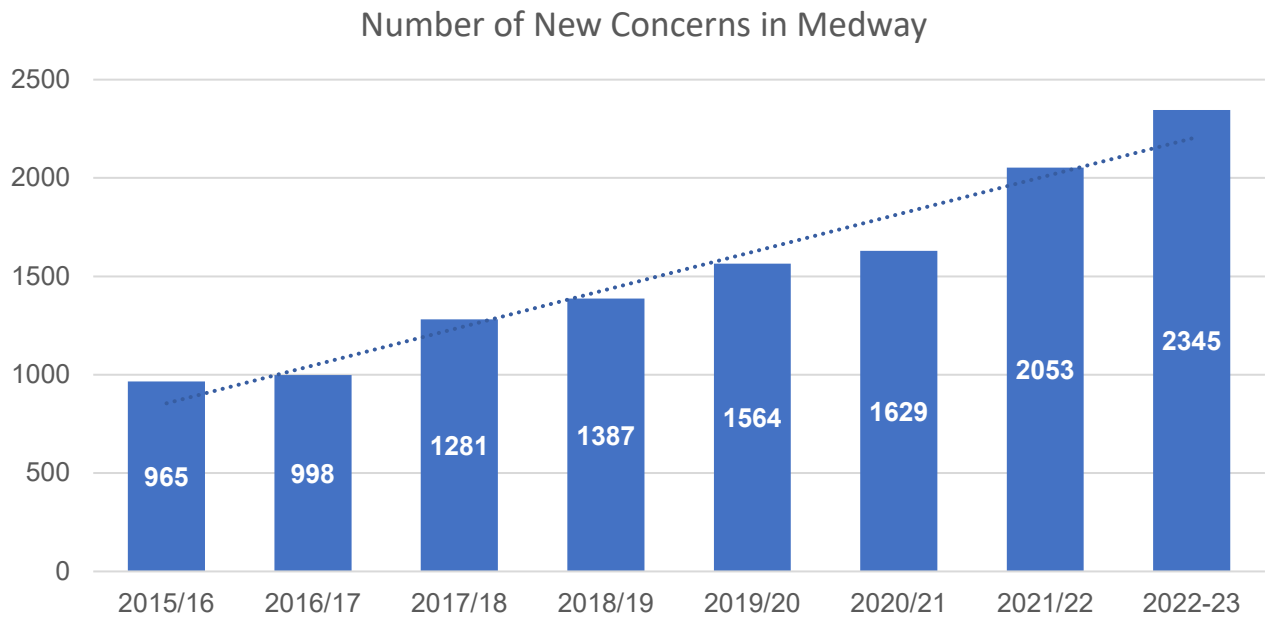
The data in this report is extracted from Medway's electronic monitoring system – MOSAIC.

The data has been submitted to NHS Digital as part of the annual statutory return for safeguarding adults the SAC (Safeguarding Adults Collection).

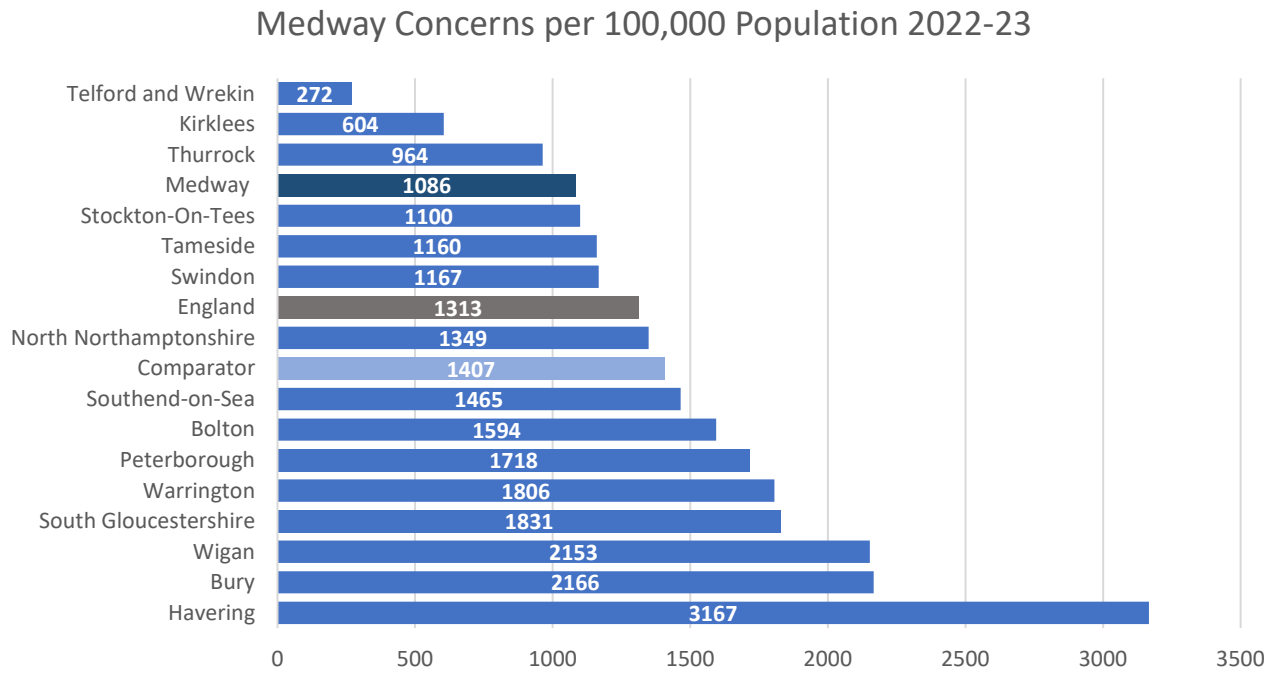
2. New Safeguarding Concerns and Enquiries

2.1 New Concerns

The following section looks at the number of new concerns and enquiries raised in 2022-23 and the demographics of individuals subject to a new safeguarding enquiry. The analysis covers annual trends and comparisons with other local authorities in Medway's CIPFA (nearest neighbours model) comparator group.

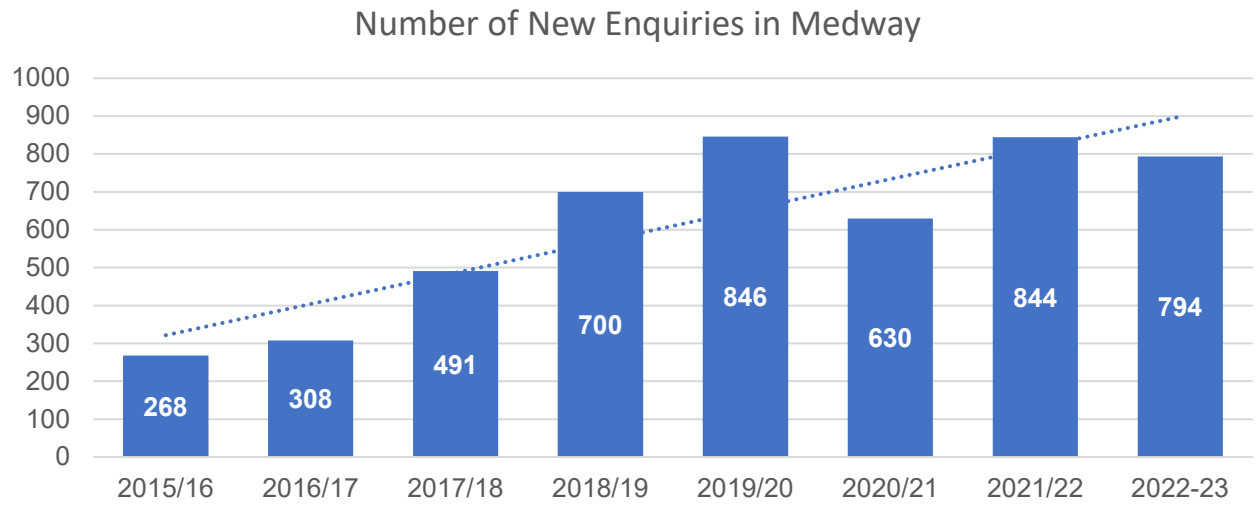


The number of new safeguarding concerns raised in Medway has seen a consistent increase since 2015-16 to 2020-21. There was a more significant increase of 26% from 2020-21 to 2021-22 and a lower increase between 2021-2022 and 2022-23 of 14%. However, the increase between 2020-21 and 2022-23 is 44% which may be reflective of a further feeling of relaxation from the Covid 19 pandemic, it is also worth considering educational channels promoting a wider awareness of abuse, what it can look like and how to report it.



Medway ranks 4th out of the sixteen local authorities in the CIPFA comparator group for new concerns per 100,000 population in 2022-23. This is 21% below the figure seen nationally, which is closer than in 21-22 where Medway 27% below national. We continue to assess crime reports from the police or vulnerable adult alerts from SECAMB before they are raised as a Concern.

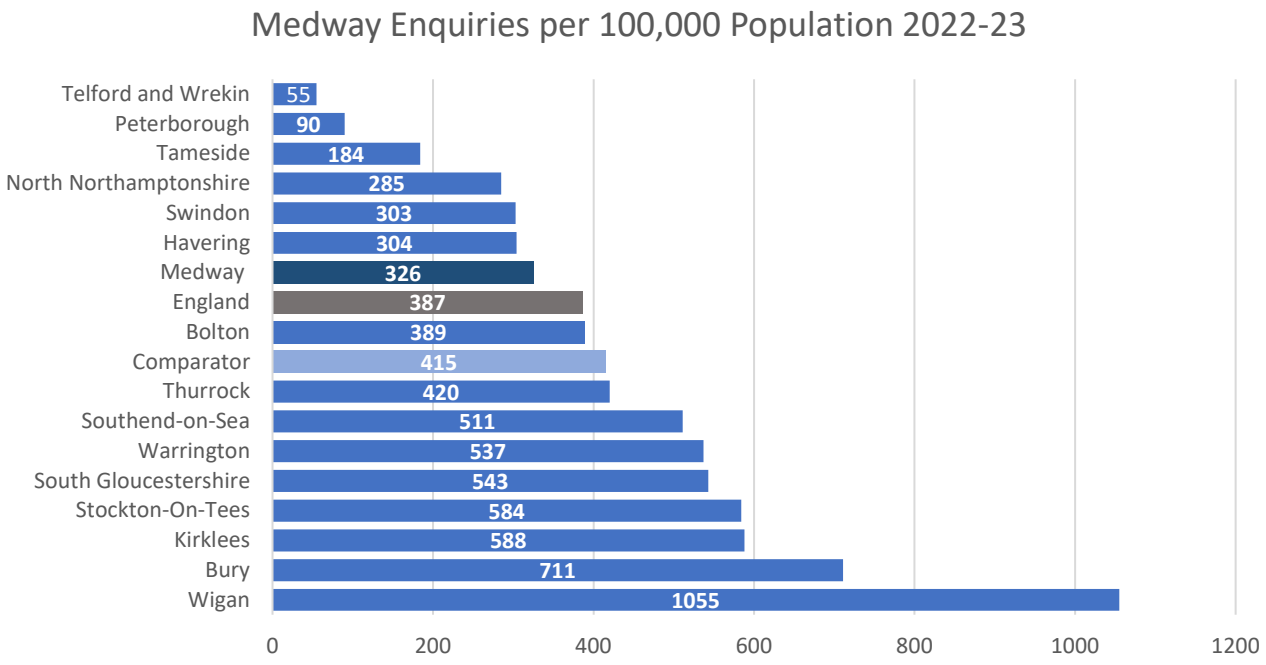
2.2 New Enquiries



There has been a 6% decrease in the number of new safeguarding enquiries raised from 2021-22, a 26% increase from 2020-21 but a slight decrease from the figure seen before the Covid 19 pandemic. Again, careful analysis will need to be conducted to ascertain the true impact the pandemic has had on raising and recording of enquiries.

New Enquiries	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022-23
Section 42	262	281	408	627	727	501	724	704
Other	6	27	83	73	119	129	120	90
Total	268	308	491	700	846	630	844	794
% Section 42	97.8%	91.2%	83.1%	89.6%	85.8%	79.5%	85.8%	88.7%

The number of non-statutory enquiries has seen a decrease of 25%, with the number of Section 42 enquiries only decreasing by 3% and therefore remaining consistent with 2019-20 and 2021-22.

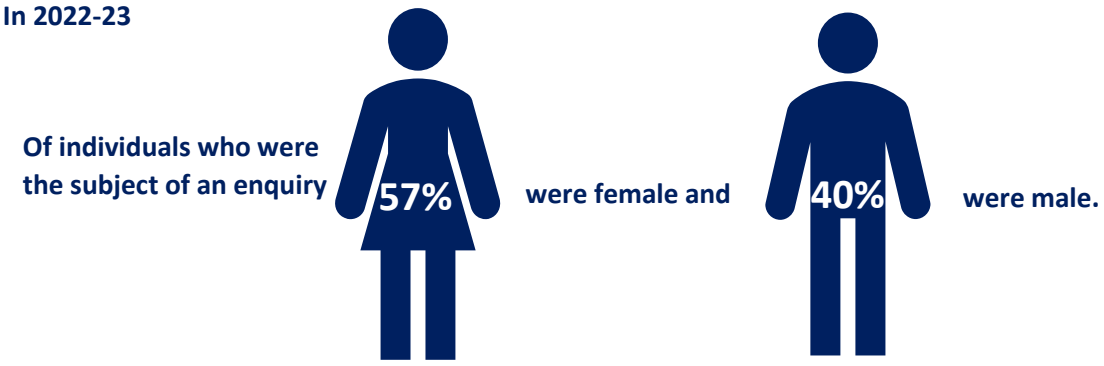


The number 2022-23 of new enquiries per 100,000 sees Medway ranked 7th within the comparator group; 19% below the national figure which was at 4% in 2021-22.

2.3 Demographics of Adults at Risk

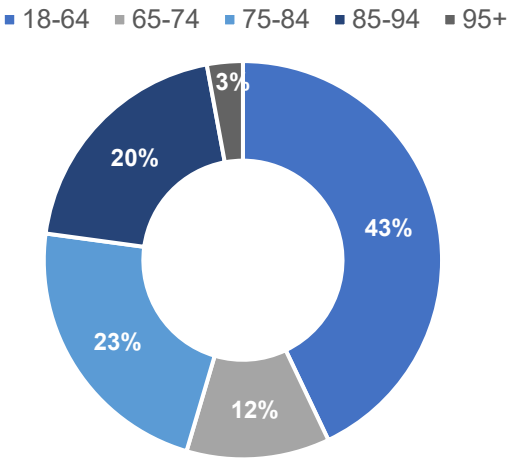
This section looks at the demographics of individuals subject to a new safeguarding enquiry in 2022-23.

Gender



There has been a consistent proportional split across genders in past reporting years. This year there were a number of unknown genders at 3%

Age Group



43% of individuals subject of a new safeguarding enquiry were aged between 18-64 years. The remaining 57% were 65+ with the larger proportions of individuals within the 75-84 and 85-94 age groups jointly accounting for 43% of the total number of individuals.

Ethnicity

Ethnicity	2019-20	2020-21	2021-22	2022-23
White	89.5%	86.4%	84.3%	83.8%
Mixed / Multiple	0.5%	0.9%	1.0%	1.1%
Asian / Asian British	2.5%	1.9%	1.7%	2.1%
Black / African / Caribbean / Black British	1.1%	1.7%	1.5%	1.9%
Other Ethnic Group	0.5%	0.9%	0.6%	1.0%
Refused	0.1%	0.0%	0.3%	0.0%
Undeclared / Not Known	5.7%	8.2%	10.5%	10.1%

The proportional split across ethnic groups for individuals subject to a new enquiry has decreased over the years by 6% from 2019-20 to now, showing the shift of ethnic diversity within Medway. The percentage of clients where the ethnicity is unknown has increased by 44% from 2019-20 to now.

Primary Support Reason

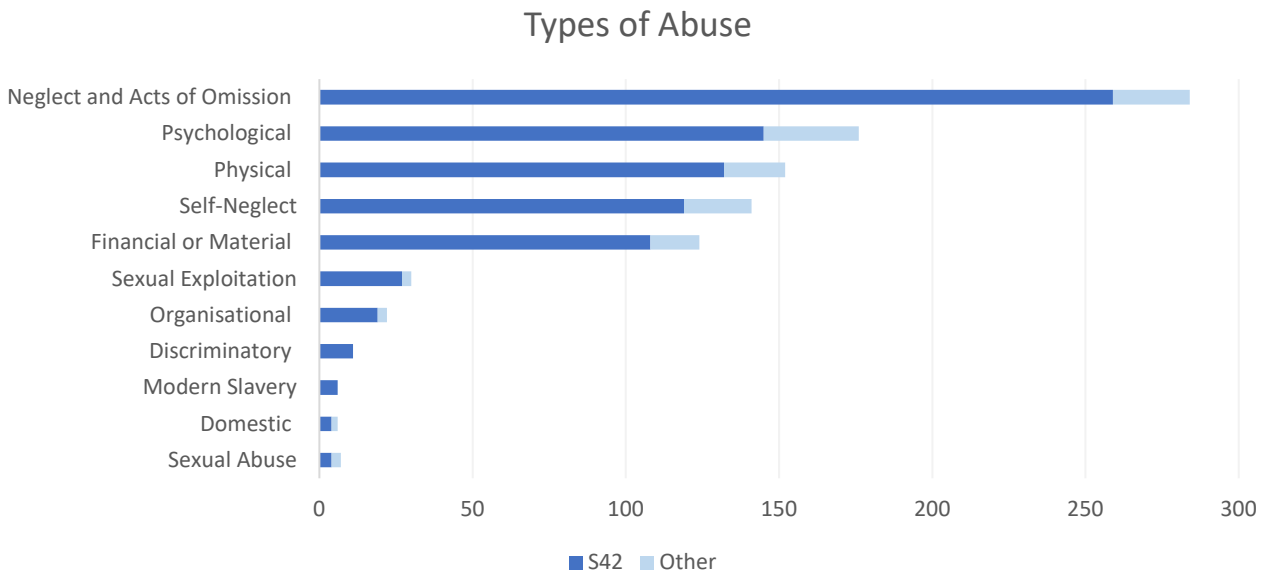
Primary Support Reason	2019-20	2020-21	2021-22	2022-23
Physical Support	42.6%	44.3%	45.3%	40.7%
Sensory Support	0.3%	0.3%	1.0%	1.0%
Support with Memory & Cognition	2.5%	2.9%	2.0%	1.7%
Learning Disability Support	4.4%	8.2%	8.4%	7.5%
Mental Health Support	1.4%	8.2%	7.2%	5.4%

Social Support	1.4%	1.7%	2.6%	3.3%
No Support Reason	43.5%	35.0%	33.5%	40.9%
Not Known	0.0%	0.0%	0.0%	0.0%

Historically the most prevalent Primary Support Reason (PSR) has been Physical Support. However, this reporting year we have seen those who are not currently receiving direct support from Medway adults social care services take a very slight lead on Physical Support. The proportion of individuals subject to a safeguarding enquiry who have a support reason of Learning Disability and Mental Health has decreased by 25% and 11% respectively, with Social Support seeing an increase of 27%.

3. Closed Enquires

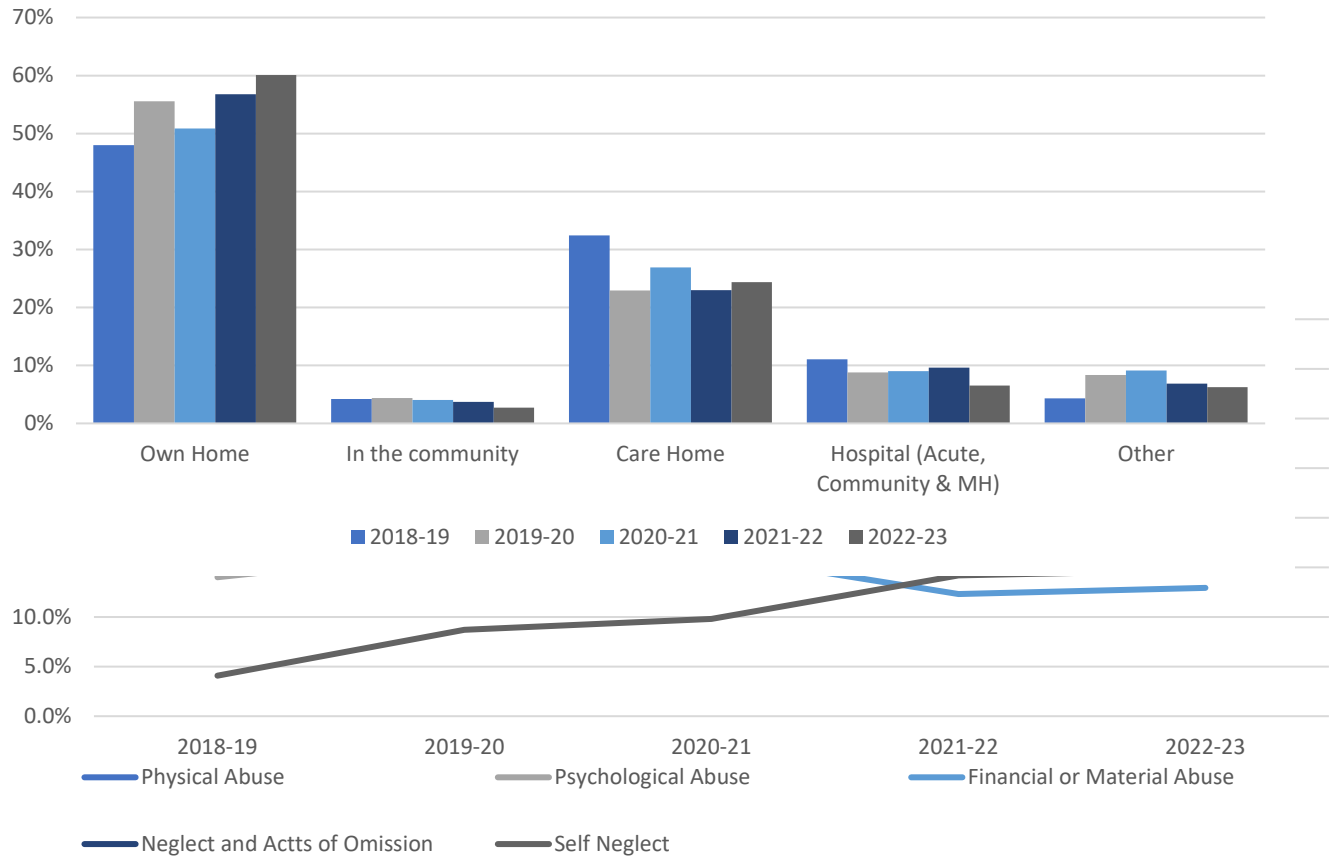
3.1 Types and Location of Abuse



The types of abuse for closed enquiries in 2022-23 reveals that neglect and acts of omission was the most prominent reason presenting in safeguarding enquires. Psychological, physical abuse, self-neglect and financial are the next most prevalent types of abuse reported.

Assessing the proportions of enquires related to the five main types of abuse over the past five years shows that neglect and acts of ommision have always made up the the highest proportion for types of abuse.

The average of enquiries over the time period remains at 31%. Both physical and financial abuse have seen a decline in proportions since 2017-18, whereas Phychological and self neglect have both increased. Phychological abuse has seen a gradual increase, 31% over 5 years, self negelct sees a much more distinct increase; 260% since 2018-19.



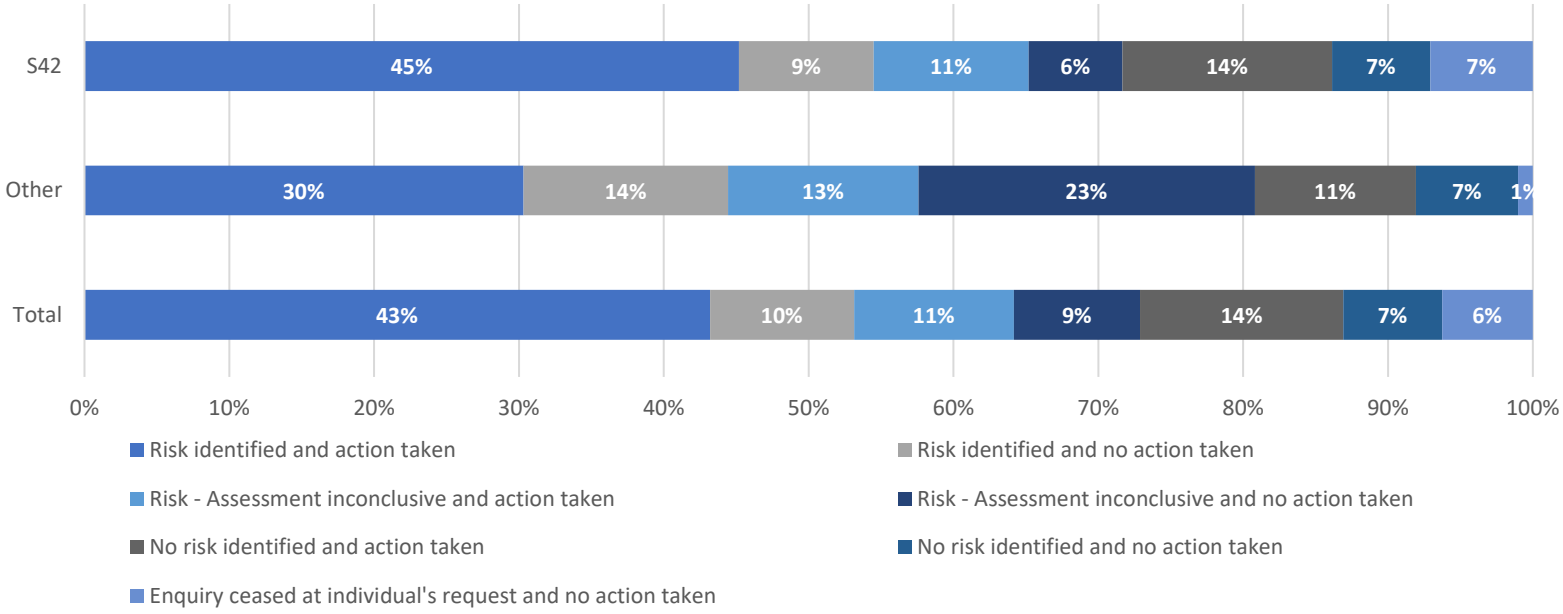
The most prevalent location of abuse has been in the victims own home and is very much on an upward trend. The proportion of incidents within hosptial settings has seen a declince since 2018/19 reducing from 11% down to 7% in 2022-23. There has been some fluctation in the proportions of safeguarding incidences in care homes. 2018-19 saw a peak of 32% but the average over the 5 years has been 26% with 24% of closed safeguarding enquiries having been recorded as happening within a care home.

4. Outcomes of Closed Enquiries

The following section looks at the outcomes for closed enquiries covering the identification of risk and actions taken. For those where risk was identified whether the risk remained or was reduced or removed. There are

cases where risk will legitimately remain after a safeguarding enquiry has been completed e.g. an individual may want to maintain contact with a family member who was identified as a source of risk.

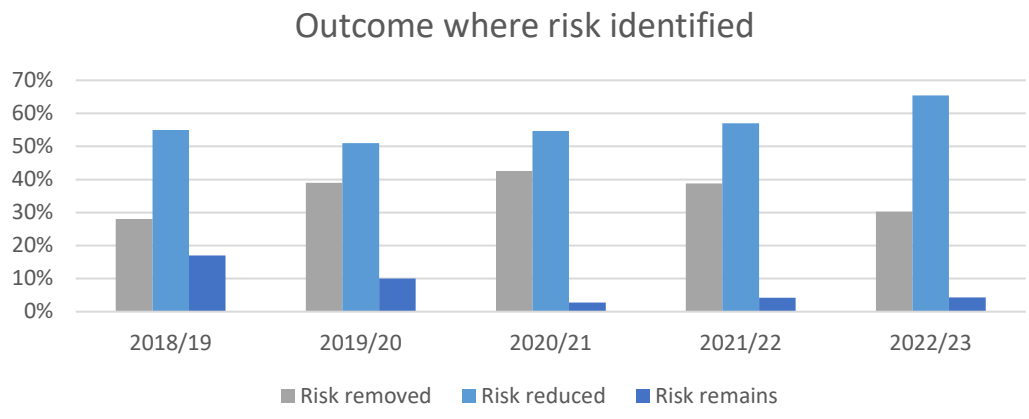
4.1 Identification of Risk



In 2022/23 53% of all closed Enquiries had a risk identified (substantiated) and 21% had no risk identified, this is in line with last year's figures of 50% and 24%. 34% of non-statutory Enquiries were inconclusive compared to 17% of S42.

68% of closed Enquiries had action taken in 2022/23 whether a risk was identified or not, compared to 72% in 2021/22.

4.2 Outcome



Where a risk was identified in a closed enquiry, 30% saw the risk removed, a decrease from 2021-22's 39%, and in 65% of cases the risk was reduced an increase on 2021-22's 57%. In the remaining 4% of cases the risk remained. This still represents a significant reduction in the proportion of cases where risk remained from 2018-19 to 2019-20 where the risk remained in 10%-17% of cases.

4.3 Making Safeguarding Personal

Making Safeguarding Personal aims to put the person and their desired outcomes at the centre of safeguarding enquiries so safeguarding becomes a process completed with the alleged victim as opposed to something done to them.

For any safeguarding enquiry, an individual or their representative is asked what their desired outcome of the investigation would be. Over the past 3 years an average of 81% of individuals (or their representative) were asked and expressed outcomes. An average of 18% were not asked and the remaining 1.6% were not recorded.

In 2022-23 for those who did express outcomes:

Over the past five years there has been a consistent decline in the proportion of those asked for their outcomes where those outcomes were not achieved and higher proportions of cases where the outcomes were fully achieved. In 2022-23 71.2% of individuals had their outcomes fully achieved, which is in line with the 2022-22 national figure of 67.1%.

Kent County Council Data

5. Background to the data

The data in this report is extracted from Kent's electronic monitoring system – MOSAIC.

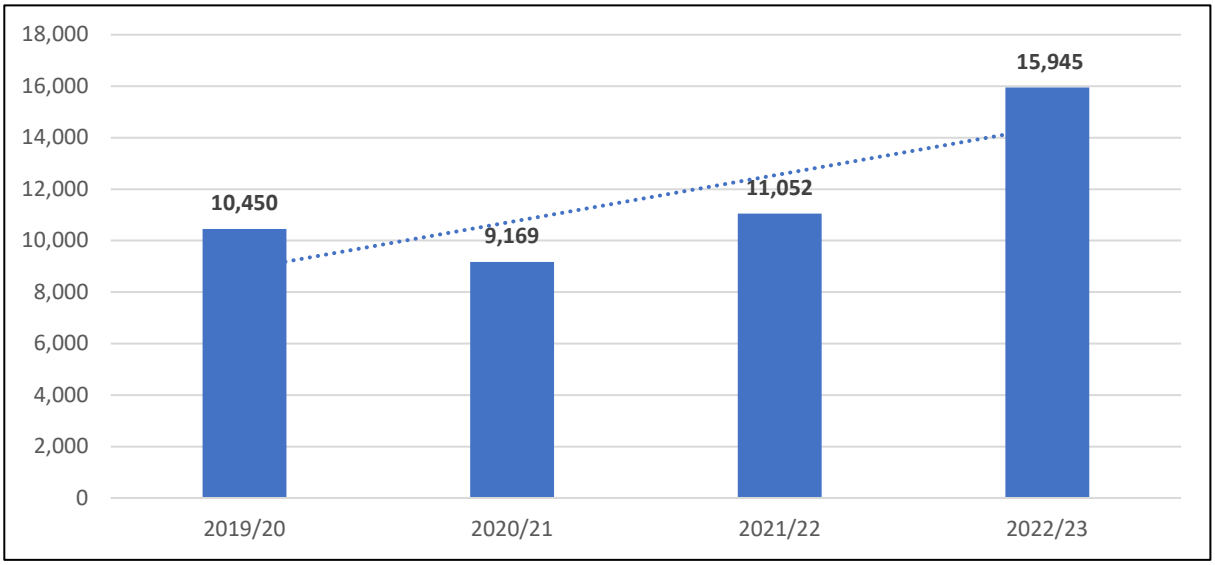
The data has been submitted to NHS Digital as part of the annual statutory return for safeguarding adults, the SAC (Safeguarding Adults Collection).

6. Safeguarding Concerns and Enquiries

6.1 Safeguarding Concerns

In 2022/23, KCC received 15,945 safeguarding concerns, this was an increase of 43% on the previous year.

Figure 1: The number of safeguarding concerns received in Kent

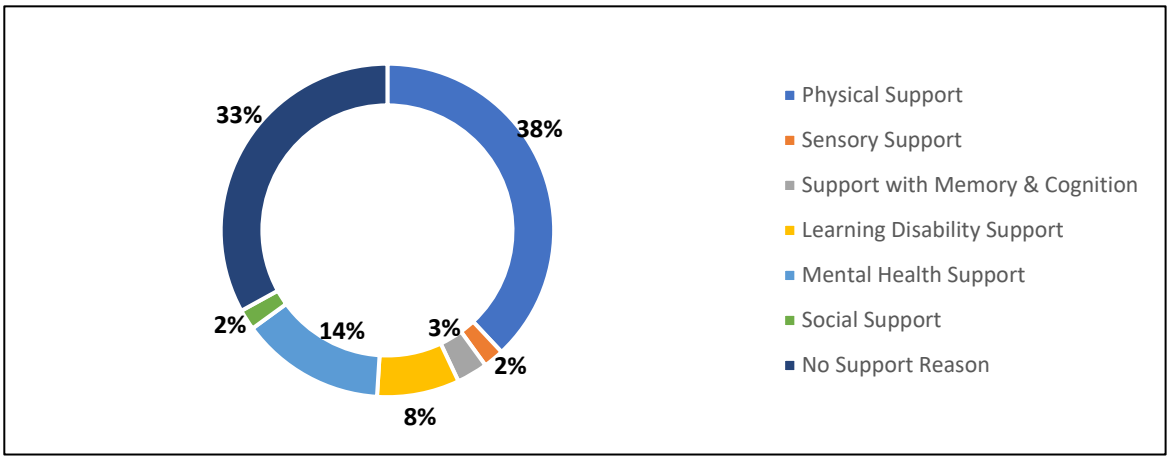


At a national level, the number of safeguarding concerns increased by 9% compared to 2021/22.

Adult Social Care (ASC) offered a safeguarding consultation service until December 2021. There was an increase in concerns being raised via the KASAF forms once this service stopped. In addition, in March 2022, ASC introduced an online safeguarding referral form for members of the public and professionals to use and ceased the use of the Kent Adult Safeguarding Alert Forms (KASAF) forms. There is a significant upturn in safeguarding concerns received via the online form. It has been noted that not all safeguarding concerns submitted require a safeguarding response and that the online form could be used incorrectly for a Care Needs Assessment or other contact from ASC. This has been noted when a person is waiting for a care needs assessment.

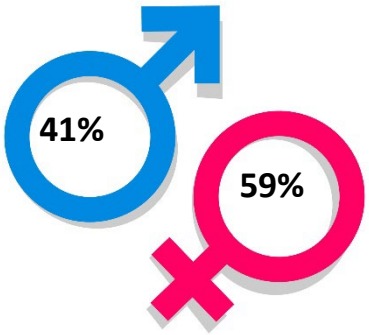
Physical Support remains the most prominent primary support reason, for 38% of individuals, followed by 33% with no support need.

Figure 2: Primary support reasons for safeguarding concerns



Primary Support Reason	2022/23 figures	2022/23 Proportion	% change from 2021/22
Physical Support	**4,321**	**38%**	**4%**
Sensory Support	**259**	**2%**	**-1%**
Support with Memory & Cognition	**329**	**3%**	**2%**
Learning Disability Support	**865**	**8%**	**-**
Mental Health Support	**1,547**	**14%**	**-**
Social Support	**209**	**2%**	**-**
No Support Reason	**3,708**	**33%**	**-5%**

Breakdown of Females and Males with a Safeguarding concern in 2022/23. There has been no significant change when compared to last year's figures.



Age Band	Kent (Census 2021)	2022/23 Concerns Proportion	% change from 2021/22
18-64	**74.2%**	**47%**	**-1%**
65-74	**13.7%**	**11%**	**2%**
75-84	**8.7%**	**19%**	**1%**
85-94	**3.1%**	**19%**	**-**
95+	**0.3%**	**4%**	**-1%**

The majority were female, mainly aged over 65 years old, and on ethnicity, white, however there was a large proportion where ethnicity was unknown or refused.

Ethnicity	Kent (Census 2021)	2022/23 Concerns Proportion	% change from 2021/22
Asian / Asian British	3.8%	2%	-1%
Black / African / Caribbean / Black British	2%	2%	-
Mixed / Multiple	1.1%	1%	-
Other Ethnic Group	0.7%	1%	-
White	90.9%	78%	2%
Not known / Refused	1.5%	16%	-1%

The levels of unknown ethnicity across Safeguarding and other areas of Adult Social Care have been raised and discussed with the Directorate Management Team.

When looking at the published figures from the national Safeguarding Adults Collection (SAC), Kent has consistently been below the National rate, which has been increasing since 2020/21. However, the accelerated increase seen in 2022/23 could put Kent above the National rate.

Figure 3: the rate per 100,000 of safeguarding concerns recevied by Kent and Nationally (source: NHS Digital)

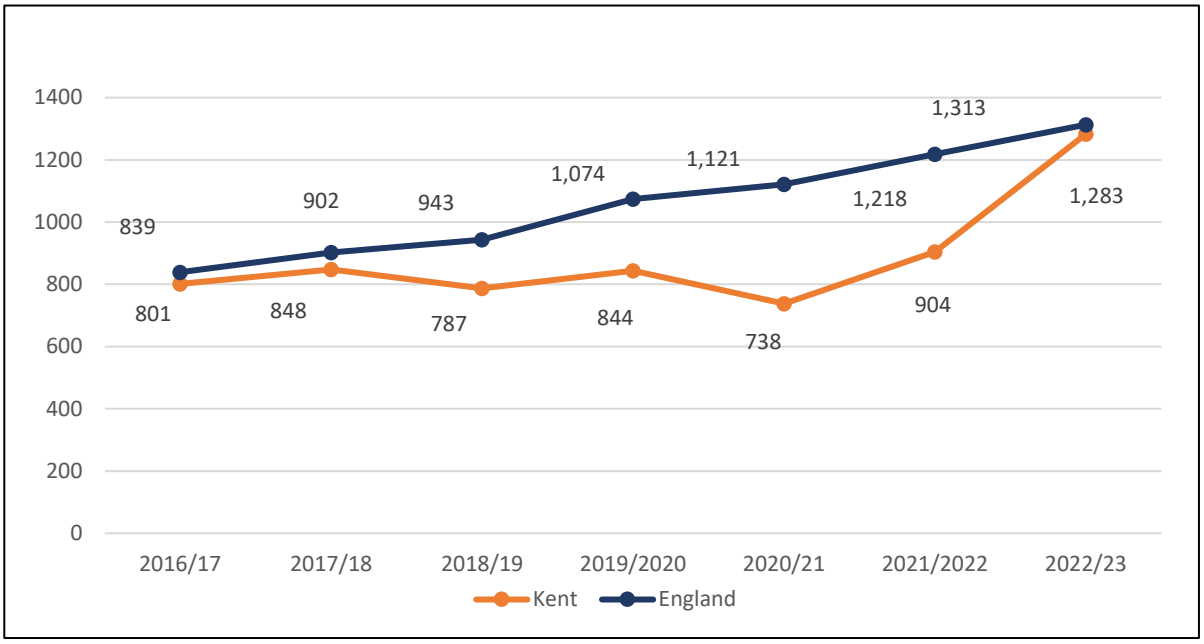
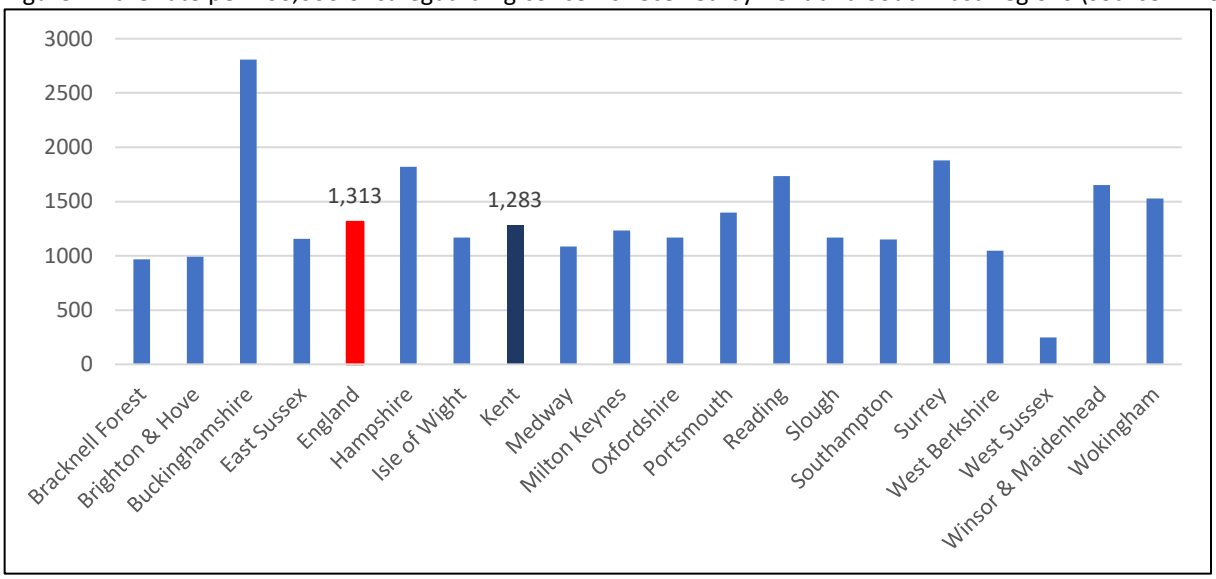


Figure 4: the rate per 100,000 of safeguarding concerns recevied by Kent and South East Regions (source: NHS Digital)



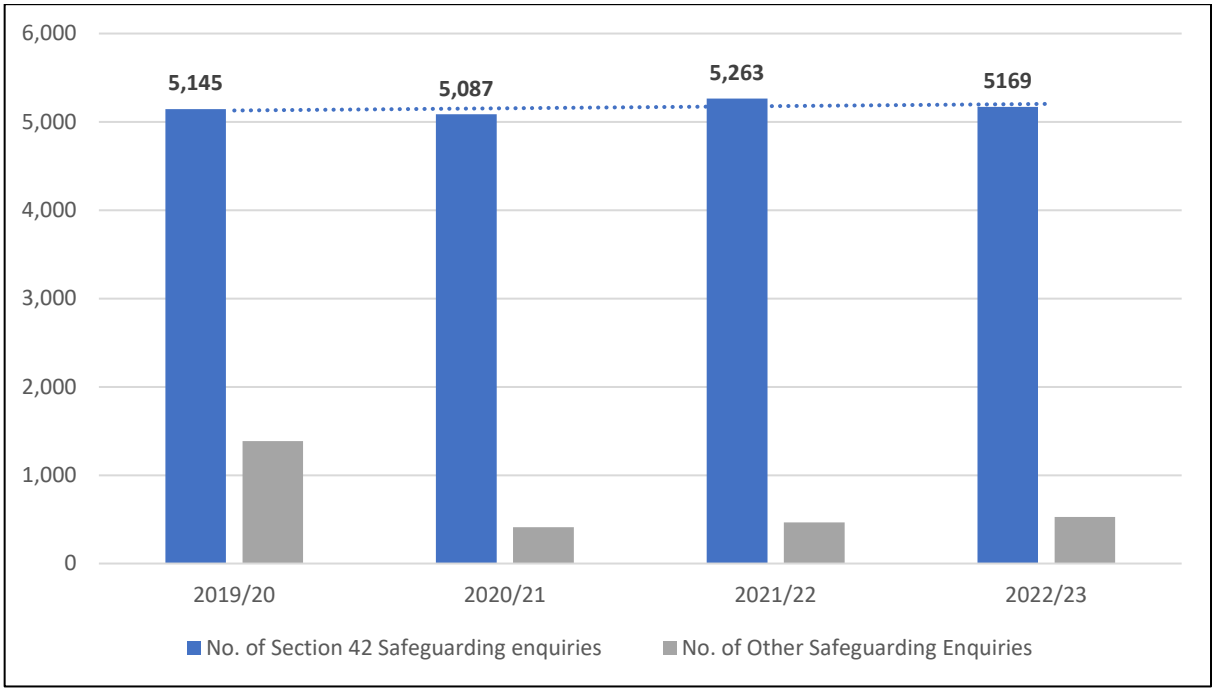
6.2 Conversions from Concerns to Enquiries

In 2022/23 the rate of conversion from concern to enquiry was 36%, which is a decrease from 52% the previous year, and 60% the year before that. As highlighted previously, not all safeguarding concerns received require a safeguarding response and this could account for why the conversion rate from concern to enquiry has decreased. Nationally, the amount of concerns that later became enquiries was 29% in 2022/23, which was a slight decrease of 1% compared to 2021/22.

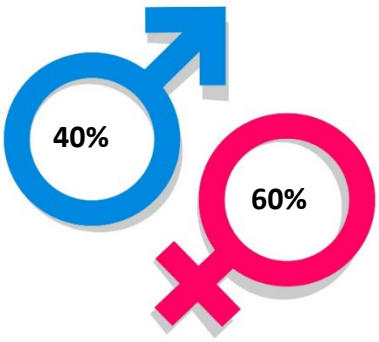
6.3 Safeguarding Enquiries Commenced

A total of 5,697 enquiries were commenced in 2022/23 which was a 1% decrease on the previous year. However, at a national level, the amount of section 42 enquiries increased by 7% compared to 2021/22 and the number of other safeguarding enquiries decreased by 21%. For the total amount of enquiries nationally, the amount increased by 4%.

Figure 5 : The number of safeguarding Section 42 and Other enquiries received in Kent



Looking at S42 enquiries only, there was no gender or age difference in those going onto a S42 Enquiry, there were proportionally more with a Physical Support reason and less with No Support reason.



Breakdown of Females and Males with a safeguarding enquiry in 2022/23.

The split between males and females remains largely the same with a small increase of 2% for females and a decrease of 1% for males.

45% of individuals subject of a safeguarding enquiry were aged between 18-64 years. The remaining 55% were aged 65+.

Age Band	Kent (Census 2021)	2022/23 Enquiries Proportion	% change from 2021/22
18-64	74.2%	45%	-2%
65-74	13.7%	11%	2%
75-84	8.7%	21%	-
85-94	3.1%	20%	-
95+	0.3%	4%	-1%

Most people were White (81%) with a 2% increase compared to last year. 13% of people did not have a recorded ethnicity.

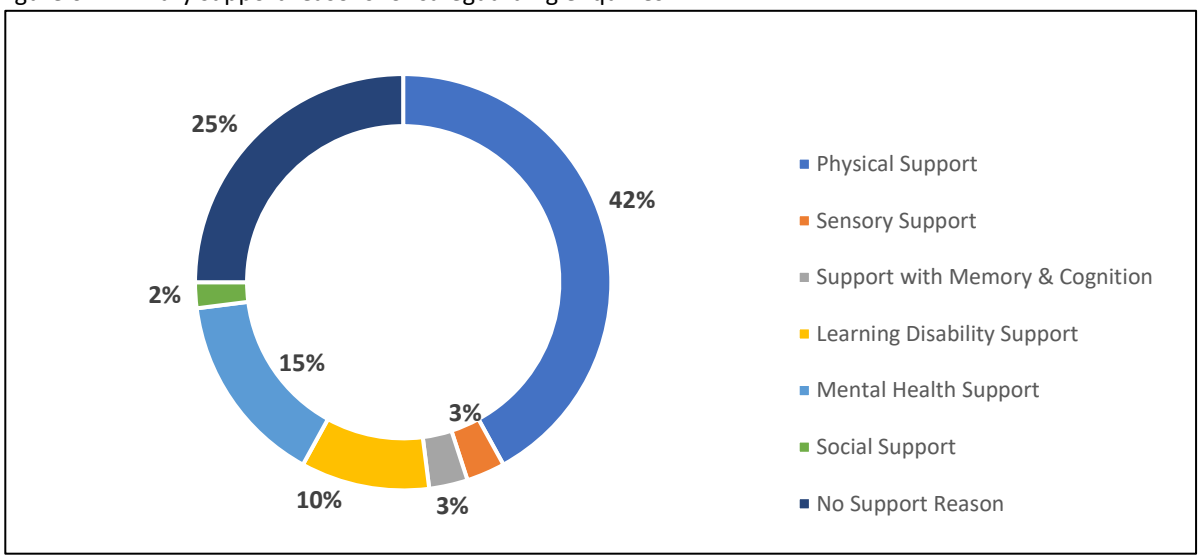
Ethnicity	Kent (Census 2021)	2022/23 Enquiries Proportion	% change from 2021/22
Asian / Asian British	3.8%	2%	-1%
Black / African / Caribbean / Black British	2%	2%	-
Mixed / Multiple	1.1%	1%	-
Other Ethnic Group	0.7%	1%	-
White	90.9%	81%	2%
Not known / Refused	1.5%	13%	-

Nationally, most people who had a safeguarding enquiry were females, aged 85 or over and were White. Also, as with the Kent data, there was also a large percentage (13%) of people who did not have their ethnicity recorded.

The most common Primary Support Reason this year was Physical Support with 42%. This is followed by people who had no support reason, which accounted for 25% of people. This is also seen at a national level with 38% of people receiving physical support followed by 17% of people not receiving support.

The proportion of people with a safeguarding enquiry who have a support reason of either Physical Support or Memory and Cognition have seen the highest increases of 3% compared to last year.

Figure 6 : Primary support reasons for safeguarding enquiries



Primary Support Reason	2022/23 figures	2022/23 Proportion	% change from 2021/22
Physical Support	**1,830**	**42%**	**3%**
Sensory Support	**114**	**3%**	**-2%**
Support with Memory & Cognition	**152**	**3%**	**3%**
Learning Disability Support	**424**	**10%**	**-3%**
Mental Health Support	**663**	**15%**	**1%**
Social Support	**77**	**2%**	**-1%**
No Support Reason	**1,099**	**25%**	**-2%**

6.4 Safeguarding Enquiries Concluded

In total 5,815 enquiries were concluded in 2022/23, 5,394 were S42 and 421 were other Enquiries.

Figure 7: the rate per 100,000 of safeguarding enquiries concluded by Kent and Nationally (source: NHS Digital)

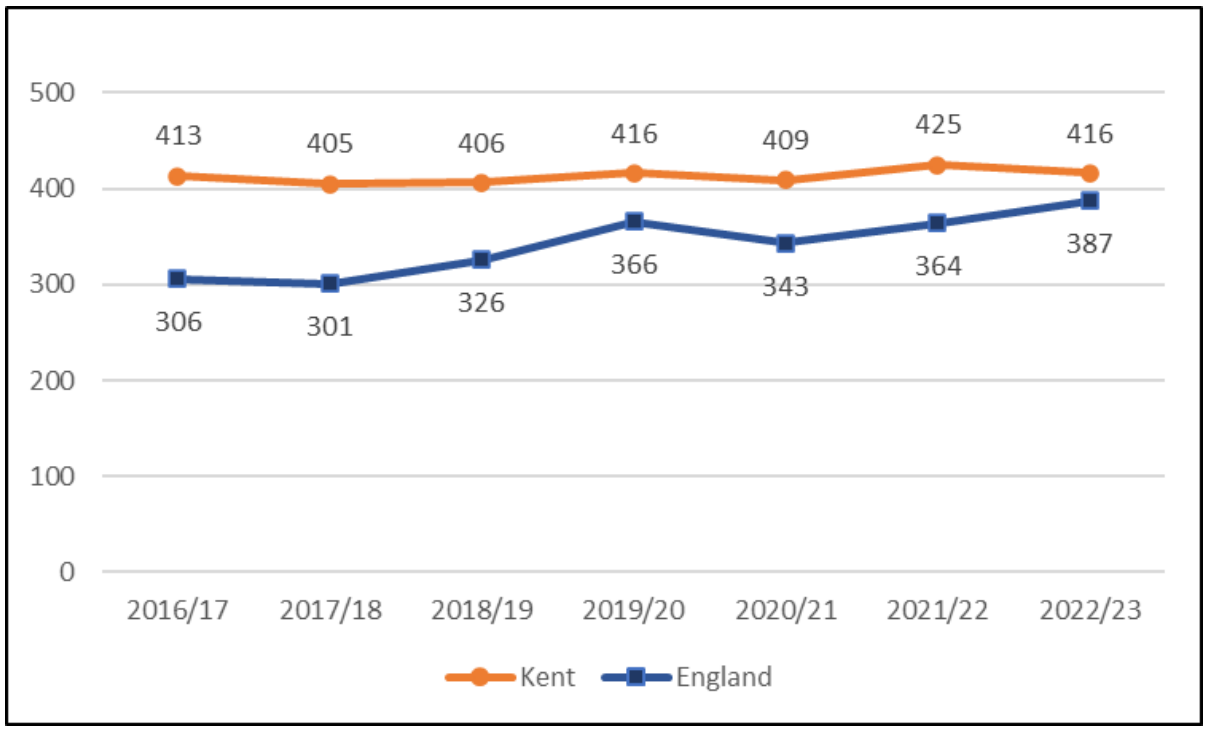
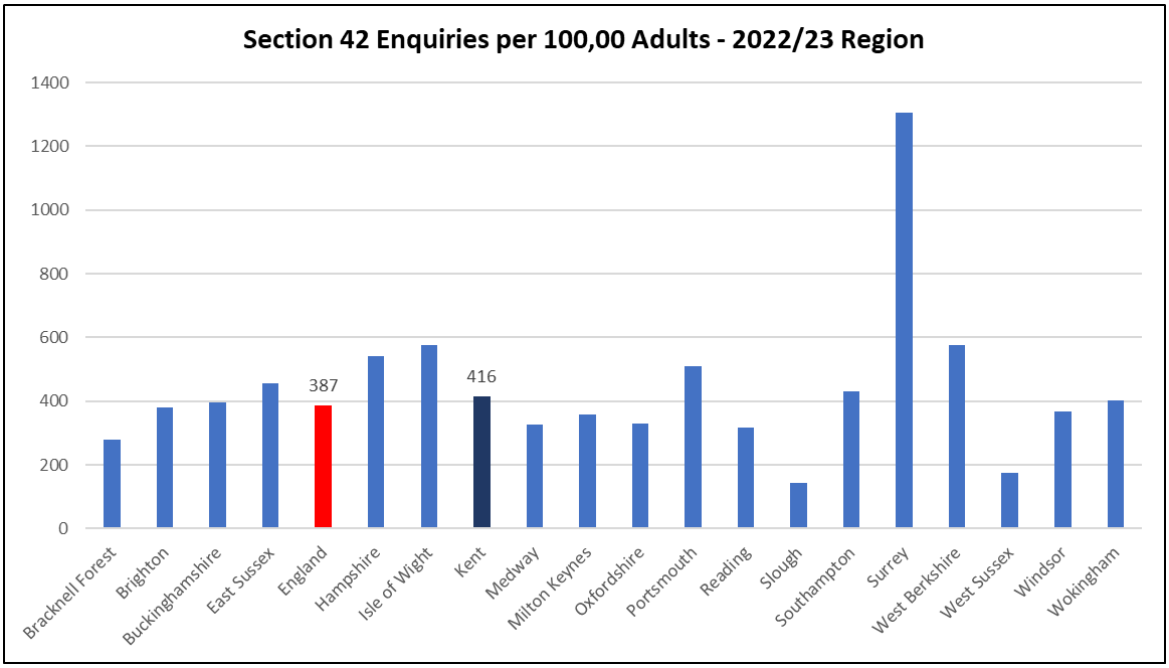


Figure 8: the rate per 100,000 of safeguarding enquiries concluded by Kent and South East Regions (source: NHS Digital)

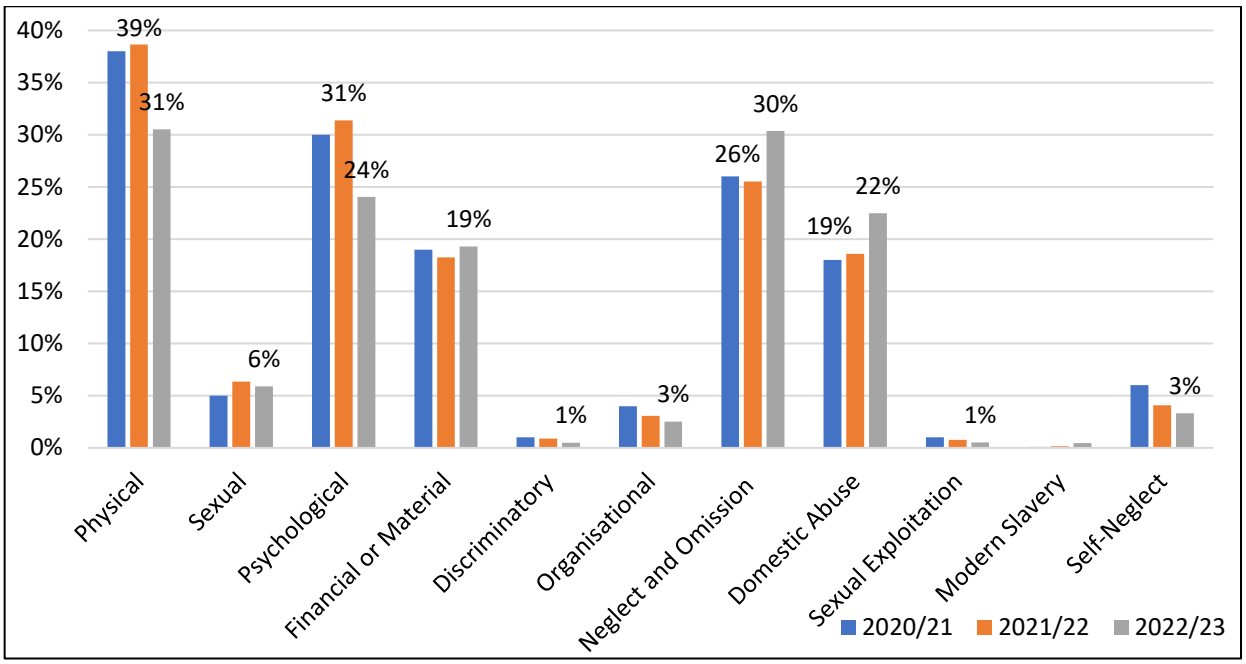


This section looks at both S42 and Other concluded enquiries together. Physical abuse continues to account for the main risk, although this has decreased by 8% on the previous year. KCC has seen an increase in the number and proportion of Neglect and Acts of Omission, which is now at a similar level to Physical Abuse. There was another increase in Domestic Abuse, with a decrease in psychological abuse.

It is not known why there is a decrease in the number of physical abuse enquiries for the year 2022/23. Further analysis would need to be undertaken to see if there is a reason behind this change if it is also noted for 2023/24. The increase in neglect and acts of omission could be as a result of better reporting following awareness raising of safeguarding. Targeted work has also been undertaken on clearer recording and raising awareness of Domestic Abuse, which could account for the increase shown in the table below.

Nationally, Neglect and Acts of Omission is the main source of risk, followed by Physical Abuse. This is the same position as last year. There was a, 11% increase for Neglect and Acts of Omission and a 7% increase for Physical Abuse. The source of risk with the highest increase is Discriminatory Abuse, which has risen by 42%. There were no sources of risk which saw a decrease in 2022/23 for England.

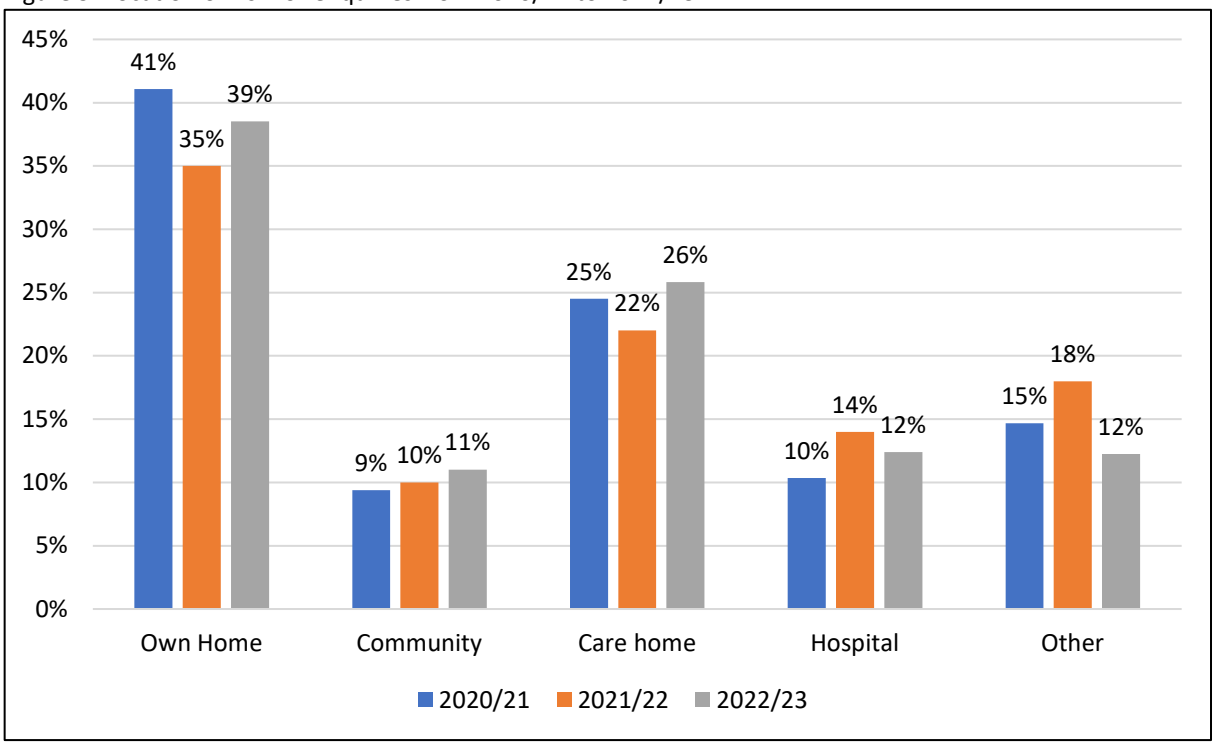
Figure 8: Type of risk for enquiries from 2020/21 to 2022/23



As with previous years, Own Home (39%) was the most prevalent location of abuse, followed by Care Homes (26%). The decrease in Other is following targeted work in 2021/22 by the mental health safeguarding teams concluding safeguarding enquiries in a Mental Health Hospital setting.

At a national level, as with the Kent, the most common location of abuse was Own Home (47%), followed by Care Homes (33%). No decreases in any locations of abuse were seen at a national level.

Figure 9: Location of risk for enquiries from 2020/21 to 2022/23

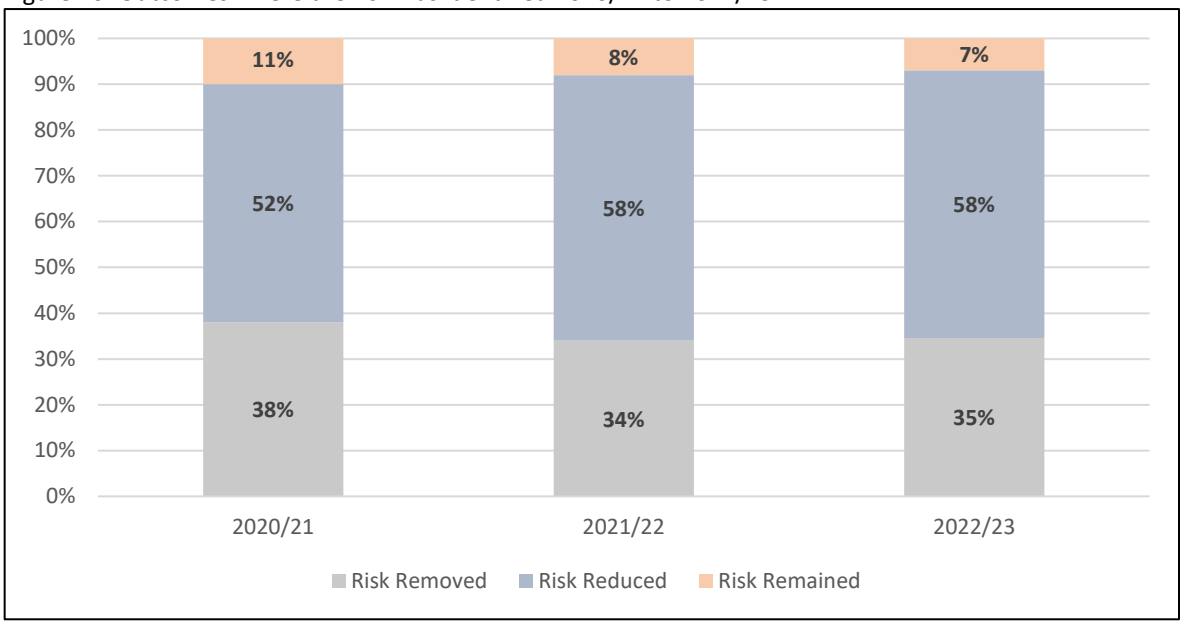


Risk Assessment Outcomes: where a risk was identified action was taken, and even if no risk was identified action was still taken.

Following identification of a risk, 35% the risk was removed (a 1% increase), for 58% the risk was reduced (no change) and only 7% the risk remained (a 1% decrease).

At a national level, 24% saw the risk removed (4% increase) after it had been identified. 66% saw the risk reduced (7% increase) and 9% had the risk remain (15% increase).

Figure 10: Outcomes where the risk was identified 2020/21 to 2022/23



Kent and Medway Safeguarding Adults Board Annual Report 2022-2023

Appendix Two – Partner Highlights

Contents

As part of the quality assurance framework, agencies are required to report on how they are meeting the Board's three strategic priorities. This report provides some examples of good practice from the responses received.

Note: Some of the good practice examples may not be unique to the agency but will only have been listed once, to avoid repetition of good practice examples and allow for the inclusion of other highlights.

1. Promoting Person Centred Safeguarding

Agency	Example
Ashford Borough Council (ABC)	**Ashford Borough Council Website:** Has a dedicated page in respect of safeguarding which has a link signposting people to the KMSAB "Concerned About an Adult" information leaflet and it highlights that it is available in a number of languages; these leaflets in all languages available were placed in the Council's Customer Contact Centre for Adults Safeguarding Awareness week, as part of the display. The leaflets remain available to the public. **Concerned About an Adult Literature**: In addition to the above, we requested translated leaflets for additional languages spoken by our refugees (which were not available at the time); these have now been provided and form part of the "welcome" pack that is given on their arrival. These will also be provided at the training centre our refugees attend.
Ashford Borough Council (ABC)	**Safeguarding Adults Awareness Week 2022:** Awareness was raised in a number of ways to both the public and internally, with staff. This included: • Three face-to-face events in the town centre; this was a joint event with the Police on the Monday (Exploitation), Tuesday (Vulnerable Adults) and Friday (Domestic Abuse). • A display within the Civic Centre Customer Contact Centre, with various literature and posters provided by KMSAB as well as some leaflets specific to cuckooing and domestic abuse. • Display in the window of the One You public health shop in Park Mall, Ashford Town Centre; this facility is a joint partnership between ABC, Kent Community Health Foundation Trust and KCC Public Health.

	• Daily information blogs on the staff Smart Hub (internal intranet) on that particular day's topic. • Sharing of information on social media. Not only were there posts on the main ABC site, there were also some on our sister Ashford Port Health site. • Leaflets for distribution were shared with the Council's Welfare Intervention Officers and Domestic Abuse Co-ordinator to share at clinics they held or attended. Leaflets were also shared with our Refugee Resettlement Team to make available at their learning facility. There is no known feedback from members of the public in respect of making referrals following this awareness week, however, the events were well received on the day by those that came to speak to us. Feedback from colleagues in respect of internal communication included: *"Thanks for this series, it has been really informative and will help me personally in recognising issues and possibly supporting others in the future*"
Ashford Borough Council	**Ensuring the Voice of the Adult is Heard:** We interact with all of our customers by listening and talking to them about any concerns they may have. This is done by various officers and teams across the organisation. Some examples include: • Community Safety Officer and Environmental Protection Officers: when carrying out visits or joint initiatives with other agencies, such as the Police. • Welfare Reform Intervention Officers: Work either independently or carry out joint visits with Social Services giving them an awareness of those most vulnerable. • Ashford Monitoring Centre (AMC) Lifeline: This service is mainly utilised by older, vulnerable adults, but can also be installed at a property where someone is experiencing a safeguarding issue (e.g. a domestic abuse case). All AMC operators receive ABC's level 2 Safeguarding Training and are therefore able to identify and raise any concerns they have for referral. A yearly questionnaire specific to the Lifeline service is sent to clients who are then able to return it either confidentially or with their personal details. It can also be an opportunity for them to disclose information separate to the Lifeline services, such as a safeguarding concern. • Engagement with residents in Independent Living Schemes: These include various events that residents and others from the local community can attend and enjoy, such as coffee mornings, all with the aim to tackle social isolation and loneliness. These also give residents the opportunity to raise any items of concern. Staff involved in all of the above will either signpost individuals to relevant support and services as appropriate, or make a referral via the Council's prescribed process. Safeguarding Concerns have also been raised by ABC Councillors which they have either reported directly (where there is an immediate concern of risk) or

	called in to the Council's Designated Safeguarding Officer or relevant officer to report their concerns.
Canterbury City Council	**The Council's Newsletter**: "Tenants News and Views" has been used to promote keeping safe messages to over 5000 tenants in the district. During 2022/23 the newsletter contained items on how to spots the signs of cuckooing, fire safety, and how to identify scams.
Canterbury City Council	**Rough Sleepers Initiative - We just stopped by…" cards:** The Council's Rough Sleepers Initiative has produced "we just stopped by…" cards. These are left on tents and sleeping bags, where we are not able to make contact with the person sleeping rough, to give them a list of useful contact details including where to get medical help, access to free lunches, mental health outreach services, beddings etc.
Dartford & Gravesham NHS Trust	**National Safeguarding Adults Awareness Week:** Dartford & Gravesham NHS Trust (DGT) participated in safeguarding adults Awareness week 2022, the safeguarding team ran a number of workshops during the week which included self-neglect and hoarding, domestic abuse in a tech-society, exploitation and county lines. During safeguarding adults awareness week, the trust promoted the work of the KMSAB and the resources available by taking the 'talking tea trolley' to the wards and departments. This gave staff the opportunity to discuss the safeguarding adults agenda whilst having a biscuit and a cup of tea. KMSAB leaflets, posters and information were given to the staff at these sessions. The trust intranet shares the link to the KMSAB as well as the 'stop adult abuse' information leaflets in a variety of languages allowing engagement from all. Each workshop generated good discussions especially regarding self-neglect and hoarding.
Dartford & Gravesham NHS Trust	**#heretohelp- Safeguarding Guardian Badge:** As part of safeguarding adults week, the trust launched the #heretohelp- Safeguarding Guardian badge for use in all areas across the trust, promoting the message that safeguarding is everyone's business to other staff members, patients and visitors.
Dartford & Gravesham NHS Trust	**Involvement of the Individual and/or their Family and Friends in Safeguarding:** Family and friends are involved where appropriate in the safeguarding agenda, supporting their relatives through the process. The trust values the views of the patient, families and carers following safeguarding concerns raised in order to improve practice, this has included using examples of concerns raised in teaching sessions. The Trust has also supported a patient making a short film regarding their experience as a patient, this is available on the training platform for all staff to access. The trust has a patient experience lead who welcomes patient's views and experiences in order to support patient led change and feedback.
Dartford & Gravesham NHS Trust	**Safeguarding Training:** Safeguarding training is held as a 'Family Focused' face to face session encompassing the whole family approach. During the training the work of the KMSAB is explained. The session also covers professional curiosity and the importance of being professionally curious. The training looks and demonstrates how to make a safeguarding referral and the type of information that is required as well as definitions of abuse. On the whole,

	information provided in the safeguarding referrals has improved. Staff attending the training are aware how to access safeguarding information on the trust intranet as well as the KMSAB, the criteria for making a referral and who to contact.
Dartford Borough Council (DBC)	**Safeguarding and Mental Capacity Act Training:** Dartford Borough Council places a strong emphasis on ensuring staff are well-informed about Mental Capacity and its practical application, which has been integrated into the Level 2 training. Compliance levels are monitored and reported to the DBC Safeguarding Steering Group to ensure high adherence rates. To gauge the effectiveness of training, staff are provided with evaluation templates to reflect on the usefulness of their training and track knowledge progression from before to after the training. Regular intranet messages are posted to prompt and remind staff about supporting guidance documents and where to turn if they have safeguarding concerns or seek further information. The Safeguarding Steering Group staff recently underwent a retraining session for their Level 3 certification, while all Category B staff completed Level 2 training. Both courses were organised by an external provider. To ensure accurate records of completion rates, monthly monitoring of safeguarding level 1 training is conducted in collaboration with HR, allowing for the addition or removal of staff members as needed. Safeguarding training is an integral part of all new staff inductions and our ongoing staff review and appraisal process. Training adherence rates are consistently above 90%.
Dartford Borough Council	**Elders' Forum:** Dartford hosts an Elders' Forum, which is a means of two-way communication with the elder community and provides information specifically relevant to this higher risk group.
Dover District Council (DDC)	**National Safeguarding Adults Awareness Week:** During KMSAB safeguarding adults week, the community services team worked in collaboration with other departments and support agencies to deliver small events across the Dover District. We used these engagement events to promote the work of the Board and for all residents to voice their opinions on the work of the Board. Owing to the diversity within our communities, we are able to use the translated materials from the Board to remain inclusive in our engagement.
Dover District Council (DDC)	**Wellbeing Roadshow:** We held a number of events during our wellbeing roadshow – 2022. The wellbeing roadshow was set up to help address mental health, social isolation and the impact of Covid-19 on individuals. There were 3 locations identified across the district, where residents were most likely to have experienced these issues. The main objective of the roadshow was to signpost individuals to support services, offer guidance around safeguarding matters using KMSAB literature, whilst raising awareness of charities and community groups in their area.

Dover District Council (DDC)	**Safeguarding and Engagement Toolkit:** The safeguarding and engagement toolkit has been used on a number of occasions, by sharing the toolkit internally and with external partners, we have been able to communicate with residents whom we may never have interacted with face to face. DDC has an engagement platform called "Keep Me Posted" which is used to communicate safeguarding advice, notices and updates, this is complemented by our Instagram, Facebook and Twitter platforms.
East Kent Hospitals University Foundation Trust (EKHUFT)	**Independent Safeguarding Consultant Review and All Age Safeguarding Deliverables Action Plan:** The key focus for 2022-2023 for the Trust was to address the recommendations as outlined in the Independent Safeguarding Consultant review which was undertaken in February 2022. This was achieved through the development and implementation of an All Age Safeguarding Deliverables (AASD) action plan. One of the main outputs from the AASD action plan was the development of the 'all age safeguarding strategy'. The strategy outlined 5 key priorities for the Trust which were aligned to the Trust's core values and were used to address and maintain compliance for the Care Act, Domestic abuse, Mental Capacity Act and Deprivation of Liberty Safeguards **(**MCA/DoLS) and Prevent.
East Kent Hospitals University Foundation Trust (EKHUFT)	**Governance - Safeguarding Operational Group:** The Trust has strengthened its governance at operational level through the development of a Safeguarding Operational Group that was aligned to the Care Groups Governance, Patient Safety, Patient Experience and Complaints and this commenced in September 2022. All key aspects relating to patient experience are mitigated at this group and there is now a system in place where any complaints that have evidence of safeguarding concerns are overseen by the safeguarding team. The safeguarding team also attends the Patient Participation Group to update the group on any key developments relating to safeguarding.
East Kent Hospitals University Foundation Trust (EKHUFT)	**New and Updated Safeguarding Policies and Information for Patients**: The Trust was able to utilise existing safeguarding policies which were updated, and new policies were developed to reflect how and what staff are required to do to support patients. The safeguarding adults policy now includes details relating to section 9 of the Care Act, and carer assessments that patients can be referred to, a section on making safeguarding personal, as well as how patients and staff can be empowered to speak out about safeguarding. The new Mental Capacity Act (MCA) Deprivation of Liberty Safeguards (DoLS) policy, clinical restraint policy, missing persons policy, Prevent policy and the new domestic abuse policy all include key areas that will enable staff to strengthen professional curiosity. For example, the MCA/DoLS policy now has a section on the differences between functional and executive capacity and what staff are required to do in the event that a patient demonstrates functional capacity, however, how they may need to consider if they lack executive capacity. All policies now reflect the need to involve families and carers in safeguarding activities. A safeguarding leaflet to be provided to patients on admission is being developed and a new bedside leaflet that is given to patient on admission

	contains a section on safeguarding and how patients can contact the safeguarding team to raise concerns if they have any. There are now posters on advocacy and safeguarding and MCA and Mental Health Act, which all departments now have in place and staff can refer to this to support patients.
East Kent Hospitals University Foundation Trust (EKHUFT)	**Governance and Joint Working:** Safeguarding now attends the Patient Participation Group and reviews all patient experience surveys. A Patient Experience representative attends the Safeguarding Operational Group and provides updates on patient experience activities and agree how any gaps will be mitigated and areas for targeted work. For example, deaf patients and safeguarding, as a result of patients and relatives raising concerns for this to be addressed. There is now a new process to capture information relating to Think Family coordinated jointly with the Safeguarding Children team and an increase in capturing details where there is potential parental mental health and or domestic abuse.
Folkestone and Hythe District Council (FHDC)	**Training/eLearning, including mandatory adult safeguarding eLearning:** The new eLearning platform combining adult and child safeguarding went live in January 2023, and 376 members of staff have completed this so far. New Designated Safeguarding Officers (DOs) receive more detailed safeguarding training, and shadow an experienced DO to ensure full understanding of the role including how to refer adults to KCC.
Folkestone and Hythe District Council (FHDC)	**External Awareness Raising Activity:** Externally our Community Safety Unit team attended several events at which they raised awareness of safeguarding and related issues and how to get advice and support on these – these included Folkestone Pride, the Air Show, Turnerstone Community Hub Launch, engagements with the Cadets, etc. as well as seasonal campaigns including Christmas and Halloween.
Folkestone and Hythe District Council (FHDC)	**Proactive advertising about the safe spaces:** these are refuges for members of the public to access for any reason such as fleeing domestic abuse or crime, experiencing anxiety or other mental health issues, etc. The first of these spaces launched early 2023, with more to come over the coming year across the district. https://www.folkestone-hythe.gov.uk/community-safety/safe-space
Folkestone and Hythe District Council (FHDC)	**Economic and Financial Abuse Training** - Welfare, Revenue and Benefits and Customer Service teams have recently received training on Economic and Financial Abuse, allowing them to recognise warning signs of this type of abuse and to reflect on the ways in which they should handle cases where there is potential abuse, and adjust practice accordingly (e.g. where an individual in financial difficulty indicates that they do not have access to the household bank account, not simply asking to speak to the partner who controls the finances).

Gravesham Borough Council (GBC)	**Safeguarding Training**: All staff and members are required to undertake Safeguarding Training. In addition to the Adult Safeguarding Level 1, Child Safeguarding Level 1, and Modern Slavery and Human Trafficking online training, the Lead Safeguarding Officer has developed a GBC-specific briefing and delivered face-to-face training to review the council's safeguarding policy and procedures,
Gravesham Borough Council	**Safeguarding Briefings:** There is a rolling programme of live (online) Teams Safeguarding Briefings for all staff to book into, which highlights the key areas from the Council's safeguarding policy and key KMSAB messages, such as Carers, Safeguarding Adults Reviews, Self-neglect process, etc. This session also goes through referral forms and talks through the importance of consent.
Gravesham Borough Council	**Gravesham Vulnerability Panel:** Gravesham Vulnerability Panel brings together a wide range of statutory and voluntary sector agency representatives each month. Agencies may each come into contact with a vulnerable adult whose complex needs or support requirements cannot be dealt with by that agency alone but requires specialist support from other service providers. The lead agency may refer the individual to the Panel, whereby information is shared on dealings partners may have had with the individual to provide clarity on the level of support already in place or gaps in support that is needed. Many cases have been very successfully resolved over several years and have included tailored support packages for individuals who have been homeless, have had drug and/or alcohol dependency issues, mental health conditions or that have been suspected of being victims of exploitation.
Gravesham Borough Council	**Awareness Raising:** The council has been involved in a lot of awareness raising and led on events around Modern Slavery and Domestic Abuse. The council chairs the multi-agency Gravesham Modern Slavery Working Group, and for Modern Slavery Awareness Day on 18th October 2022, our Communications Team produced a range of posters with helpline contact details to display in the Gateway at the civic centre, around the town and in flyers for partners to share.
HCRG Care Group (formerly Virgin Healthcare)	**Safeguarding Champions:** There are designated safeguarding champions trained at level 3, with a defined clear role description, within all our teams. Colleagues can contact a Safeguarding Champion both in and out of hours. Looking forward, we intend to extend this role further to include other colleague groups as such as non-clinical team colleagues to become a safeguarding link person, supporting the Safeguarding Champion role. This we feel, will encourage more colleagues to have a safeguarding awareness and be involved with safeguarding concepts and updates.
HCRG Care Group (formerly Virgin Healthcare)	**Safeguarding Supervision:** All colleagues are encouraged to reflect and participate in regular supervision sessions. Teams receive specific safeguarding supervision during their team meetings, and this is usually based upon a case that the team have had to deal with or a more complex patient where we feel that the learning is appropriate. The business unit continues to undertake monthly learning events chaired by the Director of North Kent. We also hold monthly complex care case reviews to improve our understanding of our patients needs and how we can improve support to them. This is a multi-disciplinary approach to our vulnerable and complex cases with various

	professionals attending to ensure referrals and processes are being followed and that the most vulnerable people are being cared for by the correct services.
HCRG Care Group (formerly Virgin Healthcare)	**Safeguarding Adults Awareness Week**: During our Safeguarding Awareness Week in November 2022, our theme was responding to contemporary safeguarding challenges such as county lines, domestic abuse, cyberbullying, and self-neglect. Leading up to the awareness week, we held a national workshop to discuss the importance of holding professional boundaries when working directly with service users. This included working through some practical scenarios regarding the challenges of social media and everyone's responsibilities and ensuring compliance with social media policies.
HCRG Care Group (formerly Virgin Healthcare)	**Safeguarding Information:** Across all our community bases and inpatient wards, there are visible safeguarding information boards to aid colleagues in their knowledge of who the leads are and how to escalate safeguarding concerns. There are also prompts for colleagues on categories of abuse and relevant contact numbers. These information boards also display the regular KMSAB newsletters, translated leaflets, alongside our own posters and leaflets.
HCRG Care Group (formerly Virgin Healthcare)	**Community Support:** Recognising the impact of the rising costs of living, including energy supply during winter, as an organisation, we invested in thermal fleece blankets for distribution to identified vulnerable housebound persons during our home visits. This was in addition to donations of a large number of new toys for a cross section of age groups as Christmas presents to local charities. In the height of summer, there were two major water supply burst pipes on the Isle of Sheppey, cutting the water supply off completely, and we ensured our vulnerable community patients within that locality received bottled water regularly and welfare checks.
HCRG Care Group (formerly Virgin Healthcare))	**Safeguarding Training**: We have a robust statutory and mandatory training matrix in place which includes safeguarding training. Service compliance is discussed at our Quality & Governance meeting each month and overseen by our Head of Operations. All colleagues must undertake safeguarding mandatory training as part of their induction process. Both the Safeguarding Lead and the Head of Quality & Patient Safety present key messages at the new colleague induction programme to ensure that all colleagues, regardless of position appointed, receive the same initial safeguarding awareness training.
Healthwatch	**Healthwatch Kent and Medway websites**: During the 2022-2023 period we have implemented a new section on our Healthwatch Kent and Healthwatch Medway websites under the safeguarding heading. The link leads to a page titled 'how to recognise abuse and neglect' which has made it much easier for members of the public to find and access safeguarding information. The page includes links to the Kent and Medway Safeguarding Adult Board site.

HM Prison Service	**Safeguarding within prisons**: All staff are trained during their initial training to identify self-neglect and abuse by others. These fall within the categories of self-harm, Mental healthcare, and victim support. Help to care for this cohort of men within the custodial setting is plentiful. We have monthly safeguarding meetings which cover those with acute Neurodiversity needs, learning disabilities/difficulties (LDD) and physical care needs. We track identification through to assessment and care package is put in place. Those then receiving care packages are discussed monthly. People vulnerable to exploitation and physical abuse by others are discussed at our monthly Safer Custody meeting, with victim support follow ups after every incident of violence. All our Prison Offender Managers are trained in safeguarding and identifying signs and offences which will make our adult prisoners more vulnerable to abuse by others. We have employed a neurodiversity lead to focus on the care given and to enhance the support in place for people with the most severe learning difficulty/disability (LDD) needs. We also have a LDD lead who is employed through our partner agency OXLEAS who will spend time listening to the voices of those who require extra care and bridge the gap between the prisoner and the staff by creating bespoke management plans.
Kent and Medway Integrated Care Board (ICB)	**National Safeguarding Adults Awareness Week:** The KMSAB social media content plan was shared on NHS Kent and Medway social media channels during the national safeguarding adults awareness week. This saw a reach of 584 contacts on Facebook and 680 impressions on Twitter. The collaborative activity undertaken by board members to promote the week saw an increase in contacts to the KMSAB website. Information about safeguarding adults week was further shared on the NHS Kent and Medway website and was promoted internally to NHS Kent and Medway staff via blogs on the internal staff system. Leaflets and promotional materials were made available at each of the NHS Kent and Medway work-based sites and made available to all primary care practices via the sharing of the KMSAB toolkit via the Primary care bulletin and safeguarding lead forums. The new primary care practitioner commenced a data capture of safeguarding support contacts requested from primary care in December 2022. 27 contacts were received in the first quarter following safeguarding adults awareness week, evidencing support for safer outcomes for the population of Kent and Medway
Kent and Medway Integrated Care Board (ICB)	**Dartford Elders Forum:** The NHS Kent and Medway safeguarding team also undertook a presentation at the Dartford Elders forum during Safeguarding adults' awareness week and used this as an opportunity to promote the tricky friends video created by the Board. This resource was used to inform attendees about "spotting the signs". Resources from the board were shared including 75 bags, 75 leaflets, 100 trolley tokens and 80 folded cards. Feedback from individuals was very positive, with people noting that they were not aware of safeguarding before the presentation and asking for additional resources that they could take to other groups and employers they attended. Representatives were able to link individuals with the boards toolkit where information can be accessed. The NHS Kent and Medway safeguarding team

	also supported other health commissioned services in their promotion activity during the week.
Kent and Medway Integrated Care Board (ICB)	**Healthwatch Awards**: At the Healthwatch 2023 awards NHS Kent and Medway were awarded in the category of involving people in the commissioning and delivery of services category as well as in the category for listening to people's views
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	**Safeguarding Training:** Training compliments policy content for a systemic approach to education and awareness raising. KMPT safeguarding training is reflective of both the Adults and Children's Intercollegiate Documents. These statutory frameworks are followed with the inclusion of local learning from Safeguarding Adult Reviews (SAR), Child Serious Case and Rapid Reviews, and Domestic Homicide Reviews (DHR) to enable continued reflective learning and development to stimulate professional curiosity. Supplementary Domestic Abuse, Stalking and Harassment (DASH RIC) training, and Bite Size topical safeguarding session have been delivered to compliment the statutory training. Making Safeguarding Personal is embedded into policy and training, essentially as part of the promotion of openness, transparency and person-centred care. KMPT's safeguarding training compliance has been a significant achievement in the delivery of volume and quality to ensure KMPT staff are given the support and tools in identifying and responding to safeguarding concerns. Training is delivered in a variety of styles to stimulate discussion, and encourage professional curiosity. Training compliance has been achieved due to the commitment from the safeguarding team, support from leaders, monitoring and promotion from the learning and development team, and support from the IT team in providing the technology and equipment for virtual and face to face learning. Safeguarding training data is collected and monitored by the learning and development team for external team scrutiny and transparency in reporting.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	**Professional Curiosity**: KMPT front line staff continually demonstrate their commitment to safeguarding by providing patients with time and the forum to have the difficult discussions to identify abuse. This level of professional curiosity has supported patients to discuss abuse and ask for help. KMPT referral data is positive evidence of both this activity.
Kent County Council (KCC)	**Making Safeguarding Personal (MSP):** MSP is essential to ensure that the person we are supporting remains at the centre of the safeguarding process, and able to express their wishes and have their voices heard throughout. To further strengthen the feedback received from the adult at risk, starting in March 2023, Strategic Adult Safeguarding, working alongside operational colleagues initially in the Ashford Canterbury and Coastal area; are contacting selected individuals who have been through the safeguarding process and have previously provided consent to be contacted. These experiences, described by the person will provide valuable learning and will be shared with colleagues to contribute toward ongoing practice improvement. This work aims to continue into 2023/24 and will help to shape associated literature and

	guidance in relation to the safeguarding process and how this will impact the person at the centre of the support provided.
Kent County Council (KCC)	**Safeguarding Older People from Domestic Abuse:** as Domestic Abuse has increased over the last few years, accelerated previously by Covid, concerns have been especially highlighted by support services, around a lack of recognition of the impact of domestic abuse for older people, and the issues faced when trying to access suitable services. As part of Safeguarding Awareness Week in November 2022, KCC Strategic Safeguarding organised a workshop, in collaboration with Clarion, for frontline practitioners to highlight this disparity and to help colleagues to potentially challenge any unconscious bias they may have. This event was attended by over 140 multi-agency operational colleagues from Adult Social Care, Health (including GPs), Police, and Voluntary Organisations. Feedback was received from over 70 colleagues who attended the event, highlighting the positive impact the training will have on their future practice, "*really helping to identify potential domestic abuse where previously they may not have*" - again re-enforcing the importance of professional curiosity and recognition of the subtleties of coercive control.
Kent County Council (KCC)	**The Kent and Medway Suicide Prevention Programme:** The suicide prevention programme is in place and delivers outcomes in two ways; By funding services and projects which reduce the risk of suicide and self-harm and by providing system leadership, research and quality improvement projects. These services include Amparo, who provide suicide bereavement support, Release the Pressure, a free resource, offering support for anyone who needs it, 24hrs a day, 7 days a week. Amparo worked with 129 bereaved families and individuals in 2022/23, and the feedback showed what a difference this service is making to people's lives: *"I will forever be grateful for Amparo, and the incredible tireless work that they do".* *"With the emotional support, I am learning to live alongside and around my grief day to day***".**
Kent County Council (KCC)	**Research project:** The Kent and Medway Suicide Prevention team worked with Kent Police to identify that 30% of all suicides in Kent and Medway between 2019 & 2021 were impacted by domestic abuse (either as victim, perpetrator or child growing up in an abusive family unit). This research influenced Government policy as it was cited by Sajid Javid, the previous Secretary of State for Health, in June 2022, when he announced that domestic abuse will be included in the National Suicide Prevention Plan for the first time. (Javid,S. (2022) 'Health and Social Care Secretary of State speech on suicide prevention.' The Kent and Medway Suicide Prevention team produced a Domestic abuse and suicide briefing paper. Their research has already led to many of the national organisations (including the Home Office and Dept of Health) to prioritise this issue for the first time. This paper highlights their research to provide frontline practitioners with the skills and knowledge to reduce the risk of suicide amongst people impacted by domestic abuse.

Kent County Council (KCC)	**The Kent and Medway Suicide and Self-Harm Prevention Annual Conference:** took place in December 2022, attended by 130 in person delegates plus an additional 100 delegates who joined virtually. This event was a great opportunity to raise awareness and share best practice in relation to suicide prevention. We can see from Safeguarding Adult Reviews and Domestic Homicide Reviews, sadly suicide remains a recognised concern and therefore this event and the overall work of the team provides an essential source of information. In 2022,
Kent Community Health NHS Foundation Trust (KCHFT)	**Specialist Safeguarding Service:** The Trust has a dedicated specialist safeguarding service to support the organisation with meeting its safeguarding duties in line with national and local legislation and guidance, and to promote the key safeguarding principles. KCHFT staff can access a dedicated safeguarding consultation duty line for specialist support, advice and guidance, safeguarding supervision and training. The safeguarding team further supports staff with complex safeguarding cases, professional escalation and referrals into social care.
Kent Community Health NHS Foundation Trust (KCHFT)	**National Safeguarding Adults Awareness Week**: As part of safeguarding adults awareness week, the safeguarding team joined up with the Integrated Care Board to set up a safeguarding stall at the ONE YOU shop in Ashford town centre. It was really heart-warming to see how the One You staff connect with the community, it was clear the support they provide is invaluable. It was such a warm and welcoming environment. The One You staff had created a window display so anyone walking by could see key contacts and signposting with ease. Many conversations were had with the One You staff and the members of public who dropped in. One person noted they had a shop board they could display some of the posters, another took some items to share with their church, and someone took away some domestic abuse sign posting for a peer they were worried about. It was really positive how the public were embracing safeguarding, thinking about themselves, others and what safeguarding meant to them.
Kent Community Health NHS Foundation Trust (KCHFT)	**Safeguarding and Mental Capacity Link Workers:** The Trust has safeguarding and mental capacity link workers, whose role is to work at team/service level to make sure key safeguarding messages and person-centred safeguarding is embedded in practice. The link workers meeting provides opportunities to share examples of good practice and challenges, and surveys are used to determine the impact of the link workers in practice.
Kent Community Health NHS Foundation Trust (KCHFT)	**Safeguarding Audit:** To seek assurance on how person-centred approach is embedded in the Trust, the safeguarding team conducted a short audit of all safeguarding adult referrals made by KCHFT staff between July and August 2022. The aim was to review if Making Safeguarding Personal (MSP) is evidenced within safeguarding referrals made, including consent to referral and the service users' views and wishes. There was a total of 56 records reviewed for this audit. The audit evidenced that the consent for referral was sought in 87.5% and rationale was provided if staff were unable to gain consent, 75% of referrals included MSP. Following the audit further awareness was raised about MSP, and that all questions are answered, via monthly safeguarding 'news brief' and processes and procedure safeguarding workshops.

Kent Community Health NHS Foundation Trust	**Family and Carer Involvement:** The Trust's work to ensure improved family carer involvement has continued in 2022/23. The Trust is a member of the Triangle of Care which is a national initiative; the KCHFT community hospital matrons, carer champions and participation managers presented the continuing work to identify, support and improved involvement for carers to the Carers Trust who oversee the Triangle of Care nationally. As a result, KCHFT were successful in achieving our first-year accreditation as members of the Triangle of Care scheme and still remain the first non-mental health service to join as members. The Trust embarked on our second year working with our community services to develop their development plans to improve family carer involvement. The Trust is in the process of recruiting community carer champions to support the implementation. In June 2022, KCHFT delivered a joint carers conference in partnership with Kent and Medway Partnership Trust (KMPT). The conference, held in Ashford, was attended by more than 80 family carers and representatives from our partner carers organisations across Kent, including IMAGO, Carers Support East Kent, Involve Kent, Crossroads Kent, with representation from Healthwatch, One You and Kent County Council. The event helped to raise awareness of carers and the challenges they face in their caring role and gave them the opportunity to talk first hand to carers organisations about their experiences.
Kent Fire and Rescue Service (KFRS)	**Safeguarding Training:** In March 2022, we started our in-house face to face training delivery. Both the Level 3 and 4 and enhanced Level 2 courses have been created internally following National Fire Chiefs Council (NFCC) Train the Trainer course. Last financial year we trained 98% of those identified as requiring Level 3 / 4 safeguarding training. This Level 3 and 4 safeguarding training was delivered to all Corporate Management Board (CMB) and senior roles with strategic overview of safeguarding including our Chief Officer and Directors, Assistant Directors, heads of teams and all Designated Safeguarding Officers (currently 23 DSOs across the service). Last year, we trained 93% of those identified as requiring enhanced Level 2 training. Enhanced Level 2 training is aimed at front facing colleagues who, as part of their role, will case manage and may need to make onward referrals, record justification and decision making. For example, Building Safety Inspectors and Safe and Well Officers. We are now embarking on Level 2 training for firefighters which will run from May 2023-May 2024. This is in addition to the Level 1 training that they have all already completed. To date, 18 Station Leaders have been trained, with the remaining 27 booked to complete by summer 2023.
Kent Fire and Rescue Service (KFRS)	**Raising awareness through recording and change of process:** We have updated our process of recording a safeguarding concern (which is through our control room). There is now a safeguarding referral form to be completed after a call is made to control. This form provides an account from the person spotting the concerns, reminds about consent and to record whether consent was given. It also captures the voice of the person. This not only provides better information for the Designated Safeguarding Officers (DSO) who will case manage and make onward referrals, it is also consistent with adult social care referrals and puts the customer in the centre. This ensures that making safeguarding personal

	(MSP) is acted on each time a colleague is required to make a referral to our safeguarding team. Taking on board the learning from SARs highlighting the need for better MSP approach. It is possible to raise referrals 24/7 and we have increased the number of Designated Safeguarding Officers available out of hours to provide advice.
Kent Police	**AWARE Risk Assessment:** Kent Police launched a new risk assessment process for highlighting concerns about adults at risk and children. This new risk assessment is based on the AWARE principles. Aware stands for Appearance, Words, Actions, Relationships and Environment. This new process encourages professional curiosity and ensures the right information is provided to partners for ongoing safeguarding and support for vulnerable people through the Central Referral Unit (CRU). It will also enable prioritisation of reviews for onward referrals to partners. In 2022 Kent Police referred over 2233 concerns around adults at risk of abuse or neglect to partner agencies.
Kent Police	**VAWG Walk and Talk Events:** Kent Police has held a number of Violence Against Women and Girls (VAWG) "Walk and Talk" events across Kent and Medway. The purpose of a VAWG Walk and Talk is to identify locations of vulnerability and engage with the community in those locations to better understand how Kent Police and our partners can reduce highlighted risks. This is a multi-agency approach to understand how communities feel and what action can be taken to tackle local safety issues and alleviate those concerns. This is important to understand wider public perception of safety and what it means to them to tackle the issue of VAWG, reduce vulnerability and build resilience. The objective of this event is to both reassure the wider public and businesses operating in the area and to raise awareness on this subject. Kent Police carried out 14 Walk and Talk events across the year and 2 larger online events open to the public.
Kent Police	**Hourglass IDVA Service:** The Office of the Police and Crime Commissioner launched a new older person independent domestic violence advisor (IDVA) scheme in Kent and Medway in association with Hourglass. Hourglass are a charity specialising in working with adults who are at risk of harm or abuse. They have a confidential 24/7 helpline which offers: • Support for any older person experiencing or at risk of abuse or exploitation. • Support if someone is unsure if abuse or exploitation is happening to them or someone else. • Support for anyone with concerns about an older person, e.g. family, friends, neighbours, paid carers or professionals, etc • Information and advice relating to safer ageing and prevention of abuse. More information can be found at Hourglass (wearehourglass.org)

Kent Police	**TrueCall Nuisance Call Blockers:** Kent Police made available 100 TrueCall nuisance call blocking devices to nominated members of the public. TrueCall devices screen numbers and block nuisance calls automatically, thus helping to protect people who are vulnerable to fraud. Partner agencies and police officers and staff can nominate members of the public most vulnerable to fraud. Those who meet the eligibility criteria will receive one of the TrueCall devices. The TrueCall devices are fully funded and provided by the Kent and Medway Fraud Panel working in Partnership with Trading Standards.
Kent Police	**My Community Voice:** After its launch in 2022, the My Community Voice (MCV) messaging service has continued to grow. MCV is a two-way engagement tool set up by Kent Police for residents, businesses and community groups in Kent and Medway. MCV enables Kent Police to update users with news, alerts, appeals, engagement events and general policing activities. Members of the public can choose what information they receive from Police and how they receive it – whether that's by email, text or voice mail. They can also share or reply to the messages they receive, enabling improved two-way communication, information sharing and problem-solving opportunities for the force. There are currently over 11000 users registered for alerts and messages. Messaging around anti-social behaviour, local crimes and fraud is regularly circulated.
Maidstone and Tunbridge Wells NHS Trust (MTW)	**National Safeguarding Adults Awareness Week:** During safeguarding adults awareness week, the Trust sent out daily bulletins using the Ann Craft Trust resources and links to the KMSAB especially in relation to self-neglect and hoarding. The Trust's Discharge Liaison Teams are keen to ensure that issues in relation to self-neglect and hoarding are recognised and dealt with for patients. These cases very often become complex discharges, with colleagues from the multi-agency setting involved to safeguard patients in these situations.
Maidstone and Tunbridge Wells NHS Trust (MTW)	**Adult Safeguarding in Practice**: Trust staff demonstrate a good awareness of their duties in relation to safeguarding adults and will seek clarity on matters in relation to safeguarding adults from the Safeguarding Team. There is evidence that staff will pursue information and take action on behalf of adults who are at risk, in order to promote the safety and well-being of patients, family members, visitors and staff. Trust staff have also shown professional curiosity and concern for people who are not their patients, for example raising safeguarding concerns for family members who are at risk due to the patient being admitted.
Maidstone and Tunbridge Wells NHS Trust (MTW)	**Safeguarding Adults at Risk Policy and Procedure**: The Safeguarding Adults at Risk Policy and procedure has been updated, emphasising the link to the KMSAB website and associated resources. It also includes 'How to Guides', giving links to the KMSAB associated documents in relation to the guides. The Guides include:- • How to make a safeguarding referral – hospital setting or MTW provider resource • How to make a safeguarding referral - community setting • How to guide: Self-neglect and hoarding

	• How to refer for carers' support • How to refer adults who are requiring an assessment for care and support needs • How to signpost adults with an addiction (suspected or known) to alcohol or drugs to services • How to refer a case for Safeguarding Adults Reviews (SARs) • How to manage concerns raised about persons in a position of trust (PiPoT) processes • How to recognise and raise safeguarding concerns in relation to pressure ulcers • How to recognise and raise safeguarding concerns about domestic abuse pertaining to adults at risk It is hoped that this gives greater clarity to Trust staff about how to follow the KMSAB processes appropriately and also emphasises the fact that work in relation to safeguarding adults is completed in collaboration within the multi-agency setting.
Maidstone Borough Council (MBC)	**Safeguarding Champions:** Maidstone Borough Council has a number of safeguarding champions across each department to be the first port of call for initial safeguarding concerns, before escalating to the Designated Safeguarding Officers for the Council. All safeguarding concerns are logged securely, and changes have been made to ensure we have a person-centred approach. Our internal form now asks **'**Is the individual aware a safeguarding has been raised?'.
Maidstone Borough Council (MBC)	**Housing Journey Map**: Following feedback from residents, MBC has driven forward a journey map for those experiencing trauma, to help navigate the housing process and to be able to receive more support via the embedded links for a holistic approach. The journey mapping has been developed directly from feedback, through conversation with service users and victims to help understand what they needed at a particular moment in their life.
Medway Community Healthcare (MCH)	**Audit of Safeguarding Referrals:** We undertook an audit of the quality of safeguarding referrals, which included questions around making safeguarding personal. Findings indicated that MCH staff are aware of the types of abuse associated with adults and are able to articulate this in safeguarding referrals. They are aware of the impact of care and support needs on an individual and how these can increase the risks to our patients, particularly if an individual is self-neglecting in a particular area of their life. Work remains in embedding the use of the pressure ulcer decision making tool when concerns relate to pressure damage and in evidencing that capacity has been assessed prior to making referrals in the best interest of our patients. Clinicians also need to feel more confident in having those, sometimes difficult, conversations around why they feel a referral is required and in discussing what the patient would like to happen in relation to a safeguarding referral being made (making safeguarding personal)

Medway Community Healthcare (MCH)	**Safeguarding Training and Information.** We developed workshops compliant with the Intercollegiate Document at Level 3, targeting Mental Capacity Act practice and 'difficult conversations in safeguarding'. We updated our intranet/ internet pages to facilitate easier access, access to KMSAB information and Easy Read documents.
Medway Council	**Making Safeguarding Personal:** Adults who have been involved in the safeguarding system are offered the opportunity to provide feedback on their experience of this. At completion of the section 42 enquiry, the subject of the enquiry or their representative is asked to take part in feedback. Uptake for this remains low, so a 'dip (random) sample' audit was completed, this identified that no one had agreed to complete this. A learning session was held with the safeguarding staff to ensure they understood what this is and the importance of it. The plan is to dip sample this again next year. We have received feedback from those who use our services that evidences positive interactions with individuals, families, and partners. "having individuals make contact and listen has made a big difference" "I just wanted to say a big thank you for all of your efforts in the beginning of our nightmare! It is finally coming to an end and we have managed to get the issue resolved with the council. You were compassionate and understanding to our situation, that empathy really made a difference to us." At the bi-annual divisional meeting those with lived experience have attended and told their story. Those with lived experience attend the bimonthly Equality, Diversity and Inclusion Network.
Medway Council	**Safeguarding Training:** To support practice, considering findings from Safeguarding Adult Reviews, training has been delivered on 'strengths based practice' and 'developing / use of professional curiosity.
Medway Foundation Trust	**National Safeguarding Adults Awareness Week:** During national safeguarding adults awareness week we undertook "trolley dashes" to the clinical areas promoting the work of the safeguarding team and the wider KMSAB. A promotional stand was also in place engaging with patients and family, promotion of KMSAB, discussion about safeguarding concerns, processes, promotion of carer's assessments as well as guidance and signposting for care and support needs assessments.
Medway Foundation Trust	**Safeguarding Information**: Patient 'what to do if you have a concern' leaflets are available indifferent languages on the intranet pages and the virtual noticeboard "Padlet", for staff as required.
Medway Foundation Trust	**Patient First Programme:** The Trust is currently working on a number of initiatives and during the past year has focussed on rolling out the Patient First programme. This is the Trust's new strategy and is about developing a structure to enable staff to identify, develop and deliver necessary improvements to keep patients safe. True North describes what we should be continually striving towards, the things that we know will create high quality care and a better experience for our patients. Under our five strategic themes

	will sit our True North objectives. Safeguarding is a part of the new strategy alongside patient safety and patient experience.
National Probation Services	**Awareness Raising:** Topics of relevance/interest are disseminated to staff via regional and local bulletins. For example, self-neglect and hoarding was part of the adult safeguarding week bulletin and guidance issued to staff in Autumn 2022. Other examples include the promotion of national safeguarding adults awareness week. Messaging included "the aim of the week is to create a time where we can all focus on safeguarding adults and raising awareness on how to spot the signs and report concerns. Everyone should be aware of the role they can play in helping to prevent abuse and this week is a chance to start a nationwide conversation about safeguarding, so that we can be better together."
Sevenoaks District Council (SDC)	**Internal Steering Group of Designated Officers:** An Internal Steering Group of Designated Officers meet bi-monthly to support the safeguarding function for the organisation and disseminate learning. Each Council department is represented on the Group and raises safeguarding referrals and outcomes, alongside sharing good practice.
Sevenoaks District Council (SDC)	**Self-Neglect and Hoarding**: Understanding and responding to self-neglect remains an ongoing priority and there is recognition of the risk of self-neglect increasing. Our Hoarding Co-ordinator works in partnership with Peabody, funded through the Better Care Fund. They provide a holistic approach and refer onto other services if needed.
Sevenoaks District Council (SDC)	**Domestic Abuse and Violence Against Women & Girls (VAWG**) Domestic Abuse and VAWG remains a continuing priority. Our Safeguarding Group works closely with the Community Safety Partnership in terms of learning and early prevention, to increase an understanding of adults who have care and support needs and are experiencing domestic abuse or coercion and control. Five training sessions for SDC staff and partner agencies took place in Nov/Dec 2022 on various aspects of Domestic Abuse and Violence Against Women & Girls.
Sevenoaks District Council (SDC)	**Homelessness**: A Homeless Risk Management group responds to concerns relating to a group of individuals who are homeless and have additional vulnerabilities relating to mental health and/or substance misuse. As part of this, a course was provided, tailored for Homelessness teams, regarding adverse childhood experiences.
Swale Borough Council	**Domestic Abuse Support Board:** 85% of our local Domestic Abuse (DA) Support Board is made up of survivors of DA, giving a voice to those who have the lived experience.
Swale Borough Council	**Professional Curiosity**: Within internal training "professional curiosity" is encouraged in all work areas, and the promotion of "ask one more question" reinforced. This has proved fruitful with a recent case. The worker suspected, from limited information, that the client was suffering controlling and coercive behaviours. With using their professional curiosity and engagement with the client it became very apparent that this was in fact happening. The client had not identified herself at the time as being subject to this. Given the time and

	ability to discuss the behaviours she realised that it was not appropriate. This resulted in support being put in place to take back control and for her to engage with appropriate support.
Swale Borough Council	**National Safeguarding Adults Awareness Week:** Swale BC, along with our partners, delivered a public event. This involved KCC wardens, Swale BC staff and Police Community Support Officers. Literature provided by KMSAB was used on the stand, along with other items around promoting safety. The event was conducted on a Friday at a local supermarket. During the event a lady approached staff with concerns for a neighbour. She was advised where she could report issues and get support, for which she was very thankful. Daily briefings of topic area were given and circulated via staff intranet. The KMSAB communication plan was provided to the communication team to utilise for Twitter, Facebook pages, member briefing along with staff briefings..
Thanet District Council	**National Safeguarding Adults Awareness Week**: TDC led a week-long event around the Thanet District, to support professionals to share their knowledge and expertise with the community, as well as their professional networks, by delivering presentations on various safeguarding topics linked to their own organisations, related to the topics of the week. Followed by afternoon open drop in sessions for the public to come along and speak to agencies present about anything of concern. Safeguarding materials were given out to both professionals and the public which offered support and knowledge to members of the community and professionals. Delivered across Thanet and the Thanet surrounding villages. Objectives achieved: ● Shared knowledge and expertise amongst professionals ● Shared knowledge and expertise to offer support to local residents of Thanet ● Made positive links with local residents and listened to their needs/ concerns and issues ● Established, and encouraged, networking amongst professionals ● Gave local residents the information to make informed choices and to raise esteem and confidence ● Gave professionals information to encourage communities to be resilient- improve self esteem - make better choices and manage their mental health better.
Thanet District Council	**Walk and Talk events (4 events):** Walk and Talk event across the district, taking place during the evening. Speaking to residents and visitors of Thanet about safety at night as well as giving information on professional services, including KMSAB, and support numbers. Surveys were taken on the events relating to how safe individuals feel. These were multi-agency events and included translators for our eastern European community. Staff were also available should any disclosure or concerns be made.
Thanet District Council	**Community shield:** Thanet has over 50 safe spaces, as well as all buses (Stagecoach). Southeastern stations in Thanet are also in the process of being 'signed up' to our safe spaces scheme (Community Shield). Each organisation - shops, petrol garages, hairdressers, cafes, buses and trains are all given information on safe spaces, how to deal with vulnerable people in their

	premises, as well as having information on safeguarding for both children and adults. More information on the community shield scheme is available here.
Tonbridge and Malling Borough Council (TMBC)	**Rough Sleepers Task and Finish Group:** A Rough Sleepers Task and Finish Group has been established to identify rough sleeping in the borough and look at what actions/support can be offered to help individuals into accommodation and off the streets.
Tonbridge and Malling Borough Council	**Sharing Learning:** Published safeguarding adults reviews and information/ newsletters are circulated to Safeguarding Designated Officers. Recommendations from SARs are discussed at the Safeguarding Officer Study Group.
Tonbridge and Malling Borough Council	**Awareness Raising:** Safeguarding information stands have been organised in Tonbridge during Safeguarding Adults Awareness Week. Safeguarding leaflets and information were available on the Community Safety stand at various community engagement events (Tonbridge and Malling Seniors Forum information and advice day) and events held in priority communities (Trench and East Malling). The KMSAB leaflet with information regarding adult abuse (in Ukrainian) is handed out to all new arrivals in the borough under the Housing for Ukrainians scheme.
Tonbridge and Malling Borough Council	**One You Health Team**: Action plans are in place to support vulnerable people and assist them engage with services. The 'One You' health team provide one to one support and group sessions for people struggling with physical and/or mental health issues. Appropriate referrals are made when safeguarding concerns are raised by individuals.
Tunbridge Wells Borough Council	**Safeguarding Training:** All new staff to TWBC continue to receive Safeguarding training as part of the mandatory induction training. From January 2023 this training was moved from online to classroom training and the training pack updated.
Tunbridge Wells Borough Council	**Modern Slavery Awareness Training:** Modern slavery awareness training was provided by Porchlight's modern slavery and human trafficking champion to the Housing Options Team in January 2023, to increase their understanding and raise awareness of the signs to look out for and to help them understand the National Referral Mechanism process.
Tunbridge Wells Borough Council	**Social Media:** The Council used its official Twitter account (@TWellsCouncil) to tweet to its 11,000 followers during Safeguarding adults awareness week, providing details of the KMSAB, how to make a referral if concerned about an adult at risk and video showing the signs to look out for with modern day slavery and how to report these concerns.

2. Strengthen System Assurance

Agency	Example
Ashford Borough Council	**Our organisation's internal monitoring of quality of practice and resourcing:** There are a number of ways monitoring is achieved; this includes: • Six-monthly safeguarding update reports to senior Management Team, which include details of the number of referrals in the period since the previous report and type of referral (to highlight any trends); details on training that has taken place; anonymised summary of complex and high-risk cases; update on the number of Safeguarding Adults Reviews and Domestic Homicide Reviews; updates on thematic reviews and self-assessments; events, such as the Safeguarding Adults Awareness week; any update to the Safeguarding Policy. • Yearly Report to the Council's Overview & Scrutiny Committee: includes similar information to the above and is set out to cover the yearly update of the Council's Safeguarding Policy; accountability & governance arrangements; various actions taken (work of the Safeguarding Lead Officers, updates to other related policies, self-assessments, events such as National Safeguarding Week, multi-agency meetings); referral update; training update. • Safeguarding Lead Officers meeting: These are an opportunity for lead officers to share concerns and experiences in dealing with complex cases, and are also an opportunity to apply professional curiosity at a strategic level. • Multi-agency meetings: These include District Safeguarding meetings, Best Interest meetings, Vulnerabilities Panel, MARAC, Ashford Community Safety Partnership and Community Safety Unit. Not only are these an opportunity to discuss topics of concern they are also an opportunity to look at joint partnership initiatives and events. • Feedback from internal training, in particular the level 2 interactive training where feedback is sought from those in attendance.
Canterbury City Council	**Designated Safeguarding Officers:** The council's team of Designated Safeguarding Officers meet every month to review all records of concern submitted by staff to provide oversight and ensure responses are timely and appropriate. In some cases, additional safeguarding actions may be requested. Any themes or trends are fed into the Council's wider safeguarding group. For instance; the high incidence of calls taken from people disclosing suicidal idealisation led to the council producing procedural notes for call centre staff to ensure they were consistent in taking safeguarding and supportive actions.
Canterbury City Council	**Rough Sleeping Initiative – Street Diagnostic Tool:** The council's rough sleeping initiative team use the Street Diagnostic Tool. This helps provide insight into where people have come from prior to homelessness and what agencies they were involved with, this has helped develop the interagency relationships needed to support them.
Canterbury City Council	**Safeguarding Audits:** The council carries out safeguarding audits with its commissioned and third party agencies, who deliver services to adults at risk

	or children. As a result, the council is assured that these agencies are compliant with their safeguarding duties.
Dartford & Gravesham NHS Trust	**Monthly Safeguarding Committee:** The Trust holds a monthly safeguarding committee meeting, which is attended by external agencies, in order to give assurances that the safeguarding agenda is being met. We report on referrals themes and outcomes, good practice and areas of improvement. This allows the safeguarding team to support areas and departments to share learning outcomes and to promote areas of good practice along with improvement to practice.
Dartford & Gravesham NHS Trust	**Making Safeguarding Personal**: Following safeguarding concerns raised, the patient, family and/ carers are encouraged to be involved with the process. It is the Trust's aim to be transparent in safeguarding processes and involvement is key. This allows for changes to processes and systems, allows for patients to tell 'their story' which is always impactful and instrumental in driving change. Patients' stories are used during the safeguarding training. The complaints department and patient advice and liaison service also support feedback and patient input following concerns raised.
Dartford & Gravesham NHS Trust	**Training and Awareness Raising:** Safeguarding processes are discussed during training, staff are made aware of the journey of the referral and accountability of the Trust, the local authority and partner agencies. They are also reminded of the Trust intranet safeguarding page and the links to the KMSAB website, where staff are directed to find further information regarding the safeguarding agenda, processes and useful links.
Dartford Borough Council (DBC)	**Multi-Agency Forums**: Dartford Borough Council demonstrates its commitment to partnership working through its multi-agency groups, comprised of professionals from various fields across its services. This approach facilitates information sharing and the identification of areas for improvement. Dartford has also adopted a Care Leavers policy as part of its initiatives.
Dartford Borough Council (DBC)	**Safeguarding Steering Group:** As part of its routine, the Safeguarding Steering Group dedicates a standard agenda item to discuss the quarterly referrals received, categorised by nature (e.g., adult, child, domestic abuse). This agenda item also includes a comparative analysis, presenting figures from previous quarters, facilitating the identification of significant increases in referrals or concerning trends. Dartford Council maintains a centralised recording system for all referral records, subject to review by the policy lead to ensure that referral outcomes have been pursued and are actively monitored. Additionally, the agenda consistently addresses staff training statistics.
Dartford Borough Council (DBC)	**Safeguarding Guidelines for External Providers:** DBC's 'safeguarding guidelines for external providers' builds due regard around safeguarding into contracts using a tiered approach, based on the level of contact the external provider will have with children and adults at risk, and the type of service being procured. Contract monitoring arrangements are in place where DBC reserves the right to check external providers' safeguarding arrangements at any time, on reasonable notice. External providers are also expected to regularly review and update their safeguarding policies to ensure they capture the most recent legislative and compliance requirements and up-to date guidance.

	The council also has a "contractor concern" process built into its main customer facing contract, as a first point of contact if safeguarding issues are encountered when the contractor is undertaking its operations in the community.
Dover District Council (DDC)	**Multi-Agency Meetings:** We attend: Bi-Weekly multi-agency risk assessment conference meetings, Bi-Weekly safeguarding meetings, Bi-Weekly Vulnerability panel meetings and any ad-hoc safeguarding meetings. At these meetings partners come together to discuss vulnerable individuals, each partner undertaking their own responsibilities to safeguard them.
Folkestone and Hythe District Council (FHDC)	**The Homes for Ukraine scheme**: The Homes for Ukraine scheme was set up in March 2022, following the outbreak of war in February 2022. It was recognised that additional resource would be needed to ensure that those entering the district from Ukraine were safeguarded, and a new role of Refugee Resettlement Coordinator was created to meet this need. This has ensured that information and messages on a range of subjects, from the KMSAB leaflet on how to protect yourself from abuse, to support with housing and benefits, could be shared with this group, so that they know where to go for help should they need it. The weekly newsletter providing a range of information to guests, hosts, and others is shared with over 750 individuals across the district.
Folkestone and Hythe District Council (FHDC)	**Residents at Napier Barracks and Adult Asylum hotels:** Residents at Napier Barracks and Adult Asylum hotels, as well as adults arriving from hotels outside of the district, require particular safeguarding support to ensure their welfare needs are met. FHDC work with other agencies (including Home Office) to safeguard asylum seekers through a multi-agency forum process.
Folkestone and Hythe District Council (FHDC)	**National Safeguarding Adults Awareness Week** - Domestic Abuse in Tech Society took place during National Safeguarding Adults week in November 2022. The virtual event focussed on how digital technologies are being used by perpetrators. The aims were to: think about the impact of gender stereotyping and misogyny; build an understanding of the 'manosphere' and incel ideology and culture; identify what incel extremism looks like; consider who may be vulnerable to indoctrination to incel extremism; share straight forward strategies and ideas that can counter and build resilience to misogynistic attitudes and beliefs.
Folkestone and Hythe District Council (FHDC)	**Asylum Webinar:** In January 2023 an Asylum webinar was held in order for the public to understand how temporary asylum accommodation in the district was being managed. This was to reassure the public in the F&H district area that all partner agencies were working together to address key concerns. The webinar enabled a fuller understanding of the roles and responsibilities of each partner agency in addressing this issue (including the Home Office, Migrant Help, Health agencies, Police, etc). This work is considered best practice both county wide and nationally. More information is available on this link:https://www.folkestone-hythe.gov.uk/community/asylum-accommodation-responses
Folkestone and Hythe District Council (FHDC)	**Designated Safeguarding Officers:** To ensure that the organisation can effectively deal with safeguarding concerns, a larger number of trained designated officers for safeguarding have been recruited across the

	organisation, to ensure that a duty rota can be operated effectively to give daily coverage to deal with any safeguarding concerns that arise. The rota is updated on a fortnightly basis. This system also allows a greater knowledge of safeguarding across different teams within the council.
Gravesham Borough Council	**The LIFT (Low Income Family Tracker) project**: The LIFT (Low Income Family Tracker) project is a partnership between Policy in Practice (PiP) and Gravesham Borough Council. This project has helped to deliver a reduction in the number of households in relative poverty from 2814 (44%) to 2,744 (42.7%). The project commenced in February 2021 with the then driver being to support vulnerable households within the borough proactively and financially through the COVID-19 pandemic. However, a further driver has since emerged in the shape of a cost of living crisis. Between March 2022 and July 2022 the number of households in Gravesham who were in fuel poverty increased by 16%; 205 households had fallen into food poverty and households in a cash shortfall had risen by 127%. The purpose of the project is to collate data held by the council and Universal Credit data to identify households in the borough that may have low affordability and/or high vulnerability to tailor council services to meet the needs of the residents. It is to ensure that those eligible for Housing Benefit and local Council Tax Reduction scheme are paid/credited with the correct sum in a timely manner. It also assists in the council proactively identifying and being able to financially support vulnerable households through interventions, without the need for them to make an application i.e., removing a barrier.
HCRG Care Group (formerly Virgin Healthcare)	**Care Quality Commission (CQC) Assessment:** We continue to evidence our responsiveness in supporting the changing needs of our local health population. Our contributions were acknowledged within our July 2022 CQC inspection reports for our four registered sites, rating us 'good' as an adult community health provider across North Kent and Swale.
HCRG Care Group (formerly Virgin Care)	**Safeguarding Governance and Audit Processes**: Safeguarding quarterly assurance reports are shared within the internal Quality & Governance meeting, which in turn feeds into the HCRG Care Group National Safeguarding Subcommittee and National Clinical Governance Committee which informs the Executive Board. These assurance reports are provided to the Integrated Care Board, in line with reporting requirements set out by the NHS standard contract. HCRG Care Group also have a monthly Safeguarding subcommittee that discuss regional and local issues within the organisation, this in turn is fed back to the teams via our Quality & Governance meeting. An annual safeguarding audit takes place within each team to ensure that our required standards are being maintained, action plans are used and monitored to address any identified gaps from these audits. This is monitored and supervised by the Safeguarding Lead with set remedial actions taken if required, to ensure completeness. The Quality & Governance meeting ensures that the organisation examines all incidents related to safeguarding, promoting the welfare of the adult at risk, whilst also promoting learning opportunities.

Healthwatch	**Review of feedback:** We undertake a monthly review of feedback received about partner organisations and share this with providers to inform and highlight issues within the health and social care system.
HM Prison Service	**Safeguarding and Safer Custody Meetings:** Our safeguarding meeting is our primary mechanism for identifying system issues and escalating risks. Our safeguarding meeting and safer custody meetings are well attended by our partners. This includes, psychology support, KSS 'Blossoms' support for personal care, psychiatric support, primary healthcare representatives and prison staff.
Kent and Medway Integrated Care Board (ICB)	**Safeguarding Training and Support for 'Public Facing' Staff:** Whilst the KMSAB Self-Assessment (SAF) feedback acknowledged that largely the role of the new ICB did not include operational services, the panel did offer key feedback for the ICB to consider strengthening support, training, and assurance for the small number of staff that do have front facing public roles, to enable the underpinning of knowledge from safeguarding learning. Evidence of improvements were provided in the final action plan in December 2022 including: • Bespoke training detailing responsibilities in line with KMSAB self-neglect policy and procedures including legal powers of intervention were provided for Continuing Health Care staff working with adults at risk. Further to this, ICB training was reviewed and updated for all ICB staff. • Safeguarding support and supervision provided for Continuing Health Care staff by attending complex case meetings. • Assurance that database systems used by specialist placement teams include prompts to document safeguarding concerns.
Kent and Medway Integrated Care Board (ICB)	**Independent Audit:** During 2022- 2023 NHS Kent and Medway commissioned an independent audit from a specialist business assurance provider (TIAA) to review the controls and monitoring arrangements in place within the ICB to ensure that commissioning of safe services includes adequate provisions for safeguarding. The review commenced in January 2023 and feedback will be received for quarter 1 in 2023-2024.
Kent and Medway Integrated Care Board (ICB)	**Safeguarding Benchmarking Toolkit for Primary Care:** The ICB ensures that NHS Kent and Medway retain responsibility for supporting and monitoring the quality of safeguarding practice for Primary Care services across Kent and Medway. During 2022-2023 a safeguarding benchmarking toolkit was launched to support practices in undertaking self-assessment with safeguarding standards. This has enabled us to target support to practices where safeguarding is identified as an improvement action with CQC inspections, and therefore support improvement to safeguarding governance and performance in these practices. New internal monthly safeguarding operational meetings detail how the ICB is undertaking compliance and improvement work to inform onward reporting. The ICB also provides external assurance in the form of reporting quarterly on safeguarding standards to NHS England. Submissions have been made for each quarter during 2022 – 2023.

Kent and Medway Integrated Care Board (ICB)	**Participation in Steering Group Meetings:** NHS Kent and Medway has established and participated in specific groups such as the co-occurring conditions group and the Liberty Protection Safeguarding steering group to ensure experience and feedback for larger projects and national changes are listened to, and support for commissioned services is planned. For example, the work undertaken by NHS Kent and Medway as part of the co-occurring conditions subgroup has led to the upskilling of refuge staff, with a view to increasing access to safe accommodation for individuals living with co-occurring conditions.
Kent and Medway Integrated Care Board (ICB)	**Escalation of Concerns Leading to Positive Change**: A case escalation example, supported by the NHS Kent and Medway safeguarding team, resulted in multi-agency conversations around availability of care needs assessments for adults at risk who are experiencing homelessness on release from prison. Linked learning from the escalation, including action around the Homelessness Reduction Act, was shared to services responsible for commissioning care within secured estates.
Kent and Medway Integrated Care Board (ICB)	**Safeguarding Training for Primary Care Staff:** Further system wide annual safeguarding training for Primary Care staff was provided during June and July 2022 and saw over 1400 individuals attend. Feedback was received and this was very positive with one individual noting "Excellent Safeguarding Training session, the best in my 33 years of being a GP!".
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	**Safeguarding Activity**: All safeguarding activity is captured on the DATIX system which reports activity to care group managers, service managers, the safeguarding team and directors, to ensure a measurable, transparent and responsive approach to safeguarding. This enables the identification of themes and trends and potential areas that need increased awareness for assurance and responsiveness. Safeguarding activity is reported via the Quality Digest ICB report, Patient Safety and Mortality Review Group and Trust-wide Safeguarding Group, which includes the Integrated Care Board, CQC, Police, Local Authority, and internal leads, for a shared and transparent safeguarding approach. Any areas of concerns are considered and resources and support, via bite-size team meetings, training and supervision, have been delivered. The learning and development team support with capturing staff training and resource feedback to enable learning, adaption, or continuation for a continuous learning approach.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	**Roles and Responsibilities:** KMPT has Safeguarding Champions represented in each care group. Safeguarding Champions have access to bi-monthly Champion meetings in which themes and learning are discussed. In addition, other agencies are invited to share what they do and the latest developments. KMPT additionally hold a quarterly Trust-wide safeguarding meeting in which the ICB, Local Authority, CQC, Kent Police, and partner agencies are invited to listen, promote, share, and contribute to widening and improving communication, understanding of agencies, whilst supporting KMPT's safeguarding agenda.

Kent County Council (KCC)	**Carers Month** - **May 2022**: Activity during carers month included a series of 'practice postcards' and an interactive event for carers, led by the KCC Adult Practice Development Team, within Strategic Safeguarding and Quality Assurance. The event focussed on "carers perspectives on caring in the social care environment", linking closely to the release of the Kent adults carers strategy 2022 to 2027, a panel discussion was broadcast live on MS Teams to practitioners across the adult social care and health directorate. Four people who had undertaken (or were undertaking) a caring role came together with a Service Manager, Involve Carers and a Practice Development Officer, to talk about how it felt to be a carer, and how they interacted with the social care landscape. The discussion was followed by a question and answer session with members of the audience.
Kent County Council (KCC)	**Registered Managers Conferences:** These events are for Providers from a wide range of settings, including care homes, supported living and domiciliary, with guest speakers. KCC Strategic Safeguarding attended a conference in September 2022, and held an information stall, enabling us to meet providers, signpost to relevant services, and provide guidance in relation to raising safeguarding concerns. We also raised awareness of the work of the Kent and Medway Safeguarding Adults Board, by using their promotional materials on the stall to initiate many conversations. One conversation focused on a concern about self-neglect, and we were able to promote the clutter rating as a useful tool to gauge the severity of a hoarding situation, and how to progress, depending on the outcome. In addition, Strategic Safeguarding held an information session at the event, giving a presentation on the findings from Safeguarding Adults Reviews and Domestic Homicide Reviews, looking at the published DHR in relation to Sylvie. The interaction with the providers and feedback received from the event was very positive, and identified a real understanding of the issues faced in relation to the impact on carers and the importance of understanding the legal framework around areas such as Lasting Power of Attorney (LPOA) etc.
Kent County Council (KCC)	**Domestic Homicide Review (DHR) Lessons Identified Webinars.** The Kent Community Safety Partnership held five 'Domestic Homicide Review (DHR) Lessons Identified Webinars' over the last year. The webinars provided the opportunity to share the findings from the completed DHRs with frontline practitioners and professionals across the county, as well as highlighting where practices have changed, areas that could be improved and changes to government guidance. In 2022, due to the large number of DHRs that had recently been published, the move to virtual delivery during the pandemic, and the ability to record events meant the same content did not need to be delivered repeatedly across the county. Instead, five events covering four different themes (Children and Domestic Abuse, Suicide and Domestic Abuse, Carers and Cultural Competency) and seven DHRs (and two SARs) were delivered. Break out rooms and online polling tools were used to encourage interactivity, and guest speakers from elsewhere in the country could easily present during the event.

	An event involving bereaved family members was also held this year, which had an overwhelmingly positive response. The two Children and Domestic Abuse themed webinars were delivered jointly with the Kent Safeguarding Children Multi-Agency Partnership (KMSCP) and the Carers themed webinar was delivered with the Kent and Medway Safeguarding Adults Board (KMSAB) and included two SARs. The five webinars were delivered with over 600 people attending in total. Feedback was sought to help evaluate the effectiveness of the webinars and to shape future events. Overall, feedback was received from over 180 attendees who indicated the events were very well received, a selection of comments are below; • '*I will reflect more on relationships of carers and the cared for. I will have more professional curiosity and consider language used during assessments.* ' • '*Reinforces the need to listen to what is being said to you by a client. Sometimes it is the unsaid that speaks the most volume and can highlight the need for them needing more support*.' *'I found the seminar completely engaging and well put together. The information provided and the space to reflect was suitable within the time allocated. Very well done!'*
Kent County Council (KCC)	**Kent Community Warden Service:** The Kent Community Warden Service continues to see our wardens trained as ESTHER Improvement Coaches, who support the development of other staff across organisational and professional boundaries and create a culture of continuous improvement and sustainable development. Under the Esther model professionals ask "what is best for Esther?" to ensure person-centred care and builds on the strengths of our Community Wardens, highlighting their ability to adapt to community and the individual residents' need(s). The work undertaken by the Community Wardens covers a wide range of situations and circumstances including many examples of social isolation, self-neglect and hoarding, substance dependency, dementia cafés and one case also included support for depression and improving mental health and wellbeing. Adult Social Care colleagues work closely with the Community Warden Service, who are a recognised trusted member of the communities they support. Example: A Community Warden set up 'Let's Eat' over a year ago for one of the communities they support, by gathering support from local businesses and the Parish Council who helped finance the project and the local college providing the services of their catering students. The project tackles social isolation and food poverty. The Christmas dinner event in 2022 saw around 40 residents attend to share food and conversation in the warmth. This event has fostered several new friendships during the time the project has been running, which is helping to alleviate social isolation and loneliness. At the Let's Eat events, the Community Warden provides the opportunity for residents to talk with

	them on an individual basis – a surgery to raise concerns and issues. This has helped residents to find solutions to address multiple issues which may have otherwise continued. Due to its success this is now a monthly event which now runs alongside a 'Let's Chat' coffee morning
Kent County Council (KCC)	**Financial Abuse Toolkit:** In October 2022, KCC Financial Services team, in collaboration with Adult Strategic Safeguarding, reviewed and updated the **Financial Abuse Toolkit** and shared this resource with the Kent and Medway Safeguarding Adults Board for multi-agency partners to use as appropriate. The toolkit aims to provide practitioners, and those working and supporting adults in social care and health, with the information they need to recognise, and report suspected cases of financial abuse. The toolkit highlights how effective partnership working between departments, such as Adult Social Care and Health, Internal Audit & Counter Fraud, Trading Standards, Client Financial Services & Safeguarding as well as external partners e.g. Kent Police, Care Quality Commission and NHS Counter Fraud Service, may create better outcomes for adults and offer more robust investigatory actions. Providing case examples that demonstrate how financial abuse safeguarding enquiries (Section 42 of the Care Act 2014) can be conducted effectively and links to additional useful resources.
Kent Community Health NHS Foundation Trust	**KCHFT Learning Disability Team:** In 2022/23 the KCHFT Learning Disability Team has provided support to various residential/ care settings to improve the care being provided to clients with learning disabilities and to reduce the risk of poor care provision leading to potential safeguarding. Where safeguarding concerns have been raised in care settings for people with learning disabilities and CQC are involved or where care settings have struggled to maintain CQC standards, the KCHFT learning disability staff increased their presence within these settings, supported the training of staff who work in the settings, helping to improve quality of care and ensured the needs and voices of the clients are heard and met.
Kent Community Health NHS Foundation Trust	**KCHFT Frequent Service User Service (FSU).** The KCHFT Frequent Service User Service (FSU) works with frequent users of the urgent care system, those attending accident and emergency departments in West Kent. The team works closely with safeguarding, and all the agencies involved in a patient's care, to support and ensure safety and wellbeing. In 2022/23 the FSU team continued to provide a holistic and patient led model of care and support. The outcomes demonstrated that the support, provided by the FSU team, improved measures for anxiety, loneliness and isolation, perceived health and continued to demonstrate a reduction in urgent care use on average by 70-85%.
Kent Community Health NHS Foundation Trust	**KCHFT Rough Sleepers Service:** In 2022/23 the work of the KCHFT Rough Sleepers Service continued, the service received 252 referrals from local authorities across Kent and Medway and provided a total of 790 treatment interventions. The primary function of the service is to provide easy access to health care to people who are homeless or rough sleeping across the county, with the aim of promoting self-management and support to re-engage with mainstream services. The service runs regular clinics held at dedicated venues across the districts, where clients can drop in to see the complex care nurse

	and can receive treatment, advice, support, and an onward referral if necessary. The team will also go to the client's temporary address or to where they are rough sleeping. The focus is to support people managing long term conditions and referrals to Dentaid who provide a mobile dental service to homeless and rough sleeper service users identified by the KCHFT rough sleeper service in agreed localities. Multi agency working is key to the service delivery, offering holistic support alongside relevant agencies (substance misuse, housing, voluntary sector, police etc). The service users were asked 'If you had not been seen today (by the KCHFT nurse) would you have gone elsewhere for health advice?' out of 21 people who were asked, 18 responded to say they would not have sought help, 1 would have gone to the hospital, 1 to the chemist and 1 would have used the GP.
Kent Fire and Rescue Service (KFRS)	**Roles and Responsibilities:** Over the past year we have invited different agencies to attend our Designated Safeguarding Officer team meetings to improve our understanding of their role and responsibilities. For example: Area Referral Management Team for KCC, Kent Police Modern Slavery Input and KCC Gypsy and Traveller Site Managers. It has been really worthwhile for us to understand more about other teams and by building good networks we have been able to work more collaboratively together.
Kent Fire and Rescue Service (KFRS)	**Inspections and Audits:** **HMICFRS:** His Majesty's Inspectorate of Constabulary and Fire Rescue Services (HIMCFRS) carried out their inspection of KFRS from June-July 2022. The report was published in January 2023 and **HMICFRS** graded the service: • 'good' at effectively keeping people safe and secure from fire and other risks; • 'outstanding' at efficiently keeping people safe and secure from fire and other risks; and • 'good' at looking after its people. **Safeguarding comments** were as follows: The service responds well to safeguarding concerns. Staff we interviewed told us about occasions when they had identified safeguarding problems and gave us specific examples. They told us they feel confident and trained to act appropriately and promptly. There is a safeguarding competency framework in place for all staff, who complete mandatory training. The service's e-learning package has also been adopted by two other services. The service continues to learn from events, such as domestic homicide reviews, safeguarding adults reviews and serious case reviews. These are actioned and monitored through the service's operational learning processes. Since our last inspection the service has also introduced a dedicated safeguarding team. **KCC Audit.** In February 2023 Kent County Council carried out an internal audit of safeguarding at KFRS. Their report was published in March 2023, and they awarded the service as HIGH assurance, which is the highest mark achievable. This is a fantastic result and shows the progression of safeguarding within the service since the last audit in 2019.

Kent Police	**Data:** In 2022 Kent Police investigated 4832 crimes involving adults at risk. Furthermore, Kent Police notified the Local Authority of 2233 safeguarding concerns involving adults at risk.
Kent Police	**Kent & Medway Fraud Panel:** Working closely with partners, Kent Police has established and chairs the Kent and Medway Fraud Panel. The Fraud Panel has been formed to work collaboratively in investigating allegations of fraud, prosecution of offenders, recovery of criminal assets and the safeguarding of residents and victims.
Kent Police	**Domestic Abuse Hub:** The Domestic Abuse (DA) Hub went live in May 2022 and provides the public with a 'Rapid Video Response (RVR)' option for those reporting high risk non-immediate DA calls. By using technology to interact with victims at the earliest opportunity, the DA Hub identifies risks quicker, tasks fast time actions, coordinates the swift arrest of high harm perpetrators and makes immediate referrals to partners. During the first six months officers and staff within the DA Hub have spoken on video for over 1,510 hours and provided first response to 1,903 victims.
Kent Police	**Special Measures Advisor:** Recognising the need to support those vulnerable to harm and abuse to navigate the criminal justice process, Kent Police has introduced a new role for 12 months called the Special Measures Advisor. The main responsibility within the role is working across the force to improve the identification and update of special measures, to support vulnerable victims and witnesses when providing evidence.
Maidstone and Tunbridge Wells NHS Trust (MTW)	**Quality Assurance of Safeguarding Concern Referrals:** All Trust staff are able to raise safeguarding concerns both in relation to hospital related incidents and for community related incidents. All safeguarding concern forms are copied into the MTW safeguarding team and are reviewed. These reviews highlighted that a small percentage of safeguarding concern forms are not appropriate referrals for safeguarding and as a result direct feedback was given individually to staff. It became apparent that the safeguarding concern form was being used by Trust staff to refer for a care needs assessment under the Care Act (2014) or for a carers assessment under the same Act. As a direct response to this confusion the Safeguarding Team developed an 'Infographic' to inform staff about the different referral routes for their patients. This has also been sent out Trust wide via our Communications Team and can be used as a poster for staff to refer to.
Maidstone and Tunbridge Wells NHS Trust (MTW)	**The Mental Capacity Assessment re-audit:** The Mental Capacity Assessment re-audit in 2023 demonstrated an improvement in staff documenting their mental capacity assessments for our patients, however the Trust is keen to ensure that the compliance of documenting assessments of mental capacity is increased. As such, the Trust has developed an Action Plan to work to, to enable staff to improve their practice and increase their confidence and competency in relation to MCA. The Trust's MCA Clinical Nurse Specialist is working to ensure that this Action Plan is completed. Also, this specialist is delivering Level 3 MCA training and bespoke MCA/DOLS training where indicated and requested. It is hoped that this will enable staff to grow their confidence in applying the Mental Capacity Act (2005) into their practice.

Maidstone and Tunbridge Wells NHS Trust (MTW)	**Trusts Safeguarding Team:** The Trust's Safeguarding Team has grown in the past year; in that we now have a senior nurse covering the Mental Capacity agenda. This nurse also deputises for the Named Nurse for Safeguarding Adults in an absence, and this has proven to be a positive course of action. However, of note, the Matron cohort have a strong attitude towards getting safeguarding right and are very much of the view that safeguarding is everyone's business. They are able to spread this attitude out within the Trust and are good allies to the safeguarding agenda.
Maidstone and Tunbridge Wells NHS Trust (MTW)	**Safeguarding Learning and Improvement Panel**: The Trust's Safeguarding Learning and Improvement Panel is a sub panel to the Trust's main Serious Investigations (SI) Panel. This panel is chaired by the Deputy Chief Nurse for Quality & Experience, with the Named Nurse for Safeguarding Adults, and Designated Nurse representation from the ICB. The purpose of this panel is to review Safeguarding Investigation Reports and the ensuing learning and action plans emanating from these investigations. As part of that review, we check with the presenters of the investigation their understanding of the nature of adult safeguarding and check that the investigation has answered all of the concerns that have been raised. The panel then decides whether or not the allegation of abuse is upheld, partially upheld, insufficient evidence, no further action under safeguarding, or not upheld.
Maidstone Borough Council (MBC)	**Multi-Agency Meetings**: We hold or attend a large number of multi-agency meetings to ensure individuals/families are safeguarded and have the relevant support. Some of these meetings include: • Multi-Disciplinary Team (MDTs) led by NHS • Community Safety and Vulnerable Person's Group • Domestic Abuse Forum • multi-agency risk assessment conference (domestic abuse) • Multi-agency public protection arrangements (MAPPA) • Homeless Prevention Forum
Maidstone Borough Council (MBC)	**Trauma informed Practice:** In 2022 we hosted the first trauma-informed event titled 'Reframe for Resilience', alongside colleagues at KCC, which saw 48 attendees from a wide-range of organisations across Kent. The event is being repeated in July 2023, following its success.
Medway Council	**Multi-disciplinary Team Meeting (MDT):** A monthly joint multi-disciplinary team meeting (MDT) has been developed between adult social care and drug and alcohol services. During the meeting, safeguarding cases are identified by both Turning Point and Adult Social Care. Case discussions are held in the MDT and joint care plans for individuals are discussed and agreed. This has enabled robust joint visits, when necessary, identification of those individuals where there are barriers to engagement and benefit from face to face interactions, it has prevented delay and duplication and provided a forum in which all discussions are recorded and monitored. The Principal Social Worker, in the weekly adult social care update has shared a reflection on multiagency working and shared this link.

	https://www.scie.org.uk/integrated-care/research-practice/activities/multidisciplinary-teams
Medway Council	**Performance Data:** Team Managers and Senior Social Workers use Power BI (data system) to monitor activity performance. This feeds into a safeguarding dashboard which is scrutinised by senior managers. Further oversight is provided through our Quality Assurance & Improvement Board, chaired by the Director. If any issues are identified, action plans are agreed to address these, for example, audit activity, learning sessions. This forms part of our internal assurance process. Safeguarding case audits have been completed quarterly in the last year. The audit cycle is month 1 audit, month 2 analysis, month 3 learning. The principal Social Worker and Operational Safeguarding Lead have been working on a new Quality Assurance Framework, that is due to be finalised in 2023.
Medway Council	**High-Risk Panel:** The internal High-Risk Panel continues to support practitioners working with individuals we find difficult to engage, make what appear to be unwise decisions and live with a high level of risk. This supports practitioners and ensures senior management are aware of these individuals. Work continues on the operational guidance for staff where individuals do not engage and how MOSAIC (internal computer system) can be used to ensure that there is management oversight where interventions are closed due to non-engagement.
Medway Council	**Multi-agency Collaboration:** Collaborative partnership working has continued. From an exercise previously completed, to identify the different multi agency panels across Medway, Adult Social Care now has a presence on every panel, including, Multi-agency risk assessment conference (for high risk domestic abuse), Blue Light (for individuals with drug and/or alcohol dependency), Integrated Locality Review and Vulnerability panels. These also serve as a mechanism to share the role and remit of adult social care with partner agencies and those who use services.
Medway Foundation Trust	**Governance Arrangements**: The Trust has strengthened its internal governance and assurance processes over the past year. There is visibility of safeguarding from 'Ward to Board'. We have provided Board level training to the executive and non-executive members of the Board. Highlighting the key themes and issues for safeguarding our patients.
Medway Foundation Trust	**Multi-agency Collaboration:** In the past year we have re-established safeguarding management meetings, with the ICB designate and social care representatives, for 6 weekly reviews of open safeguarding cases. It is an opportunity to discuss and challenge outcomes. This allows for more effective and timely outcomes and learning to be identified. The Trust works in conjunction with Oasis domestic abuse charity, IMCA Libra service, DoLS office, IMAGO, Forward Trust, Integrated Discharge Team and social care to provide safe discharge for patients.

National Probation Service	**Common Assessment Tool:** The Probation Service uses a common assessment tool to assess risk and need. This is called OASys and an assessment is expected to be completed in all probation managed cases. Included in the OASys is an assessment of vulnerability of a person on probation. There is also a mechanism to flag such cases on our national case management system.
National Probation Service	**Multi-agency Collaboration:** The Probation Service is not an accommodation provider but works in partnership with Local Housing Authorities and Social Services Departments to try and meet accommodation needs.
Sevenoaks District Council (SDC)	**Safeguarding Reporting System**: A new Safeguarding Reporting System is in place and came into effect from Dec 2022. The QES systems means that all referrals are in one place and staff manage them directly.
Swale Borough Council	**KMSAB Resolving Professional Differences, Escalation Policy:** The newly revised Resolving Professional Differences Policy has been embedded within local practice and this is included in the safeguarding policy. This has been used in several cases to progress actions where necessary.
Swale Borough Council	**Swale Vulnerability Panel:** This panel continues to run smoothly and continue to have good partnership buy in.
Thanet District Council	**Multi Agency Hub:** Thanet District Council has a multi-agency hub, which includes: Thanet District Council, Kent Police, multi-agency task force, Department of Work and Pensions, Kent Fire and Rescue Service, Social Care, and more agencies which hot desk from the environment. This group of people sit within the main council offices. Information is shared to allow an immediate action to take place and/or a plan to be put in place for safeguarding concerns raised.
Tonbridge and Malling Borough Council	**Certificated Courses for Taxi Drivers:** Certificated courses for taxi drivers take place - this includes the completion of a safeguarding test.
Tonbridge and Malling Borough Council	**Weekly Community Safety Meetings.** Weekly Community Safety meetings take place, with Police and partner agencies, to share concerns. Safeguarding, hoarding, exploitation and vulnerable adults are standing items on the agenda.
Tonbridge and Malling Borough Council	**Vulnerable Persons Board**: A monthly Vulnerable Persons Board (which is linked to the Community Safety Partnership with Borough Council reps attending), ensures that we're sharing information in relation to vulnerable people.
Tunbridge Wells Borough Council	**Quality Assurance:** Work commenced in 2022-23, led by the Strategic and Operational Safeguarding Leads, to help identify system issues and increase assurance that the Council has effective safeguarding arrangements in place. A review is being undertaken in relation to posts within the organisation and ensuring posts have a safeguarding level clearly defined and that appropriate training is targeted to staff at these levels. Work is also ongoing to review the Council's standard contracts templates and procurement process, to ensure

	that there is greater reference to safeguarding responsibilities of persons contracted by the Council to deliver services. This work commenced in 2022-23 but is ongoing and will be concluded in 2023-24.
Tunbridge Wells Borough Council	**Multi-Agency Working:** There are several examples of the Council leading on, and being a key stakeholder in, multi-agency work to effectively support the safeguarding of vulnerable adults, which are also examples of how agencies increase their understanding or the roles and responsibilities of partner organisations. • **Rough Sleeper meetings** – the Housing Options Team leads 3-weekly rough sleeper meetings, focusing on multi-agency partnership work to support individuals identified as rough sleeping. Individual rough sleepers are discussed, and appropriate actions taken by partners to safeguard the welfare of individuals and supporting them away from the street. Agencies in attendance include Change Grow Live, Kent Police, Porchlight, Lookahead, NHS, Bridge Trust, Probation, Mosaic Centre. • **Domestic Abuse Forum** – The Community Protection teams across West Kent hold Quarterly Domestic Abuse Forums with representation from the West Kent district councils, Kent Police, KCC, Lookahead, Dad United, Domestic Abuse Volunteer Support Services, Family Matters, NHS, Protection Action Stalking, Clarion, Sanctuary Housing, West Kent YMCA, West Kent Housing Association, Victim Support. The forum focuses on multi-agency partnership working in the area of domestic abuse and achievements against the West Kent Action Plan, which has been updated for 2023-24 to have 4 key priorities: o Provide support for survivors of domestic abuse o Support for children and young people o Support and sanction for perpetrators o Education, promotion and prevention • **Tunbridge Wells Vulnerability Board** - The Vulnerability Board is a multi-agency practitioners' group that enables and encourages partnership working to protect vulnerable people from crime and anti-social behaviour in the borough of Tunbridge Wells. The purpose of this forum is to provide a framework for partners from a variety of agencies and organisations to ensure that services are offered that are aimed at prevention and intervention towards victims and, where necessary, perpetrators. Membership incudes, TWBC, Kent Police, KCC, Lookahead, NHS, Change Grow Live, Community Mental Health team, Domestic Abuse Volunteer Support Services and local housing providers.

3. Embed Improvement and Shape Future Practice

Agency	Example

Ashford Borough Council	**Professional Curiosity and Supervision:** Ashford Borough Council's generic 1:1 (supervision) form has been adapted to enable staff involved with safeguarding to discuss how they have dealt with specific complex cases/cases of concern with their line manager. There is also an information sheet on the staff SmartHub (Intranet) on supervision specific to safeguarding which suggests areas for discussion. In addition to this some staff, for example the Welfare Intervention Officers, have received specific external supervision sessions. The Council's safeguarding section of the SmartHub includes an information sheet "Professional Curiosity and Disguised Compliance". There are a number of forums where professional curiosity can be applied and where practice can be reflected upon; these include the Safeguarding Lead Officers' meetings and the multi-agency vulnerabilities panel.
Ashford Borough Council	**Safeguarding Adult Reviews (SARs):** Each published SAR is shared with Safeguarding Lead Officers and are discussed as a standing agenda item at this group's meetings. Discussions include lessons learned, especially those that relate to the work carried out by our authority, for dissemination to team members as applicable. The Level 2 Safeguarding Training may also be updated if relevant. A copy of each SAR report is held on a shared MS Teams Group for Safeguarding Lead Officers. There is also an information sheet on SARs, which has a link to the specific KMSAB webpage, on the Council's Safeguarding section of the SmartHub (intranet) that is available to all staff.
Ashford Borough Council	**Promoting good practice:** This includes: • A regular weekly safeguarding update email to the Safeguarding Lead Officers' Group to disseminate as appropriate. These include information from the KMSAB, external training and seminars, procedures such as that for SARs, links to external newsletters and bulletins, updates to external policies & procedures (e.g. KMSAB's). • Events such as Adults Safeguarding Awareness Week. • Sharing relevant safeguarding information received from the Kent Community Safety Team, KMSAB and others with partner agencies, as appropriate (for example the Ashford Community Safety Partnership). • Staff Smart Hub: This has a specific safeguarding section which includes information such as a link to the Council's Safeguarding Policy; reporting and recording procedures; details of the DSO, lead officers and support; referral forms; information on a number of safeguarding related elements such as The Care Act, Mental Capacity Act, DHRs, Adolescent to Parent Violence & Abuse, the Council's Modern Slavery & Human Trafficking Statement, mate crime and much more. • Close partnership working: Ashford is very good at working in partnership with other agencies whether it be in respect of day-to-day specific issues or larger joint initiatives, as well as through a number of multi-agency meetings. Two examples of this are: ▪ Farrow Court Independent Living Scheme: Ashford Borough Council is trialling an initiative at Farrow Court in conjunction with the NHS to provide a community health hub and to prevent people attending the hospital when community services could meet their needs. This is also

	an opportunity to pick up any safeguarding concerns prior to them escalating. ▪ The Safer Streets Project: This is in partnership with the Police and part of which forms work in respect of the Violence Against Women & Girls agenda. The project has included various environmental improvements in the town centre; educational sessions in schools around healthy relationships; delivery of Active Bystander training to a large number of frontline staff operating within the town centre; defining a number of safe spaces; various equipment and merchandise (such as personal alarms and devices to prevent drink spiking); additional CCTV; a Safer Streets App, specifically in relation to Ashford Town Centre and the Night-time Economy, with information to allow people to make an informed decision about their route across the town centre and which includes a SOS button.
Ashford Borough Council (ABC)	**Safeguarding Training:** All staff are required to complete a 'level 1' e-learning module on safeguarding as part of their induction and then on a rolling programme. This is also now mandatory to elected members (Councillors). Relevant customer facing staff (including housing officers and welfare officers) as well as managers have to complete the level 2 training. Although covered in the main safeguarding training, there is also specific e-learning training in respect of Prevent and Modern Slavery & Human Trafficking on the Council's training portal. Safeguarding Lead Officers and key staff also have access to, and attend, external training, webinars and seminars. **Level 2, Safeguarding Training Feedback:** Overall feedback on this course, delivered by ABC's training officer, Designated Safeguarding Officer and/or Safeguarding Lead Officers (Adults and Children) has been really positive. Comments on this specific training have included: • "*It was helpful for this to be set in an ABC/local government type context and to hear about and learn from the experience of colleagues.*" • "Always valuable to have a safeguarding update and you always pick up something new." • *"Really informative and really helpful. Able to ask questions as they came up and really great course. Hard subject matter but delivered really well, all speakers were really knowledgeable and course was well delivered."*
Canterbury City Council	**Learning from Safeguarding Adults Reviews (Self Neglect):** Recent SARs have highlighted the lack of awareness and use of the KMSAB procedures for those who self-neglect and demonstrate hoarding behaviours. As a result the council's safeguarding lead has attended a number of front line staff team meetings to give a briefing on self-neglect, using the newly revised procedures. As a result, awareness has been raised and teams are more confident in carrying out risk assessments and taking a multi-agency approach.

Canterbury City Council	**Learning from Safeguarding Adults Reviews (Safe-discharge):** Canterbury City Council has been a lead agency reviewing hospital discharge protocols to ensure that housing is included as a key partner in after care plans. To meet the needs of rough sleepers being discharged from hospital the council has worked with the Integrated Care Board to successfully secure ongoing funding for a multi-disciplinary team who can provide an enhanced level of care to those clients, following a successful pilot. Combining both housing & clinical expertise will continue to improve outcomes for the most vulnerable people sleeping rough.
Canterbury City Council	**Safeguarding Adults Training:** The council has commissioned the Ann Craft Trust to carry out Level 2 and Level 3 adult safeguarding training which was delivered to 56 front line staff. In addition, we also included key agencies whom we commission, in the council's core safeguarding training offer. The following organisations have attended safeguarding training with us in the last year: Kent Refugee Action Network, Espressions Art, Canterbury Housing Advice Centre, Rising Sun Domestic Abuse Service, Canterbury Welcomes Refugees. Opportunities to increase learning in addition to core adult safeguarding training have been maximised this year, including: • Attendance at KMSAB Open session on Alcohol Dependency & Adult Safeguarding • Attendance at KMSAB training Self Neglect & Hoarding Awareness • KMSAB SAR Learning Event • Promotion of the SCIE Mental Capacity Act online course Key learning points and resources are shared throughout the Council via the Safeguarding Key Contacts Group.
Dartford & Gravesham NHS Trust	**Safeguarding Adults Training:** All staff have a level of safeguarding training depending on role and responsibility in line with the Intercollegiate Document. Levels one, two and three are delivered via e-learning, the Family Focused training is delivered as a whole day face to face training. Compliance with training is monitored via the training platform with staff being made aware of the training requirements and when their compliancy is due to expire. Training compliance is also monitored as part of the appraisal process. Training compliance for level 1 at the time of writing stands at 96%, Level 2 95%
Dartford & Gravesham NHS Trust	**Sharing Learning from Safeguarding Adults Reviews:** Learning from SARs is shared via internal meetings. All published SARs are made available to read on the trust intranet and are shared during the safeguarding training
Dartford Borough Council	**Learning from Safeguarding Adults Reviews (Carers):** Recent SARs have highlighted the need for carers to be signposted to carers' assessments and support where appropriate. As a result, we actively encourage our staff to use the "Think Family approach" and our safeguarding policy has recently been updated to include this information.
Dover District Council	**Sharing Learning from Safeguarding Adults Reviews:** The Lead Safeguarding Officer reviews all SAR and DHR cases published, looking at best practices and looking at ways to implement within the day to day safeguarding function.

	These cases are distributed to the Dedicated Safeguarding Officers and Community Safety partners to help improve their own safeguarding practices. It is hard to obtain quantifiable data in regards to safeguarding, but we work closely with partners to recognise trends or emerging themes. Safeguarding (including: Children, Young People and Adults) is one of the key priorities the Dover District Community Safety Partnership Executive has identified in its four year plan, this is supported by an action plan to support the coordinated approach being undertaken as a collective, with the sharing of good practices.
Dover District Council	**Multi-agency working:** Safeguarding cases are always discussed with a designated safeguarding officer before escalation to a safeguarding referral. This ensures that cases are managed and perhaps dealt with via different agencies. Talking about situations often reduces the risk and allows further opportunity for support to be referred to. If in doubt social services are always contacted, even if it is for information purposes only. DDC work with other partners, if it is felt necessary, before making a safeguarding referral. For example, Kent Police and mental health teams. This is often via email, or via the District Vulnerability Panel, chaired by Kent Police.
East Kent Hospitals University Foundation Trust (EKHUFT)	**Safeguarding Adults Training**: The safeguarding adult workforce development programme, from August 2022-March 2023, focused on enabling the staff to develop further skills and knowledge and competencies in safeguarding leadership. This was achieved through undertaking a skills analysis using the domains from the Intercollegiate Document (ICD) to identify gaps in competencies to ensure that roles and responsibilities were aligned to this and that the team could demonstrate progression in this. The Trust also developed safeguarding competencies for all staff which will be rolled out in 2023 and have updated safeguarding training to reflect learning from the safeguarding reviews and section 42s.
East Kent Hospitals University Foundation Trust (EKHUFT)	**East Kent Homelessness Pathway Pilot:** The Trust was involved in a pilot relating to people who were homeless, and the outcome of this was completed which indicated that there was much need to continue this project, as such it was extended by the ICB. The safeguarding team worked closely on this project with the Homelessness Adult Safeguarding Practitioner, providing support on the interface between homelessness and safeguarding. A short video about the homeless pathway project is available here.
Folkestone and Hythe District Council (FHDC)	**Ensuring the voice of the person (or their representative) who has been involved in our safeguarding system is heard in respect of their safeguarding experience:** • Following KMSAB feedback on how to make safeguarding personal, FHDC have looked into their practice in order to embed this approach further into safeguarding activity, including putting additional information on the intranet. • Internal safeguarding procedures have been updated to ensure questions about Making Safeguarding Personal are now included in the safeguarding form staff use, and the Designated Officer group have

	been made aware that staff referring a concern to them need to have completed this section. Additionally, the new online safeguarding system also includes questions about the individual's wishes. • In handling safeguarding concerns - allowing opportunity for individuals to properly express feelings and views around how they have been treated/ what has occurred.
Gravesham Borough Council	**Improvement activity following SAF – Focus on consent**: It was highlighted in last year's KMSAB self-assessment framework audit (SAF) that we needed to be more thorough in establishing consent within safeguarding referrals. This has been built into the internal safeguarding alert form, officers are required to confirm if the individual has confirmed they consent to a referral being made or not. If not, the Safeguarding Lead or Community Safety Manager contacts the individual to talk through support options and ensure they are happy to consent. The need to gain consent is also highlighted in the safeguarding briefing delivered to officers.
Gravesham Borough Council	'**Safeguarding Pledge':** The council's Safeguarding Policy details the council's 'Safeguarding Pledge' ensuring all staff are aware that the safeguarding of children and vulnerable adults is everyone's responsibility. The policy details clear instruction of the reporting of concerns and key points of contact within the council.
Gravesham Borough Council	**A Multi-Disciplinary Approach to Homelessness:** A number of SARs have highlighted the issues of homelessness and self-neglect. Over the past 18 months, the council has proactively been working with a number of partners across the borough to provide an all year-round Homelessness Shelter service to the homeless in the borough. This has not just been about providing shelter but has also included the provision of advice and support from professionals. Gravesham is working in partnership with North Kent Mind, Change Grow Live, Gravesham Sanctuary, Methodist Church, HM Prisons, Probation, Community police, Look Ahead, Eastgate counselling services and Serveco to manage and deliver a multi-disciplinary approach to homelessness within the Borough. Provision of services to the homeless is a priority for GBC. In the past year a number of changes have been made to the team to ensure it is providing the best support it can to those who need it. A Rough Sleeping Partnership Manager has been appointed to coordinate the work of the council and its partners; a Housing Resettlement Officer works with those in temporary accommodation to help them find a route to a permanent home, and a Prison Navigator to ensure a release from prison does not result in homelessness. The Rough Sleeping Partnership has enabled rough sleepers to have a voice and has built trust within this community.
HCRG Care Group (formerly Virgin Healthcare))	**Safeguarding Serious Incidents**: All Serious Incidents are monitored by the Senior Leadership Team via the Quality & Governance meeting. Common themes and trends are discussed each month for wider learning to occur and improve practice.
HCRG Care Group (formerly Virgin Healthcare)	**NHS Friends and Family Test**: Like all NHS providers, we ask people who use our services to feed back to us on their experience using the NHS Friends and Family Test. In 2022-23, 1462 people rated our services in North Kent and 97.13% said they had a positive experience of our service.

Healthwatch	**Analysing feedback:** General feedback heard by Healthwatch is analysed and any relevant themes arising are shared with KMSAB.
Kent and Medway Integrated Care Board (ICB)	**Safeguarding Spotlight Survey:** In April 2022, the NHS Kent and Medway Safeguarding team undertook a staff safeguarding spotlight survey. This provided us with feedback from staff on their experiences and areas for progress. Over 90 % of respondents stated that they were confident on how to contact our safeguarding team. As a team we were able to utilise the opportunity of the newly formed organisation to re-launch our team and ensure our contact details were available on the new KAM (internal) system and then promote our team further as part of the activity we undertook during safeguarding adults' awareness week.
Kent and Medway Integrated Care Board (ICB)	**Safeguarding Adults Training**: Kent and Medway CCG had, in 2020 – 2021, revised its availability of adult safeguarding training due to the Covid 19 pandemic. During 2022 -23 it was recognised that the NHS Kent and Medway safeguarding team needed to prioritise a review of training delivery to ensure that, as a newly established ICB, NHS Kent and Medway could be assured that its workforce is knowledgeable and confident in the application of their safeguarding adult roles and responsibilities. Following the establishment of the new organisation, a training needs analysis was undertaken to ensure that all employees were mapped according to the Adult Safeguarding: Roles and Competencies for Health Care Staff. New face to face modules for level 1 and 2 training were designed. • All staff working in the ICB can access safeguarding adults training according to the mapped training need. • At end of year 2022/23 82.81% of staff had received the new version of level 1 safeguarding adults training. 100 % of ICB staff were trained at level 2, 84.75% of staff had received prevent training. • The new level 2 training is due for delivery in July 2023.
Kent and Medway Integrated Care Board (ICB)	**Sharing Learning from SARs:** The team support the culture of learning as it embeds in the new ICB; the team have worked to ensure that there is a clear process in place to share learning from SARs to primary care services across Kent and Medway. This is undertaken by ensuring that learning from reviews is shared via: • Regular GP bulletins • Reflective synopsis of case learning at monthly safeguarding lead forums • Reflective presentations for involved practices. NHS Kent and Medway has further shared learning from SARs / reviews via: • NHSE regional safeguarding meetings to enable wider regional and national themes to be reflected upon and learning shared beyond, and by, Kent and Medway. • To commissioning and contract teams to influence changes in processes and pathways. (An example of this has been project plans such as youth worker projects, Hospital Independent Domestic Violence Advisors and Homelessness pilots as well as ensuring that

	linked worked around strategy and policy improvement is shared with relevant ICB teams, for example learning from review around Section 117 responsibilities being effectively shared with Mental health commissioners to influence programmes of work.
Kent and Medway Integrated Care Board (ICB)	**Primary Care Quality Matrix:** NHS Kent and Medway also introduced a new Kent and Medway Primary care quality matrix during 2022-23 which included the safeguarding bench marking toolkit. The quality matrix provides guidance for primary care to measure compliance against national standards and supports system wide improvement.
Kent and Medway Integrated Care Board (ICB)	**Care Home Standards Document**: During 2022-23 NHS Kent and Medway has continued to work on a care home standard document with NHS safeguarding colleagues across Surrey and Sussex. This work aims to explore good practice across the region and use this to develop a tool that can support equitable and measurable assurance for good safeguarding standards across the region. This work is being supported by the NHSE regional team to ensure that the good practice identified can be shared.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	**Making Safeguarding Personal:** KMPT utilise the KMPT 'Make Safeguarding Personal' leaflet to enable safeguarding discussions both proactively and in response to abuse. This leaflet is accessible as hard copies or via a download. These leaflets explain what safeguarding is and what making safeguarding personal looks like. KMSAB's posters 'noticing is not nosiness'' are distributed and visible in public and staff areas to stimulate awareness and enable discussion. Making Safeguarding Personal is embedded into safeguarding adults training and policy. The voice of the adult is discussed during consultations and training to ensure a person centred approach and consideration of risks and next steps. Care plans developed by practitioners with patients is a core function of KMPT care, this ensures a partnership approach in the recovery of mental ill health. The KMPT safeguarding team 'spot check' referral activity to ensure the voice of the patient is evident, and where necessary target intervention to ensure this is consistently applied as appropriate.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	**Health Independent Domestic Violence and Abuse Advocate/Advisor (HIDVA):** In 2021, the KMPT safeguarding team successfully secured funding from the Office of the Police and Crime Commissioner (PCC) to fund a dedicated Health Independent Domestic Violence and Abuse Advocate/Advisor (HIDVA) role within the Trust. The PCC funding is until March 2025. Patients accessing KMPT services require specialist mental health intervention that cannot be supported in primary care. This means that the people exposed to domestic violence and abuse have combined vulnerabilities which increase both the risks and challenges in accessing the right support. Thanks to the support from the PCC fund and the appointment of the HIDVA role, we have been able to support people to reduce some of those challenges, by listening, responding and advocating. Some of the patients supported by the KMPT HIDVA have identified as having a disability, being from ethnic minority groups, being from the LBGTQ+ community, being non-binary, male

	and female. Importantly the KMPT HIDVA has enabled accessibility of support to people in our communities.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	**Safeguarding as Everyone's Responsibility**: KMPT adhere to one of the most important principles of safeguarding, that it is everyone's responsibility. Health care staff frequently work with people in their moments of greatest need and can witness health and social inequalities which have a direct impact on the lives of people they care for. The Adult Safeguarding: Roles and Competencies for Health Care Staff intercollegiate document (2018) 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. KMPT are held to account by the ICB, the Safeguarding Children Partnerships, NHS England, Care Quality Commission and KMSAB via reporting mechanisms, such as KPI (key performance Indicators), inspections, and Section 11 and self-assessment framework returns. The KMPT executive board also ensures KMPT are compliant with safeguarding statutory functions and has a workforce committed and confident to prevent harm and responds to abuse.
Kent County Council (KCC)	**Strategic Safeguarding Team Talks:** Strategic Safeguarding met with over 50 teams, within KCC, during 2022/23. The team talks were given to various operational teams within Adult Social Care and the wider authority, such as Adult Safeguarding teams, Childrens Social Work services, Kent Registrars, Customer Care and Complaints and the Kent Enablement and Recovery Service, among many others. These talks were to provide an oversight of the work undertaken within Strategic Safeguarding and the Kent and Medway Safeguarding Adults Board. They raised awareness of the Safeguarding Adult Review (SAR) and Domestic Homicide Review (DHR) processes, and the themes highlighted within published reviews and provided useful resources to use within practice. A feedback form was produced by Strategic Safeguarding to measure the impact the Team Talks had on practitioners' and their practice. The feedback received so far highlighted that staff now had a much greater awareness of the work of the Kent and Medway Safeguarding Adults Board, creating links with the Board and understanding the importance of reflection within team meetings to sharing the lessons learnt from SARs and DHRs; by using tools such as the reflective briefings produced for operational learning by Strategic Safeguarding, to help continually improve practice.
Kent County Council (KCC)	**Reflective Briefings:** in 2022/23, learning from a selection of reviews published by the Kent and Medway Safeguarding Adults Board (KMSAB) and the Kent Community Safety Partnership (KCSP), have been shared with operational colleagues in the form of reflective briefings, produced by KCC Adult Strategic Safeguarding. Themes identified within the reviews, are highlighted and additional useful guidance, research and relevant policies are also included. These briefings provide essential learning in an accessible and meaningful way for colleagues within Adult Social Care, and form part of the continual improvement in practice, focusing on key areas such as self-neglect,

	impact on carers, professional curiosity, the necessity of person-centred care and support, and the importance of cultural competence. In order to continually measure the impact these briefings have on frontline practice, Strategic Safeguarding created feedback forms for all briefings, providing a voice for practitioners, to highlight what difference the information shared has made in their day-to-day work and suggestions to help us to shape future briefings.
Kent County Council (KCC)	**Quality Assurance Framework:** To further quality assure the practice undertaken in Kent, KCC launched their own Quality Assurance Framework in December 2022, to ensure that we are consistent in the standard of practice we're delivering, and it complements and coordinates with our Practice Framework (launched In June 2022). Together, these frameworks form the basis of our journey to become the best we can be in Adult Social Care practice. Our quality assurance activities will help us to have a much better understanding of how things are going in practice and what support is needed, which will be especially important following the move to our future ways of working. The quality assurance measures include undertaking quarterly Practice Audits within Adult Social Care. These audits began in January 2023 and will evolve going forward, in-line with feedback from colleagues. The Practice Audits are approached in a supportive manner and viewed as an enabler to develop the learning culture that we want to achieve within Adult Social Care. The audit findings across the county will be analysed by managers, and reports will subsequently be written for the Quality Assurance Governance Board. The recently created **Quality Assurance Governance Board** will be held every 3 months. It met for the first time in January 2023. The purpose of the Board is to analyse and evaluate the effectiveness of performance and quality assurance mechanisms in place across Adult Social Care, which will subsequently inform service delivery, strategic planning and commissioning. The Corporate Director for Adult Social Care will act as Chair and a person with lived experience will be co-chair. Other members of the group will include the Director of Operations, the Senior Responsible Officer for Self-Directed Support, the Senior Responsible Officer for Social Care Reform, the Assistant Director for Strategic Safeguarding, Practice, Policy and Quality Assurance, the Principal Social Worker and People with lived experiences.
Kent County Council (KCC)	**Your guide to adult social care in Kent 2022:** The annual "Your guide to adult social care in Kent 2022" for the public, and people that draw on care and support, includes a section regarding safeguarding but this is a key message throughout. It is a practical guide to getting support and there is signposting to support organisations.
Kent County Council (KCC)	**Engagement Roadshow**: In 2022, the team delivered a public in-person engagement roadshow, held in community locations across the county such as libraries, community hubs, hospitals and public buildings etc. This enabled face to face conversations and awareness raising amongst people that would

	not normally have the opportunity to hear about social care and understand where they can find the information they may need. **Kent Care Summit:** At the 2022 Kent Care Summit around 300 delegates came together from a number of key stakeholder groups including providers and the public to discuss and explore key topics and challenges facing the care sector. The Social Care Futures principles were used as a basis for discussion and the commissioning intentions were co-produced from April 2022 as a result. These focused on person-centred commissioning and refer to the Making a Difference Every Day vision which highlights living a full and safe life (Kent Commissioning Intentions).
Kent County Council (KCC)	**Self-Neglect Workflow: N**ew KCC internal system changes are also being implemented, with the creation of a "self-neglect workflow" in January 2023. This workflow has been built into the adult social care electronic database (Mosaic) and can be used at any point during adult social care intervention with the person, providing a dedicated space to clearly record all information and actions taken in relation to self-neglect. This will provide much greater oversight of anyone who may be self-neglecting, the support provided to them. A briefing and guidance for this new workflow was sent to operational colleagues in February 2023, and highlighted further within internal communications in March 2023. Feedback will be sought from operational colleagues, on the use of the new workflow at the end of the first quarter for 2023/24.
Kent Community Health NHS Foundation Trust (KCHFT)	**Safeguarding Adults Training:** KCHFT continue to deliver a safeguarding training programme in line with the adult, children and looked after children (LAC) safeguarding intercollegiate documents for all staff groups in level 1,2,3,4 and Board level target audience. The training is delivered using a blended approach of both e-learning and instructor led topic specific workshops for level 2 and 3 staff groups using virtual platforms. The workshops include safeguarding processes and procedures, domestic abuse, self-neglect, learning from safeguarding adult reviews (SARs), domestic homicide reviews (DHRs) and local safeguarding children practice reviews (LSCPRs), exploitation and mental capacity act practical application, all highlighting the importance of person- centred care. Staff receive mandatory safeguarding training updates every 3 years and have access to webinars using national network platforms, KMSAB multiagency training and KMSAB learning from SARs sessions. All training is evaluated, the feedback received is used to update the training and training facilitators are peer-reviewed. The impact of training is evident through reviewing the safeguarding referrals, calls into KCHFT safeguarding consultation line, annual safeguarding audit, patient safety incidents and clinical practice. The activity comparison shows staff recognition of key safeguarding concerns and action taken.

Kent Community Health NHS Foundation Trust (KCHFT)	**Quality Assurance of Referrals:** To drive the importance of good quality safeguarding referrals to the local authority, the safeguarding team has introduced a process to monitor the quality of safeguarding referrals. All safeguarding referrals raised by KCHFT staff are scored against 5 set criteria for good referrals; a point is given for each met criteria resulting in 5 points being marked against a good quality referral or 1 for poor referral. Short feedback is then provided to the referrer, including positive aspects and areas on how to improve future referrals.
Kent Community Health NHS Foundation Trust (KCHFT)	**Safeguarding Data:** In 2022/23 KCHFT staff sought support for 1043 concerns, showing recognition to support people at risk and indicating the complexity of the need for people at risk in the community. This is 12.5% higher compared to 2021/22 and 70% higher than 2020/21. The increase has been further seen in concerns about neglect (increase by 28%), people with care and support needs (increase by 29%), domestic abuse (increase by 38%) and mental health (increase by 16%).
Kent Community Health NHS Foundation Trust (KCHFT)	**Mental Capacity Act Awareness Week:** The Trust continued to strengthen the application of mental capacity act (MCA) in practice and held an MCA Awareness week 24 – 28 October 2022, which included sharing of key MCA messages with staff and patients to highlight lasting power of attorney, what capacity is, and awareness of deprivation of liberty safeguards (DoLS). A resource pack was created and shared with safeguarding and MCA link workers in practice areas and the trust community hospitals and further support tools were created; such as an MCA crib sheet to support completion of MCA assessment and DoLS care plan.
Kent Fire and Rescue Service (KFRS)	**Safeguarding Adults Training:** At a national and regional level, KFRS has created e-learning modules for both child and adult safeguarding. These have now been adapted by 3 other fire services. We have also written level 3 and 4 training and shared this with 5 other services around the UK for their safeguarding leads to adapt and deliver the training to their colleagues. We trained another safeguarding manager from Bedfordshire in November 2022 and are proud to be supporting others in creating bespoke safeguarding training for fire services.
Kent Police	**Victim Needs Assessment:** To ensure Kent Police meets its requirements under the Victim's code 2021, and in order to better support victims of crime and to ensure their wishes and needs are considered, Kent Police has introduced a Victims Needs Assessment. This assessment takes place for every victim engaged with. It records issues such as safeguarding and any support needs such as use of an intermediary or communication requirements.

Kent Police	**Making Kent Safer Plan:** In 2022 the Office of the Police and Crime Commissioner launched the 2022 – 2025 "Making Kent Safer" Plan. The plan can be found here (kent-pcc.gov.uk). The plan clearly states that the Police and Crime Commissioner will set priorities for the Chief Constable, these include working with residents, communities, and businesses to prevent crime and anti-social behaviour, tackle violence against women and girls and protect people from exploitation and abuse. The Police and Crime Commissioner also states that he will hold all agencies to account for the delivery of an effective and efficient criminal justice system, will work in partnership with the police and others to prevent crime and anti-social behaviour and commission services for victims that are needs-led.
Kent Police	**Statutory Reviews Lessons Learned Newsletter:** Kent Police continues to play a key role in carrying out Safeguarding Adults Reviews and to ensure multiagency learning is in place. SARs are shared and stored centrally on the Crime Academy SharePoint Pages. The Protecting Vulnerable People Governance and Scrutiny team track the resulting recommendations from both the independent report and the internal independent management report (IMR). However, to assist in learning, the Serious Case Review Team produce a newsletter looking at themes from SARs and include key learning from the IMR writers. This then complements the completed SAR learning when it is circulated.
Maidstone and Tunbridge Wells NHS Trust (MTW)	**Learning from Safeguarding Adults Reviews:** Safeguarding Adults Reviews are shared at the Safeguarding Adults Committee in report format with all of the actions from each SAR noted. Even when an action is not specifically for MTW to complete the Trust will consider the impact of each recommendation in relation to MTW's practice, so that Senior Teams and individuals are sighted on this. Leaders within the Discharge Liaison Team have attended SAR workshops and are keen to promote the use of the KMSAB Self Neglect policy and procedure. Where concerns arise in relation to safeguarding issues for patients who are being discharged, they will liaise within the multi-agency to seek out remedies for patients and will escalate to the Safeguarding Team where support is needed.
Maidstone and Tunbridge Wells NHS Trust (MTW)	**Safeguarding Adults Training**: All staff who work for the Trust receive safeguarding adults training in line with the updated Adult Safeguarding: Roles and Competencies for Health Care Staff (Intercollegiate Document) published by the Royal College of Nursing, first edition 2018 and updated June 2022. March 2023 compliance for: - Level 1 Safeguarding Adults Training is at 95.5% Level 2 Safeguarding Adults Training is at 92.2% Level 3 Safeguarding Adults Training is at 78.4% Level 2 Mental Capacity Act (MCA) Training is at 70.0% - This was put back to zero compliance in March 2022 after a redesign of training. Level 3 MCA Training is at 73.2% - This was put back to zero compliance in March 2022 after a redesign of training.

	The Trust decided in March 2022 to re-start the Level 3 Training Offer after the training was reviewed and compliance target audiences were reset. This meant that we 'zeroed' both Safeguarding Adults Level 3 and MCA Level 3 training from that date. We advertised out that ALL registered practitioners who are patient facing needed to receive both Level 3 Safeguarding Adults and Level 3 MCA Training. The Trust compliance target is set at 85% and within the last 13 months the compliance has risen from 0% to Safeguarding Adults Level 3 78.4% and MCA Level 3 73.2%, this remains on an upward trajectory.
Maidstone Borough Council	**Safeguarding Champions and Supervision:** We have specialist staff members who are expert in safeguarding and support, who work alongside our wider staffing teams and Safeguarding Champions to ensure a robust response across the organisation. We have regular safeguarding champions meetings. Also, through the dissemination of safeguarding we look to review our own processes and support mechanisms to make sure they are adequate. We have recently implemented as a standard safeguarding item on all one to one's meetings for those staff in front facing support roles within Housing. This ensures any concerns or worries, are escalated, and reported through the best channels and the staff have the opportunity to seek support, give opinions and advice in difficult and challenging cases. We also seek to review trends and the biggest concerns within MBC via the Power BI dashboard (data dashboard).
Maidstone Borough Council	**Clinical Supervision:** Often through this front facing work, we work with very complex individuals and wider households – we ensure our staff team are well trained and have emotional resilience to deal with these complex cases. The team all have access to clinical supervision which was introduced in late 2022 and helps them work through challenges and difficulties. Any concerns which are discussed in the meetings – are raised via normal management processes.
Maidstone Borough Council	**Self-Neglect and Hoarding:** Through our hospital discharge programme, we have contracts in place to support those who are hoarding/self-neglect to prevent a hospital admission. We work alongside Mid Kent Mind to provide weekly counselling support (between 6-18 weeks dependant on the circumstances) with support to provide some cleaning and/or clearance works. This is provided free of charge to residents. This helps reduce unnecessary pressures on the NHS by repeat admissions or GP appointments. Cases are subject to an initial home assessment and acceptance from clients. It can also lead to other avenues of support by statutory and/or voluntary agencies. Mid Kent Mind have a good success rate for engagement.
Medway Community Healthcare (MCH)	**Safeguarding Adults Training**: All MCH staff are required to attend Safeguarding Training commensurate with their role, overall compliance is currently at 92%
Medway Council	**Safeguarding Peer Review:** A safeguarding peer review was undertaken in February 2022, and the report was published in June 2022. The peer review considered the following areas: • Leadership • Quality of Practice • Structure and Resources

	• Performance • Partnerships The findings were welcomed, with many positives alongside challenges to consider. As a result, an action plan was written to support improvement. One of the significant recommendations was to consider the structure of our safeguarding teams. Work has begun to create one safeguarding hub to ensure consistency of practice throughout the customer journey.
Medway Council	**Safeguarding Adults Training:** We continued to offer bespoke training on the role of the Enquiry Officer and the role of Designated Senior Officer in 2022/23. Feedback from the training has been positive.
Medway Council	**Learning from Safeguarding Adults Reviews (SARs**): Learning from SARs has been shared with staff in the safeguarding hubs and with managers at the monthly safeguarding hub meeting. To increase the reach to the whole adult social care (ASC) workforce, a monthly Principal Social Worker (PSW) and safeguarding bulletin has been developed. Specific actions from SARs are monitored at the monthly SAR/Domestic Homicide Review action meeting, this is chaired by the Assistant Director for ASC and attended by the Head of Service, Operations Managers, PSW and Safeguarding Lead. The Operations Managers manage the locality and specialist teams and can share relevant information with those teams.
Medway Foundation Trust	**Safeguarding Adults Training:** We have resumed face to face training for level 2 and 3 during the past year to put a specific emphasis on local learning and awareness, roles and responsibilities of staff in the Trust and ensuring that Making Safeguarding Personal is emphasised.
Medway Foundation Trust	**Making Safeguarding Personal and Audit Activity**: The safeguarding recommendation form information is added to the patient electronic records; this specifically includes the patient's wishes. A safeguarding audit of the quality and compliance with all fields of a safeguarding referral is undertaken including patient consent.
National Probation Service	**Feedback from Persons on Probation:** Through the review period, the Probation Service has been developing ways of ensuring service users' voices are heard. Latterly this has led to the development of an initiative to better engage and collaborate with People on Probation. Although not specifically a forum for adult safeguarding issues, feedback around lived experiences of Persons on Probation including prison leavers is gathered via this route.
Sevenoaks District Council (SDC)	**Safeguarding Policy:** The Safeguarding Policy was updated in January 2022 and added in extra policies following guidance from the KMSAB. This was formally approved through our committee process and has a review process in place.
Sevenoaks District Council (SDC)	**Warm Spaces Initiative:** SDC launched our Warm Spaces initiative as part of the cost of living response, enabling a number of community spaces, where people can find warmth and access to services. We are now considering evolving these as Safe Spaces.

Swale Borough Council	**Learning from Safeguarding Adults Reviews (SARs):** Safeguarding Adults Review outcomes and relevant recommended practice change are reported in the Senior Management Team Quarterly report. Recommendations for localised practice are included within annual reviews of safeguarding policy and procedures. The recommendations are tracked and managed to ensure that SARs are not just a paper exercise.
Swale Borough Council	**Self-Neglect:** We have devised and launched an internal self-neglect procedure which is linked in with our safeguarding policy.
Thanet District Council (TDC)	**Community Services Manager:** The Community Services Manager attends county and national conferences, organised by KCC, KMSAB and the Local Government Association. Learning from these are then disseminated to the rest of the organisation for organisational improvement. The dissemination happens via TDC safeguarding forum and then down to the teams via the safeguarding champions.
Tonbridge and Malling Borough Council	**Learning from Safeguarding Adults Reviews (SARs):** Safeguarding Adults Reviews and Domestic Homicide Reviews are standing items at the quarterly internal safeguarding meeting, to raise awareness and understanding of the issues with staff.