Appendix A

Kent and Medway Safeguarding Adults Board

Annual Report

April 2024 – March 2025

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

Purpose	The Board[1] is a statutory multi-agency partnership which assures adult safeguarding arrangements in Kent and Medway are in place and are effective. It does 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.
3 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 are 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.
Board Members	**Independent Chair** – Andrew Rabey **Statutory Partners** – Kent County Council, Medway Council, Kent and Medway NHS Integrated Care Board, Kent Police **Other Partner agencies** - Advocacy People, Department for Work and Pensions, East Kent Hospitals University NHS Foundation Trust, HM Prison Service, Kent and Medway NHS and Social Care Partnership Trust, Kent Fire & Rescue Service, Maidstone and Tunbridge Wells NHS Trust, Medway NHS Foundation Trust, Public Health (Kent and Medway), Dartford and Gravesham NHS Trust, 12 District and Borough Councils across Kent, HCRG Care Group, Kent and Medway Healthwatch, Kent Community Health NHS Foundation Trust, Kent Integrated Care Alliance, Medway Community Healthcare, Probation Service, South East Coast Ambulance Service NHS Foundation Trust. **New members welcomed in 2024-5: A representative for Kent and Medway Universities and a named lead for homelessness.**
Vision	"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".
Strategic Plan Priorities	The KMSAB Strategic Plan 2022 – 2025 is available on the KMSAB website. The priorities are 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.

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

Board structure

Executive Group

Delivers the responsibilities as set out in the Care Act 2014 and the supporting statutory guidance

Business Group

- 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 partnerships 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.

Working Groups (WG) – terms of reference available on the KMSAB website.					
Communications and Engagement (CEWG)	**Joint Exploitation (JEG)**	**Learning and Development (LDWG)**	**Practice, Policy and Procedures (PPPWG)**	**Quality Assurance (QAWG)**	**Safeguarding Adults Review (SARWG)**
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 improve practice and prevent abuse.	This is a joint group with Medway's Safeguarding Children Partnership. Kent Safeguarding Children Multi-Agency Partnership are also represented. 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.	Co-ordinates the commissioning, delivery and evaluation of the Board's multi-agency safeguarding adults training programme.	Develops, reviews, and updates the Board's policies and procedures, in line with changes in legislation, guidance and good practice - identified through Safeguarding Adults Reviews, research, audit, practice, performance monitoring and feedback from practitioners or those with lived experience.	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.	Delivers the Board's statutory responsibility to conduct Safeguarding Adults Reviews and holds agencies to account for the delivery of action plans to achieve improvement in practice.

Section 2. Priorities and Achievements

This section details how we delivered against our strategic priorities during 2024 – 2025. It is recognised that activity can span more than one priority.

Priority - Promote Person Centred Safeguarding - Putting adults at the centre of our work.

Objectives:

- Raise awareness of adult safeguarding to ensure that people understand what abuse is, how to recognise the signs and how to seek help.
- Enable residents of Kent and Medway to voice their opinions on the work of the Board.
- 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.
- 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.

What we achieved:

Kent and Medway Safeguarding Adults Board Website

- The Board has an independent website (Kent & Medway SAB website) to ensure that adult safeguarding information is accessible for both professionals and members of the public.
- Visits to the website have continued to increase. In summary:

Section Title	Total Views 2024-2025
About KMSAB	34476
What is Adult Safeguarding	31270
Making Safeguarding Personal	11684
Professional Curiosity	10418
Worried About an Adult?	25009
Professionals	85149
Information for Carers	19008
Total	217014

National Safeguarding Adults Awareness Week	• Members supported National Safeguarding Adults Awareness Week by actively raising awareness of adult safeguarding, both within their organisations and with members of the public. The theme of the national campaign was "working together to establish safer cultures". More information about the week is available on the Ann Craft Trust website.
	• To support agencies, the Communication and Engagement Working Group developed social media content for each day and updated the toolkit of awareness raising materials. This includes resources such as leaflets, posters and email signature banners. Agencies are encouraged to utilise this toolkit to share messages about adult safeguarding throughout the year. It is promoted through the newsletter, meetings and training.
	• KMSAB partner agencies participated in the week by sharing the social media messaging and hosting events within their agencies. Agencies tailored their contributions to address their own targeted priorities. Detailed examples of specific activity delivered during the week, and the impact of this, can be found in appendices two and three.
	• Acknowledging that some people do not access digital content, public facing events also took place during the week, such as information stands in public places and 'ward walks' in hospitals. These generated positive engagement with members of the public.
	• The Independent Chair of the Board was interviewed for Heart Radio Kent, which has an average reach of 36,000 listeners per day[2].
	• There were 7181 visits to the KMSAB website during the week, including:
	  ○ 584 visits to the safeguarding explained page
	  ○ 416 visits to the types of abuse page
	  ○ 504 visits to the report abuse page
	  ○ 423 visits to the useful resources for the public page
	• The KMSAB learning and development managers hosted an evening, online, learning event on 'Adult Safeguarding and Professional Curiosity'. 59 delegates attended, their feedback included:
	'Enjoyed the session and engagement with other participants. Found it very helpful.'
	'Thank you for a most engaging and informative session. I left inspired to carry on learning in this field so that I can pass on my learning to others.'

Engagement with Local	• During 2024/2025, a brief article, titled "Are you concerned about an adult?", continued to be included in every

[2] https://media.info/radio/stations/heart-kent/listening-figures

Communities	edition of Medway Matters, a community magazine delivered 3 times per year to every household in Medway. • Members of the KMSAB and the Business Unit hosted a stand at the Kent Police Open Day on 30 June, where over 7000 members of the public were in attendance. Engagement at the stand was high, with a continuous flow of visitors interested in learning more, sharing their experiences, seeking advice and collecting resources for future reference. • As part of their work, the Independent Chair of the Board, Board Manager and the Board's Business Development and Engagement Officer, continued to meet with charities, voluntary sector and other community leads. • In October 2024, Members of the KMSAB business unit attended the 'sight matters' exhibition, arranged by the Kent Association for the Blind. In addition to raising awareness of adult safeguarding, attendance at the event provided the opportunity to seek views on the communication preferences of people who are sight impaired or blind. • The KMSAB hosted an exhibitor stand at the Kent registered managers conference, an event for registered care home and homecare staff. The event was attended by 250 delegates and 50 other stall holders representing 40 organisations.
Support for Relevant Targeted Awareness Campaigns	• The Communication and Engagement Working Group produced materials to support the following targeted awareness campaigns during 2024-2025, as they aligned with common themes identified in safeguarding adults reviews: ○ Alcohol Awareness Week ○ Carers Week ○ Hoarding Awareness Week ○ Learning Disability Week • The prepared media content was shared by KMSAB partners. Following this, there was an increase in visits to the KMSAB website. Between April and August 2024—during which many of the campaigns took place, alongside the Kent Police Open Day—the website received 79,070 visits, representing a 109% increase. Specific sections also saw significant rises in traffic: visits to the 'Information for Carers' page increased by 165%, 'What is Adult Safeguarding?' by 117%, and the 'Useful Links and Resources' section by 89%. • Example of activity during learning disability week - Learning Disability Week 2025 Makaton Flash Mob - A Sky Full Of Stars
Professional Curiosity	• The KMSAB's professional curiosity webpages provide a central repository for guidance, resources, videos and useful links. These pages continue to be promoted, using various methods, to encourage reach and support professional development and awareness across partner agencies. • During 2024 and 2025 the web content was accessed 10,418 times, representing an increase of 109% from the previous year (2023-2024).

	• In addition to the open session hosted during safeguarding adults awareness week, the KMSAB Learning and Development Managers facilitated safeguarding adults review workshops on 'Professional Curiosity and Unconscious Bias', attended by over 60 delegates. Feedback included:
	  ○ *Thank you very much for this training which gives us tools and understanding to contribute to make our communities a better place to live for everyone.*
	  ○ *The session was very thoughtful, and thought provoking. A gentle reminder to think and question my assumptions. I appreciated the practice tips and the models to think things through.*
	• The Quality Assurance Working Group asked each agency to complete an 'annual agency report' update, this was to include how they embed 'professional curiosity' and what processes are in place to allow them to reflect on their practice and receive appropriate supervision. Responses are included in appendices 2 and 3.

Individual/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 to determine what support may be required to enable them to contribute. • When drafting the terms of reference for commissioned Safeguarding Adults Reviews, members consider whether the review would benefit from broader panel representation. This may include the involvement of a subject matter expert, cultural advisor, advocacy service, charity representative, or other relevant contributors. • In 8 (67%) of the SARs published since the last annual report, listed in section 3.4, either the individual themselves or at least one family member or someone close to the individual felt able to contribute to the review.
Accessible Communication	• In response to feedback from the public facing events, the KMSAB's leaflet which explains how to recognise and respond to abuse was translated into two additional languages - Yorùbá and Tamil. The leaflet is now available in 28 different languages. These are promoted widely at in person events and through social media. • The leaflet is also available in easy read and British Sign Language (BSL) friendly formats. • Appreciating different learning styles and accessibility preferences, the KMSAB also makes videos available, such as the 'tricky friends' animation and Hampshire's adult safeguarding animation. • The Board's website and materials are regularly audited to ensure that they meet the accessibility requirements for public sector bodies.

Healthwatch Kent and Healthwatch Medway	• Healthwatch leads met regularly with the Independent Chair of the Board and the Board Manager during the year. These meetings provided the opportunity for Healthwatch to share insights into information that they have received relating to adult safeguarding. This information is triangulated with other information received by the Board to support existing work or to identify new areas of focus.
	• Healthwatch Kent and Medway are represented at each KMSAB Executive Board meeting and have a standing item on the agenda, to provide an update on their work programme and completed projects which focus on the views of people with lived experience of health and social care. Two thematic reports were presented to the Board this reporting period, these were aligned with themes identified in SAR learning and other activity:
	  ○ Co-Occurring Conditions, Access to Mental Health Services for those with Substance Misuse Issues - The Experience of Mental Health Services from those with Drug and Alcohol issues
	  ○ Steady Steps towards a solid future: People's views and experiences about frailty, frailty assessments and falls prevention services.
	• In relation to carers, the frailty report found that 19% of people in Cohort B (randomly selected public sample) identified as a Carer, 3% of whom were young carers. However, when interviewed 48% of this cohort said that they played a role in supporting someone who they considered frail. People spoke about helping with a range of household tasks, emotional support and social interaction. This suggests that many of the people supporting friends and family in their daily life don't see this as being a carer. This information will help to inform how the Board raises awareness of carers rights to a carers assessment.

Awareness of Advocacy Services	During 2024-2025 the Board continued to promote advocacy services. In addition to features in the newsletter and advocacy representation at Board meetings:
	  ○ The July 2024 KMSAB newsletter highlighted the 'VoiceAbility' charity and its 'Use Your Power' campaign, which promotes safeguarding and appropriate placements. It advocates against the long-term detention of individuals with learning disabilities and autism in mental health hospitals. The campaign includes a video, sharing lived experiences. The Board also hosted an open session to further raise awareness.
	  ○ The Board's self-assessment framework included a standard relating to advocacy, by March 2025 there was a 91% achievement rate.
	• The Advocacy People continued to champion the role of advocacy in safeguarding by actively raising awareness among professionals and ensuring practitioners understand when and how to make referrals. Their aim is to make sure individuals' rights are upheld throughout safeguarding enquiries. To support this, they developed and shared a revised statutory advocacy flowchart with referrers, which has led to an increase in appropriate and timely referrals.

	• Advocates have participated in KMSAB open sessions, including the September event on Safeguarding and the Care Act's wellbeing principle. During the sessions they are able to share their expertise and represent the views of people with lived experience. Following the events, they cascade new learning across the wider teams.
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 must enhance their involvement, choice and control as well as improving quality of life, wellbeing and safety. • The Board continued to update and promote their dedicated MSP webpages. The pages were accessed 11,684 times between 1 April 2024 and 31 March 2025, an increase of 62% on the previous year. • To measure how agencies embed MSP in practice, relevant standards were added to the self-assessment framework 2023. By March 2025, there was a 94% achievement rate. • The September KMSAB newsletter highlighted the *Making Safeguarding Personal in Self-Neglect* workbook, developed by Research in Practice. Drawing on research and Safeguarding Adult Reviews (SARs), the resource explores how personalised safeguarding approaches can positively impact the health, wellbeing, and safety of individuals who self-neglect. • The newsletter also promoted NHS England's trauma-informed care e-learning, following findings from the Safeguarding Adults Review 'Stephen', which recommended that agencies provide staff with trauma-informed practice training.

Priority - Strengthen System Assurance – Checking that organisations are working well together to support adults

Objectives:

- Establish a mechanism to identify system issues and risks to provide assurance to Kent and Medway residents that effective safeguarding arrangements are in place.
- Improving public understanding of the roles and responsibilities of partners.
- Improving interagency understanding of the roles and responsibilities of other partner organisations.
- Agencies discharging their respective responsibilities to safeguard people.
- Ensure effective Board to Board/Partnership arrangements.
- Ensure an effective functioning Board with appropriate support structures.

What we achieved:

Multi- Agency Risk Management Framework	• In response to learning from SARs, and having evaluated best practice in other areas, the Practice Policies and Procedures Working Group developed a Multi-agency Risk Management (MARM) Framework. • The MARM framework is designed to support anyone working with an adult where there is a high level of risk of harm and the circumstances sit outside the statutory adult safeguarding framework, but where a multi-agency approach would be beneficial. It enables a proactive approach which helps to identify and respond to risks before crisis point is reached. It can be initiated by either statutory or non-statutory organisations. • The MARM promotes a person-centred approach, by actively seeking the involvement of the individual/their advocates to establish the outcomes they wish to achieve and working collaboratively to develop strength-based action plans to support those outcomes. • The MARM Process was launched on 1 April 2025. The following documents were produced to support implementation across agencies: ○ MARM Flowchart ○ Quick Guide to the MARM ○ MARM Agenda Template ○ MARM Case Studies ○ MARM Training Slides *Evaluation Forms* ▪ Initiating Agency ▪ Invited Agency ▪ Lived Experience Feedback • Additionally, each agency was asked to identify an implementation lead, to embed the document in training, policies and practice. The KMSAB has learning events planned for later this year. • Regular evaluation meetings have been arranged to review how the process is being embedded in practice. Feedback from an initial MARM meeting included: "It was useful to build a bigger picture of the individual's support needs".
Kent and Medway Threshold Tool	• As reported in the last annual report, the findings from Safeguarding Adults Reviews (SARs) and performance data highlighted the low proportion of safeguarding concerns referred to the local authority which progressed to a safeguarding enquiry. SAR learning also identified issues in relation to the quality of referrals, practitioners understanding of roles and responsibilities and what makes a good safeguarding referral.

	• A collective understanding of what constitutes a safeguarding concern is vital to ensuring that people receive the right support, by the right agencies at the right time. It also equips practitioners with the knowledge to escalate concerns if they do not agree with the decision made, or seek alternative pathways of support should the criteria not be met. • In addition to the measures listed in the previous report, Kent and Medway Local Authorities created a threshold tool, to support decision making prior to making a referral. This was endorsed by the Board and was widely promoted. • The threshold tool has been well received, with feedback such as: ○ "I have been making colleagues aware of its existence, both when discussing a specific case and in general staff training. Several colleagues have commented that they have found it really helpful when they've had a case that was borderline for making a referral, as it allowed them to easily establish the severity of the concerns they had, based on the examples given, and see if that met the criteria for the referral or not." (District Council Safeguarding Lead).
Quality Assurance Framework	• During 2024-2025, Quality Assurance Working Group (QAWG) members reviewed and continued to implement the quality assurance framework, which sets out the methods and tools used to measure the effectiveness of partners' safeguarding activity. • The Chair of the Quality Assurance Working Group during 2024-2025 was Lee-Anne Farach, Director of People & Deputy Chief Executive, Medway Council.

2023 Self-Assessment Framework	• One of the most comprehensive quality assurance tools utilised by the Board is the 'self-assessment framework' (SAF).
	• All agencies represented on the Board are asked to complete a series of questions to measure progress against key quality standards. The purpose is to enable them to evaluate the effectiveness of their internal safeguarding arrangements and identify and prioritise areas needing further development.
	• Agencies are required to assess how well their organisation is achieving each standard/requirement, using a red, amber, green (RAG) rating. They are also required to provide supporting evidence and complete an action plan for any requirements graded red or amber, detailing how compliance would be achieved. Agencies have 18 months to complete the SAF.
	• During 2024-5 Quality Assurance Working Group members continued to measure compliance against the 2023 SAF standards, detailed in the last annual report. The 36 standards related to:
	  ○ Outcomes for, and the experiences of, people who use services
	  ○ Leadership
	  ○ Service delivery and effective practice

	○ Performance and resource management • At the time of writing, the 2023 SAF had concluded. Of the 36 agencies who completed the SAF, 5 had achieved green ratings for all standards. Overall, 82% of standards were assessed as green, indicating strong compliance. 16% were rated amber and 2% red, highlighting areas requiring further attention. As the number of outstanding actions was higher than previous years, the Independent Chair of the Board and the Quality Assurance Group Chair will meet executive leads for agencies with outstanding actions to seek assurance that these will be addressed and risk mitigation put in place. Additionally, the quality assurance working group has reviewed the data to establish if there are any themes which can be supported by other working groups, such as targeted training, policy updates, briefing notes or other collaborative initiatives.
Development of 2025 SAF	• Quality assurance working group members developed the 2025 Self-Assessment Framework, which was approved by the Executive Board. • The 'thematic' SAF includes 14 standards, primarily based on learning from SARs, to measure how effectively recommendations are being embedded in practice. Standards were also informed by emerging themes from wider board activity and developments in national and local guidance, legislation and policy.
Annual Agency Reports	• All KMSAB partner agencies are required to complete an annual agency report to provide examples of how they 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 33 responses were submitted. Appendix 2 and Appendix 3 provides some good practice highlights from the responses received.
Use of Qualitative and Quantitative Data	• The Quality Assurance Working Group has agreed draft measures for the KMSAB data dashboard, which will be piloted using data from Quarter 1 of 2025–2026. The initial dataset will focus on key indicators including the number of safeguarding concerns raised, the proportion progressing to Section 42 enquiries, categories of abuse and Making Safeguarding Personal outcomes. • Currently, monthly data submissions are received from Medway Council, while Kent County Council Adult Social Care provides annual data returns. • The Board seeks and utilises qualitative data to identify good practice, system issues and risks, and to provide assurance. Many of these data sources have been referenced throughout this annual report. • Examples of how qualitative data has made a difference: ○ Recognising this was a theme in safeguarding reviews and referrals, the KMSAB developed a briefing on Managing Diabetes and Mental Health Together.

	○ Feedback from staff during training events on the barriers and enablers to implementing the self-neglect policy has been used to inform the self-neglect thematic safeguarding adults review. ○ In response to learning from SAR referrals and SAF responses, the Board developed guidance on "the 10 golden rules of record keeping". ○ Information is used to inform training and other learning opportunities, such as open sessions, to share good practice.
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 ○ Multi Agency Risk Assessment Conference (MARAC) • Update reports from the Kent and Medway Health and Wellbeing Boards, Community Safety Partnerships and Safeguarding Children's Partnerships are received and considered by the Business Group. • Kent and Medway Public Health representatives attend and contribute to Board meetings. • 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. • Examples of effective partnership arrangements include: ○ KMSAB Learning and Development Manager worked with public health to design and deliver safeguarding content for their co-occurring conditions training. KMSAB representatives also spoke at the alcohol related brain damage conference, which was held on 26 March, providing an opportunity to share learning from SARs and discuss improvement activity. This was a sold-out event, reaching 330 delegates. Feedback was extremely positive, examples include: ▪ "The quality of the speaker sessions and breadth of knowledge offered made the event extremely rewarding. The conference was very well presented and remained engaging throughout the day. Thank you." ▪ "This was a worthwhile event and I have shared my thoughts and information with my wider team. "

	▪ "Much better awareness on impact - powerful lived experience accounts" ○ Hosting Joint Domestic Homicide Review and Safeguarding Adults Review learning events. ○ The Domestic Abuse Senior Project Officer and the Senior Community Safety Practice Officer were involved in the review and update of the Board's Domestic Abuse Policy.
KMSAB Executive Meetings	• The Board Executive Membership met on 4 occasions in 2024-2025. 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: ○ Safeguarding individuals with autism and complex needs: Kent and Medway Dynamic Support Arrangements – (in response to learning from SAR Stephen) ○ Safe discharge from hospital and other settings ○ Second national review of SARs – Presentation by Professor Michael Preston-Shoot ○ Mental Health Transformation progress update ○ Safeguarding in Emergency Departments ○ Response to homelessness Ministerial letter ○ Referral processes to the Local Authority (SAR Learning) ○ Presentation on SAR Lummy ○ Presentation on SAR Patsy
District Safeguarding Leads Meeting	• To improve the sharing of information, intelligence and best practice between the Board and 12 district councils across Kent, a quarterly Adult Safeguarding District Safeguarding Leads meeting is held. The meeting is Chaired by the Chief Executive of Gravesham Borough Council. • This meeting has demonstrated clear benefits. For example, members identified common areas for improvement within the SAF and collaborated to address them. Some districts shared best practice around safeguarding assurance for commissioned contracts, while others jointly developed 'Was Not Brought' guidance. This collective approach enabled safeguarding leads to support one another, meet required standards, and promote greater consistency across districts.
No Surprises Principle and Escalation Policy	• As detailed in the strategic plan, the Board follows the 'No Surprises' principle whereby safeguarding partners, as part of collaborative working, keep each other informed of significant or relevant matters, especially those that may arise in public, in relation to their safeguarding responsibilities. • The Board continued to raise awareness and promote the use of the revised escalation policy for resolving practitioner differences.
Quarterly	• A contextual safeguarding report is shared and discussed with relevant partner agencies at the quarterly Joint Exploitation

Contextual Safeguarding Report	Group meetings. • These reports provide district level intelligence on areas of concern in each locality which may impact on children and adults at risk, and what actions are in place to mitigate the risk, for example increased police presence or targeted work.
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 the area. Work is focused on promoting person centred safeguarding, ensuring appropriate and timely support is provided to those at risk of radicalisation. • In February 2025, 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 2026. Additionally, a Prevent and Serious Organised Crime (SOC) awareness week was held in September 2024 providing free webinars to upskill partner agencies on a range of relevant subjects. 2000 people from KMSAB partner agencies attended the webinars during the week, and very positive feedback was received. A further Prevent and SOC awareness week will be held in October 2025. • Following the tragic murders in Southport and violent disorder in summer 2024, a significant increase in Prevent referrals has occurred which has impacted on all specified authorities in the UK. • All KMSAB partners have a Prevent duty as outlined in the Counter Terrorism and Security Act 2015.

Priority - Embed Improvement and Shape Future Practice -Helping the organisations we work with to keep getting better.

Objectives:

- The voice of the person is listened to and there is evidence that their wishes are respected.
- Learn from experience and have a workforce that is knowledgeable and confident in the application of their safeguarding adults roles and responsibilities.
- Develop the right balance between support and challenge aimed at system improvement.
- Partners will be able to contribute to safeguarding at regional and national level.

What we achieved:

Delivered our Training Offer	• Following successful appointment to the newly developed Learning and Development Manager post, the Board recommenced multi-agency training on 1 April 2024. The following core modules, predominantly for staff from the statutory sector, were offered throughout the year:
	  ○ Adult Safeguarding Legal Literacy
	  ○ Collaborative Working in Section 42 Enquiries
	  ○ Domestic Abuse and Adult Safeguarding
	  ○ Self-Neglect and Hoarding
	• Between April 2024 – March 2025, 42 workshops were held, with 614 delegates participating.
	• Examples of feedback:
	  ○ "I feel much more confident in dealing with self neglect and hoarding...thank you, you have made it seem much more easy to understand and link up the processes etc"
	  ○ "an empathetic, engaging and insightful trainer. Having attended all 3 levels of DA training, I am confident that I have gained sufficient knowledge and insight to deliver an informed, survivor-led and trauma-informed service to victims and survivors of DA. Thank you"
	  ○ "extremely knowledgeable and helpful; and was able to put complex situations into real-world scenarios making them easier to understand. Many thanks"
	• A proportion of places on each course were allocated to other agencies, such as GPs, local councils and the voluntary and charity sector, providing provision for those requiring more in-depth safeguarding training.

SAR and Joint Workshops	In addition to the core offer, and other training already mentioned in this report, the following learning events were held during 2024-2025 to share the learning from reviews.
	• Two, half day, Joint SAR and Domestic Homicide Review learning events were held in October 2024, the sessions focused on **co-occurring conditions** and included a 10-minute recorded input from a mother whose daughter was tragically murdered by her partner. Her message to practitioners was to 'listen, don't dismiss them' in relation to the views of families. 245 frontline professionals attended across the two sessions. 46 out of 54 (85%) attendees who completed the event evaluation rated the event as excellent or very good. (This increased to 100% when including the rating of 'good'). Delegate feedback was very positive, particularly regarding the presentation from Louise's mother:
	  ○ "Having feedback from families really reinforced the importance of listening to the families voice."
	  ○ "I thought the webinar was excellent and I was very moved by Louise's mother, talking about their experience and

	what led up to the loss of her daughter." • Two half day learning events on **Professional Curiosity and Unconscious Bias** (referred to on page 7) • Two half day learning events on **Legal Literacy.**
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. Examples of comments received have been highlighted in the relevant sections of this report.

Kent and Medway Safeguarding Adults Board Policy and Procedures	• The Board's main policy, "Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway", is supplemented by a number of additional policies, which are updated in accordance with a policy update schedule.
	• During 2024/2025, Practice, Policies and Procedures Working Group members completed their review and revision of the following documents:
	  ○ Managing Concerns around People in Positions of Trust (PiPoT)
	  ○ Escalation policy; resolving practitioner differences for referrals and adult safeguarding
	  ○ Multi-agency Protocol to Safeguard Adults with Care and Support Needs who are Impacted by Domestic Abuse
	• As referenced, two new documents were also developed:
	  ○ Multi-Agency Risk Management Framework
	  ○ Practitioner Resource - Supporting Persons who are Homeless, at Risk of Homelessness or Experiencing Multiple Exclusion Homelessness.
	• 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. Subject matter experts are included in the membership of the task and finish groups established to update the documents.
	• The Domestic Abuse Policy was significantly redrafted and incorporated learning from SARs and Domestic Homicide Reviews in respect of carers causing harm and carers at risk of harm.

Monitoring of Safeguarding Adult Reviews (SAR) Action Plans	• As detailed in section 3, learning is identified and responded to at all stages of the SAR process. • **Single agency recommendations identified by the SAR author** - At the conclusion of each SAR, an action plan is completed to address the recommendations for improvement set by the independent author. The actions are quality assured by the SAR working group to make sure that they are specific, measurable, achievable, realistic and have clear timescales (SMART).

	Updates are submitted to the SARWG for approval and sign off. They must have the appropriate evidence to support. • **Thematic Recommendations -** Where a review identifies recommendations and learning that is more systemic or thematic, this is added to the Board's thematic action plan. Each theme has a list of the SARs where the theme was a feature and a summary of the actions taken by the Board and others system partners (such as public health) to address the recommendation/theme. • The themes are shared when a SAR is commissioned, so that members can build on learning rather than replicate it. Key themes are shared with the Board's working groups, so that these can be incorporated into their work programmes. • The following themes were closed during 2024-5 as members agreed that there had been a significant amount of work undertaken within the system to address the theme and there are ongoing quality assurance mechanisms in place to continue to monitor progress, such as the Board's self-assessment framework: ○ Establishing the literacy and communication needs of individuals and recording and responding to these appropriately ○ Effective communication between agencies ○ Legal literacy ○ Supervision, practice and performance management ○ Professional curiosity
Safeguarding Adults Review – Quality Assurance Checklist	• The KMSAB business unit completed an informal review of the SAR process, to seek to reduce the time taken from commissioning a review to report publication. • The review identified several factors that were contributing to delays in sign off, which affected the timeframe for completion. • To address this, business unit staff reviewed, updated and re-launched the Safeguarding Adults Review Quality Assurance Checklist, SAR Sign Off Quality Markers with the support of the Board Executives.
Sharing of Good Practice	• Many of the quality assurance tools, designed by the Board, ask agencies to highlight good practice examples so that these can be shared, as they can be an impactful method of learning. Examples of good practice are regularly included in the Board's newsletter, training and open sessions.
National SAB Managers 'We See You – We Hear You' Excellence	• The 2024 National Safeguarding Adults Excellence Awards were led by Bexley SAB, on behalf of the national network of SAB managers. • Representatives from the community warden service won in two categories. ○ A KCC Warden won the 'Innovation' award for creating *Men's Moving Minds*—a support group for men facing mental ill health and loneliness. Developed with input from people with lived experience, the group has grown steadily, with members gaining confidence, forming friendships, and actively participating. Many now attend other community groups together, and their

Awards	isolation has noticeably reduced. ○ Tonbridge, Malling and Maidstone Community Warden Team won the 'Partnership Champion' category for their work in supporting residents who are living in hoarded properties. The Independent Chair of the Board met with the team to present them with their award.
Board and Working Group Feedback Questionnaires	• As part of the Board's commitment to continuous improvement, feedback was sought from all representatives who attend Board and working group meetings, providing the opportunity to comment on what is working well and areas for future improvement and development. • Feedback received was presented to the relevant group. Feedback was extremely positive. KMSAB Executive Group feedback included: ○ It is a good networking opportunity and a sense check as to whether what we are doing within our individual organisations is also in line with local and national priorities. It is an opportunity for our organisations to have a voice in the direction of safeguarding within Kent and Medway. ○ The range of organisations represented and that the meetings are very effectively and engagingly chaired. It allows an opportunity to share knowledge and experience across the county. ○ Robust membership provides good challenge. • Feedback from the Communication and Engagement Working Group questionnaires, led to a merging of the core (communication leads) and wider (safeguarding leads) working groups.
Learning from SAR Referrals that do not Meet the Criteria	• As detailed in section 3, when a SAR referral is received, the Board business unit will establish which KMSAB partner agencies have been involved with the individual and will send them a summary of agency involvement form to complete, with relevant and proportionate information relating to their involvement with the adult. • The referral and summary of agency involvement forms are considered by the SAR working group's decision making panel. • This process is very robust and is similar to a 'rapid review' for each referral. Where a SAR is not commissioned, the group will still highlight any good practice and identify any single agency learning. There may also be occasions where learning is identified that whilst not meeting the SAR criteria, would benefit from awareness raising. Examples of work completed has been included in section 3. • All actions identified by the group are monitored until they are complete.
SAR Video and Reflective Learning Briefings	• To support the sharing of SAR learning, and in acknowledgement of individuals' different learning styles and preferences, published SAR reports are now accompanied by a short video summary. The videos are available on the following link: Kent and Medway SAB - Safeguarding Adult Reviews (kmsab.org.uk) • 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 took place during 2024-2025: ○ Kent Fire and Rescue Service – Safe and Well Visits and Adult Safeguarding (linked to learning from SAR Phyliss) ○ Bexley SAR Aaron and Millie (theme of exploitation of individuals with a learning disability) ○ Wellbeing Principle (learning from SAR Stuart) ○ Voiceability – use your power campaign ○ Professional Curiosity ○ Men's Independent Domestic Violence Advisors (IDVA) and Domestic Abuse Advocacy Service.
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. • An additional 60 individuals requested to be added to the newsletter distribution list during the year, taking the number of subscribers to over 440 people/agencies, with many cascading the information further within their organisations.
Regional and National Forums	• The Independent Safeguarding Adults Board (SAB) Chair attends the national SAB Independent Chair Network and chairs the regional meeting of Independent SAB Chairs and SAB Managers. • The Board Manager attends the regional meeting and also attends the national SAB Manager's network, attended by 170 SAB managers. • These network meetings are extremely beneficial and provide the opportunity to share information, resources, best practice, learning and collaborate on joint projects. They also provide the Boards with a stronger national voice, should they wish to escalate concerns to relevant government departments. • The networks have established 4 task and finish groups to address the following workstreams from the national SAR analysis report: ○ Developing the evidence base across the four domains (direct practice, inter-agency collaboration (the team around the person), organisational support for practice and the management of practice (supervision, training availability of policy), and governance (audits, multi-agency policies and training) ○ Arranging a summit on adult safeguarding ○ Improving and measuring the impact of SARs

	○ Reviewing the Care Act 2014 (ten years on) • The networks produced a best practice guidance document on the interface between SARs and Coronial processes (September 2024) and professional curiosity guide (March 2025). • A London SAB contacted the KMSAB to request permission to adopt the self-neglect and hoarding policy and another SAB wished to utilise the KMSAB competency framework.
Thematic Review of Self-Neglect	• As self-neglect continued to be a theme in SARs and SAR referrals, both locally and nationally, the KMSAB commissioned a thematic review to identify systemic learning, rather than individual 'case' learning. The key lines of enquiry included; ○ what is helping and hindering practitioners working in a long term trauma informed way? ○ What can be learnt through this review about the application of eligibility criteria and the law in relation to adults at risk of, or experiencing self-neglect? ○ How effective are local partnership arrangements when working with self-neglect? ○ How can the review be used to encourage different ways of gaining access to a person and assessing their mental capacity effectively? • The report is expected to be completed by January 2026. As part of the review, the author has met with frontline practitioners and the Board Executive members.
Second National Analysis of Safeguarding Adults Reviews: April 2019 - March 2023[3]	• The second national analysis of safeguarding adults reviews was published in July 2024. The report lists 31 improvement priorities. • Analysis is divided into 5 domains: ○ direct practice with individuals • interagency practice - the team around the person • organisational support for best practice • SAB governance • the national legal, policy and financial context within which adult safeguarding is situated. • The lead author of the review, Michael Preston Shoot, attended an Executive Board meeting to present the findings, including a summary of local findings. • The Business Unit used the quality markers to inform the revision of the SAR sign off checklist. • The Independent Chair of the Board and KMSAB Manager are involved in national work to address key recommendations made in the report.

[3] Local Government Association (LGA) & Association of Directors of Adult Social Services (ADASS). (2024). Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023. Local Government Association.

Section 3. Safeguarding Adults Reviews

3.1. 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)[4]

More information on the SAR process is available on the KMSAB website.

3.2. 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.

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

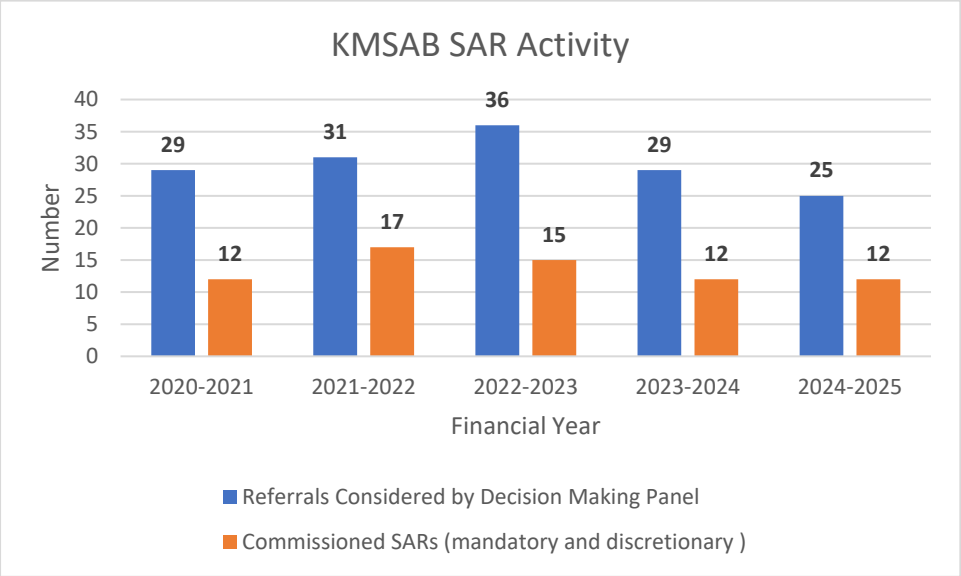
3.3. Safeguarding Adults Review Activity

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.

2024/5 was the second consecutive year where there was a reduction in the number of SAR referrals received, although the number commissioned remained the same as 2023-2024.



The KMSAB received 25 new SAR referrals between April 2024 and March 2025, of these:

- 9 mandatory SARs were commissioned.
- 3 discretionary SAR was commissioned.
- 13 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.

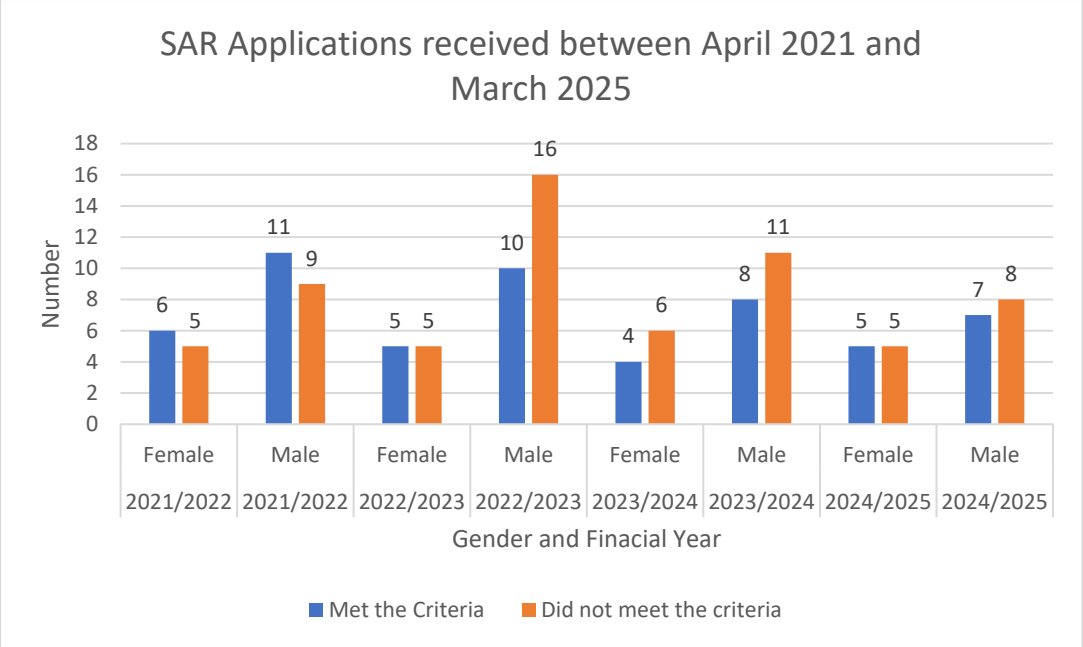
Gender - SAR applications received between April 2021 and March 2025[5]

There continues to be more SAR referrals for males. Of the 25 SAR referrals received between April 2024 and March 2025, 60% were for males and 40% for females. In 2023-2024 the proportion was 34% female to 66% male. In 2022/2023 the proportion was 28% female to 72% male.

The gender breakdown of SARs commissioned reflects the referral rate, with 59% of SARs commissioned relating to males and 42% females.

	Referrals (Number)	Percentage of referrals Received	SARs commissioned (Number)	Percentage of SARs Commissioned
2024/2025				
Male	15	40%	7	59%
Female	10	60%	5	42%
2023/2024				
Male	19	66%	8	67%
Female	10	34%	4	33%
2022/23				
Male	26	72%	10	67%
Female	10	28%	5	33%
2021/2022				
Male	20	65%	11	65%
Female	11	35%	6	35%

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



The conversion rate of application to commissioned SARs for female and males is consistent this financial year, with 47% conversion rate for males and 50% for females. The 2023-2024 rate was 42% for males and 40% for females.

Ethnicity - applications received between April 2023 and March 2025

Due to a new data validation process at SAR decision making meetings, the data capture of ethnicity is more robust.

Of the 25 referrals received, 88% of the individuals were 'White British-English'. 4% any other white background and 8% white Irish.

Ethnicity	Total Number of applications	Number of referrals meeting the criteria	Percentage of referrals meeting the criteria
Any other white background	1	1	100%
White - English / British	22	11	50%
White - Irish	2	0	0%

The ethnicity of individuals the SAR relates to is similar to the national picture. In the national SAR analysis, ethnicity was only identified in a third of SAR reports submitted for the review. "Where it was specified, individuals were most commonly described as white (just over a quarter of the overall number of individuals) with smaller numbers identified as Black, African, Caribbean, Black British, Asian or Asian British."[6]

[6] Local Government Association (LGA) & Association of Directors of Adult Social Services (ADASS). (2024). Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023. Local Government Association. Page 12

	Any other ethnic group	Any other white background	Asian or Asian British – Indian	Asian or Asian British/ Any other Asian background	Black or Black British - African	White British /English	White - Irish	No Consistent Capture/ unknown
2024-2025								
Referrals		1				22	2	
Commissioned		1				11	0	
2023-2024								
Referrals	1	1			2	23		2
Commissioned	1	1			1	8		1
2022-2023								
Referrals	2	2	1	1		29		1
Commissioned	1	0	0	0		14		0

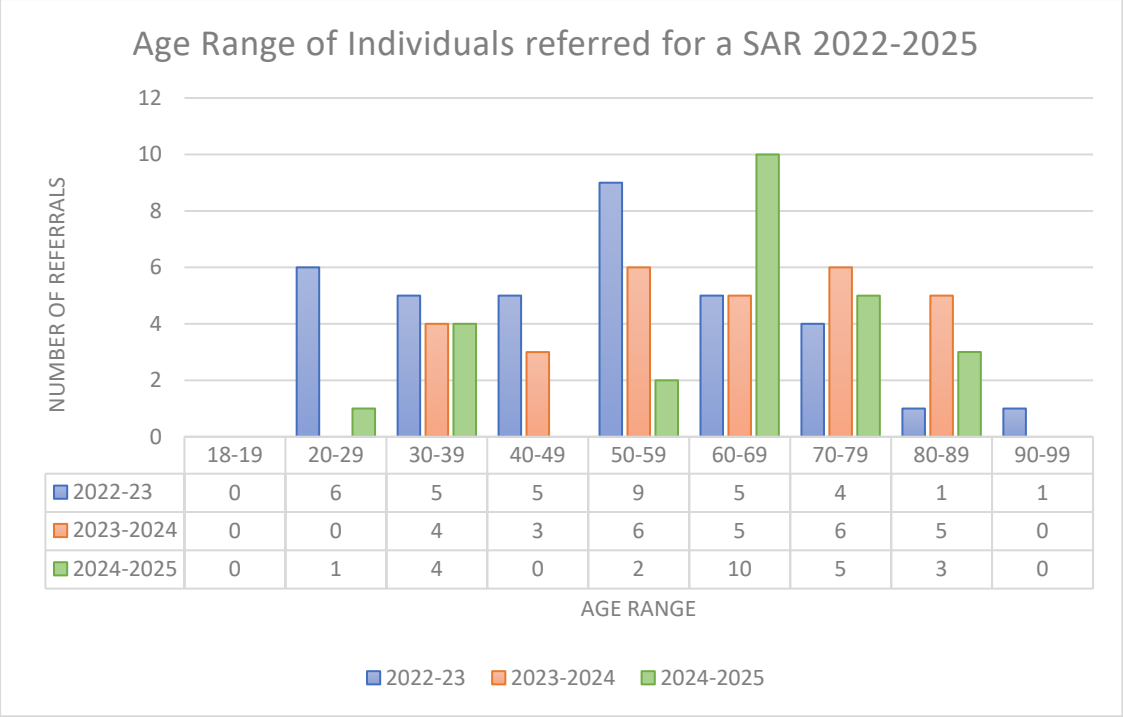
Age – SAR applications received between April 2024 and March 2025

Age range	Total number of applications	Number of referrals within age range meeting the criteria	Percentage of referrals within age range meeting the criteria
<20	0		
20-29	1	0	0%
30-39	4	3	75%
40-49	0	0	0%
50-59	2	0	0%
60-69	10	8	80%
70-79	5	1	20%
80-89	3	0	0%
90-99	0	0	0

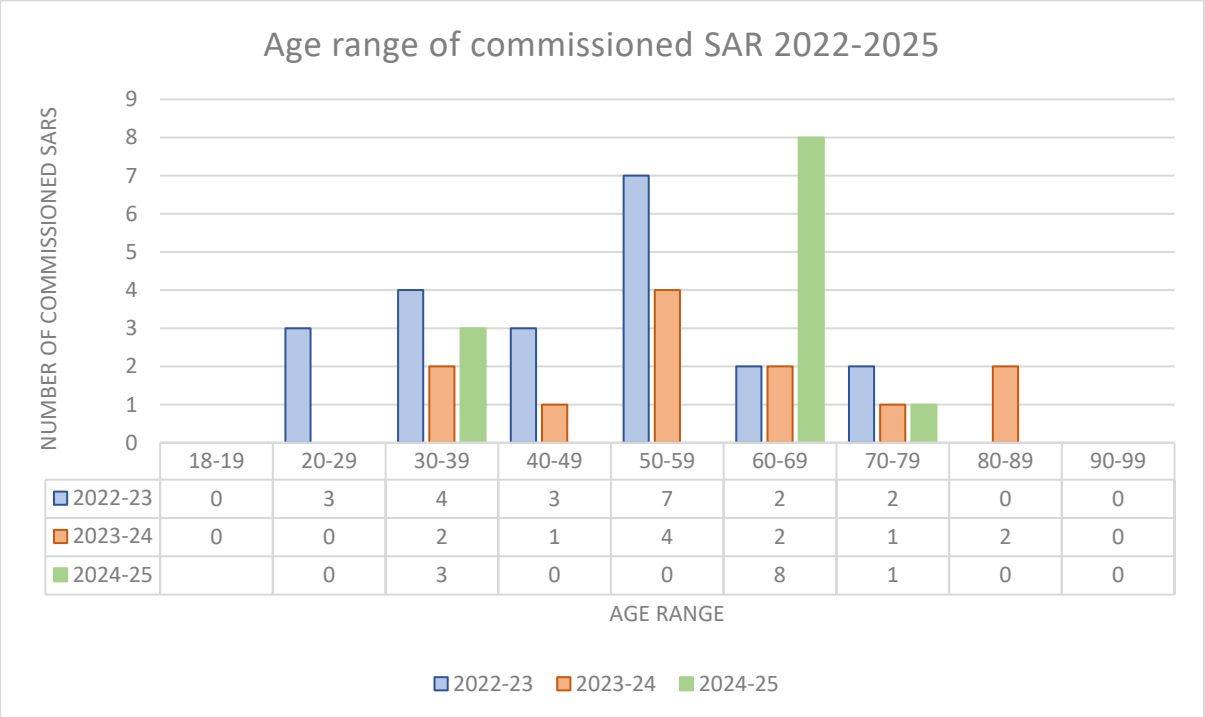
Of the SAR referrals received, the most frequent categories were the 60-69 age range, the 70-79 age range and the 30-39 range. As expected, due to the numbers received, most SARs were commissioned relating to individuals aged between 60-69. It is noted that within the 70-79 age range, only one of the 5 SAR referrals met the criteria, a similar position to last year, and of the 3 referrals received in the 80-89 category, none were found to meet the criteria. The Board Manager has reviewed the SAR decisions in respect of these categories to ensure that there is no unconscious or other bias. The decisions made were found to be

proportionate in accordance with the SAR criteria. Additionally, although the criteria were not met, members of the panel did identify single agency actions, areas for practice development/support or points of clarification. In these circumstances, recommendations were made and actions implemented. Some examples include:

SAR referral one	The circumstances were not found to meet the criteria as abuse and neglect were not a factor in the individual's death. One agency was assigned actions to complete. Additionally, Board members produced and published the following guide in response to the referral: Learning Briefing in relation to: Recognising bereavement, the emotional wellbeing of vulnerable adults following retirement/health deterioration and suicide pacts.
SAR referral two	The circumstances were not found to meet the criteria as abuse and neglect was not a factor in the individual's death. An after action review had identified learning for the health agency. Two health agencies were asked for an assurance report, reflecting on the circumstances of the referral.
SAR referral three	No concerns were identified in the way agencies worked together, there was evidence that agencies effectively applied their legal duties and responsibilities. It was acknowledged that it would be helpful to summarise the provisions available to support people experiencing deteriorating health and loss of independence. KMSAB members produce the following: kmsab - kent and medway psychological support.pdf
SAR referral four	No concerns were identified in the way agencies worked together and abuse and neglect were not a factor in the individual's death. As a proportionate preventative approach, and to share learning in relation to the referral, the Board shared messaging in relation to falls. This included a presentation from Healthwatch at an Executive Board meeting.



	18-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99
2022-23	0	6	5	5	9	5	4	1	1
2023-2024	0	0	4	3	6	5	6	5	0
2024-2025	0	1	4	0	2	10	5	3	0



	18-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99
2022-23	0	3	4	3	7	2	2	0	0
2023-24	0	0	2	1	4	2	1	2	0
2024-25		0	3	0	0	8	1	0	0

3.4. 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.**

Cranston Full report	Summary Video
Published: 15 August 2025	**Methodology**: Traditional Review
Recommendations related to: - • Safe-discharge from hospital • Communication between agencies and information sharing • Application of the self-neglect and hoarding policy • Record keeping	

Chelsea Full report	Summary Video
Published: 8 April 2025	**Methodology:** Day Review
Recommendations related to: - • Enhancing staff training and awareness of palliative and end-of-life care • Application of the self-neglect and hoarding policy • Ensuring mental capacity assessments are appropriately considered, recorded, and used to inform decision-making • Working with individuals where there are barriers to engagement	

Carissa Full report	Summary Video
Published: 19 March 2025	**Methodology**: Traditional Review
Recommendations related to: - • Effective multi-agency working • Supporting individuals who have long term conditions, consideration of mental capacity and advanced care planning • Support for carers • Domestic abuse	

Lummy Full Report	Summary
Published: 14 March 2025	**Methodology**: Day Review
Recommendations related to: - • Equity for mental health inpatients in receiving care and treatment through the cancer pathway • Quality of communication between agencies	

- Support for carers
- Effectiveness of pain management for mental health inpatients

Harvey Full report	Summary Video
Published: 28 February 2025	**Methodology**: Day Review
Recommendations related to: - • Recognising and supporting individuals who frequently access emergency services • Consideration and recording of mental capacity assessments • The importance of being registered with a GP • Understanding the interface between the Mental Capacity Act and the Mental Health Act • Alcohol and substance dependency/co-occurring conditions	

Alan Full Report	Summary Video
Published: 28 February 2025	**Methodology**: Day Review
Recommendations related to: - • Safe discharge from hospital and effective communication between agencies, including effective communication within Electronic Discharge Notices (EDNs) • Working with individuals where there are barriers to engagement • Application of the self-neglect and hoarding policy	

Keita Full Report	Summary Video
Published: 7 February 2025	**Methodology**: Traditional Review
Recommendations related to: - • The importance of making safeguarding personal • Effective communication between agencies and multi-agency working • Responsiveness of services to the needs of people who experience homelessness or are at risk of homelessness. • Raising awareness of the Human Rights Act 1998 to help identify when a formal assessment may be needed	

Saunders Full Report	Summary Video
Published: 7 February 2025	**Methodology**: Day Review
Recommendations related to: -	

- The importance of following the Accessible Information Standard (2015), ensuring that people with disabilities or sensory impairments receive information in formats they can understand.
- The difference between safeguarding with a small 's'—everyday preventative actions—and Safeguarding with a capital 'S', formal statutory procedures under the Care Act.

Additionally, there were specific recommendations for the community health charity involved in the review.

Alcohol Thematic Review Full Report	
Published: 13 January 2025	**Methodology**: Thematic Review
Recommendations - • Hold a seminar on legal powers/legal literacy/Mental Capacity Act specifically for assisting alcohol dependent drinkers • Support the actions set out in the Kent Drug and Alcohol Strategy 2023 – 2028. In relation to the outcome on page 24 of the strategy, "Working in partnership to share data and intelligence in order to identify those at risk of drug / alcohol related harm and exploitation and to provide safeguarding and intensive support" • Promote the pathways available for people dependent upon alcohol. • Learning from reviews related to drug and alcohol deaths across Kent and Medway should be pooled to support a coordinated, system-wide approach to sharing findings and responding to recurring themes	

Simone Full Report	Summary Video
Published: 12 December 2024	**Methodology**: Traditional Methodology
Recommendations related to: - • Working in a trauma informed way • Identifying suicide risk in individuals experiencing or who have experienced domestic abuse. • Effective communication between agencies and multi-agency working, including multi-agency meetings. • The importance of accurate and detailed record keeping which includes the rationale to support the decisions made.	

Patsy Full Report	Learning briefing Video
Published: 23 October 2024	**Methodology**: Traditional Methodology
Recommendations related to: - • Effective communication between agencies	

• Using the appropriate pathways to address high risk domestic abuse • Safeguarding and self-discharge from hospital • Utilising a 'think family approach'

Unpublished review - this review was not published at the request of the individual concerned.	
Learning shared with practitioners 14.01.2025	**Methodology**: Traditional Methodology
Recommendations related to: - • Raising awareness of the indicators of sexual abuse • Violence against women and girls • Capturing individuals' protected characteristics	

The Board is reliant on partner agencies to share the learning from reviews and incorporate these into practice. The effectiveness of this is measured through the Board's self-assessment framework and other quality assurance measures, already detailed in this report.

As previously highlighted, 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 learning to be raised from SAR decision making stage onwards. Themes 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 additional actions taken during 2024/2025. These are in addition to activity that individual agencies undertake and the information provided in section 2.

Recommendation/Theme	Actions taken by the Board
Multi-Agency Working/Information Sharing This theme was a feature in (8) 67% of the SARs published during this period.	• Activity to address this theme has been summarised in section 2 – "Strengthening system assurance, checking that organisations are working well together to support adults". The most significant change being the development and launch of the Multi-Agency Risk Management Framework.

Think Family and Person Centred – Strength Based Practice. Including consideration of protected characteristics and the communication preferences of individuals
This theme was a feature in (6) 50% of the SARs published during this period.
	• Each of the Board's working groups has continued to incorporate think family, making safeguarding personal and strength-based practice in their annual delivery plan actions.
	• The Board produced a British Sign Language Friendly version of its 'How to protect yourself from abuse' leaflet - KMSAB leaflet - BSL friendly
	• The Practice, Policy and Procedure Working Group (PPPWG) received input from SPACE Matters in April to support the integration of trauma-informed principles into policy development. This complemented wider efforts to raise awareness of Adverse Childhood Experiences (ACEs), including a feature in the KMSAB April newsletter, ensuring agencies are informed of the impact of ACEs in the context of adult safeguarding.
	• As detailed in section 2 of this report, the Communication and Engagement Working Group has promoted advocacy, making safeguarding personal materials and trauma informed practice through newsletters, events, the website and open sessions. For example, the July KMSAB newsletter raised awareness of the EmergencySMS text 999 service, developed specifically for people with hearing loss or difficulty with speech (Sign Health website)**.**
	• The 2025 self assessment framework will focus on how the lessons from relevant SARs and information shared by the Board has been embedded, through the inclusion of the following standards:
	  ○ The organisation promotes the principles of a 'Think Family' Approach
	  ○ The organisation promotes a trauma informed approach to safeguarding adults at risk of abuse or neglect
	  ○ The organisation is able to deliver safeguarding responsibilities effectively to individuals who are

Recommendation/Theme	Actions taken by the Board
	Neurodiverse or who have learning disabilities/difficulties. ○ The organisation adopts a proactive approach to routinely seeking decisions made in advance. Professionals have awareness and the organisation has a system for recording decisions made in advance (such as advanced decision making/advanced statements). ○ The organisation can demonstrate that it takes into account the views and wishes of the individual, or their advocate, when considering safeguarding.
Legal Literacy – Including the Mental Capacity Act This theme was a feature in (5) 42% of the SARs published during this period.	• Activity to address this theme has been summarised in section 2 – "Embed improvement and shape future practice" Additionally: • The document 'legal framework and interventions' was added to the KMSAB website as a standalone document and was widely promoted. It highlights the different enforcement powers that can be used as appropriate where there are additional issues identified for a person who is high risk, such as excessive hoarding - KMSAB Legal Framework and Interventions • The 2023 self-assessment framework included 8 standards relating to legal literacy. • A executive functioning grab sheet has been added to the useful resources tab of the KMSAB website, this document provides guidance and links to support practitioners when undertaking capacity assessments relating to executive decision making.
Evidence Based Decision Making and Effective Record Keeping This theme was a feature in (4) 33% of the SARs published during this period.	• KMSAB policy documents reference the importance of effective record keeping and evidenced based decision making. • The Board developed and shared good practice guidance on record keeping - KMSAB 10 Golden Rules of Record Keeping • This theme is closely connected to the theme of 'enhancing legal literacy'. Activity to address that theme will also cover the importance of evidence-based decision making. For example, the inclusion of this in training content. • Agencies are required to evidence the recording of decisions to meet SAF requirements. For example the 2023 SAF included the following measure: ○ The organisation has systems and processes in place to ensure that relevant staff working with adults at risk are aware of the Mental Capacity Act and how and when to apply it. Decision

Recommendation/Theme	Actions taken by the Board
	making is recorded appropriately.
Safe-discharge from hospitals This theme was a feature in (3) 25% of the SARs published during this period	Board members remain aware of the national and local pressures in relation to hospital discharge and have sought updates at Board and related meetings. In addition, safe discharge falls under 'shared outcome 5' of the Kent and Medway Integrated Care Strategy**.** • The Independent Chair of the Board requested that all hospital trusts, community healthcare trusts, KMPT and Cygnet healthcare undertake an audit of their discharge arrangements, with the following compliance markers: o Were the person's/their advocates views incorporated into discharge? o Were relevant partner agencies involved in discharge planning? o Where required, was there a discharge planning meeting and were the appropriate agencies in attendance? o Was information regarding discharge shared with the person/advocate/carer? o Was support from agencies/different services confirmed and set up prior to discharge? o Was a discharge notification/letter sent to the GP? o Was MCA appropriately considered, as part of discharge planning? o Was safeguarding of the person /carers/children considered? o Was discharge appropriately recorded on the person's record (in line with your agency's processes?) • Agencies were asked to audit a minimum of 10% of hospital discharges from quarter 1 2024/2025 • The audit findings were presented to the SARWG membership and the Independent Chair of the Board. An associated action plan was developed. • A formal report was presented to Board Members in December 2024 by the Kent and Medway Integrated Care Board, covering the following: o Response to SAR learning in respect of self-discharge and absconding and how emergency departments are responding to patients who attend the emergency department and leave before treatment has been provided. o The findings of emergency department quality visits and safer discharge.

Recommendation/Theme	Actions taken by the Board
Identifying and Responding to Self-Neglect and Hoarding This theme was a feature in (3) 25% of the SARs published during this period.	Activity to address this theme has been summarised in section 2 Additionally: • The KMSAB Learning and Development Managers hosted 4 self-neglect full day workshops for non-statutory partners. • The September KMSAB newsletter raised awareness of Making Safeguarding Personal in self-neglect - workbook, which was produced by Research in Practice and draws on evidence from research and safeguarding adult reviews (SARs) to identify how making safeguarding personal can make a difference to the health, wellbeing and safety of people who are self-neglecting. • The SAF 2025 includes the following measure: ○ 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.
Domestic Abuse This theme was a feature in (3) 25% of the SARs published during this period.	Activity to address this theme has been summarised in section 2

The Care and Support Statutory Guidance states that "where the SAB decides not to implement an action then it must state the reason for that decision in the Annual Report". During this reporting period the Board has been required to close the following action which was not implemented, for the reason specified:

SAR and recommendation	Rationale	Mitigation
Stephen - Recommendation 10 (part b) National Health Service England (NHSE) South East should ensure that this SAR is raised with the National NHSE Safeguarding Board.	**NHSE Rationale** - The recommendation in the SAR did not reflect the NHS governance mechanisms in place to capture learning from statutory safeguarding reviews.	NHSE advised that there is no National NHSE Safeguarding Board, there is a national safeguarding steering group (NSSG). Challenges with availability of placements for adults and children with additional and complex needs is to be presented as part of the next regional safeguarding update to the NSSG in October 2025. It is not possible to receive presentations on individual SARs at this meeting. The

		SARWG offered to provide the learning from related SARs that was presented to the national SAB Chairs network to support this item. There is a Regional Safeguarding Steering Group, their focus is to oversee the delivery of high-quality safeguarding processes across the region. The group reviews safeguarding assurance in line with the statutory requirements in (SAAF 2024 NHS England » Safeguarding children, young people and adults at risk in the NHS). This group identifies any risks and ensures there is appropriate escalation and mitigation. ICBs share learning from statutory reviews in their quarterly reports produced for this meeting. SAR themes are also reported on the NHSE Serious Case Review Tracker (SCRT, which is reviewed at every meeting. Individual SARs are not considered at this meeting. NHS England published renewed Commissioning Guidance in February 2024, summarising the evidence base for high-quality, reasonably adjusted inpatient care – including care for people who are autistic. ICBs are currently delivering 3-Year Plans to localise and align their commissioning practice to the Framework by March 2027. NHS England has also published supplementary guidance on best practice in meeting autistic people's needs in adult acute and psychiatric Intensive Care Unit settings, which ICBs are expected to draw upon when delivering their 3-Year Plans.

Section 4. Spotlight on Homelessness

In May 2024, the Minister of Housing and Homelessness and the Minister for Social Care wrote to all Directors of Housing and Directors of Adult Social Services in England, and all Safeguarding Adults Board Chairs, to set out recommendations for Safeguarding Adults Boards regarding individuals rough sleeping. These were as follows:

1. Governance structure, accountability and system-wide change:

a. SABs should ensure their governance structure has the necessary mechanisms to hold partners working with people rough sleeping accountable.

b. SABs should act as an active presence in system-wide governance discussions. These discussions should seek outcomes which promote the integration of experience informed practice into service standards.

2. Named board member for rough sleeping: SABs should designate a member of the Board to lead and update on complex or stalled cases within the local authority's Target Priority Group (TPG) of people rough sleeping. DLUHC Rough Sleeping Initiative advisers will soon be reaching out to local authorities to support closer working between rough sleeping teams and Safeguarding Adults Boards.

3. Strategic plans, annual reports and procedures: SABs should actively reference rough sleeping and homelessness in annual reports and strategic plans. Promoting workforce safeguarding and legal literacy is also strongly recommended.

4. Safeguarding Adult Reviews: In compliance with the Care Act 2014 ("Section 44"), SABs should proactively commission Safeguarding Adult Reviews in cases of deaths involving rough sleeping. There should also be a clear focus on implementing learnings from the reviews.

Examples of Recent Board Activity

As homelessness had been highlighted as a theme in Kent and Medway Safeguarding Adults Reviews (both referrals and commissioned reviews) some of the activity listed below, was already in progress.

- Practice, Policies and Procedures Working Group Members worked with housing teams and other relevant agencies, such as porchlight, to develop a Practitioner resource: supporting persons who are homeless, at risk of homelessness or experiencing multiple exclusion homelessness. Half day workshops have been planned to further raise awareness of the document.

- The Board commissioned a thematic SAR in relation to homelessness. The review is currently in progress and includes previous SAR referrals, where the circumstances were found not to meet the criteria for a mandatory SAR, where homelessness was a

feature. Individuals with lived experience of homelessness will be included in the review.

- The following SARs have been published where homelessness was a feature:

  Ian
  Elizabeth Eastley
  Douglas
  Laurence
  Rosie and Emma
  Thomas
  Keita

- Whilst housing has been represented on the KMSAB Executive through the attendance of a Chief Executive representative for the districts and the Director of Adult Social Services (DASS) for Medway Council, membership now includes a named lead for rough sleeping. They have a standing item at each Board meeting to update the executive membership on work in progress and any areas requiring additional support.

- The Independent Chair of the Board and Board Manager attended the District Chief Executives meeting, in July 2024, to discuss the ministerial letter and seek support for related work. Presentations and updates were also delivered to the Kent Housing Group and the Kent Domestic Abuse Local Partnership Board Meeting.

- Healthwatch commissioned a spotlight report on housing and homelessness in Kent and Medway. This was presented to the Board in June 2025.

- In their 2024-5 annual delivery plan, Quality Assurance Working Group Members agreed to pilot a multi-agency audit. It was agreed that to help inform the KMSAB's response to the Ministerial letter, the audit would focus on a set number of cases in relation to people who are experiencing, or are at risk of experiencing, rough sleeping in Kent and Medway. This was to include the multiagency response to the individual's needs. The audit took place in April/May 2025 and findings are due to be presented to the Board and will be used to inform the thematic SAR.

- A questionnaire was sent to the 12 Kent Districts and Medway Housing, to develop a position statement in relation to the following:

  - Number of people in the agreed target priority group (TPG)
  - In addition to the TPG, the number of individuals sleeping rough or individuals who were sleeping rough and are currently accommodated 'off the street' or other short term/ temporary accommodation identified as at high risk of harm/abuse
  - Any challenges experienced in supporting these individuals into accommodation
  - Number of individuals' whose circumstances are 'stalled'

- Comment on Protected characteristics
- What is in place, what is working well?
- Areas the KMSAB need to be cited on

- As Kent is a two-tier authority (with 12 district council) the Board's self-assessment framework has been sent to districts since 2021. Safe Discharge arrangements, including people who were identified as rough sleeping/homelessness was a feature in the 2023 SAF.

- District Council Safeguarding leads are represented at all KMSAB working group meetings. Housing representatives attend relevant task and finish group and SAR meetings.

- The 2025 self-assessment framework includes two standards relating to homelessness.

- Alcohol Change UK, in partnership with Kent County Council and services across the country, is running a national project to develop a national guidance document on appropriate accommodation options for vulnerable and dependent drinkers that services find difficult to engage into mainstream treatment.

Good practice examples:
East Kent Homelessness Project - East Kent Homelessness Project
Medway Multiple Disadvantage Network and Making Every Adult Matter - Medway - MEAM
Maidstone Trinity - Trinity – Maidstone's New Community Hub - MBC News Website

Examples of documents the Board has raised awareness of:

- Radical safeguarding toolkit for homelessness
- Discharging people at risk of or experiencing homelessness
- Supporting people experiencing homelessness and rough sleeping : Emergency Department pathway, checklist and toolkit.
- Kent & Medway Domestic Abuse & Additional Barriers Framework
- Homelessness: duty to refer – for NHS staff
- Home First Discharge to Assess and homelessness.

Acronyms

CEWG	Communication and Engagement Working Group
DHR/DARDR	Domestic Homicide Reviews /Domestic Abuse Related Death Review
DLUCH	Department for Levelling Up, Housing and Communities (now Ministry of Housing, Communities and Local Government)
ICB	Integrated Care Board
JEG	Joint Exploitation Group
KCC	Kent County Council
KMPT	Kent and Medway NHS and Social Care Partnership Trust
KMSAB	Kent and Medway Safeguarding Adults Board
LDWG	Learning and Development Working Group
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NHS	National Health Service
PPPWG	Practice, Policy and Procedures Working Group
QAWG	Quality Assurance Working Group
SAF	Self Assessment Framework
SAR	Safeguarding Adults Review
SARWG	Safeguarding Adults Review Working Group
SECAmb	South East Coast Ambulance Service

Glossary of terms

Care Needs Assessment	If an individual thinks that they have any care and support needs, they are entitled to a free care needs assessment. A care needs assessment provides the opportunity for an individual to share information, with adult social care, about their situation and what changes they would like to make in their life. A care needs assessment looks at how needs impact on wellbeing and the outcomes the individual would like to achieve in their daily life. Adult Social Care will assess care and support needs with the individual and decide if they are at the level where they need support. Needs could be eligible if the individual is not able to do a combination of certain things that significantly affect their wellbeing. These may include: • washing themselves • getting dressed • going to work, college or volunteering • keeping the home safe to live in. More information is available here: Medway Kent

Carers Assessment	A carer's assessment is free and anyone over 18 can ask for one. A person can have a carers assessment even if the person they care for does not get any help from the council, and they will not need to be assessed. The assessment might recommend things like: • someone to take over caring so the carer can take a break • gym membership and exercise classes to relieve stress • help with taxi fares, if the carer does not drive • help with gardening and housework • training how to lift safely • putting the carer in touch with local support groups • advice about benefits for carers A carer does not need the permission of the person they are caring for to request a carers assessment. More information is available on the KMSAB website.
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 on the KMSAB website. More information on how to respond to self-neglect and hoarding concerns can also be found on the KMSAB website.
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 on the government website.
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 on the NHS England website.
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 on the KMPT website.
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	The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over

2005 (MCA)	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.
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.
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.
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 on the SECAmb website.