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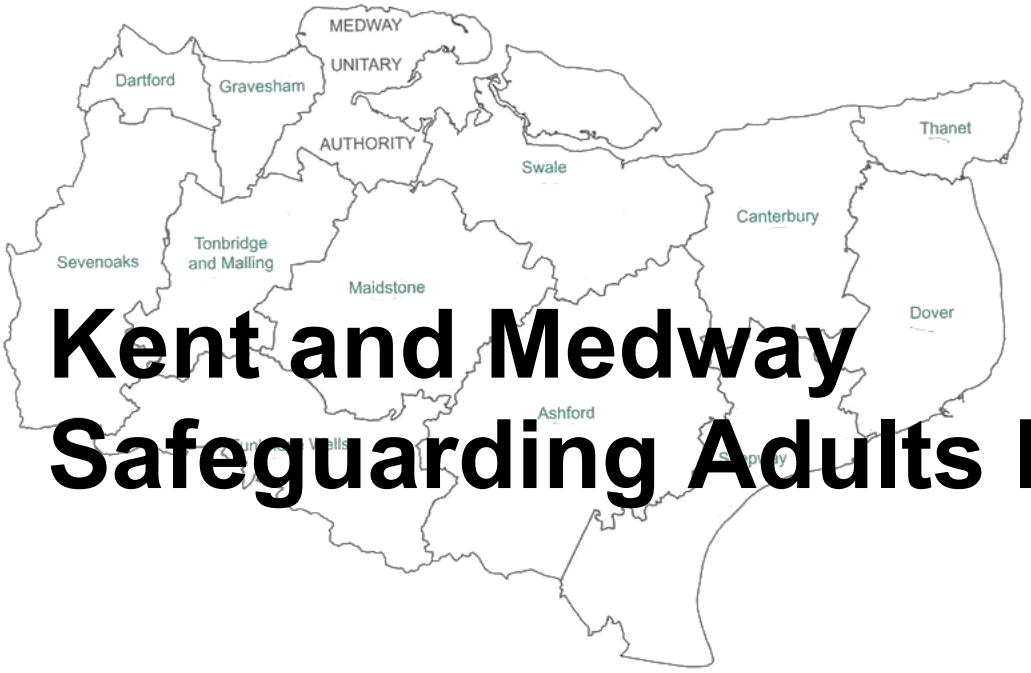

Kent and Medway Safeguarding Adults Board

Annual Report

April 2017 – March 2018

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Message from Deborah Stuart-Angus, Independent Chair, Kent and Medway Safeguarding Adults Board

It gives me great pleasure to present the Annual Report of the Kent and Medway Safeguarding Adults Board. I hope you would agree that this is a very real reflection of the huge amount of work that is undertaken to effectively safeguard adults at risk across Kent and Medway.

I would like to take this opportunity to express my sincere thanks to all of our Board members and partners, for the massive contribution they all make, every day, to making Kent and Medway a safer place.

Deborah Stuart-Angus
Independent Chair of the Kent and Medway Safeguarding Adults Board

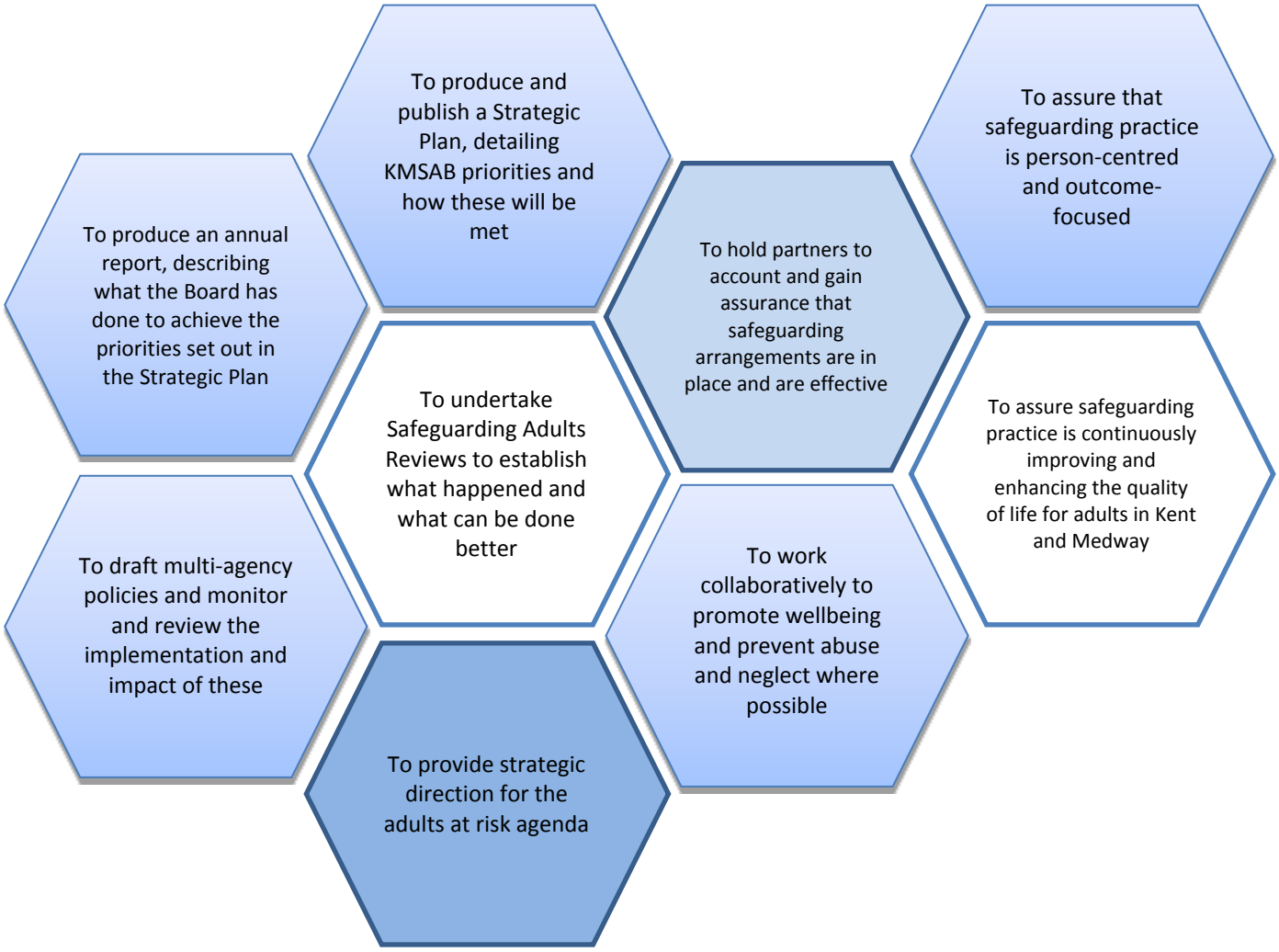
Section 1. Role of the Kent and Medway Safeguarding Adults Board

About us

The Kent and Medway Safeguarding Adults Board (KMSAB) is a statutory multi-agency partnership which assures that adult safeguarding arrangements in Kent and Medway are in place and are effective. It oversees how agencies co-ordinate services and work together to help keep Kent's and Medway's adults safe from harm, promote wellbeing, prevent abuse and protect the rights of citizens. The work of the Board is supported by KMSAB policies and procedures, which all agencies sign up to.

Our Purpose

The responsibilities of the KMSAB include:



Our Membership

KMSAB has an Independent Chair, Deborah Stuart-Angus, who provides leadership, vision and support.

The statutory partners are:

- Medway Council
- Kent County Council
- Kent Police
- NHS Clinical Commissioning Groups across Kent and Medway

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

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

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

Our Structure

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

The Board works closely with other strategic groups and partnerships, such as Local Safeguarding Children Boards, Community Safety Partnerships and Health and Wellbeing Boards to ensure key priorities are shared, to promote efficiency and joint working and reduce duplication. For example, the Risk Threats and Vulnerabilities Working Group is a joint group with Kent and Medway's local Safeguarding Children Boards.

Medway Safeguarding Adults Executive Group (MSAEG) was established in 2016 to bring together senior representatives from the key agencies responsible for the effective delivery of Adult Safeguarding in Medway. The MSAEG works collaboratively to deliver the strategic priorities of the Kent and Medway Safeguarding Adults Board, strengthening local delivery, oversight and governance. Update reports are provided to the KMSAB Business Group at each meeting.

Kent and Medway Safeguarding Adults Board

Responsibilities:

- Oversee the governance arrangements and budget of KMSAB.
- Seek assurance that safeguarding arrangements are in place and partners act accordingly to help protect adults at risk in Kent and Medway.
- Challenge each other and other organisations if there is a belief that actions or inactions are increasing the risk of abuse and/or neglect.
- Work together to promote the prevention and protection of adults with care and support needs by making strategic decisions and ensuring that effective systems and processes are in place.
- Ratify and adopt the Strategic Plan and ratify the Annual Business Plan and ensure its delivery.
- Ratify and share the Annual Report and consider how to improve contribution to safeguarding.
- Take overarching responsibility for Safeguarding Adults Reviews, ensure that learning is shared and that remedial actions are robust and lead to practice improvement and improved outcomes for adults at risk.
- Adopt the principle of continuous learning and improvement across the partnership to collaborate, safeguard and promote the wellbeing and empowerment of adults.

Medway Safeguarding Adults Executive Group

Kent and Medway Safeguarding Adults Board - Business Group

Responsibilities:

- Hold KMSAB Working Groups to account for delivery of KMSAB Strategic Plan and Business Plan.
- Review KMSAB Working Groups' annual work programmes/delivery plans.
- Receive update reports from other relevant Partnerships and Boards to share learning and identify areas for development.
- Receive and scrutinise update reports from KMSAB Working Groups and use these to monitor progress and to identify developing gaps, risks and issues that need to be addressed.
- Be accountable for making decisions concerning the implementation of KMSAB's Strategic Plan and associated delivery plans.
- Make recommendations to the Board for decisions which required higher level scrutiny and agreement or budget implications.

Learning and Development Working Group	Practice, Policy and Procedures Working Group	Quality Assurance Working Group	Risk Threats and Vulnerabilities Working Group	Safeguarding Adults Review Working Group
This working group is responsible for the co-ordination, commissioning, delivery and evaluation of the KMSAB multi-agency safeguarding adults training programme.	This working group reviews and updates the multi-agency safeguarding adults Policy, Protocols and Guidance for Kent and Medway, and associated documents.	Co-ordinates quality assurance activity and evaluates the effectiveness of the work of all KMSAB's partner agencies, to safeguard and promote the welfare of adults at risk of abuse or neglect.	Oversees multi-agency activity around Trafficking, Radicalisation and Gangs through information sharing and the development and implementation of an integrated strategy.	This working group ensures that the KMSAB carries out its statutory responsibilities in respect of Safeguarding Adults Reviews and other learning reviews, such as case audits.

Section 2. Priorities and Achievements

This section details how we delivered against our priorities for 2017 – 2018

Priority one: We will engage with residents of Kent and Medway, empowering and enabling them to contribute to safeguarding and the work of the Board

What we aspired to

- The voices of Kent and Medway residents will be represented at KMSAB via a virtual citizens' panel.
- Feedback will be used to influence the work of the Board, including policies, procedure and practice.
- Residents of Kent and Medway will be more informed about the work and purpose of the Board.
- Residents of Kent and Medway will be clear on how to recognise and report abuse and neglect.

What we achieved

- Engagement and Communications Group - The KMSAB is continuously pursuing ways to engage with service users, carers and the public. The ambition is to provide ways for them to influence the work of the Board and empower and enable them to contribute to safeguarding in Kent and Medway. This is one of the top priorities for the Board, but due to the size and population of Kent and Medway it is also one of the most challenging. Having trialled different models of engaging with existing forums, KMSAB members agreed to establish an "Engagement and Communications Group" to progress this work. The Group will help the Board to raise its profile, reach service user and carer groups, and determine how best to ensure that important messages are delivered.

- Engagement of Family Members in Safeguarding Adults Reviews - The views of family members and carers are sought, where appropriate, as early in the Safeguarding Adults Review (SAR) process as possible and they are kept informed of progress by the Independent Author of the SAR. To support family members and carers once the Review is complete, and prior to any decision that needs to be made regarding possible publication, the Independent Author meets with agreed family representatives, to go through the report findings and answer any questions. At the end of the SAR, the Independent Chair of the Kent and Medway Safeguarding Adults Board sends a personal letter to all family members who may have been involved.

  One of the strengths of the recent SAR learning workshops was the involvement of relatives and carers. When the findings of the SAR in respect of person 'D' were presented, carers spoke about what the person was like and their experiences of spending time with them. Although a relative did not feel able to speak at each event, they wrote some words about their loved one, which were read by someone on her behalf. Much of the feedback received praised relatives and carers, explaining that it was a very powerful and personal way to support and deploy learning.

  Previously the Board has always anonymised SAR reports by using a title such as "Mrs C" and "Mrs D", but having listened to the views of family members involved in more recent reviews this has changed. A fully anonymised name, such as "Violet Hughes" is now used,

as family members consulted felt that this was more personal and meaningful. Going forward this may however have to be reviewed owing to changes in legislation.

The Safeguarding Adults Review Working Group is developing a SAR information leaflet for families and carers to explain the process. This will also be made available in 'easy read' format.

- Review of Making Safeguarding Personal Literature - Kent County Council and Medway Council ensure that Making Safeguarding Personal is integral to the safeguarding process and seeks the views and wishes of the adult concerned, throughout the Enquiry, and will try to meet their desired outcome(s) whenever possible. The Making Safeguarding Personal literature was reviewed to ensure that it was Care Act compliant and that questions were clear and suitable for everyone to answer. Easy read versions are also available if required. An additional factsheet has been developed to provide more information on the safeguarding process for anyone experiencing this, should they require it.

- Safeguarding Adults Awareness Week 9-13 October 2017 - As well as being good practice, Safeguarding Adults Boards have a duty under the Care Act to prevent harm and "raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect"[1] . Research has found that successful awareness raising campaigns can make a significant contribution to the identification and prevention of abuse.

  To help spread the message on how to recognise and report abuse and neglect and highlight the support and services available for those at risk or experiencing abuse, Board members arranged and held a safeguarding adults awareness raising campaign between 9-13 October 2017. The campaign was framed around the theme "Respect not Neglect", which reflected findings highlighted in recent KMSAB Safeguarding Adults Reviews.

  Each agency prepared a schedule of activities for the week. Events included:
  - multi-agency information and community engagement events (one-stop shops) held in Bluewater, Dover, Sittingbourne, Chatham and the University of Kent, Medway Campus.
  - awareness raising through social media and press coverage.
  - an information session on recognising and responding to radicalisation.
  - staff workshops and conferences.
  - domestic abuse one-stop shops.
  - a self-neglect workshop.
  - public information stalls and attendance at local community groups.
  - fraud and scam awareness sessions at banks.

  These events were well attended, and very positive feedback was received.

- Redesigned Self Assessment Framework (SAF) - All agencies represented on the Board are asked to complete an annual 'self assessment framework', a series of questions to measure progress against key quality standards. All responses are rated (red, amber and green) and evidence to support the rating is required. The completed assessment is reviewed by a peer

[1] Care and Support Statutory Guidance Issued Under the Care Act 2014

review panel to ensure consistency and to offer support and guidance. Any actions rated red or amber require regular update reports to the Quality Assurance Working Group (QAWG) and Board to ensure the required standards are achieved.
In 2017 the QAWG reviewed and strengthened the SAF document. Questions relating to participation and involvement include:

- Does your organisation have information, in a variety of formats, accessible to adults at risk and their families about safeguarding? This should include who to contact if they are concerned about an adult at risk.
- How does your organisation seek the views of those that experience your services – How often is this analysed?
- What are the themes and trends from service user feedback and how has this information been used?
- Can your agency demonstrate that service users are invited and supported to attend safeguarding meetings?
- Evidence or demonstrate how the views of adults at risk are specifically listened to.

What we need to do next

- Develop and implement a communications and engagement plan to:
  - ensure regular communications are set up with service user groups and outcomes are fed into future planning.
  - communicate safeguarding information to partners so that they can disseminate information on the Board's behalf
  - promote the work of the Board and messages on how to recognise and report abuse, throughout the year.

- Plan and promote Safeguarding Adults Awareness Week 2018.

Priority two: We will ensure that we learn from the outcomes of Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs) and Children's Serious Case Reviews (SCRs) and these directly influence practice improvements

What we aspired to

- All multi-agency partners are informed of the outcomes of reviews and share the learning across their agency to improve practice.
- Outcomes are improved for people at risk of harm.
- There is a clear communication strategy/process for the dissemination of lessons learnt and related good practice examples, which lead to practice improvements.

What we achieved

More information on individual SARs in progress and commissioned in 2017-18 is available in section three. Key achievements for priority two include:

- Updated SAR Communication Protocol - Members of the Safeguarding Adults Review Working Group (SARWG) worked with partner organisations' communications leads to update the SAR communications protocol. This document details the roles and responsibilities of each organisation at the point a SAR is published, to ensure information is shared, the views and wishes of family members are considered and any press release is co-ordinated. The revised protocol was approved by the KMSAB.

- Learning from SARs - Following the completion of a SAR, the Independent SAR Author is required to attend a KMSAB meeting to present the findings of their review to Board members. The recommendations made are considered in detail at this meeting and Board members have a responsibility to share the learning within their organisations. Four SARs were completed and presented to the Board during 2017-18. In addition to this, in 2017 the KMSAB held an extraordinary meeting to consider the findings of two SARs, which were linked to former residents of Kent, commissioned by other Safeguarding Adults Boards. The learning from these was circulated to KMSAB members to cascade within their organisations. Learning is also shared with the Learning and Development Working Group to inform training, and the Practice, Policies and Procedures Working Group, so they can make any required policy amendments.

  If a SAR is to be published, the Independent Chair of the KMSAB sends a communication to all partner agencies, providing a brief overview of the key findings, learning points for staff and advising of the publication date. The member agencies share this with relevant staff in their organisation and wider.

- SAR Workshops - Three SAR learning events took place in March 2018, reaching a total of over 460 members of multi-agency staff. In preparation for the events, working group members undertook a thematic review to establish the key learning from the four KMSAB SARs, two case audits and two out of area SARs, to share at the event. In addition to this thematic summary, the workshops considered one case in detail to emphasise the message that safeguarding is personal. As self-neglect was one of the main concerns identified in the thematic review, the workshops consequently included a session on this. The multi-agency training provider also attended a session so that the learning could be shared throughout the commissioned training. Feedback from the event was extremely positive.

- SAR Action Plans - Once the recommendations of a SAR or case audit have been approved by the Board, partner agencies are required to produce an action plan to explain how they will address the recommendations made. Individual agencies' returns are collated into one action plan for each SAR, which is quality assured by the SAR Working Group. Once satisfied with the quality, the action plan is shared with KMSAB members for final approval and to progress.

  To help monitor the progress of all actions agreed, an overarching action log has been developed to record all SAR actions. KMSAB members are required to provide a quarterly update on what they have achieved and what actions remain outstanding. This is discussed at each Working Group meeting and any key achievement or areas of concern are highlighted to the Board.

- Representation on Domestic Homicide Reviews (DHR) and Kent Children's Serious Case Review (SCR) steering/working groups - To encourage the sharing of learning between groups, a member of the SARWG now also attends the DHR and SCR Working Groups. In addition to this, representatives from the KMSAB, Medway Safeguarding Children Board, Kent Safeguarding Children Board and the Domestic Homicide Review lead have met to discuss recent review findings and to scope a more formal shared review of themes, with the intention that this can be used to inform areas for closer joint working. The KMSAB has also been engaging with the Learning Disabilities Mortality Review (LeDeR) Programme to establish how their reviews, of the deaths of people with learning disabilities, link with the SAR process and how lessons can be shared across the Boards.

- Quality Assurance of SARs – With regard to signing off each part of the SAR process, senior managers are required to make the decisions. Latter stages require sign off by Board members and the final sign off is made by the Independent Chair of the KMSAB. To help ensure greater consistency and to support managers, SAR Working Group members have developed a 'quality assurance sign off checklist'. This means that at each stage of sign off, managers have a list of things they must ensure have been addressed before they can approve the document.

  The Chair of the SARWG has been involved in a joint task and finish group, led by Domestic Homicide Review (DHR) Steering Group, to review and strengthen the terms of assignment, contract, job description and recruitment process for Chairs/Authors undertaking DHRs and SARs. Following this, a successful recruitment campaign took place with new Chairs/Authors appointed.

What we need to do next

- Hold a joint thematic review to look at the findings of all recent, local SCRs, DHRs, SARs, LeDeRs and case audit findings to establish whether there are any consistent findings and how these can be addressed across Boards.
- Greater engagement with LeDeR programme.
- Work with communications leads to discuss more ways of sharing the learning.
- Attendance at Medway Safeguarding Children Board Case Review Group.
- Further engagement at national level regarding learning from other Boards via the results from research that is being developed and the consideration of the development of the national SAR library.

Priority three: We will ensure our structure and governance arrangements enable us to meet our statutory duties effectively and efficiently

What we aspired to

- KMSAB is well regarded and well respected.
- All Board and Working Group members are clear on their roles and responsibilities.
- KMSAB works effectively with other Boards.

What we achieved

- Board Restructure - The KMSAB held a development day on 14 July 2017, those present agreed the Board's vision mission statements and strategic priorities. The group then determined the most suitable structure to deliver these. The new structure (page 6) allows the Business Group to focus on how Working Groups and others are delivering the Strategic Plan. This enables the over-arching Board to focus on strategic issues and priorities. Funding for the new structure was agreed and the new model became operational on 1 January 2018.

- KMSAB Membership – Throughout the restructure it was stressed that the KMSAB will only be effective if the right people are involved. Members of the Board have a strategic role for safeguarding and promoting the welfare of adults within their organisation, and therefore must be able to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account. Board members reviewed the membership of the Board, Business Group and all Working Groups to ensure that there was adequate representation from each agency and that those nominated had sufficient knowledge and authority to make the decisions required.

- Terms of Reference and Constitution – To support the new structure, the KMSAB Constitution and Terms of Reference for all KMSAB Working and Board groups were reviewed and updated. These documents detail the purpose of the group and what is expected of members. They are available on the KMSAB website.

- Roles and Responsibilities - To ensure that all Board and Working Group members are clear on their roles and responsibilities, these were agreed and outlined in the following documents:
    - Restructure papers to the Board
    - KMSAB Constitution
    - Terms of Reference

The roles and responsibilities of the Independent Chair of the KMSAB and Board Business Unit were also detailed in these documents.

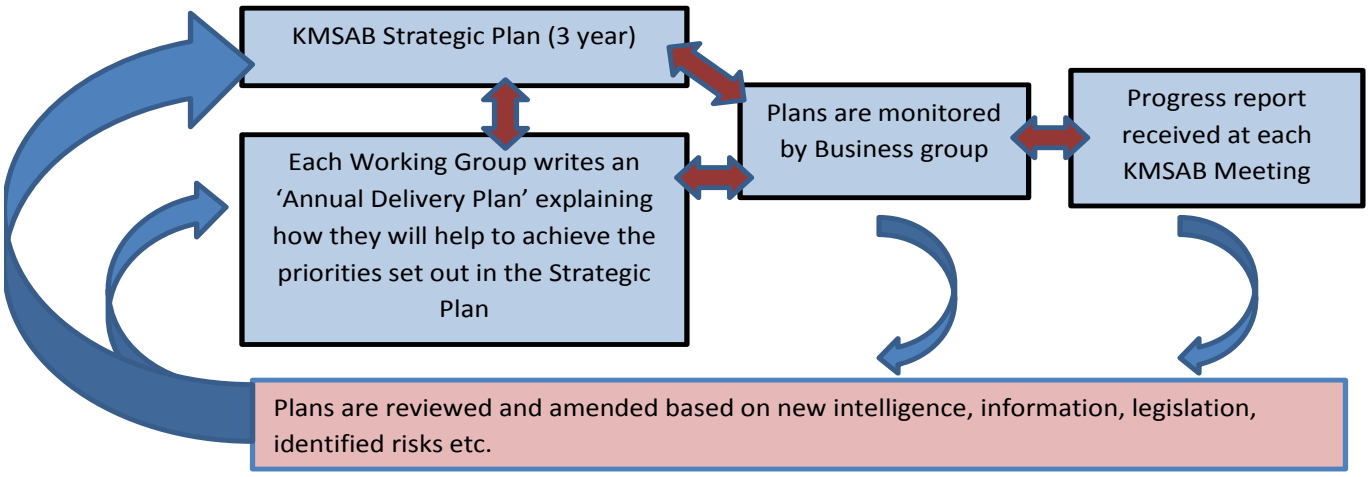
- Work with other Boards - The Board works with other strategic groups and partnerships, such as The Kent Safeguarding Children Boards, Medway Safeguarding Children Board and the Community Safety Partnerships. There is shared membership across many working groups and update reports from key Boards are received at each Business Group meeting.

- KMSAB Strategic Plan 2018-21 - Having agreed the KMSAB vision, mission statement and strategic priorities (see section 5), members developed a three-year strategy and business plan. This provides information on what the Board intends to achieve, how and within what timeframe. To support this high-level plan, each Working Group is required to produce an 'annual delivery plan' which goes into more detail about the tasks the Group will be undertaking to meet the three chosen priorities of Prevention, Awareness and Quality. Medway Safeguarding Adults Executive Group has also developed a delivery plan. The Chairs of each Working Group are required to provide a progress update at each Business Group meeting. The following ratings are used to measure progress against each action:

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

If any tasks are rated amber or red, Working Group chairs must provide the reasons for this and explain what mitigating actions have been put in place.

Planning process:



What we need to do next

- Consult on and promote the Strategic Plan.
- Achieve the actions set out in the 'Annual Delivery Plans'.
- Continue to embed the new structure and arrange a peer review of the Board by Spring 2019.
- Consider developing a KMSAB handbook for members.

Priority four: We will ensure that our Policies, Procedures and Guidance documents are compliant, easy to use and reviewed and updated regularly

What we aspired to

- Staff in contact with an adult at risk understand their role and responsibility in responding to abuse and neglect.

What we achieved

- Updated Policy, Procedures and Guidance - In accordance with the policy update schedule, the Practice, Policy and Procedures Working Group (PPPWG) reviewed and updated the following documents to ensure that they reflected emerging legislation, policy and any learning from Safeguarding Adults Reviews/other case reviews:

  - KMSAB Multi-agency Safeguarding Adults Policy, Protocols and Practitioner Guidance Document. The updated document can be found here.
  - Kent and Medway Multi-Agency Policy and Procedures to Support People who Self-Neglect. The updated document can be found here.

- Commenced a full re-write of the Multi-agency Safeguarding Adults Policy, Protocols and Guidance Document - when Working Group members completed the annual update of the Board's main policy, protocols and guidance document (PPG) it was agreed that a full re-write should be undertaken for the 2018-19 update. As this this is particularly complex and highly labour intensive, a task and finish group was established to lead this work. Task and finish group members developed and circulated a questionnaire to practitioners from all agencies to ask for their views on the current document and what improvements they would like made. Task and finish group members reviewed the responses received and have used these to inform the future redesign.

What we need to do next

- Ensure all KMSAB policies and procedures are GDPR complaint.
- Continue to review the Board's policies and procedures at the frequency determined in the policy update schedule, or sooner in response to any legislative or national policy changes or any other intelligence received by the KMSAB.
- Complete the re-write of the Multi-agency Safeguarding Adults Policy, Protocols and Guidance Document.

Priority five: We will provide a high quality multi-agency training offer

What we aspired to:

- Well informed and appropriately skilled workforce leads to practice improvements.
- Course content is updated regularly to reflect best practice and lessons learned from local and national SARs as well as relevant DHRs and SCRs.

What we achieved

- Commissioned New Training - The Kent and Medway Safeguarding Adults Board commissions multi-agency safeguarding adults training specifically for staff from the statutory sector, covering the roles and responsibilities of statutory partners in relation to Safeguarding Adults Section 42 Enquiries. Following a successful tender process, the new multi-agency safeguarding adults training programme was launched in May 2017, and training commenced in June, rolling out the following commissioned courses:

  In relation to Section 42 Care Act 2014:
  - Policies, Procedures and Agency Responsibilities
  - Undertaking and Managing Enquiries
  - Effective Contribution and Collaboration in Decision Making

  More information on this training can be found here.

  Each agency's introductory/foundation training sits below these multi-agency workshops, as has always been the case.

- Attendance Figures - The Board's multi-agency training programme for 2017-18 was completed, with a total of 761 staff attending training - an increase of 85% from last year's total of 412. This increase can be partly attributed to the fact that the training now comprises two one-day workshops, and one two-day workshop, whereas previously both the Level B and Level C courses were of two-day duration. Course take-up and attendance levels for the year are summarised below:

Course Name	No of workshops held in year	Total No. of persons attending	KCC	Medway Council	Health - KMPT	Health - Other	Kent Police	KFRS	Prob-ation	Other
Policies, Procedures and Agency Responsibilities	17	299	164	43	15	37	21	5	12	2
Undertaking and Managing Enquiries	19	308	174	43	40	29	16	4	1	1
Effective Contribution and Collaboration in Decision Making	9	154	87	20	17	11	14	3	2	0
Annual Totals	**45**	**761**	**425**	**106**	**72**	**77**	**51**	**12**	**15**	**3**

In addition to the training detailed above, agencies may supplement this with their own training programmes.

- Developed a Training Evaluation Framework - The Learning and Development Working Group (LDWG) developed a framework to outline the formal methods to be used to obtain feedback on the effectiveness of the multi-agency training and the impact it has on practice, recognising that training is only one of a number of factors which impact on practice. The success of the evaluation framework is dependent on engagement from those on the course, their supervisors and LDWG members. The evaluation methods include:
  - "On the day" feedback
  - Delegates' feedback 3 months after successful completion of course
  - Manager's feedback
  - Experienced Observer Feedback
  - Informal 'Ad Hoc' Feedback
  - Feedback from Training Provider.

- Agency Reporting - To ensure that training materials are kept up to date and relevant, the KMSAB regularly collates key information from agencies which may impact on training. This may include any policy or operational changes, learning from case reviews/audits, SARs, DHRs, etc., feedback from services users/MSP, delegates and any other relevant information. The Learning and Development Working Group has developed an agency reporting template for agencies to complete quarterly to capture this information. The completed returns are presented at each LDWG meeting for ratification before they are shared with the training provider. Any urgent issues arising during the intervening periods are notified to the KMSAB Co-ordinator, for reference to the training provider, and captured retrospectively on the template.

- Linkages with other Working Groups - The KMSAB Working Groups are inextricably linked and work closely together to ensure the KMSAB objectives are met in a co-ordinated, holistic way. Working Groups may make recommendations for training to the LDWG. For example: the PPPWG may request bespoke training to support the launch of a new policy; the QAWG may ask for training to be amended in response to themes identified though the completion of the self assessment framework and the SAR working group regularly shares learning with the LDWG to enable training to be improved, if required.

What we need to do next

- Continue to ensure that the training provider regularly updates course content and materials to reflect best practice and lessons learned from local and national SARs as well as relevant DHRs and SCRs.
- Embed the training evaluation framework and use the findings from this to continually improve the training offer.

Section 3. Safeguarding Adults Reviews

Purpose of a Safeguarding Adults Review

The KMSAB is required to review what has happened in cases when an adult who needs care and support either dies, or suffers serious harm, when abuse or neglect is thought to have been a factor. This is called a Safeguarding Adults Review, or SAR for short. A Safeguarding Adults Review is not an enquiry into how someone died or suffered injury nor does it look to allocate blame and it is separate from any investigation which may be undertaken by the police or a coroner. What a SAR does do is look at the case in detail to see whether any lessons can be learned about how organisations worked together, or not as the case may be, to support and protect the person.

Criteria for Conducting a Safeguarding Adults Review

KMSAB 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:

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

OR

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

AND
The case(s) give rise to concerns about the way in which local professionals and services worked together to protect and safeguard adult (s) at risk.

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

More information on the SAR process is available here.

SAR Activity

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

decision. The KMSAB received seven new SAR applications between April 2017 and March 2018, of these:

- 2 cases progressed using the Case Review methodology
- 2 cases did not meet the criteria and no further action was required
- 3 cases did not meet the criteria and were addressed through the NHS Safeguarding Management process.

Completed SARs - The following SARs were completed and signed off by KMSAB members between April 2017 and March 2018 (please note all names are pseudonyms)

Anonymised name	Completion Date	Recommendations	Actions	% of action plan completed (June 2018)
Mrs D	17 July 2017	6	40	97
Mrs C	30 October 2017	17	63	89
Violet Hughes	30 October 2017	18	30	97
Beryl Simpson	10 January 2018	10	23	52

In addition to the above, some KMSAB agencies were also involved in two SARs which were led by other Safeguarding Adults Boards. The findings of these reviews were shared at an extraordinary meeting of the Board which was held in October 2017.

Themes of recent SARs - Some of the themes highlighted in recent reviews include:

- Quality of record keeping.
- Case co-ordination and management – the importance of clarifying who is leading a complex case when multiple agencies are involved.
- Importance of Mental Capacity Act in relation to Safeguarding.
- Strength of good multi–agency working/collaborative working.
- Leadership – the importance of case oversight and ownership of cases.
- Professional curiosity – what do professionals need to know? What are they concerned about? How are they going to find out? and how can appropriate lawful actions assist?
- Analytical skills – what happens to the information gathered? How it is utilised and deployed?
- Self-neglect – clarifying the threshold for safeguarding involvement.

The process for managing action plans and disseminating learning to all partner agencies is detailed in section 2 of this report (priority 2. Page 11).

Section 4. KMSAB Funding

The Kent and Medway Safeguarding Adults Board is funded by Kent County Council, Medway Council, Kent Police, Kent Fire & Rescue Service, Clinical Commissioning Groups and commissioned Health provider organisations. Each of these agencies made the following percentage contributions in 2017-18:

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

The multi-agency budget covers Board salaries for the Independent Chair, Safeguarding Adults Board Co-ordinator and Administration Officer posts. It also covers the administration costs for the various multi-agency group meetings, Safeguarding Adults Reviews, including the commissioning of Independent Authors/Chairs, and covers the full provision of multi-agency training.

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

	2015-2016 Agreed contribution (£000's)	2016-2017 Agreed contribution (£000's)	2017-2018 Agreed contribution (£000's)
KCC	**72.8**	**80.8**	**82**
Medway Council	**14.8**	**16.5**	**16.7**
Local Health Commissioners and Providers	**64.5**	**71.5**	**72.5**
The Office of the Police and Crime Commissioner	**25.3***	**28.1**	**28.5**
Kent Fire & Rescue Service	**3**	**3.3**	**3.3**
Reserve	**1.9**	**10.0**	**20**
Total	**182.3**	**210.2**	**223**

*21 received

Section 5. Priorities for 2018 - 2021

A development day for KMSAB members was held in July 2017. Members agreed the following vision and mission statements and strategic priorities for 2018 - 2021:

Vision - "The Kent and Medway Safeguarding Adults Board Partnership will all work together to ensure adults at risk of abuse or neglect are supported and empowered to live safely".

Mission - "To achieve the vision the Board is seeking assurance, through partnership working with agencies and local communities, to prioritise and deliver: prevention, awareness and quality of safeguarding".

Priorities for the next three years:

Priority 1 : PREVENTION

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

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

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

Priority 2: AWARENESS

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

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

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

Priority 3: QUALITY

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

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

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

The Strategic Plan is available on the Board's website. It provides more detail on what actions the Board will take to make sure the priorities are delivered. In addition to this, each working group has developed an 'annual delivery plan' to outline how they will deliver the strategy.

Section 6. Safeguarding Activity

Background to Data

The data for this report was extracted from the Kent County Council Social Care system (SWIFT) and the Medway Council Adult Social Care database (Frameworki).

Data included in this report is consistent with the Department of Health (DH) statutory returns: Abuse of Vulnerable Adults (AVA) for 2012-13, the Safeguarding Adults Return (SAR) for 2013-14 and 2014-15, and the Safeguarding Adults Collection (SAC) for 2015-16, 2016-17 and 2017-18.

Following the implementation of the Care Act 2014, terminology now used within safeguarding refers to Safeguarding Concerns and Safeguarding Enquiries (Section 42 Enquiries). This terminology has been used within this report.

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

The second part of the report summarises the outcome of Safeguarding Enquiries in Kent and Medway.

National comparator data was published on the NHS Digital site on 20 November 2018. To help interpret the data, NHS Digital have also developed an Interactive Power-BI Tool.

New Safeguarding Concerns and Enquiries

Number of Safeguarding Concerns

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

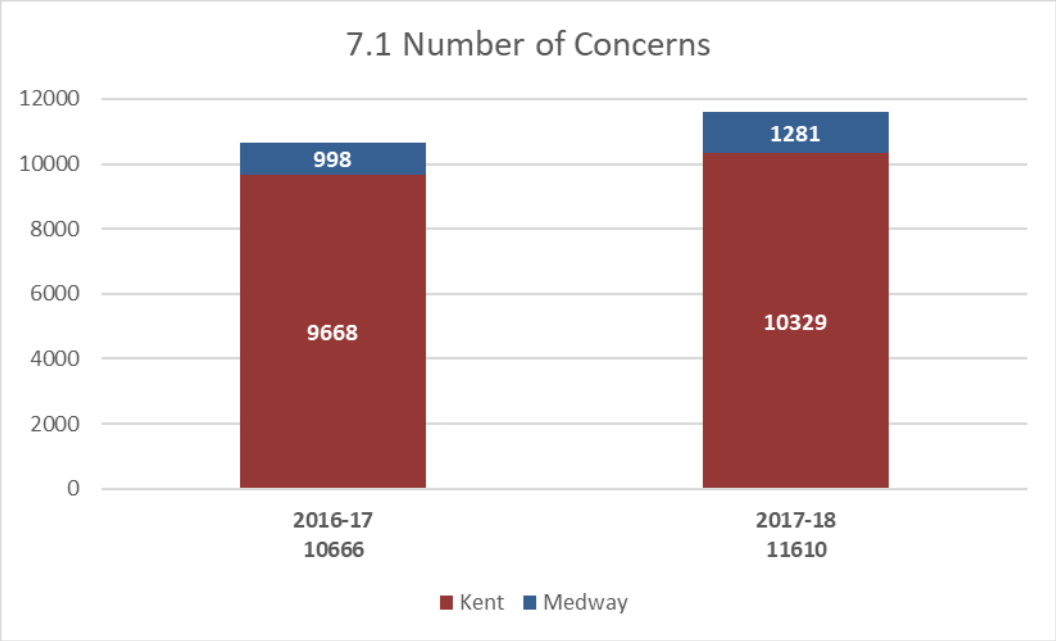


Fig 7.1: Number of Safeguarding Concerns received in Kent (red) and Medway (blue)

The number of Concerns received represents significant activity in both Kent and Medway and an increase in the number of Concerns in 2017-18 compared to the previous year. Kent saw an increase of 661 Safeguarding Concerns, an increase of 6.8%, whereas Medway observed a larger 28.4% increase (up 283). The higher figures in Medway are attributable to Concerns from Hospital settings (up 42%), Community Health settings (up 132%) and figures from care homes or supported living settings (up 95%).

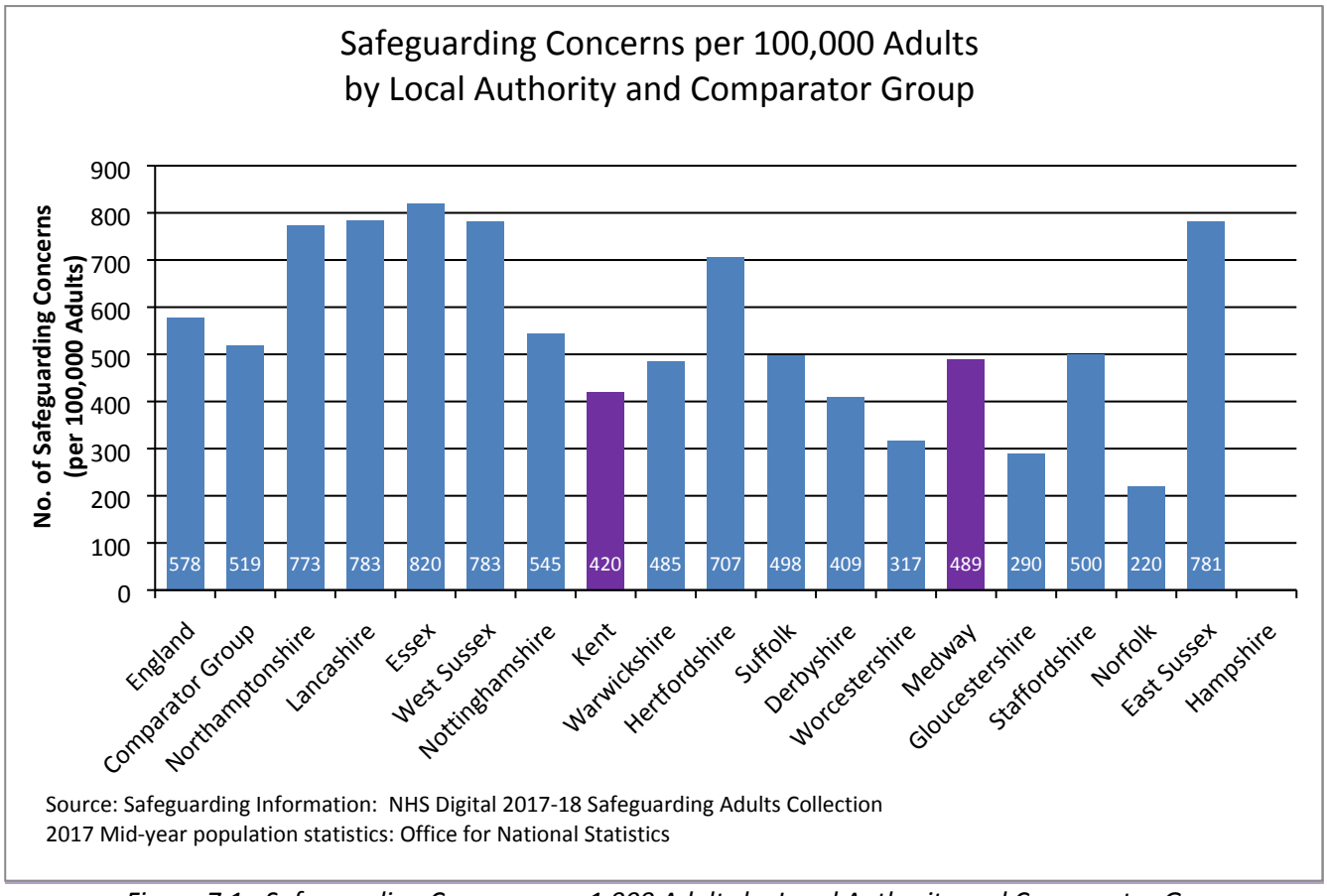


Figure 7.1a Safeguarding Concerns per 1,000 Adults by Local Authority and Comparator Group

Number of Safeguarding Enquiries and Rate of Change

In the period of April 2017 to March 2018, 6,375 new Safeguarding Enquiries were started, which reflects a 4.2% increase. The number of Enquiries initiated in Kent was 75 higher than 2016-17 (up 1.3%). A larger change was observed in Medway, with an increase of 59.4% in 2017-18 compared to the year before, up by 183 Enquiries.

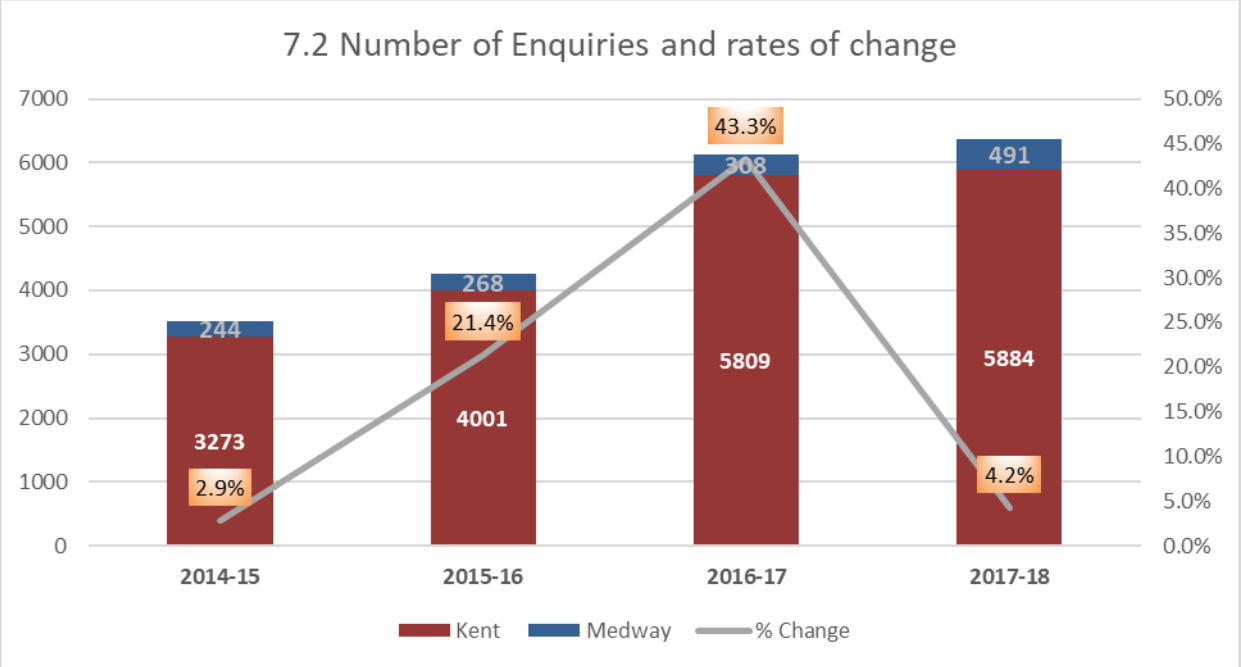
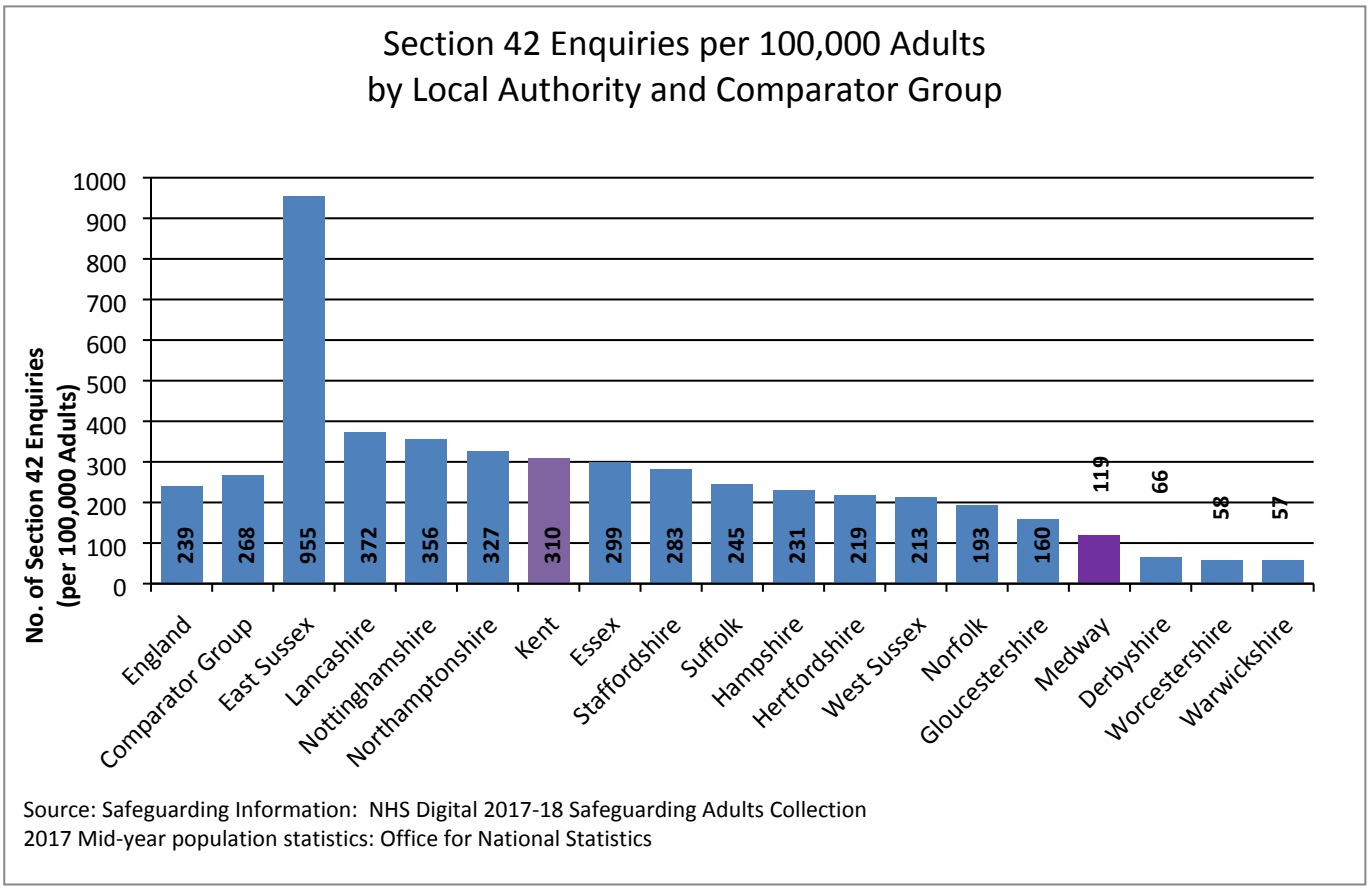


Fig 7.2: Number of Enquiries year on year, and rate of change 2014-15 to 2017-18 (grey)

The increase in Enquiry levels observed in recent years can be attributed to operational changes introduced in October 2015 to ensure compliance with the Care Act. The increase observed in Kent in 2017-18 is smaller than those observed during the two years prior, now that the new process has been embedded. Going forward the year-on-year changes are likely to be smaller. Furthermore, Medway has increased and promoted awareness of adult safeguarding and has carried out in-house training over the past year. This is thought to have contributed to the increase in concerns and Enquiries seen in Medway in 2017-18.

During 2017-18 Kent undertook a number of targeted exercises aimed at reviewing longstanding adult safeguarding cases and closing the cases where appropriate. As a result, the overall number of closed safeguarding cases increased by 1,926 compared to 2016-17, an increase of 35.6%.



Source: Safeguarding Information: NHS Digital 2017-18 Safeguarding Adults Collection
2017 Mid-year population statistics: Office for National Statistics

Figure 7.2a Section 42 Enquires per 100,000 Adults by Local Authority and Comparator Group

Age of Alleged Victims

The majority of all safeguarding Enquiries were related to the 18-64 age group with 37.7% of Enquiries (2,404) falling into this category, however this does represent a 0.4% decline from 2016-17. This is followed by the second majority falling in the 85+ age group with 27.2% (1,737), down by 0.7%.

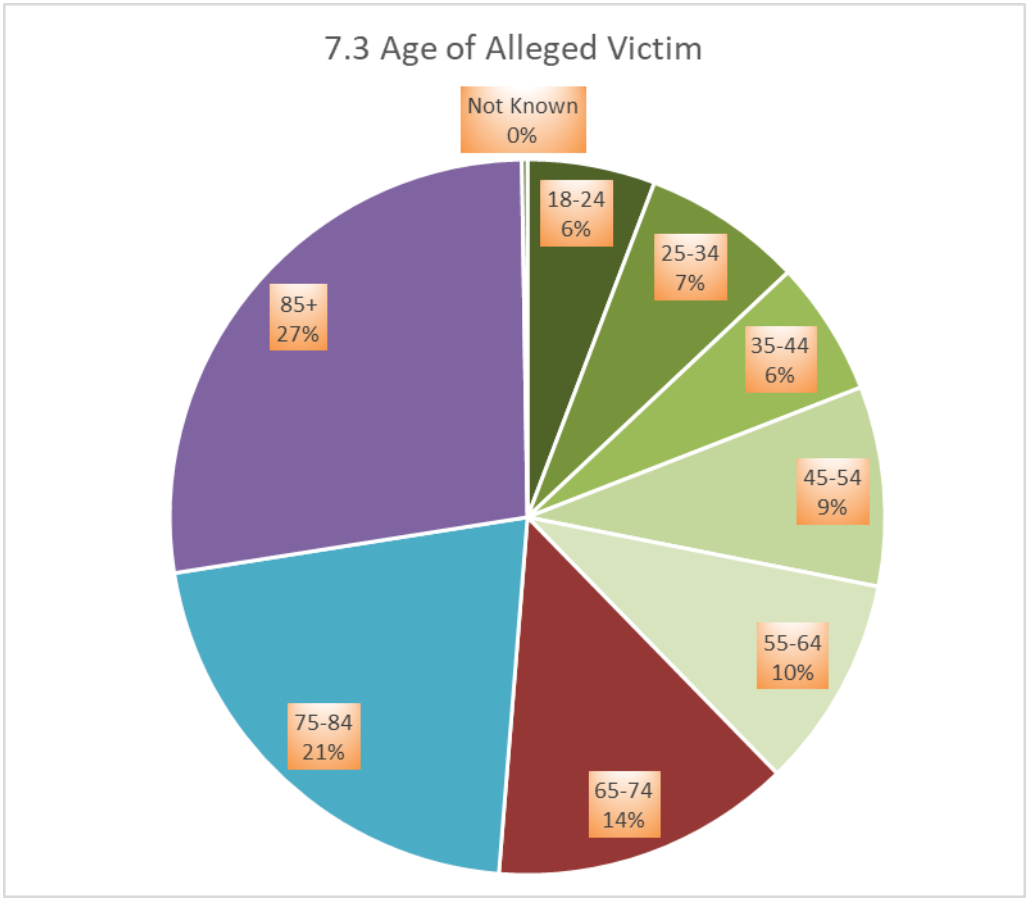


Fig 7.3: Age breakdown of alleged victims for 2017-18

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

Of the 18-64 age group, the highest proportion of Enquiries in this age band relate to the 55-64 age group, 9.6% (612) followed by the 45-54 age group, 9% (575). (The 18-24 age band, accounts for 5.8% of Enquiries (368) however if equated with a 10-year age band, it would represent a 9.6% figure).

The percentage of clients falling into the 65-74-year age category has continued to rise, with a 1% increase observed this year. The percentage of Enquiries where the age of the alleged victim is unknown has also increased slightly by 0.2%.

Gender of Alleged Victims

In 2017-18 the highest proportion of alleged victims remains female at 60.8% (3,879), which reflects an increase of 1.8% (233) compared with the 2016-17 percentage. Overall, the proportions remain consistent over the reporting periods.

It should be noted that a small cohort (less than 0.1%) falls into the *Indeterminate Gender* category.

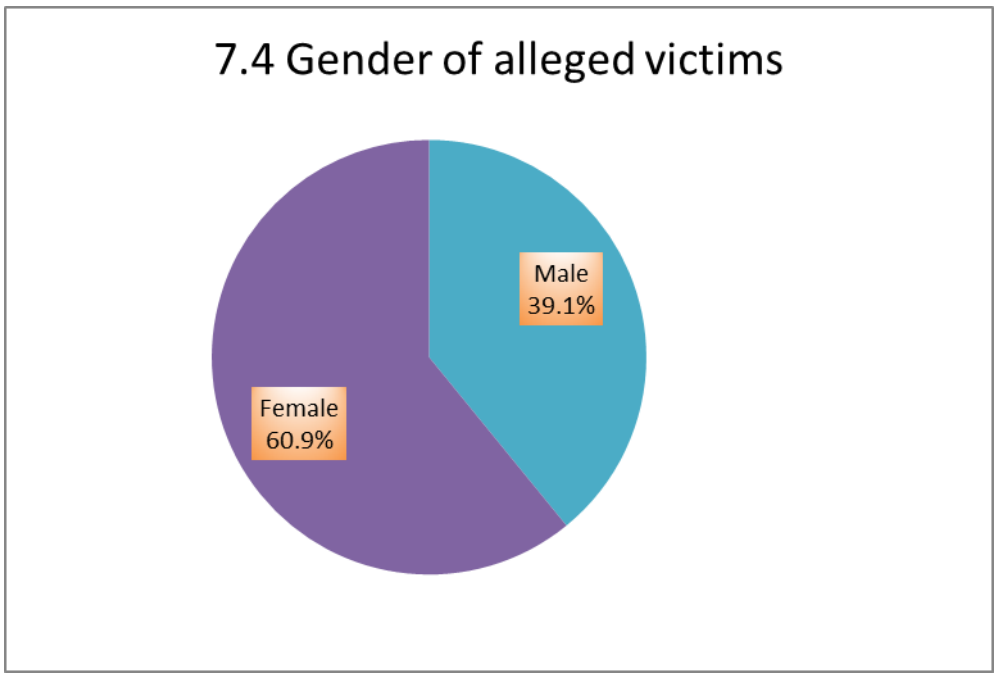


Fig 7.4 Gender of alleged victims 2017-18

Ethnicity of Alleged victims

Of all Safeguarding Enquiries initiated during 2017-18, 83% related to people from a white ethnic background, down from 86% in 2016-17. For the third year running, an increase has been observed in the percentage of Enquiries relating to people from a black and minority ethnic background, increasing 0.5% to 4.2%.

There has been a substantial increase in the percentage of cases where ethnicity data was unavailable; in some instances the client may have declined to supply the information, but in the majority of circumstances this information has not been sought and/or recorded. Efforts are being made by both authorities to promote the recording of this data.

	2014-15		2015-16		2016-17		2017-18		DoT
Ethnic Group	Number	%	Number	%	Number	%	Number	%	%
White*	3062	87.1%	3544	84.9%	5181	86.0%	5291	83.0%	⇩
BME **	118	3.4%	136	3.3%	222	3.7%	265	4.2%	⇧
Not stated/ obtained	337	9.6%	494	11.8%	620	10.3%	819	12.8%	⇧
Total	**3491**	**100%**	**3517**	**100%**	**4174**	**100%**	**6375**	**100%**	⇔

Table 7.5: Breakdown of Ethnic Group for the periods 2014-15 to 2017-18

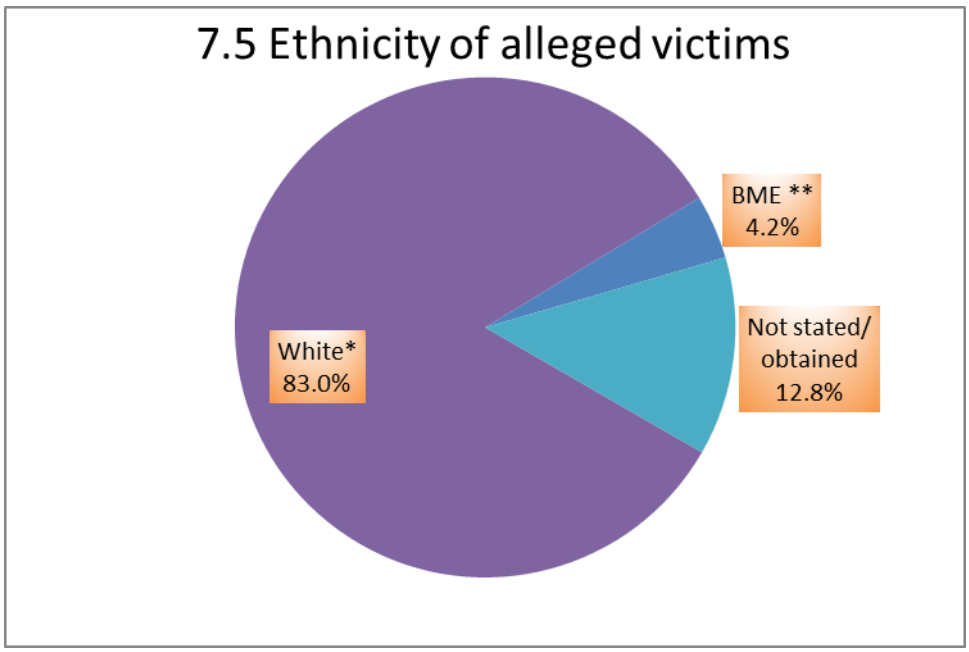


Fig 7.5: Breakdown of Ethnic Group 2017-18

** White' contains the DoH ethnic groups of White British, White Irish, Traveller of Irish Heritage, Gypsy/Roma, Other White Background*
*** 'BME' includes all Asian or Asian British, Black or Black British, Mixed and Other groups*

Primary Support Reason of Alleged Victims

As in previous Annual Reports, in both Kent and Medway, the most prevalent support reason remains *Physical Support*. This is then followed by *No Support Reason* at the time of the alleged incident, with Kent and Medway reflecting 26.9% (1,584) and 22.8% (112) of cases respectively having no support reason. The percentage of cases with no support reason are in-line with those previously reported and is to be expected, as individuals subject to a safeguarding referral will not always be receiving support from the Local Authorities.

Primary Support Reason	Kent	Medway	Aggregated
Physical Support	36.5%	61.5%	38.4%
No Support Reason	26.9%	22.8%	26.6%
Learning Disability Support	10.2%	6.9%	10.0%
Mental Health Support	14.2%	4.5%	13.5%
Support with Memory & Cognition	9.0%	2.9%	8.5%
Social Support	1.3%	1.2%	1.3%
Sensory Support	1.8%	0.2%	1.7%
Total	**100%**	**100%**	**100%**

Table 7.6 Breakdown of Primary Support Reason (PSR) for the period 2017-18

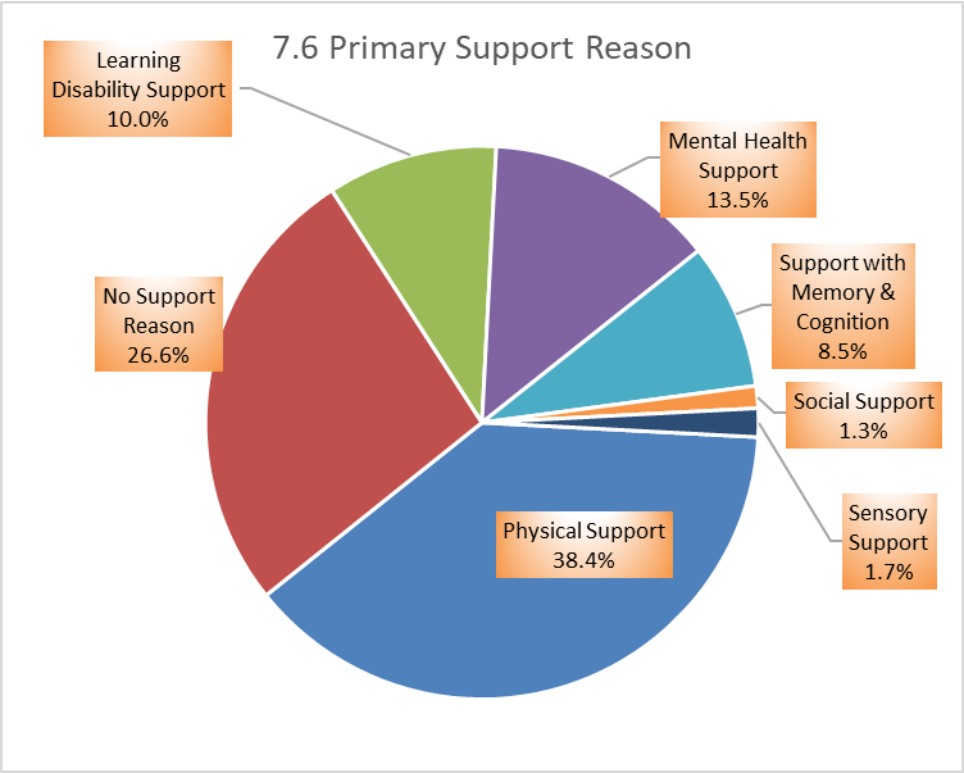


Fig 7.6 Breakdown of Primary Support Reason (PSR) for the period 2017-18 (aggregated)

Location of Alleged Abuse

Please note that from 2015-16 the method of calculating the location of alleged abuse is based on closed Enquiries in the reporting year. Therefore, the total number of Enquiries will not correlate with earlier sections of the report which detail number of Enquiries received within the reporting period.

In 2017-18 the most prominent location for incidents of alleged abuse remained within the alleged victim's own home, representing 42.8% of all incident locations (3,145). This represents a moderate increase of 1.7% compared to 2016-17. The numeric increase (922) is a reflection of the work carried out to ensure that outstanding cases were closed appropriately, with more Safeguarding Enquiries having been closed during 2017-18.

The care home setting is also a main setting of alleged incidences of abuse at 33.8% (2,481); this is a numeric increase of 549, though given the increase in the number of closed Enquiries the percentage has actually fallen by 1.9%.

Location of Alleged Abuse	2014-15 Number	2014-15 %	2015-16 Number	2015-16 %	2016-17 Number	2016-17 %	2017-18 Number	2017-18 %	DoT %
Own Home	**1209**	**34.4%**	**1262**	**34.7%**	**2223**	**41.1%**	**3145**	**42.8%**	⇧
In the community (exc. community services)	**70**	**2.0%**	**-**	**-**	**190**	**3.5%**	**248**	**3.4%**	⇩
In a community service	**116**	**3.3%**	**111**	**3.1%**	**199**	**3.7%**	**258**	**3.5%**	⇩
Care Home*	**1359**	**38.6%**	**1528**	**42.0%**	**1932**	**35.7%**	**2481**	**33.8%**	⇩
Care Home - Nursing	-	-	-	-	420	7.8%	615	8.4%	⇧
Care Home - Residential	-	-	-	-	1512	27.9%	1866	25.4%	⇩
Hospital**	**262**	**7.5%**	**171**	**4.7%**	**420**	**7.8%**	**655**	**8.9%**	⇧
Hospital - Acute	-	-	-	-	181	3.3%	422	5.7%	⇧
Hospital - Mental Health	-	-	-	-	148	2.7%	151	2.1%	⇩
Hospital - Community	-	-	-	-	91	1.7%	82	1.1%	⇩
Other***	**156**	**4.4%**	**563**	**15.5%**	**451**	**8.3%**	**554**	**8.3%**	⇩
Not Known	**345**	**9.8%**	**-**	**-**	**-**	**-**	**-**	**-**	⇔

Table 7.7: Location of alleged abuse for the periods 2014-15 to 2017-18

The following conventions apply to table 7.7 above:

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

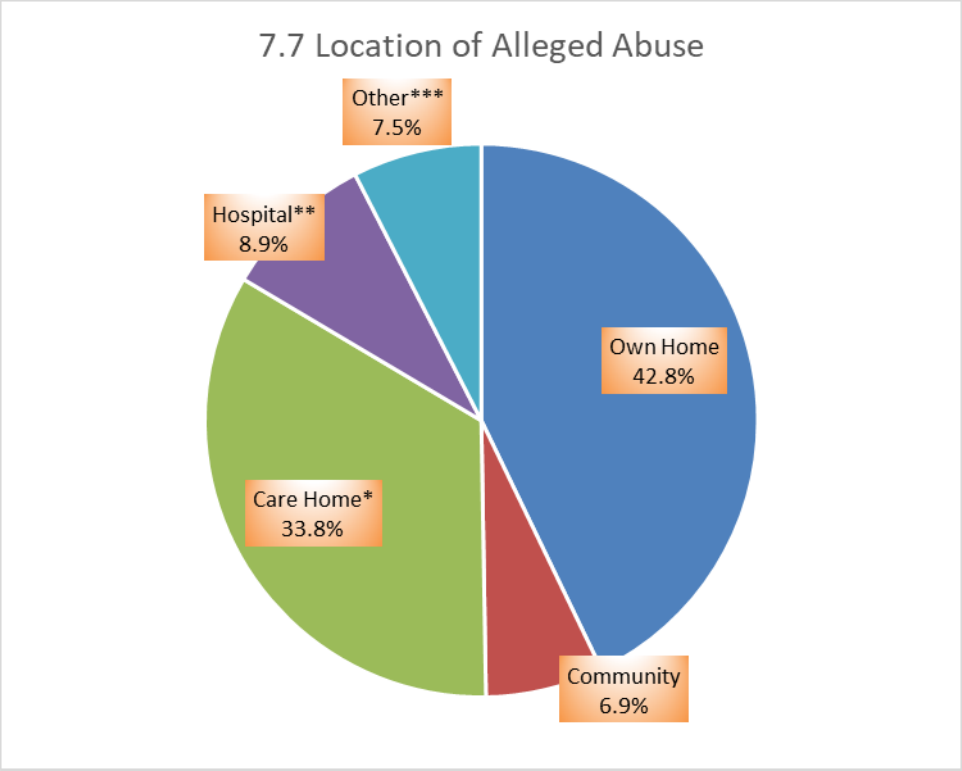


Fig 7.7: Location of alleged abuse for 2017-18

** All care home settings, including nursing care, permanent and temporary*
*** Acute, community hospitals and other health settings*
**** Includes any other setting that does not fit into one of the above categories including Not Known.*

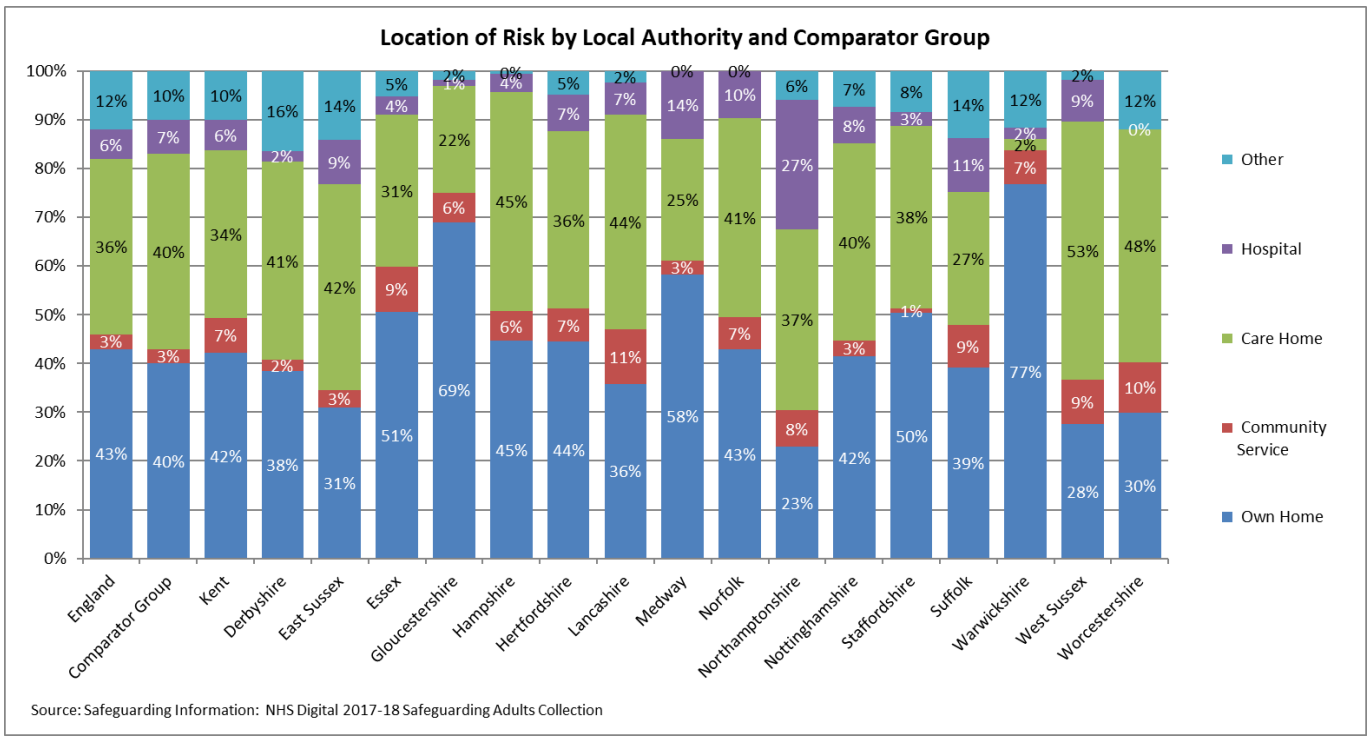


Figure 7.7a Location of Risk by Local Authority and Comparator Group

Category of Alleged Abuse

Based on concluded afeguarding Enquiries, the most predominant category of risk has remained physical abuse over the four reporting years as shown in table 7.8. Although the percentage of Enquiries relating to physical abuse has decreased by 1.5%, compared to the previous year, the actual number of Enquiries has increased by 624. The fall in percentage figure is attributable to the increased number of closed cases.

Neglect and Acts of Omission has remained the second most prevalent category of risk, increasing by 563 cases compared to the previous year and representing an increase of 0.5%.

The Self-Neglect category has also seen a further 1.8% increase during 2017-18, equating to 278 Enquiries, following a sharp upturn in 2016-17 when it increased by 5.8% of that year's total. This is believed to be related to increased professional awareness of self-neglect following the introduction of the Care Act and associated training and learning.

Categories of alleged abuse	2014-15		2015-16		2016-17		2017-18		%
	Number	%	Number	%	Number	%	Number	%	
Physical Abuse	1100	31.3%	1482	40.8%	2063	38.1%	2687	36.6%	⇩
Neglect and Acts of Omission	750	21.3%	1090	30.0%	1477	27.3%	2040	27.8%	⇧
Psychological Abuse	366	10.4%	656	18.0%	1017	18.8%	1383	18.8%	⇧
Financial or Material Abuse	572	16.3%	600	16.5%	841	15.5%	1151	15.7%	⇧
Sexual Abuse	146	4.2%	215	5.9%	302	5.6%	366	5.0%	⇩
Organisational Abuse	65	1.8%	91	2.5%	135	2.5%	155	2.1%	⇩
Domestic Abuse	-	-	75	2.1%	165	3.0%	238	3.2%	⇧
Self-Neglect	-	-	62	1.7%	405	7.5%	683	9.3%	⇧
Discriminatory Abuse	9	0.3%	24	0.7%	37	0.7%	81	1.1%	⇧
Sexual Exploitation	-	-	5 or less	<1%	37	0.7%	63	0.9%	⇧
Modern Slavery	-	-	5 or less	<1%	7	0.1%	16	0.2%	⇧

Table 7.8: Category of Risk for the periods 2014-15 to 2017-18

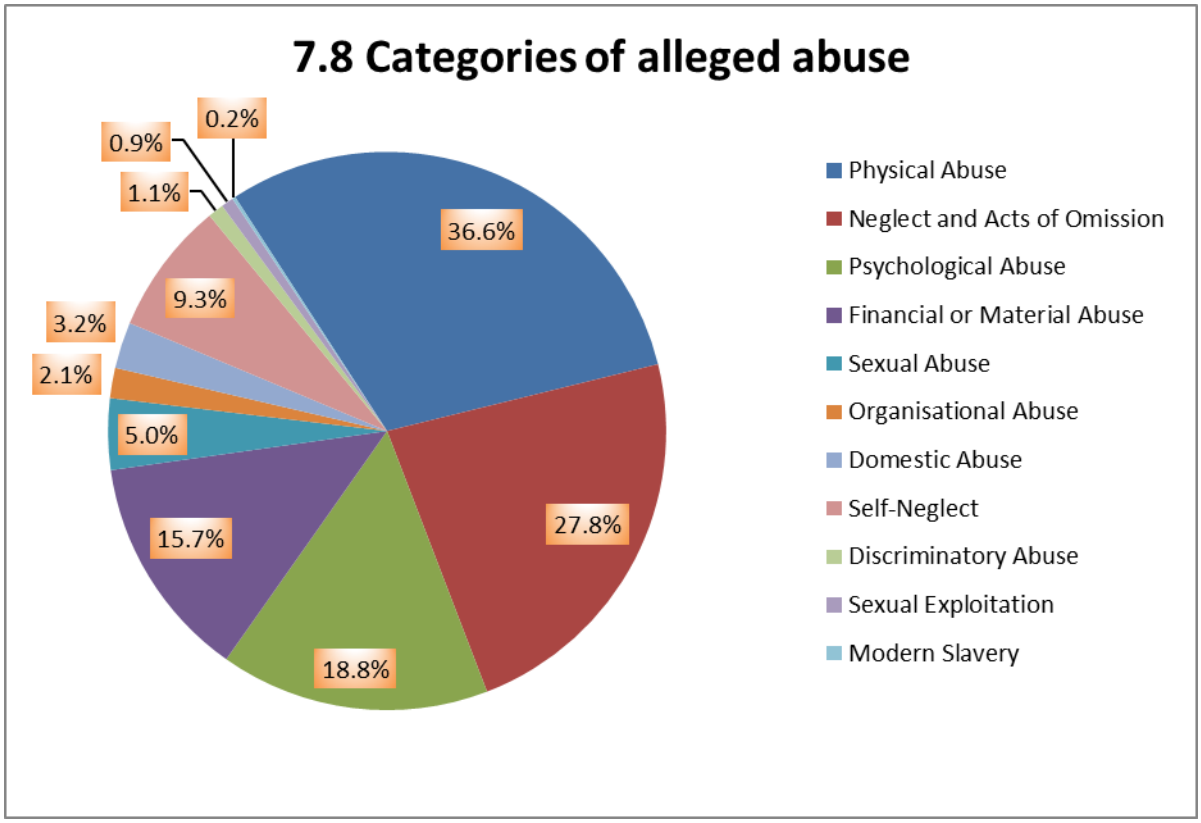


Fig 7.8: Category of alleged abuse, 2017-18

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

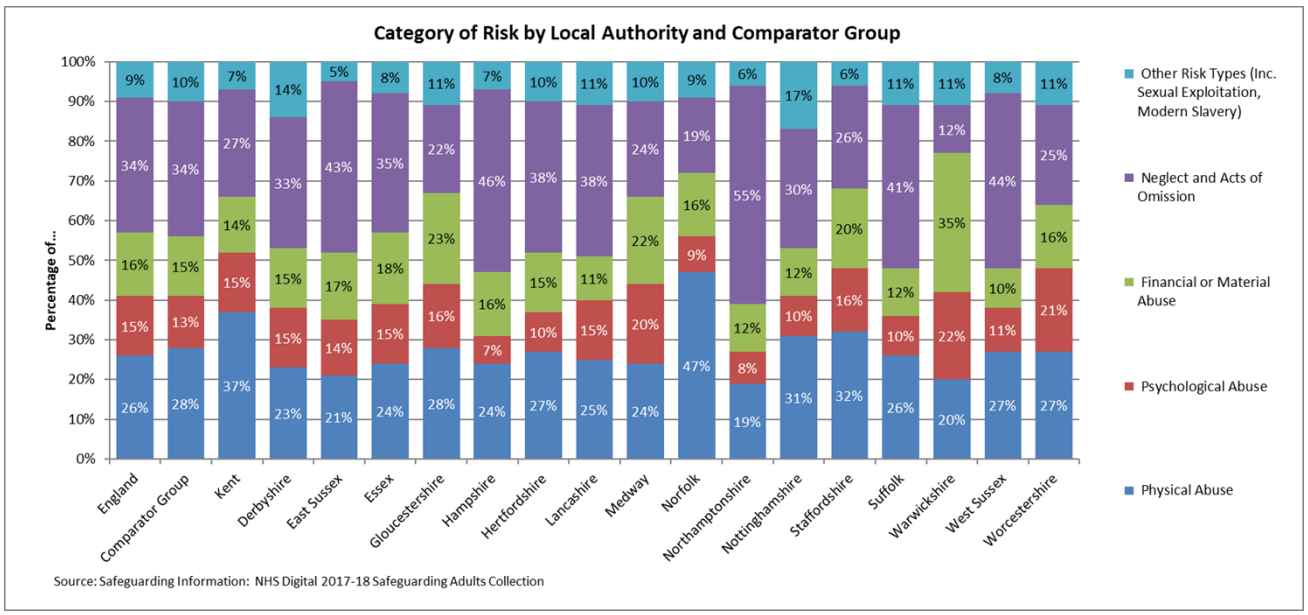


Figure 7.8a Category of risk by Local Authority and National Comparator Group. Source: NHS Digital Safeguarding Adults Collection

Source of Safeguarding Concern Leading to Safeguarding Enquiry

Table 7.9 shows the comparison of the sources of safeguarding concerns leading to Safeguarding Enquiries over the past four years. The majority of Enquiries continue to come from social care staff, consistent with previous annual reports, however there has been a 2% percentage point decrease from 2016-17 in the reporting year (albeit a numeric increase of 26). Health staff form the next group where a majority of referrals come from, demonstrating a 2.5% (45 cases) decrease from 2016-17.

The 'Other' category (carers, voluntary agencies/independent sector, anonymous, legal, other LA, Benefits Agency, Probation Service and strangers) has reflected a 4.7% (333 cases) increase during 2017-18.

Both Kent and Medway have safeguarding websites and marketing materials, accessible to members of the public. Safeguarding Awareness Week is key to increasing safeguarding awareness amongst members of the public.

Source of safeguarding concern leading to enquiry	2014-15		2015-16		2016-17		2017-18		% point change 2016-17 to 2017-18	DoT %
	No.	%	No.	%	No.		No.	%		
Social Care staff	1602	45.6%	1701	43.5%	2654	44.1%	2680	42.0%	-2.0%	⇩
Health Staff	827	23.5%	1032	26.4%	1937	32.2%	1892	29.7%	-2.5%	⇩
Other	386	11.0%	553	14.2%	546	9.1%	879	13.8%	4.7%	⇧
Police	132	3.8%	158	4.0%	225	3.7%	301	4.7%	1.0%	⇧
Family member	202	5.7%	135	3.5%	109	1.8%	131	2.1%	0.2%	⇧
Care Quality Commission	132	3.8%	125	3.2%	162	2.7%	119	1.9%	-0.8%	⇩
Self-Referral	122	3.5%	105	2.7%	18	0.3%	17	0.3%	0.0%	⇩
Housing	60	1.7%	66	1.7%	189	3.1%	162	2.5%	-0.6%	⇩
Friend/Neighbour	25	0.7%	23	0.6%	17	0.3%	20	0.3%	0.0%	⇧
Education/Training/ Workplace	22	0.6%	6	0.2%	23	0.4%	11	0.2%	-0.2%	⇩
Other Service User	7	0.2%	5 or less	<1%	5 or less	<1%	5 or less	<1%	-0.1%	⇩
Unknown	0	0.0%	5 or less	<1%	139	2.3%	163	2.6%	0.2%	⇧
Total	**3517**	**100%**	**3906**	**100%**	**6023**	**100%**	**6375**	**100%**	-	⇔

Table 7.9 Source of safeguarding concern leading to enquiry - for the periods 2014-15 to 2017-18

NB: The 2015-16 information does not include Medway data as this data was not collated.
Prior to review of Medway Council's computer system in Spring 2016, the data relating to referral source was manually input into the computer system and was difficult to report on. Following review of the safeguarding adults computer system, this data can now be collected and Medway will run a report and analyse this data on a quarterly basis to determine areas where referral numbers are high, low or non-existent. This will focus local awareness raising activity.

Closed Referrals

Outcome of Closed Enquiries

The greatest proportion of case outcomes for Kent County Council relate to substantiated cases (33.7%), with 2,341 cases wholly substantiated. The biggest increase relates to the 'not determined/inconclusive/other interventions' outcome, reflecting a 6.3% increase. The number of 'not substantiated' cases has fallen by 6.7% to 25.2% (1,751).

In Medway, the highest proportions of cases are 'not substantiated' at 30.6% (124 cases), down 1.5% from 2016-17. Cases that are substantiated represent a slightly lower proportion in Medway when compared with Kent, with 121 Medway cases (29.9%) falling into this category. 12.8% of cases (52) are 'partly substantiated', a drop of 3.2% from 2015-16.

Area	Substantiated No.	Substantiated %	Partly Substantiated No.	Partly Substantiated %	Not Substantiated No.	Not Substantiated %	Not determined/ inconclusive/ Other Interventions No.	Not determined/ inconclusive/ Other Interventions %	Investigation ceased at request of individual No.	Investigation ceased at request of individual %
Kent	2341	33.7%	319	4.6%	1,751	25.2%	2,182	31.4%	346	5.0%
Last Year:	*1,692*	*33.2%*	*270*	*5.3%*	*1,628*	*31.9%*	*1,283*	*25.1%*	*230*	*4.5%*
Medway	121	29.9%	52	12.8%	124	30.6%	65	16.0%	43	10.6%
Last Year:	*92*	*29.5%*	*50*	*16.0%*	*100*	*32.1%*	*49*	*15.7%*	*21*	*6.7%*
Total	**2462**	**33.5%**	**371**	**5.1%**	**1,875**	**25.5%**	**2,247**	**30.6%**	**389**	**5.3%**
Last Year:	*1,784*	*32.9%*	*320*	*5.9%*	*2,316*	*42.8%*	*744*	*13.7%*	*251*	*4.6%*

Table 7.10: Outcome of closed enquiries in Kent and Medway 2016-17 and 2017-18

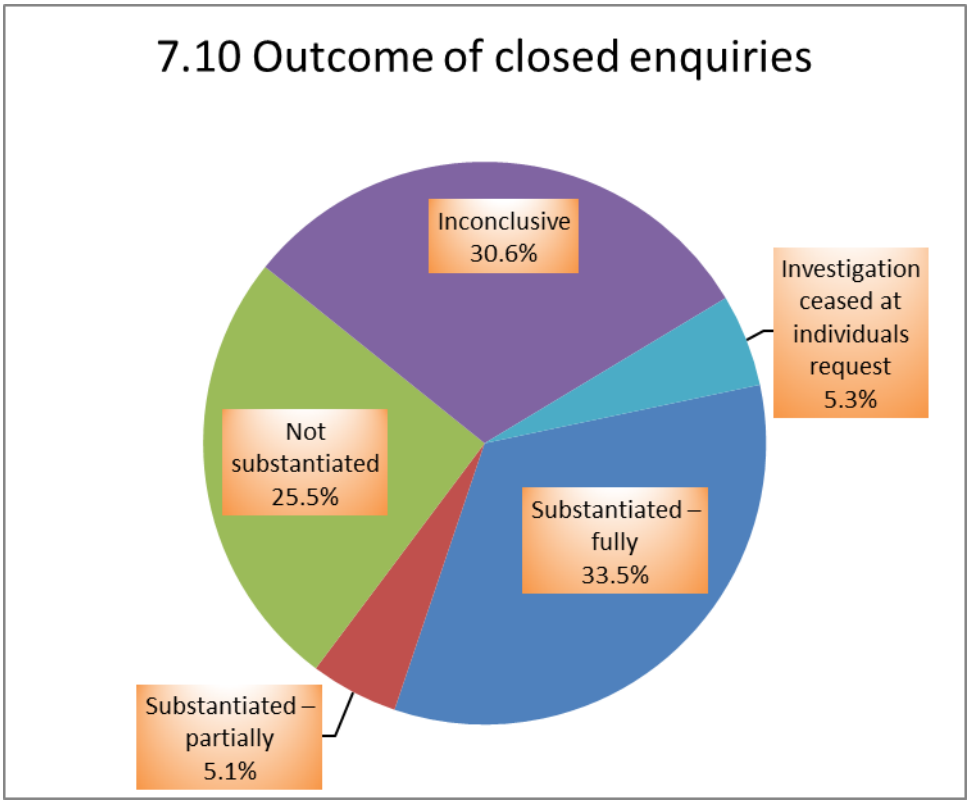


Fig 7.10: Outcome of closed enquiries in Kent and Medway 2017-18

The proportion of cases falling into the Not Substantiated, Not Determined/Inconclusive and Ceased categories is 61.4% in 2017-18, down very slightly from 61.1% in 2016-17.

Risk Outcomes for Closed Enquiries

This section looks at where a risk was identified and what happened to the risk following action being taken. Action can include anything that has been done as a result of the Safeguarding Concern or Enquiry. It can include examples such as disciplinary action for the source of risk or increased monitoring of the individual at risk.

Area	Risk Remained		Risk Reduced		Risk Removed	
	No.	%	No.	%	No.	%
Kent	160	4.3%	2,970	80.6%	557	15.1%
Last Year:	*101*	*3.9%*	*2096*	*80.3%*	*413*	*15.8%*
Medway	13	7.5%	76	43.9%	84	48.6%
Last Year:	*19*	*13.4%*	*80*	*56.3%*	*43*	*30.3%*
Total	**173**	**4.5%**	**3,046**	**78.9%**	**641**	**16.6%**
Last Year:	*120*	*4.4%*	*2176*	*79.1%*	*456*	*16.6%*

Table 7.11: Risk Outcomes for closed safeguarding enquiries 2017-18
Note: Only presents information for cases where a risk was identified

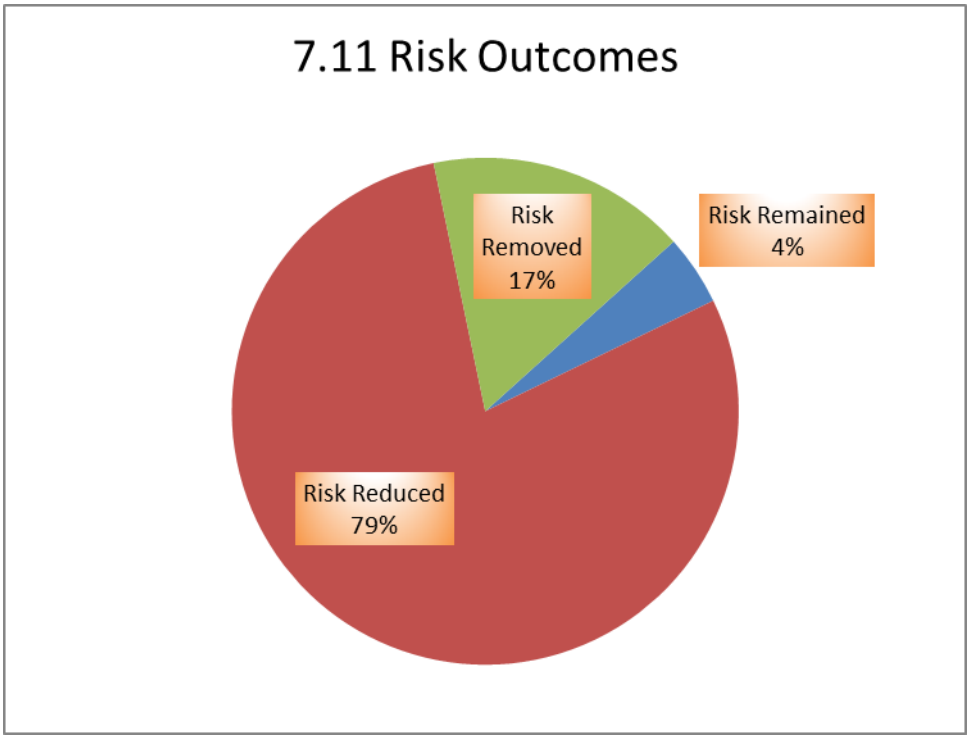


Fig 7.11: Risk Outcomes for closed safeguarding enquiries 2016-17

In Kent, there were 4.3% of cases where the circumstances causing the risk were unchanged and the same degree of risk remained – this is up from 3.9% last year. In Medway this risk outcome represents 7.5% of cases, down significantly from 13.4% in 2016-17. It should be acknowledged that there are valid reasons that a risk could remain, for example in the case of an individual wanting to maintain contact with a family member who was the source of the risk (in such an example action could still be taken to refer the individual at risk for counselling).

Table 7.11 demonstrates that in both Kent and Medway the greatest proportions relate to risk being reduced or removed; in 95.7% of cases where a risk was identified in Kent, the risk was either reduced or removed with the majority of cases falling into the *Reduced* category. In Medway a similar picture is presented, as in 92.5% of cases, where risk was identified and it was reduced or removed.

Glossary

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

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

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

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

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

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

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

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

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

Policy A policy sets out the organisations position (i.e. its shared beliefs, organisational intentions and commitments) and is a set of ideas or plan of what we should, or would do, in a particular situation. It sets out a course of action intended to influence and determine decisions, actions and other matters.

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

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

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

Protocol An official procedure or system of governing rules between organisations.

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

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

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

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

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

SAR The criteria for a Safeguarding Adults Review is detailed on page 17. Safeguarding Adults Reviews look at any lessons to be learnt about the way all local professionals and agencies worked together.

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

SCR Kent Children's Serious Case Review takes place when a child has died or sustained serious abuse and investigates the involvement of organisations and professionals to determine any lessons to be learnt.

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

If you think you or another person is at risk of harm or abuse, please contact:

KENT
Tel: 03000 41 61 61
NGT: 18001 03000 416161
Kent.gov.uk/adultprotection

MEDWAY
Tel: 01634 334466
NGT: 18001 01634 334 466
Medway.gov.uk/abuse

If someone is in immediate risk contact the emergency services on 999