ADULT SOCIAL CARE CABINET COMMITTEE

Wednesday, 18th January, 2023

2.00 pm

Council Chamber, Sessions House, County Hall, Maidstone

For Item 6 on the agenda, Members are advised to refer to the Budget Book published and shared on 3 January 2023.

AGENDA

ADULT SOCIAL CARE CABINET COMMITTEE

Wednesday, 18 January 2023 at 2.00 pm
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Hayley Savage**
Telephone: **03000 414286**

Membership (16)

Conservative (12):	Mr A M Ridgers (Chairman), Mr S Webb (Vice-Chairman), Mrs P T Cole, Mr N J Collor, Ms S Hamilton, Mr J Meade, Mr D Ross, Mr T L Shonk, Mr R J Thomas, Ms L Wright and Vacancy x 2
Labour (2):	Ms K Grehan and Ms J Meade
Liberal Democrat (1):	Mr R G Streatfeild, MBE
Green and Independent (1):	Mr S R Campkin

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

1 Introduction/Webcasting Announcement

2 Apologies and Substitutes

3 Declarations of Interest by Members in items on the agenda

4 Minutes of the meeting held on 17 November 2022 (Pages 1 - 8)

5 Verbal Updates by Cabinet Member and Corporate Director

6 Draft Ten Year Capital Programme, Revenue Budget 2023-24 and Medium Term Financial Plan 2023-26 (Pages 9 - 10)

7 Kent and Medway Safeguarding Adults Board Annual Report April 2021 - March 2022 (Pages 11 - 86)

8 Work Programme 2023 (Pages 87 - 90)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Benjamin Watts
General Counsel
03000 416814

Tuesday, 10 January 2023

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

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KENT COUNTY COUNCIL

ADULT SOCIAL CARE CABINET COMMITTEE

MINUTES of a meeting of the Adult Social Care Cabinet Committee held at Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 17th November, 2022.

PRESENT: Mr A M Ridgers (Chairman), Mr S Webb (Vice-Chairman), Mr S R Campkin, Mrs P T Cole, Mr N J Collor, Ms K Grehan, Ms S Hamilton, Ms J Meade, Mr J Meade, Mr D Ross, Mr T L Shonk, Mr R G Streatfeild, MBE, Mr R J Thomas and Ms L Wright

ALSO PRESENT: Mrs C Bell

IN ATTENDANCE: Richard Smith (Corporate Director of Adult Social Care and Health), Simon Mitchell (Senior Commissioning Manager), Helen Gillivan (Head of Business Delivery Unit), Jim Beale (Director of Adult Social Care for East Kent), Hayley Savage (Democratic Services Officer) and Dominic Westhoff (Democratic Services Officer)

UNRESTRICTED ITEMS

97. Apologies and Substitutes
(Item. 2)

There were no apologies or substitutes.

98. Declarations of Interest by Members in items on the agenda
(Item. 3)

Mr Shonk declared an interest in that a family member worked for the NHS.

Ms Meade declared an interest under Item 9, *Deprivation of Liberty Safeguards and Liberty Protection Safeguards*, in that she was a carer, and a family member had a Deprivation of Liberty Safeguard (DoLS).

99. Minutes of the meeting held on 28 September 2022
(Item. 4)

RESOLVED that the minutes of the meeting held on 28 September 2022 are correctly recorded and a paper copy be signed by the Chairman.

100. Verbal Updates by Cabinet Member and Corporate Director
(Item. 5)

1. The Cabinet Member for Adult Social Care and Public Health, Mrs Clair Bell, gave a verbal update on the following:

   (a) The Council's 2023/24 budget for adult social care and public health was being discussed to identify where savings and changes could be made whilst providing necessary services to vulnerable residents.

   (b) World Mental Health Day took place on 10 October 2022 with the theme 'making mental health and wellbeing for all a global priority'. Live Well Kent

and Medway provided mental health and wellbeing support services and was delivered on behalf of the Council and the NHS by two charities - Porchlight and Shaw Trust. Mrs Bell said these charities had seen an increase in demand for help due to the cost-of-living crisis.

(c) Mrs Bell said 'Release the Pressure' was a support helpline for people who needed immediate help and people could text the word 'Kent' or 'Medway' to 85258 to speak to a trained and experienced volunteer. An empty shop window in Fremlin Walk, Maidstone had been used to advertise the 'Release the Pressure' service until January 2023.

(d) On 11 October 2022 Mrs Bell hosted an online webinar in partnership with Cantium and Cognitive Publishing, to tackle digital inclusion. The webinar had over 200 virtual attendees and showcased Kent and Medway's Public Health Digital Inclusion Project and the Council's Empower Care Digital Inclusion Project.

(e) Mrs Bell was hosting a meeting at the end of November 2022, with the support of the LGA, with adult social care colleagues from local authorities across the Southeast region. The meeting would discuss common issues and challenges and share best practice.

2. The Corporate Director of Adult Social Care and Health, Mr Richard Smith, then gave a verbal update on the following:

(a) Mr Smith said a main focus recently was on the Council's financial situation and the local and national pressures on adult social care.

(b) Mr Smith said the Adult Social Care Cabinet Committee away day on 11 November was a positive and helpful day. Mr Smith provided a brief overview of the day which included stories from people with experience of adult social care services and the challenges they faced, an overview from the Monitoring Officer on the role of the Director of Adult Social Care and Health and the Adult Social Care Cabinet Committee, and a high-level look at the budget for Adult Social Care.

(c) Mr Smith attended the National Children and Adult Services Conference 2022 and said themes included the enormous pressure on adult social care, the challenges in the marketplace and how providers were supported, integrated care boards, the impact of social care reform, Care Quality Commission (CQC) assurance, and co-production.

3. Mr Streatfeild said the Adult Social Care Cabinet Committee Away Day had been useful and productive, and the Chair thanked all those involved in facilitating and delivering the event.

4. Asked how the Council's financial situation compared to other local authorities, Mr Smith said surveys were being carried out by the Association of Directors for Adult Social Services and the autumn survey showed the scale of the challenges that local authorities were facing, for example, assessment waiting times and time taken to put care packages in place.

RESOLVED that the verbal updates be noted.

101. 22/00096 - Technology Enabled Care Service
(Item. 6)

Ms Georgina Walton, Senior Project Manager, Innovation Delivery Team, Adult Social Care was in attendance for this item.

1. The Chair thanked Ms Walton, Ms Lisa O'Donnell, and Mr Matt Crocker (Technology Facilitators) for demonstrating to Members, prior to the cabinet committee meeting, a range of care technologies that were being used to support people.

2. Ms Walton introduced the report and provided an overview of the countywide Technology Enabled Care Service which would be in place from September 2023. She said the service would be outcome focused and contribute to long term sustainability of social care through transforming the way care and support was delivered. The service would bring together existing contracts already in place including Telecare and Kara.

3. Ms Walton responded to comments and questions from the cabinet committee, including the following:

   (a) Asked whether there was an estimate of how many people would use the service over the 7-year lifetime of the contract, Ms Walton said based on learning from other local authorities who had successfully implemented technology enabled care services and detailed profiling, potentially 35% to 50% of people would utilise the technology, with 50% by the end of the 7 years.

   (b) Asked about the cost for individuals buying the technology privately, Ms Walton said part of the specification for the contract included the option for private pay for people not eligible for social care and this may be at a reduced rate.

   (c) Asked about engagement with partners and the management and implications of data protection, including protection against fraud, Ms Walton said legal advice had been sought and a completed Data Protection Impact Assessment (DPIA) would be updated once the contract had been awarded to reflect the provider's processes and management of data. In terms of security for individuals, the Empower Care Project digital ambassadors had held sessions to train and support people to use the internet safely.

   (d) Asked about the cost avoidance opportunity figure of approximately £35million, Ms Walton said this figure had been based on learning gained from other local authorities' technology enabled care programmes. The figure had been calculated based on a reduction of 2 hours per week of care and support in the community and there were also opportunities around residential avoidance and learning and disability. Potential providers, during the procurement process, would be asked to calculate a cost avoidance figure.

   (e) Asked about demography money being used for this service, Ms Gillivan clarified that demography money was being used for alternative models of

care which including this contract. Mr Smith said ways of integrating Better Care Funding (BCF) was also being explored.

(f) Asked how quickly equipment could be allocated to someone in urgent need, Ms Walton said equipment was usually implemented within a week of a need being identified, however this depended on the complexity of need. A quick response was important when a hospital discharge was required.

(g) A Member commented on the potential for less face-to-face contact and the negative effect this could have on individuals, Ms Walton said the service complemented 'in person' care and support and the technology had the potential to overcome some financial challenges.

(h) Asked whether consultation had taken place with social workers, Ms Walton said the workforce had been part of the co-production of the service, and members of the workforce were part of the procurement process.

(i) Asked whether a single helpline would be accessible for a range of technologies, Ms Walton said one service provider would be a single contact point and that had been built into the specification for the contract.

(j) Asked what the average payment for a person taking up a service would be, Ms Walton said it was currently a non-chargeable service and financial modelling had been carried out to look at the benefits.

(k) Asked how many providers would be interested in bidding for the contract, Ms Walton said twenty providers attended market engagement events to understand the vision and plan for the service. One to one sessions were also delivered with eight providers to explore key questions which helped further develop the specification.

(l) Asked about the work involved in promoting and raising awareness of the service with Kent residents, Ms Walton said the technology facilitators had carried out demonstrations in communities and worked closely with Digital Kent to support digital inclusion, and the culture change in raising the profile of technology had been built into the specification.

(m) Asked whether the reduction in face-to-face care and support would lead to job cuts, Ms Walton said the 2-hour reduction was used to determine the cost avoidance and the contract would complement the support of care workers. The use of care technology would help deliver care and support in a sustainable way and alleviate some of the significant pressures in the social care workforce where there were issues with recruitment and retention.

(n) Asked about disparities in the availability of adequate Broadband coverage and the reliance of devices on Wi-Fi, Ms Walton said the Digital Kent programme was driving the issue of digital infrastructure, and officers were working closely with it to identify people who needed support in this area.

RESOLVED to endorse the decision to be taken by the Cabinet Member for Adult Social Care and Public Health to:

a) Procure a Countywide Technology Enabled Care Service; and
b) Delegate authority to the Corporate Director Adult Social Care and Health to take relevant actions, as required, to facilitate procurement activity.

102. Adult Social Care and Health Annual Complaints Report 2021/22
(Item. 7)

Ms Debra Davidson, Customer Care and Complaints Manager for Adult Social Care and Ms Pascale Blackburn-Clarke, Customer Experience and Relationship Manager, were in attendance for this item.

1. Ms Davidson introduced the report and provided an overview of the operation of the Adult Social Care and Health Complaints and Representations' Procedure between 1 April 2021 and 31 March 2022.

2. Officers responded to comments and questions from the cabinet committee, including the following:

   (a) Asked how complaints were fed back to directorates for improvements to be made, Mr Beale said they were fed through a continual learning and development cycle where lessons learnt were identified. Mr Beale said he met regularly with the complaints team and conversations were had with Assistant Directors to ensure that learning was being fed across teams.

   (b) Asked about the difference in number of Mosaic service users between the reports of 2021/22 and 2020/21, Ms Groombridge said the figure from the 2020/21 report was a snapshot in time on a particular day of people accessing services, rather than the number of people who received a service throughout the year.

RESOLVED that the report be noted.

103. Adult Social Care and Health Performance Q2 2022/23
(Item. 8)

Ms Helen Groombridge, Adult Social Care and Health Performance Manager, was in attendance for this item.

Ms Groombridge introduced the report and highlighted the key areas of activity and performance during quarter 2 for 2022/23.

RESOLVED that the performance of services in Q2 2022/23 be noted.

104. Deprivation of Liberty Safeguards and Liberty Protection Safeguards
(Item. 9)

Ms Maureen Stirrup, Head of Service, Deprivation of Liberty Safeguards and Ms Akua Agyepong, Assistant Director Adult Social Care and Health were in attendance for this item.

1. Ms Stirrup introduced the report and provided an overview of Deprivation of Liberty Safeguards applications received over the last 16 months and how

demand was being managed and prioritised. Ms Stirrup said feedback from the public consultation on the Liberty Protection Safeguards (LPS) Code of Practice was still awaited and it was important that the Council was prepared for the new legislation 'Go Live' date.

2. Ms Agyepong and Ms Stirrup responded to comments and questions from the cabinet committee, including the following:

   (a) Asked whether there was an approximate date when the new legislation would come into force, Ms Stirrup said central government had advised that further information would be made available in the winter of 2022.

   (b) Asked about the risk register and whether there was a thresholds projection considering the increase in cases, Ms Stirrup said that DoLS were itemised on the risk register both corporately and operationally and reviewed on a quarterly basis. Ms Agyepong said, since the Cheshire West judgment in 2014 applications had continually increased, but Ms Agyepong reassured Members that rises in applications were being monitored closely and risks were actively managed. Mrs Bell noted that, prior to the covid-19 pandemic, there had been a significant backlog, and better processes were now in place to manage the demand of increasing applications.

   (c) Ms Stirrup confirmed the White Paper would be shared with Members.

   (d) Asked whether the White Paper suggested that two medically qualified people were no longer needed for assessments and whether a previous diagnosis could be used, Ms Stirrup said the new LPS Code of Practice was proposing that a diagnosis would already be on a medical record and the Council had responded to that as part of the consultation.

   (e) Asked, when guidelines for the new legislation were issued, whether the Council could choose to deliver services above those guidelines, Ms Stirrup said the LPS Code of Practice provided the detail for the legislation and that would be used to define how the Council provided a compliant service.

   (f) Asked whether the Liberty Protection Safeguards would ease the pressure on the Council as health partners would also be dealing with applications, Ms Stirrup said it was important that the Council invested in and supported health partners.

   (g) Asked about the focus of the Council's response to the LPS Code of Practice public consultation, Ms Stirrup said subject matter experts were gathered to look at the questions within the consultation and a copy of that response would be shared with Members.

RESOLVED that the report be noted.

105. Adult Social Care Pressures Plan 2022/23
(Item. 10)

Ms Sydney Hill, Assistant Director North Kent, was in attendance for this item.

1. Ms Hill introduced the report and said the Adult Social Care Pressures Plan was a live document which included the pressures and risks to the directorate, mitigating actions being taken and lessons learnt for future planning. Ms Hill gave an overview of the pressures included in the plan.

2. Ms Hill responded to comments and questions from the cabinet committee, including the following:

   (a) Asked about the forecast of £20million in the current year on short term beds, Mr Beale said a different approach would be explored where health colleagues provided intermediate care so that short term beds were not utilised as much as they had been. Mr Smith said the spend on short-term beds had plateaued since the pandemic and joint arrangements across Kent were in place as part of the Integrated Care Strategy.

   (b) Asked whether there was data per hospital or district that could inform Members of the pressures in their own division, Mr Smith said figures were constantly changing and explained the escalation levels in the NHS were opel 3 and 4 which represented significant escalation routes.

   (c) Asked about the concept of social prescribing and whether that had the potential to relieve financial burden, Mr Mitchell said work was taking place with navigation providers, link workers and social prescribers to ensure that community gateway was a way forward through some of the statutory adult social care and health services. Mrs Bell noted that although the value of social prescribing and navigation services was understood it was important to consider the current difficult financial situation and the pressure to deliver statutory services.

RESOLVED that the report be noted.

106. Work Programme 2022/23
(Item. 11)

RESOLVED to note the Work Programme 2022/23.

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From:	Peter Oakford, Deputy Leader and Cabinet Member for Finance, Corporate & Traded Services
To:	Adult Social Care Cabinet Committee – 18 January 2023
Subject:	Draft Ten Year Capital Programme, Revenue Budget 2023-24 and medium term financial plan 2023-26
Classification:	Unrestricted

Summary:
The administration's budget report published on 3rd January 2023 sets out the background to and draft budget proposals for the capital programme, revenue budget for the forthcoming year and medium-term financial plan. The report is a standard report for the whole council focussing on the key strategic considerations underpinning the decisions necessary for County Council to agree the budget at the Budget Meeting on 9th February 2023.

The administration's overall budget strategy is intended to:
Achieve a balanced one-year budget and balanced medium-term plan with minimal unidentified savings targets
Maintain adequate reserves to mitigate financial risks/shocks and to invest in the future
Maintain a strong positive cashflow and high levels of liquidity
Maintain (but not exceeding) levels of borrowing compared to the asset base (maintaining a healthy balance sheet)
Plan to deliver a financially sustainable Council over the medium term.

In summary, the proposed draft 2023-24 revenue budget requires £39.1m savings, £15.7m additional income from fees and charges and net £14.8m from one-off use of reserves (additional contributions & draw downs, and removal of previous contributions and draw downs). The budget proposes a 5% increase in Council Tax which will generate £41.7m income to support service delivery,

The proposed draft capital programme 2023-33 includes spending of £1,644m of which £996m is funded from confirmed/indicative grants, £407m from borrowing and £261m other sources. The administration's strategy for the capital programme is to minimise the level of additional borrowing, for 2023-24 the changes to the programme represents a £9.6m reduction.

Recommendations
The Committee is asked to:
a) **Comment** on the draft capital and revenue budgets including responses to consultation
b) **Propose** any changes to the draft capital and revenue budgets for consideration by Cabinet on 26th January 2023 before the draft is presented for approval at County Council on 9th February 2023

Budget Reports

The full draft budget report and appendices may be accessed on Kent.gov.uk:
Our budget - Kent County Council

Contact details

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From:	Clair Bell, Cabinet Member for Adult Social Care and Public Health Richard Smith, Corporate Director Adult Social Care and Health
To:	Adult Social Care Cabinet Committee – 18 January 2023
Subject:	Kent and Medway Safeguarding Adults Board Annual Report April 2021 – March 2022
Classification:	Unrestricted
Past Pathway of report:	None
Future Pathway of report:	Kent Health and Wellbeing Board – April 2023
Electoral Division:	All

Summary: This report introduces the Kent and Medway Safeguarding Adults Board's Annual Report for April 2021–March 2022. The Annual Report sets out the responsibilities and structure of the Board and details how the multi-agency partnership delivered against its priorities for the year. The report also provides information pertaining to Safeguarding Adults Reviews and safeguarding activity information.

Recommendation(s): The Adult Social Care Cabinet Committee is asked to **NOTE** the Kent and Medway Safeguarding Adults Board Annual Report, 2021 – 2022, attached as appendix A.

1. Introduction

1.1 The Care Act 2014 made it a requirement for each Local Authority to establish a Safeguarding Adults Board (SAB). Kent County Council's duty is met through a joint Board with Medway Council; the Kent and Medway Safeguarding Adults Board (KMSAB).

1.2 The KMSAB does not provide frontline services, it has a strategic role which is "greater than the sum of the operational duties of the core partners"[1]. The KMSAB sets the strategic direction for adult safeguarding in Kent and Medway and seeks assurance and provides challenge to ensure that adult safeguarding arrangements in Kent and Medway are in place, are effective and are person centred and outcome focused. The KMSAB membership works collaboratively to raise awareness of adult safeguarding and prevent abuse and neglect.

[1] Care and Support Statutory Guidance. Care and Support Statutory Guidance (14.134)

1.3 Under the Care Act 2014, the KMSAB has three core duties, it must:

- Publish a strategic plan to set out how it will meet its main objectives and what members will do to achieve this. The newly developed 2022-2025 strategic plan is available on the link below: https://kmsab.org.uk/p/about-kmsab-1/annual-report-and-strategic-plan

- Publish an Annual Report to detail what the Board has done during the year to achieve its main objectives and implement its Strategic Plan, and what each member has done to implement the strategy, as well as detailing the findings of any Safeguarding Adults Reviews and subsequent actions.

- Conduct any Safeguarding Adults Review in accordance with Section 44 of the Care Act.

1.4 The Care Act 2014 states that, once the Annual Report is published, it must be submitted to:

- the Chief Executive (where one is in situ) and Leader of the Council;
- the local Police and Crime Commissioner and Chief Constable;
- the local Healthwatch; and
- the Chair of the Health and Wellbeing Board.

1.5 The supporting statutory guidance states that "it is expected that those organisations will fully consider the contents of the report and how they can improve their contributions to both safeguarding throughout their own organisation and to the joint work of the Board". As such, this report presents the 2021 - 2022 Annual Report to the Adult Social Care Cabinet Committee.

2. KMSAB Annual Report 2021 – 2022

2.1 The Annual Report details how the Board delivered against its strategic priorities of 'prevention', 'awareness' and 'quality' during 2021 – 2022. Some of the key achievements during the reporting period include:

- The Board commissioned a translation of its 'Adult abuse and what to do about it' leaflet into Ukrainian. This was completed and made available on the KMSAB website in April 2022. In addition, hard copies of the leaflet were printed so that these could be shared with Ukrainian families.

- The Board continued to deliver it's multiagency training programme. Between April 2021 – March 2022, 59 workshops were held, with 683 delegates participating. The training was closely aligned to the Board's priorities and learning from Safeguarding Adult Reviews (SAR). Feedback from delegates presented a positive picture in relation to the quality of training, increase in knowledge and how learning is embedded into practice.

- As a result of feedback received from attendees and the training provider, the half-day workshop on self-neglect and hoarding was extended to a full day session, from September 2021. The expansion allowed the learning objectives to be covered in more depth, reflecting the complexities of the topic and the learning from SARs. Additional self-neglect and hoarding workshops were commissioned to meet demand.

- Quality assurance activity identified a need to produce guidance for professionals to help them prevent adults from going missing from health and care settings, and to ensure people who go missing are found safely and are supported on their return. To address this, members of the Practice Policies and Procedures Working Group developed a protocol document "multi-agency response for adults missing from health and care settings".

- Kent and Medway Safeguarding Adults Board member's chose to align with the national Safeguarding Adults Awareness week, established by the Ann Craft Trust. The purpose of the week was to share messages with the pubic on how to recognise and report abuse and neglect, and to highlight the support and services available for those at risk or experiencing abuse. The national campaign reached over 79.4 million people through Twitter hashtags, with 59.5 thousand interactions and 47.4 thousand shares. By comparison, in 2020 the reach was 12.5 million and in 2019, 5.5 million. Locally, there were 3890 visits to the KMSAB webpages during the week, with 779 clicks to the 'report abuse page' and 510 visits to the 'useful resources for the public' page. Public facing events included attendance at coffee mornings and information stands at supermarkets and shopping centres.

- Public engagement activity continued throughout the year, for example, members of the KMSAB Business Unit hosted a stand at the Kent Police Open Day, where 14,000 members of the public were in attendance. The aim was to speak to members of the public, share safeguarding resources and raise awareness of how to recognise and respond to adult safeguarding concerns. Approximately 700 people visited the stand and engaged with the facilitators. When compared to the previous week's figures, there was a 35% (344 views to 465) increase in visits to KMSAB webpages in the week following the event.

- The Board Business Unit launched quarterly 'KMSAB open forum sessions', providing an opportunity for anyone with an interest in adult safeguarding to hear from people with a lived experience of safeguarding, and other subject matter experts. The following sessions were held in 2021-2022:
    - Safeguarding Adults Awareness – two sessions aimed at the charity and voluntary sector.
    - Sharing learning from Safeguarding Adults Reviews.
    - The Mental Capacity Act 2005.

- One of the themes identified in safeguarding adults reviews was the need to promote a person centred approach, making safeguarding personal. A dedicated page on the KMSAB website was developed to share the substantial amount of high-quality resources which had been produced by other leads, such as the Association of Directors of Adult Social Services, the Social Care Institute for Excellence, and the Local Government Association.

- During 2021-2022, members of the Quality Assurance Working Group (QAWG) continued to implement the quality assurance framework, which sets out the methods and tools used to measure effectiveness of partners' safeguarding activity. One of the quality assurance tools is the 'Self-Assessment Framework' (SAF). All agencies represented on the Board are asked to complete an annual SAF, a series of questions to measure progress against key quality standards. The purpose is to enable them to evaluate the effectiveness of their internal safeguarding arrangements and identify and prioritise areas needing further development. The standards are informed by national good practice, learning from SARs, any new legislation and guidance, policy and practice and feedback from service users and carers. In 2021 the number of agencies required to complete the SAF was increased, to include the 12 district/borough councils in Kent. North-East London NHS Foundation Trust and G4S (patient transfer services) were also asked to complete a return, as they were each involved in a SAR, commissioned by the Board.

2.2 Twelve SARs have been published since the last annual report. Further details of the reviews, learning from these, and actions taken by the Board, are set out in section three of the annual report. In summary, recommendations relate to:

- Identifying and responding to self-neglect and hoarding.
- Raising awareness of KMSAB policies and procedures.
- Working with individuals who are dependent on alcohol or substances.
- Suicide prevention.
- Legal literacy – in particular the application of the Mental Capacity Act and Mental Capacity Assessments for individuals who may have fluctuating capacity.
- Professional curiosity - the capacity and communication skill to explore and understand what is happening rather than making assumptions or accepting things at face value.
- Making Safeguarding Personal - 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.
- Agency collaboration/multiagency working - how agencies work together to support adults at risk with complex needs.
- Ensuring that organisations recognise the rights of carers to a carers assessment.
- Safe discharge from hospitals.

3. Conclusions

3.1 During 2021-2022, KMSAB and our partner agencies have built on the good work from the previous year. The Board has continued with its scrutiny and challenge role and continues to share vital messaging on how to recognise and respond to adult safeguarding concerns.

4. Recommendation

4.1 Recommendation: The Adult Social Care Cabinet Committee is asked to **NOTE** the Kent and Medway Safeguarding Adults Board Annual Report, 2021 – 2022, attached as appendix A.

5. Background Documents

None

6. Report Author

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Kent and Medway Safeguarding Adults Board

Annual Report

April 2021 – March 2022

Table of Contents

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

About us

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

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

Our three core duties

The Care Act 2014 requires that the Board:

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

Our responsibilities

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

- Assuring safeguarding practice continuously improves, to bring about better outcomes for those experiencing, or at risk of, abuse, ensuring that we make safeguarding person centred and outcome focused.
- Promoting multi-agency training.
- Holding partners to account to gain assurance that effective safeguarding arrangement are in place.
- Producing multi-agency policies and procedures and monitoring their impact.
- Working collaboratively, and with effective governance, to promote wellbeing and prevent abuse and neglect.
- Identifying the role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of adults.
- Establishing ways to analyse and interrogate data on safeguarding notifications to increase our understanding of prevalence of abuse and neglect.
- Identifying circumstances that give grounds for concern and deciding when they should be considered as an enquiry to the local authority.

- Developing strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect.

Our 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.

Our 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.

Board membership

Independent Chair:	Andrew Rabey
Statutory Partners:	Kent County Council Medway Council Kent and Medway Integrated Care System[1] Kent Police
Other partner agencies:	Advocacy People Dartford and Gravesham NHS Trust 12 District and Borough Councils across Kent East Kent Hospitals University NHS Foundation Trust HM Prison Service Kent and Medway NHS and Social Care Partnership Trust Kent and Medway Healthwatch Kent Community Health NHS Foundation Trust Kent Fire & Rescue Service Kent Integrated Care Alliance Maidstone and Tunbridge Wells NHS Trust Medway Community Healthcare Medway NHS Foundation Trust Probation Service NHS England Rapport Housing and Care South East Coast Ambulance NHS Foundation Trust HCRG Care Group (formerly Virgin Health Care)

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

[1] During the reporting period ICS arrangements were not in place, so this document refers to the previous, Clinical Commissioning Group (CCG), arrangements.

Board structure

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

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

Kent and Medway Safeguarding Adults Board – **Working Groups (WG)**	
Communications and Engagement (CEWG)	Develops and updates the Board's communication strategy, for partner organisations to implement. The purpose is to raise awareness of the work of the Board, and wider adult safeguarding issues, both within organisations and with the residents of Kent and Medway, to incite change, improve practice and prevent abuse.
Learning and Development (LDWG)	Co-ordinates the commissioning, delivery and evaluation of the Board's multi-agency safeguarding adults training programme.
Practice, Policy and Procedures (PPPWG)	Develops, reviews, and updates the Board's policies and procedures, in line with changes in legislation, guidance and good practice identified through safeguarding adult reviews, research, audit, practice, performance monitoring and user experience.
Quality Assurance (QAWG)	Designs and co-ordinates quality assurance activity to evaluate the effectiveness of the work of all KMSAB's partner agencies, to safeguard and promote the welfare of adults at risk of abuse or neglect.
Joint Exploitation (JEG)	This is a joint group with Kent's and Medway's Safeguarding Children Multi-Agency Partnerships. It oversees activity around; sexual exploitation, gangs/county lines, human trafficking/modern slavery, online safeguarding and radicalisation/extremism, to understand current trends and to protect and safeguarding the welfare of children and adults at risk.
Safeguarding Adults Review (SARWG)	Delivers our statutory responsibility to conduct Safeguarding Adults Reviews and holds agencies to account for improvement in practice.

The terms of reference and membership for each group are reviewed annually, and can be found on the KMSAB Website.

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

Our Board is supported by the KMSAB Business Unit

Section 2. Priorities and Achievements

This section details how we delivered against our priorities for 2021 – 2022. It is recognised that activity can cut across more than one priority.

Prevention – "I want to feel safe in the community where I live". What we achieved:

Delivered our Training Offer	• The Board offers multi-agency training, predominantly for staff from the statutory sector. The modules focus on the following priority areas: **One day courses** • Adult safeguarding legal literacy • Domestic abuse workshop, including a focus on stalking and harassment, harmful practices, female genital mutilation (FGM) and honour-based crime **Half day courses** • Collaborative working in multi-agency Section 42 Enquiries • Self neglect and hoarding workshop • Exploitation - including cuckooing, modern slavery, 'mate' crime and county lines • Between April 2021 – March 2022, 59 workshops were held, with 683 delegates participating. • As a result of feedback received from attendees and the training provider, the half-day workshop on self-neglect and hoarding was extended to a full day session, from September 2021. The expansion allowed the learning objectives to be covered in more depth, reflecting the complexities of the topic and the learning from Safeguarding Adults Reviews (SARs). • Additional self-neglect and hoarding workshops were commissioned to meet demand.
Tendering for new training provider	• Learning and Development Working Group Members led a tender process for a training provider to deliver the multi-agency training offer from April 2022. • In preparation for the tender, existing modules and course content were reviewed, and additional learning points included, linked to the findings from SARs and from other intelligence. It was also agreed that all five workshops would be extended to full days. • Multi-agency learning events for SARs were added to the contract to support the dissemination of key learning. • Following a successful tender process, a new supplier was appointed. The contract mobilisation process included meetings between the new provider and multi-agency staff.
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. Feedback from delegates, detailing how the training has impacted on their practice, is available on this link KMSAB Training impact on practice

KMSAB Review	• The Care and Support Statutory Guidance states that Safeguarding Adults Boards must make arrangements for self-audit and peer review. In December 2020 members commissioned Siân Walker McAllister to undertake a review of the Board to identify strengths and areas for development, to fulfil this obligation. An action plan was developed to address the recommendations made in the review. During 2021-2022, Board members delivered the action plan. This included reviewing Board membership, evaluating priorities to inform the new strategic plan and establishing ways to hear from people with lived experience of safeguarding. The actions delivered are reflected in the achievements detailed in this report.
"What Safeguarding Means to me"	• The Communication and Engagement Working Group produced a video "what safeguarding means to me" to share messages on the relevance and importance of adult safeguarding • KMSAB: Adult safeguarding awareness week.mp4 on Vimeo
Kent and Medway Safeguarding Adults Board Policy and Procedures	• All Board members, and relevant partners, are required to work to the Board's main policy document "Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway" • The policy is supported by a number of additional policies, which are updated in accordance with a policy update schedule. • During 2021/22, Members completed their review of the Multi-Agency Protocol for Dealing with Cases of Domestic Abuse to Safeguard Adults with Care and Support Needs . The review panel included commissioned providers to ensure that the views of those with lived experience of domestic abuse were reflected in the update. • 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.
Multi-agency response for adults missing from health and care settings	• Quality assurance activity identified a need to produce guidance for professionals to help them prevent adults from going missing from health and care settings, and to ensure people who go missing are found safely and are supported on their return. • To address this, members of the Practice Policies and Procedures working group developed a protocol document "multi-agency response for adults missing from health and care settings.
Prevent Duty across Kent and Medway	• 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. In February 2022, a hybrid conference on tackling Hateful Extremism across Kent and Medway was held and over 250 in person or online delegates attended. Presentations included new threats such as those associated with Incel ideology, following the tragic events in Plymouth in August 2021. A further conference will be held in February 2023. All KMSAB partners have a Prevent duty as outlined in the Counter Terrorism and Security Act 2015.

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

What we achieved:

Response to Homes for Ukraine Scheme	• We commissioned a translation of our 'Adult abuse and what to do about it' leaflet into Ukrainian. This was completed and made available on the KMSAB website in April 2022. In addition, hard copies of the leaflet were printed so that these could be shared at events and with agencies who requested them. Activity to promote the leaflet included: ○ An email was sent to all KMSAB Executive and working group members to advise that the leaflet was available and encourage dissemination. ○ The Kent local councils shared the leaflet either in their welcome packs or on their 'Support for Ukrainian Nationals' webpage. ○ Sevenoaks Council distributed the leaflets, through their housing officers, to Ukrainian families who presented as homeless. ○ The Kent and Medway CCG shared it with members of the NHS England (South- East region) network and added it to their CCG training hub. ○ The KMSAB Board Manager shared the leaflet with the National Network of Safeguarding Adults Board Managers, with many Boards adapting it for their own use. ○ The Office of the Police and Crime Commissioner shared it through their bulletin. ○ Kent Community Safety partnership added it to their bulletin. ○ The KMSAB Business Development and Engagement Officer attended a 'Medway help for Ukrainians' community event. ○ KCC shared it with their 'Vulnerable People and Communities Ukrainian Cell'. • The Communication and Engagement working group developed a social media content plan to share messaging, in Ukrainian, on how to recognise and report abuse.
National Safeguarding Adults Awareness Week	• Kent and Medway Safeguarding Adults Board members supported National Safeguarding Adults' Awareness Week, established by the Ann Craft Trust. The purpose of the week was to share messages with the public on how to recognise and report abuse and neglect, and to highlight the support and services available for those at risk or experiencing abuse. • The safeguarding issues highlighted through the week were: ○ Emotional abuse and safeguarding mental health ○ The power of language

	○ Digital safeguarding ○ Adult grooming ○ Creating safer cultures ○ Safeguarding and you • The national campaign reached over 79.4 million people through Twitter hashtags, with 59.5 thousand interactions and 47.4 thousand shares. By comparison, in 2020 the reach was 12.5 million and in 2019 5.5 million. • Public facing events included attendance at coffee mornings, information stands at supermarkets and shopping centres. • KMSAB agencies also hosted events within their organisations, such as safeguarding open sessions. • Natwest Bank in Dartford contacted the Board to request merchandise and links to the media pack to share in their community areas. • There were 3890 visits to the KMSAB webpages during the week, with 779 clicks to the 'report abuse page' and 510 visits to the 'useful resources for the public' page.
Promotion of Communication and Engagement Toolkit	• To support Safeguarding Adults Awareness Week, and to enable agencies to raise awareness of adult safeguarding during the pandemic, the Communications and Engagement Working Group continued to update and promote their Communications toolkit. This included posters, social media graphics, signature banners and video files (short graphics to be used on social media to catch attention).
Engagement with local communities	• A brief article, titled "*Are you concerned about an adult*?", was published in *Medway Matters*, a community magazine delivered to 120,000 homes across Medway. The article has been included in every subsequent edition. • Members of KMSAB and Business Unit hosted a stand at the Kent Police Open Day, where 14,000 members of the public were in attendance. The aim was to speak to members of the public, share safeguarding resources and raise awareness of how to recognise and respond to adult safeguarding concerns. Approximately 700 people visited the stand and engaged with the facilitators. When compared to the previous week's figures, there was a 35% (344 views to 465) increase in visits to KMSAB webpages in the week following the event, including: ○ 109% increase in visits to the 'useful resources for the public page', ○ 55% increase in the 'support for carers' page, ○ 90% increase to the 'types of abuse' page, ○ 14% increase in the report abuse page. • As part of their work, the independent Chair of the Board and Board Manager, continued to hold introductory sessions with charity, voluntary sector and other community leads. This also includes meetings with advocacy leads, faith leaders and

	organisations representing people with lived experience. • The Self-assessment Framework (SAF) includes standards relating to how agencies take into consideration the views of those at risk of abuse and neglect, and how and when is this information analysed. • Healthwatch Kent and Medway and the Advocacy People continued discussions with other Healthwatch areas to consider best practice and the potential development of a 'citizen's panel'.
KMSAB Open Sessions	• The Board Business Unit launched quarterly 'KMSAB open forum sessions', providing an opportunity for anyone with an interest in adult safeguarding to hear from people with a lived experience of safeguarding, and other subject matter experts. The following sessions were held in 2021-2022: ○ Safeguarding Adults Awareness – two sessions aimed at the charity and voluntary sector ○ Sharing learning from Safeguarding Adults Reviews ○ The Mental Capacity Act 2005
KMSAB Newsletter	• The Board Business Unit continued to produce and circulate a monthly newsletter sharing updates in relation to: Board activity; learning from safeguarding adults reviews; guidance and support; and relevant local and national safeguarding information. Over 290 people subscribe to the KMSAB newsletter, with many cascading it further within their organisations.

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

What we achieved:

Self Assessment Framework	• During 2021-2022, Quality Assurance Working Group (QAWG) members continued to implement the quality assurance framework, which sets out the methods and tools used to measure effectiveness of partners' safeguarding activity. • One of the quality assurance tools is the 'self-assessment framework' (SAF). All agencies represented on the Board are asked to complete an annual SAF, a series of questions to measure progress against key quality standards. The purpose is to enable them to evaluate the effectiveness of their internal safeguarding arrangements and identify and prioritise areas needing further development. • The standards are informed by national good practice, learning from safeguarding adults reviews, any new legislation and guidance, policy and practice and feedback from service users and carers. • In 2021 the number of agencies required to complete the SAF was increased, to include the 12 district/borough councils in Kent. North-East London NHS Foundation Trust and G4S (patient transfer services) were also asked to complete a return, as they were each involved in a safeguarding adults review, commissioned by the Board.

	• The SAF included 30 standards relating to:
	  ○ Participation and Engagement – Including:
	  ▪ how agencies seek the views of people with lived experience and how this information is used to influence service improvement
	  ▪ How staff are made aware of advocacy services, and assure that appropriate referrals to these are being made
	  ▪ How agencies identify individuals who may benefit from being referred for a carer's assessment
	  ○ Leadership – including:
	  ▪ Does the organisation have an accountable lead for safeguarding and what impact does leadership make?
	  ▪ Does the organisation have an escalation policy, does it align with the KMSAB policy?
	  ▪ Is adult safeguarding featured in strategic documents?
	  ▪ How does the organisation engage with the KMSAB and ensure messages and feedback from staff and service users reported to the Board?
	  ▪ How are key messages from the Board disseminated? What checks are in place to ensure that they are understood and embedded?
	  ○ Service Delivery and Effective Practice – Including:
	  ▪ How does the organisation ensure that commissioned, subcontracted and agency or locum services are compliant with KMSAB policy and procedures?
	  ▪ How does the agency identify people who may have challenges in transitioning between services and what is in place to manage and support this?
	  ▪ How agencies take into account the potential increased vulnerability of previously looked after children?
	  ○ Recruitment, supervision and allegations against staff – Including:
	  ▪ Does the organisation have safer recruitment polices and processes in place?
	  ▪ What is the criteria for carrying out and recording management oversight of individuals who are risk of harm?
	  ▪ Does the organisation have a policy in place for dealing with allegations against people who work with adults with care and support needs?
	  ▪ Does the organisation have a whistleblowing policy?
	  ○ Training – Including:
	  ▪ Does induction for all staff include basic awareness of adult safeguarding?
	  ▪ What systems and/or processes are in place to ensure that staff training is commensurate with their

	safeguarding duties and lawful responsibilities? ▪ What processes are in place to support learning from SARs, Domestic Homicide Reviews and Child Safeguarding Practice Reviews, to integrate learning into practice and training? ○ Performance management – Including: ▪ How does the organisation use safeguarding performance data and other feedback to inform safeguarding or other strategy and service delivery? ▪ How does your organisation use safeguarding performance and quality information to hold services to account? • Agencies are required to assess how well their organisation is achieving each standard/requirement, using a red, amber, green (RAG) rating. They must also provide supporting evidence and complete an action plan for any requirements graded red or amber, detailing how compliance will be achieved. Outstanding actions are monitored by the QAWG, with regular reporting to the Business Group. • To help mitigate against different interpretation of requirements, to instil more rigor in the process and to ensure greater consistency, agency leads are required to present their completed SAF analyses and evidence to a panel of 'peer' reviewers. • Of the 900 standards (30 agencies x 30 standards) initial returns indicated an 86% achievement rating (green), with 12% rated amber and 1% red. Following the peer-review, there was a 72% achievement rating (green), with 27% rated amber and 1% rated red. All agencies were rated 'amber' for two questions, as whilst most could evidence how they had shared material from the Board, more evidence was required to measure the impact and reach of these messages. Other themes highlighted through the peer review were that not all agencies had a full understanding of the range advocacy services available, or had raised awareness of the need to consider signposting to carer's assessment, where appropriate. In addition, some agencies, new to completing the SAF, had answered 'not applicable' to several questions, which peer review panel members felt were applicable. With hindsight, this was possibly due to a lack of understanding of the SAF process. To mitigate this, future SAFs will include a briefing session, to explain the standards, why these have been chosen and to provide an opportunity for questions. • The March 2022 update recorded an 86% achievement rating against the standards.
Monitoring of Safeguarding Adult Reviews (SAR) Action Plans	• Following the completion of a Safeguarding Adults Review (SAR), agencies involved must detail the actions they will take to respond to any recommendations made for improvement. SAR Working Group members quality assure these action plans, requesting remedial actions if required, and escalating concerns to the KMSAB Business Group. • The Board and its Working Groups do not wait until a SAR is completed to begin to make improvements identified as the review progresses.

Sharing of Good Practice	• Safeguarding Adults Reviews are a critical tool to help identify areas for improvements with multi-agency partnership working. It is helpful to balance the findings against examples of good practice, as these can also be a powerful way of learning. Many of the quality assurance tools designed by the Board ask agencies to highlight good practice examples so that these can be shared.
Annual Agency Reports	All KMSAB partner agencies are required to complete an annual agency report to provide examples of how they have delivered the Board's three priorities of prevention, awareness and quality, over the previous 12 months. The report also provides the opportunity to highlight safeguarding priorities and any areas of challenge. A total of 24 responses were submitted. These reports were presented at the quality assurance working group. Members reviewed the submissions, highlighting areas for clarification, good practice, and any areas of concern to be raised to the Board. Appendix 2 provides some examples of good practice from the responses received.
Making Safeguarding Personal	• One of the themes identified in safeguarding adults reviews was the need to promote a person centred approach, making safeguarding personal. A dedicated page on the KMSAB website was developed to share the substantial amount of high-quality resources which had been produced by other leads, such as the Association of Directors of Adult Social Services, the Social Care Institute for Excellence, and the Local Government Association.
KMSAB Executive Meetings	• The Board Executive Membership met on four occasions in 2021-2022. 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: o Adult safeguarding at Napier Barracks o Safeguarding at Elmley Prison, including their work to become a 'Vanguard' Prison, which aims to reduce reoffending across the criminal justice sector, and how the service safeguards individuals through securing suitable accommodation on their release. o Transitional Safeguarding – Dr Dez Holmes, Director of Research in Practice, presented this item. As it impacts children and adult safeguarding, representatives from the Kent and Medway Children's partnership were invited to join the meeting for this item. o Learning from Learning Disability Mortality Reviews (now known as Learning from Life and Death Reviews) – These reviews are part of the LeDeR service improvement programme for people with a learning disability and autistic people. o SAR 'Mark' – Mark's parents attended the Board meeting when the findings of this review were presented. o Preparation for the Integrated Care System (ICB), including governance arrangements and the role of safeguarding.

Section 3. Safeguarding Adults Reviews

3.1. Criteria for Conducting a Safeguarding Adults Review

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

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

Or

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

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

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

3.2. Purpose of a Safeguarding Adults Review

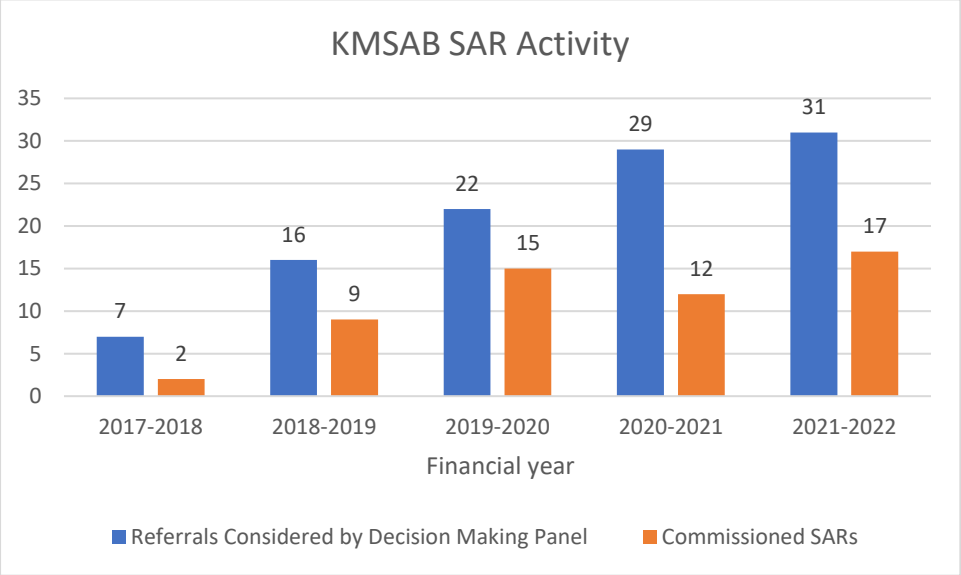
A Safeguarding Adults Review (SAR) is not an enquiry or investigation into how someone died or suffered injury and it does not allocate blame. It stands separately to any internal organisational investigation, or that from Police or a Coroner. The SAR scrutinises case and system findings and analyses whether lessons can be learned about how organisations worked together, or not, as the case may be, to support and protect the person.

3.3. Safeguarding Adults Review Activity

To ensure a robust and consistent process for determining whether a referral 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 recommendation of the panel is sent to the Independent Chair of the KMSAB for a final decision.

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

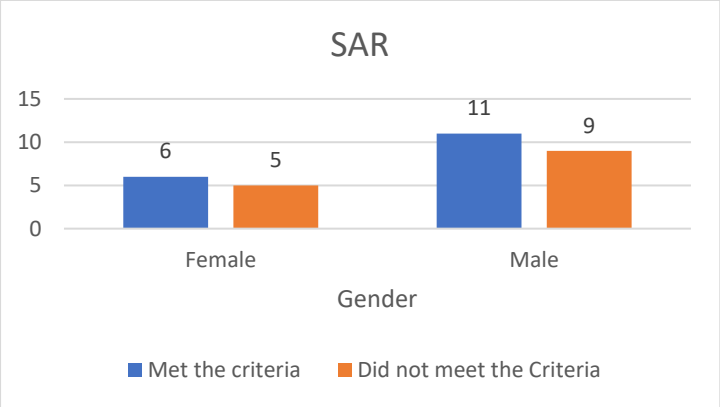


The KMSAB received 31 new SAR applications between April 2020 and March 2021, of these:

- 17 SARs were commissioned
- 14 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 2020 and March 2021

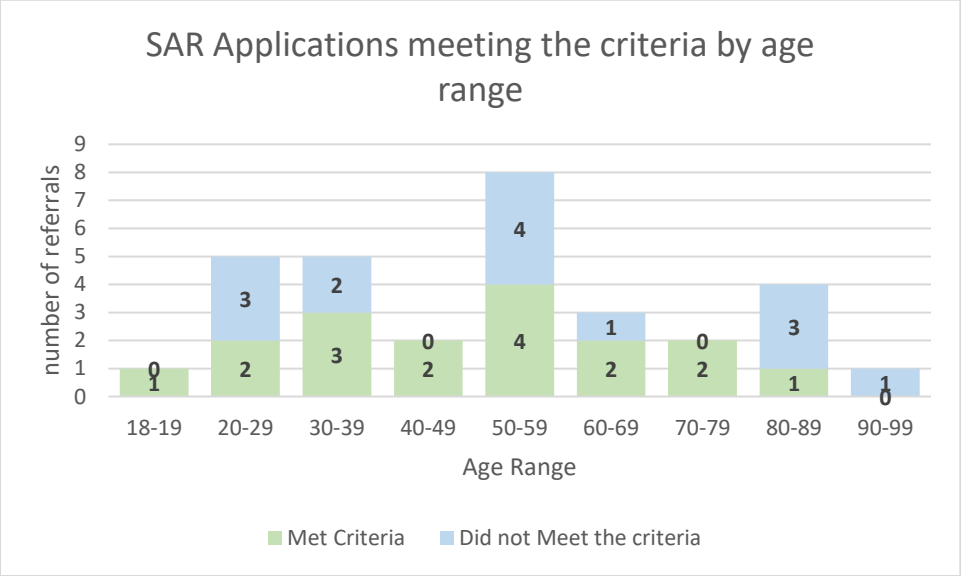


The conversion rate of application to commissioned SARs was 55% for both males and females.

Ethnicity - applications received between April 2020 and March 2021

Ethnicity	Total number of applications	Number of referrals meeting the criteria	Percentage of referrals meeting the criteria
Any other White Background	1	0	0
Other ethnicity (cannot be specified as it may make the individual identifiable)	1	1	100%
Black or Black British – Caribbean	1	0	0
Mixed – White and British – Caribbean	1	0	0
Unknown	6	2	33%
White English/British	21	14	67%

Age – SAR applications received between April 2020 and March 2021



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

Individual	Background	Findings/Recommendations
Douglas	'Douglas', a white British male, was aged 62 when he died. Agency contacts confirm that he was experiencing physical ill-health and that he was lonely and isolated. It is likely that he was being "cuckooed" at the time of his death, and he had been similarly taken advantage over the months prior to his death. Douglas was dependent upon alcohol, to the extent that this would have affected his ability to make decisions. He had also suffered a stroke which gave rise to mobility problems. Communicating with Douglas was difficult due to some speech difficulties that he had and his inability to read. On the day of his death, an ambulance was called by a carer. Douglas was found to be very unwell. He had not let carers in on previous days and had seemingly not eaten or drunk anything for three days. He was unconscious and severely dehydrated. The ambulance service recorded that the care agency had visited each day but not been able to gain entry. They had not raised an alarm. Douglas died later that same day in hospital.	Learning related to: • How agencies communicate and work with individuals with identified additional literacy and communication needs. This links to person centred practice. • Raising awareness of the Board's "Protocols for Kent and Medway to Safeguarding Adults who are at Risk of Exploitation, Human Trafficking and Modern Slavery' • Determining whether there are clear pathways for alcohol support for people in need of such support. • Clarifying the duties and responsibilities stemming from the Housing Duty and Ordinary Residence and how these impact on cross boundary working. • Raising awareness of 'Temporary Residence' facility, for registering with a GP. • Promoting the use of the KMSAB "Policy and Procedure to support people that self-neglect or demonstrate hoarding behaviour. • Ensuring that the Care Act eligibility is being applied correctly.
James	'James', a white British male, was aged 66 when he died, it was suspected that his death was by suicide. James had lived and worked for over 30 years in Town A, in Buckinghamshire. His	Learning related to: • Evaluating the extent to which there is effective partnership working to protect adults at risk of suicide

	mother described him as quiet, intelligent, and committed to his work. Some 5 years prior to his death he had an accident, where he was hit by a car. His mother explained that he sat alone for several days before she found him. This led to James experiencing panic attacks and depressive episodes. He had a period of sickness from work and then retired. Following his retirement he moved to Kent to be closer to friends, but regretted this decision, reportedly being lonely and isolated. He attempted to end his life on a number of occasions. Five days prior to his death, James had been detained under section 136 of the Mental Health Act, as he had been found on the wrong side of the barriers of a cliff top. Following his detention, he was taken to a mental health setting where, having had a full mental health assessment, he was not admitted. The crisis team visited James on the day of his death and offered him a hospital admission, which he declined.	• Recommendation that the Integrated Care System (ICS) undertake a commissioning review of the systems in place to reduce social isolation and health inequalities. • How Public Health can use the learning from this review to inform the suicide prevention strategy and ICS development.
Mark	'Mark' a white British male was aged 49 when he died. He lived at home with his parents, the eldest of three siblings. Mark had a learning disability and cerebral palsy, he attended a day care service five days a week. He was well known to this service and was a member of the service users' committee. In April 2019, Mark attended accident and emergency with his father, having returned home from a week's respite care, with reduced mobility and oral intake. Mark was discharged from hospital 2 weeks later. Following discharge from hospital, Mark was reliant on agencies to meet all his care and support needs. Despite involvement of agencies, on 18 June 2019, Mark was re-admitted to hospital with sepsis secondary to pressure ulcers. The hospital submitted a safeguarding alert to Kent County Council on 20 June 2019. A safeguarding enquiry was completed, the police enquiry	Learning related to: • The requirement for pre-discharge co-ordination for adults requiring long term care, including measures to provide assurance that the Acute and Community Trusts work together to ensure there are no gaps in the provision of equipment on discharge. • CCG (now ICB) and Adults Social Care to review the effectiveness of assessments and post assessment planning for care. These should be personalised and a named care co-ordinator in place. • Reducing delays in assessment and provision across community services, in relation to occupational therapy adaptations, including wheelchairs. • Reviewing how Annual Health Checks for people with a

	concluded no criminal wilful neglect by the agencies involved, however, when reviewing all information there was clear concern that information was not shared between agencies, which led to harm to Mark. He was discharged from hospital on 8 July 2019. On 25 July 2019 Mark was re-admitted to hospital, due to multiple pressure ulcers. He was discharged on 12 August 2019, following the decision that he required end of life hospice care. Mark sadly passed away on 15 August 2019.	learning disability are quality assured. • Raising awareness of a carer's right to a formal carer's assessment. • Advising the Care Quality Commission of any registered providers' involvement in a safeguarding enquiry.
Harpreet	'Harpreet' an Asian British woman, living with dementia and limited mobility, was aged 86 when she experienced a life-threating injury. Harpreet did not speak English, her language of heritage was Punjabi. She was cared for predominately by her husband ('Sardar'), assisted by her son ('Jas') and daughter in law. Prior to January 2020 the family had no contact with any statutory agency other than health providers, for matters consistent with normal day to day living. However, Harpreet and Sardar had visited their GP in September 2019 asking for help. The GP discussed the process of referral to Adult Social Care to obtain a needs assessment to obtain external care support. Both Harpreet and Sardar decided not to pursue this. In January 2020 Harpreet fell at home and was taken to hospital where she underwent an operation to her hip, she spent time in Intensive Care, due to low blood pressure. Following her discharge from hospital, Harpreet's son contacted her GP, expressing concerns that Harpreet's wellbeing had deteriorated and the impact of this on her and the wider family. The GP met with Harpreet, Sardar and Jas and referred them to the community health multidisciplinary team for support. Agencies	Learning related to: • Raising awareness of each agencies' Interpreters and Translation policy. • South-East Coast Ambulance Service to share their cultural awareness reference guide • KCC to arrange a quality assurance audit to ensure the additional training and changes in policy and procedure introduced in their Area Referral Management Service are driving current operational practices. A similar check should be made with the short-term pathway team.

	did liaise with the family in response to the concerns. Many offers of support were not pursued by the family as they did not meet their needs. It was acknowledged that best practice was not always followed. In June 2020, Harpreet's husband 'Sardar' cut her wrists, severing the artery and tendons. He then inflicted a similar injury on himself. The prompt attendance of police and paramedics prevented these injuries proving fatal.	
Carl	'Carl' a white British Male, was aged 57 when he died. He had a diagnosis of schizophrenia, which had been managed through community mental health services, since his late 20s. Carl had a good relationship with his GP and mental health services. He was independent and known to sometimes neglect himself. In June 2020, Carl was admitted to hospital with Hypokalaemia (Low potassium which can lead to cardiac arrythmias or renal problems), a failed discharge saw him return to hospital with the same condition, within 24 hours. In July 2020, Carl was diagnosed with pancreatic and lung cancer. He commenced chemotherapy, to slow the progress of the disease. In November 2020, he was reported, by his neighbour, to have had several falls, which led to an emergency admission to hospital. In hospital he missed several doses of his antipsychotic medication. Although it was noted that there was significant good practice from agencies in the final years of his life, the review focused on the period following his discharge from hospital to his death in February 2021. There had been a decline in his ability to care for himself and concerns raised about self-neglect. There is no evidence of agencies working well together during the crisis point. Carl had a care plan in place which should have been delivered, and any non-contact escalated and checked by other services. Carl was found	Learning related to: • Ensuring that GPs are included in making decisions with Adult Social Care and other agencies regarding individuals with complex health conditions. • There were specific actions for the commissioned service provider, in relation to training on self-neglect and how to escalate concerns. • Reviewing the discharge arrangements in the Proactive Assessment Unit. • Sharing the learning from this review with services involved in the end-of-life pathway across Kent and Medway so that there can be a reflection on the extent to which the End of Life strategy meets the needs of individuals who are wary of letting workers into their homes when they need care. • How to work with individuals, at risk of harm, who decline services. • Continuity of care.

	deceased on 4 Feb 2021, having been left without contact for several weeks.	
Caroline	'Caroline' a White British woman, was aged 38 when she died. She was diagnosed with medical conditions including epilepsy, asthma and anaemia. She had three children. In 2014 Caroline made an allegation about her husband's ('Neil') controlling and coercive behaviour, which had escalated since Neil had, allegedly, become paranoid due to recreational drug use. The couple separated and Caroline obtained a non-molestation order which was valid for 3 years. However, the couple reunited soon after the separation, with statutory agencies remaining involved with the family for 6 months. There was no further contact with police or social services for a period of three years. During 2019 Caroline was admitted to hospital on a number of occasions. Family members spoke to hospital staff, alleging that Caroline was being controlled by her husband, with safeguarding referrals made by the hospital team. Caroline would recover whilst in hospital but would quickly relapse on discharge home. Offers of a home visit to see if there was an environmental driver for the relapses was not taken up. In late 2019, Caroline was taken to hospital by ambulance, on admittance she was noted to have reduced consciousness. Caroline was transferred to intensive care the following day. A blood test identified phencyclidine (PCP or angel dust) and benzodiazepines (sedatives) were present. Caroline continued to deteriorate and did not respond to treatment, she died a few days later.	Learning related to: • Specific action for the Hospital Trust to conduct a post implementation review of the HIDVA (hospital independent domestic violence advisor) placement to ensure the aims and objectives of this post are being achieved. • Specific action for the Hospital Trust to review referral arrangements in collaboration with the Service Provider to ensure that the hospital integrated discharge team is notified of any adult at risk who may need their assistance to be safely discharged. • Specific action for the Hospital Trust to complete a quality assurance check, covering a three-month period, to ensure any identified safeguarding concerns have been raised with the internal safeguarding champion. • Specific action for the Community Health Trust to complete an audit to ensure that their 'Did not attend/Was not brought in' policy is being followed, including contacting the referring professional. • Specific action for the Integrated children's service about using the tools in their practice/quality assurance framework, such as the use of a chronology tool, to stimulate proactive intervention. • Specific action for KCC adult social care, to ensure supervising staff are aware of their statutory responsibilities when managing joint investigations

		with Integrated children's services. • Increasing awareness of the impact illicit drug use may have when undertaking an assessment under the Care Act and/or Mental Capacity Act with training provided in this respect as necessary. • Review of multi-agency meetings to ensure that there is a pan Kent and Medway capability. • Information sharing with GP practice.
Jack	Jack, a white British male, was aged 62 at the time of the review. He had been in a relationship with 'Elaine' for 12 years, and they had been married for 6 years, when she died in 2016. Jack had very little contact with anyone following her death. Both Jack and Elaine had physical and mental health conditions which affected their day-to day life. While Elaine was alive, Jack's focus had been to care and support her, and they were interdependent. Following Elaine's death, Jack's conditions, and his ability to cope with everyday matters, diminished and he began to neglect himself and his home. A variety of referrals were made to agencies and assessments planned. The review found that these assessments were either not carried out or followed up. Further concerns were that joint working protocols, designed to support and protect adults at risk, were also neglected. Jack's health had been severely affected by his own neglect. Towards the end of the review period there was an improvement in the way agencies worked together and the application of procedures. In February 2020, Jack moved into supported	Learning related to: • Reviewing the 'lead agency' procedure within the Self-Neglect Policy. • Reviewing the reporting mechanisms into Kent and Medway Adult Social Services surrounding issues of concern that fit the criteria set out for reporting under section 42 of the Care Act. • Use of the clutter score matrix by all agencies to be used when Self-Neglect is apparent. • For the community mental health team to ensure that systems are in place for determining care planning. • For Kent and Medway NHS and Social Care Partnership (KMPT) to discuss severe self-neglect cases at their red Board meetings • Hospital Discharge Teams to consider the use of KMSAB self-neglect and hoarding policy to call a multi-agency meeting.

	accommodation. This was the outcome of a meeting held in line with KMSAB Self Neglect Multi Agency working procedure. This decision was discussed and agreed with Jack. He settled well in his new home and appeared happy. However, in November 2020 Jack died unexpectedly.	
Jodie	Jodie, a White British female, was aged 39 when she died in hospital. Jodie had been known to services as an adult at risk, with the first reported physical assault, by her partner, having taken place in 2014. Little was known about Jodie before 2014, when she first came to agencies' attention, having started a relationship with a registered sex offender named 'Wayne'. In March 2014, a third-party reported that Wayne had assaulted Jodie, there followed around ten further reports of violence, including slaps and kicks, strangulation and being 'force-fed' pills. Following each disclosure of harm, Jodie would either deny the abuse, or would report the abuse and later retract her statement. Criminal charges were never brought against Wayne for causing harm to Jodie. She was subject of a Multi-Agency Risk Assessment Conference (MARAC) on three occasions, and agencies identified Jodie as a victim of domestic abuse and violence. Professionals involved with Jodie recognised the importance of establishing a relationship with Jodie, and despite many attempts to see Jodie on her own, Wayne was always present. Jodie died in hospital, at the time of her death she had Meningitis and Sepsis. She was noted to have severe bruising and neglect, or self-neglect, were considered to be factors in her death.	Learning related to: • Legal literacy and in particular, the use of inherent jurisdiction • Understanding the importance of mental capacity and, and situational capacity, particularly in the context of an individual living within a relationship where substance dependency, mental health needs and domestic abuse are apparent. • The relationship between MARAC and safeguarding processes. • Understanding coercive control and the need to seize any window of opportunity to gain and insight into the individual's life • Using a trauma informed approach to conversations. In addition to the overview report, a coercive control learning tool was commissioned. It is available here.
John and Geraldine	The SAR in respect of John and Geraldine was not published for reasons of anonymity.	Learning related to:

		• Demonstrating 'professional curiosity', the capacity and communication skill to explore and understand what is happening within a family/situation rather than making assumptions or accepting things at face value. • Legal Literacy – the appropriate application of statutory responsibilities around the Care Act 2014, Human Rights Act 1998 and the Mental Capacity Act 2005 • Self Neglect – promoting the use of the 'clutter Image rating tool' • Promoting use of the 'Kent and Medway Multi-Agency Policy and Procedures to Support People that Self-Neglect or Demonstrate Hoarding Behaviour' with private care providers. • KMSAB partners to review the various safeguarding referral forms used across Kent and Medway. The review to consider the content, format and language of the forms with a view to moving forward towards a consistent approach
Anna	The SAR in respect of Anna was not published for reasons of anonymity	Learning related to: • Discharge to Assess Process - That the 'Discharge to Assess' pathway is reviewed to ensure that it contains failsafe planning and a means of reviewing whether the plan is being delivered or whether review is required. • Safe Commissioning – gaining assurance that commissioned services have the requisite safeguarding knowledge and training • Need for consistent approach to reporting safeguarding concerns to the local authority (as John

		and Geraldine) • Self-Neglect (as John and Geraldine - above)
Lee	Lee, a White British male, was aged 48 when he was found deceased at his home. Lee was diagnosed with physical and mental health conditions including: emotional unstable personality disorder; alcoholic cardiomyopathy, high blood pressure and epilepsy. He had a dependency on hypnotic and anxiolytic (sedatives) medication. Lee was seen by community nurses for several years for blood tests. He was known to be anxious about attending appointments and so home visits were undertaken. In March 2020, he was seen by his GP who noted that Lee was stressed due to problems about council tax, he had suicidal ideation but no plan. A referral was made to the Care Navigator, requesting financial advice. The GP noted that Lee declined a Community Mental Health Team (CMHT) referral, but the GP noted knowledge of Lee's mental health baseline. In the 3 months prior to Lee's death (October – December 2020) extensive concerns were raised about his health, well-being, self-neglect and suicidal ideation. The review found that there was good practice noted during the challenging time (Covid Pandemic) but there was limited joined up working in the final months of Lee's life, with misunderstandings of each other's roles at points of crisis.	Learning related to: • Application of the 'Kent and Medway Multi-Agency Policy and Procedures to Support People that Self-Neglect or Demonstrate Hoarding Behaviour' • Making safeguarding personal
David	David, a White British male, was aged 46 at the time of his death. He lived with his brother in their family home. David was described by his best friend as being a very kind person who was very friendly towards people, as long as they accepted and respected him for who he was. She also described him as being	Learning related to: • Multi-agency working, in particular the need to consider protocols in relation to multi-agency risk management • Sharing the findings of this review with public health,

	very lonely and that apart from her and his brother, 'Michael', he had very few friends. David's father died by suicide when David was in his late 20s. David and his brother lived with their mother until she passed away in 2017. Prior to her death, the impact of the caring responsibility on David was recognised and he received a carers assessment and plan. David started drinking alcohol as a teenager and alcohol dependency was a feature during many years of his life. He had mental and physical ill-health, being diagnosed with social phobia, mixed personality disorder, depression and anxiety. He also had 'somatoform disorder' whereby he experienced physical bodily symptoms (chronic pain), in response to mental distress. It is documented that David struggled with controlling his anger which resulted in him being removed from three primary care lists (although he did have access to a GP, through the special allocations scheme) and access to non-emergency care at 2 hospitals was blocked. It was noted that David's anxiety, frustration and distress increased when he was due to be assessed, by the Department of Work and Pensions, for enhanced payments. Throughout the review period there were 18 recorded incidents of David either self-harming, threatening suicide, or having taken medication overdoses. Although these were responded proportionately and within each agencies' guidance, there was little evidence of a holistic multiagency response. David died by suicide in May 2020.	who are responsible for multi-agency suicide prevention activity within Kent and Medway • Suicide prevention • Working with alcohol dependent individuals, in particular review the training available. • Working with individuals who are 'red carded' from hospital. • The impact of chronic long term pain and the relationship between this and suicide • The implications of long-term use of opioids to treat pain

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

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

Recommendation/Theme	Actions taken by the Board
Making Safeguarding Personal Including awareness of individual's communication preferences and the use of interpreters and translation.	• Practice, Policies and Procedures Working Group members developed a dedicated page on the KMSAB website to share the substantial amount of high-quality resources that have been produced by other leads, such as the Association of Directors of Adult Social Services, the Social Care Institute for Excellence and the Local Government Association. This was promoted with Board member agencies and more widely. • The quality assurance working group asked member agencies, through their self-assessment framework return, to evidence the following: o The communication needs of individuals are taken into account when engaging with them o Making safeguarding personal is understood and applied within safeguarding practice and that the individual and/or their advocate is involved throughout o The 'think family' approach is applied when working with individuals.
Identifying and responding to Self-Neglect and Hoarding	• The KMSAB Training Programme includes a module on self-neglect and hoarding, the module was extended from half a day to a full day's training. • In response to feedback from practitioners, Practice Policies and Procedures Working group members developed a the "Kent and Medway Safeguarding Adults Board A Quick Guide to Identifying and Responding to Self-Neglect and Hoarding" to complement the main document. • Work to update the main policy document commenced in 2021. • Although out of the reporting period for this Annual Report, the Board hosted 2

	SAR learning events in September 2022, focusing on self-neglect and hoarding.
	• The 2022 SAF included the following standards:
	  ○ The agency / organisation raises awareness of the Kent and Medway Multi Agency Policy and Procedures to Support People that Self Neglect or Demonstrate Hoarding Behaviour, to relevant staff
	  ○ Employees/Staff /Volunteers within the agency/ organisation are implementing the Kent and Medway Multi Agency Policy and Procedures to Support People that Self Neglect or Demonstrate Hoarding Behaviour appropriately, effectively and in a timely manner
	  ○ The organisation provides clear information to those at risk of self-neglect and/or hoarding regarding the support that can be provided.

Awareness of KMSAB policy and procedure	• Details of all updates to KMSAB Policies and Procedures emailed to all KMSAB members for onward dissemination.
	• The KMSAB policies are promoted through the Board's newsletter and at meetings and events.
	• The Board's training provider is advised of any policy updates so that these can be incorporated into the training modules.
	• To measure the impact of this, the 2021 SAF included the following standards:
	  ○ Does your organisation have an Escalation Policy or process for raising safeguarding concerns? Does this align with KMSAB's escalation policy and procedures for adult safeguarding?
	  ○ How does your agency disseminate and promote policy updates from KMSAB?
	  ▪ What form of media is used?
	  ▪ How does the agency ensure that any changes made are understood and embedded?
	  ▪ Who is responsible for identifying any problems with implementation?
	• How do you ensure that commissioned, subcontracted, agency or locum services are compliant with KMSAB Safeguarding Adult Policy and Procedures?

	• How does the agency introduce staff to the work of KMSAB and alert them to the website and information provided by the Board that is pertinent to their area of work?
Working with individuals who are dependent on alcohol or substances	• SAR findings were shared with Kent and Medway Public Health teams, to inform their work in this area. • Presentations on SAR findings have been delivered to relevant meetings, such as those concerning co-occurring conditions (mental ill health and substance dependency) • "Learning from Tragedies – an analysis of alcohol related safeguarding adults reviews" was circulated to all KMSAB and working group members, and included in the newsletter, to reach a wider audience. • Although not in this reporting year, the Board has commissioned a thematic review of SARs where alcohol dependency is a factor.
Suicide prevention	• Findings were shared with Kent and Medway Public Health teams, to inform their work • Board members and Business group members have circulated messages on suicide prevention and support, both online (such as the newsletter) and at face-to-face events, such as Kent Police open day. • Details of how to respond to people in mental health crisis were shared across the partnership. It was also added to the KMSAB newsletter.
Safe-discharge from hospital	• In February 2021, representatives from 4 acute hospital trusts, 3 community trusts and the Director of Adult Social Services, for both Kent County Council and Medway Council attended an Extraordinary Meeting of the KMSAB to provide assurance and to detail any improvement activity in relation to safe-discharge from hospital. • Following this meeting, relevant agencies have been required to provide updates on progress. • The CCG commissioned improvement activity through their System Quality Group. The Chief Nurse met with the Chair of the Board, to provide assurance. • Improvement activity was measured through the 2022 self-assessment

	framework, which included the following standard: ○ Discharge pathways (including discharge to assess) ensure the safe transition between inpatient hospital settings and community or care home settings for adults with social care needs. Due consideration is given to adult safeguarding within this. There are means of assessing whether the plan is being delivered or whether a review is required.
Annual health checks for people with a learning disability.	• This recommendation was escalated prior to report publication. • Improvement activity was led by the CCG, as this was also found to be a feature within LeDeR reviews. • The CCG provided an assurance update to the KMSAB executive. Members were advised that 'deep dive' analysis found an increase in annual health check compliance across Kent and Medway. Other improvement activity included: ○ The CCG worked in partnership with Kent Community Health NHS Foundation Trust on their annual health check project, which identified local areas requiring more support to increase the uptake of annual health checks ○ Commissioning arrangements were altered to encourage completion.
Raising awareness of a carers right to a formal carer's assessment	• Communication relating to carer's assessment has been sent to agencies and promoted using different media. • The KMSAB Business Unit developed and promoted a specific webpage for carers, which can be found here. The page includes useful links and resources. • As a quality assurance measure, the 2021 SAF included the following question: ○ How does your agency assure that it meets its legal obligations under the Care Act so that carers are referred for a Carer's Assessment, or the need for a Carer's Assessments is highlighted to the Local Authority? • As the theme of carers has also been a feature within Domestic Homicide Reviews, the Kent and Medway Safeguarding Adults Board and the Kent Community Safety Partnership hosted a joint learning event.
Barriers to engagement – how to work with	• The SARWG, jointly with the Community Safety Partnership and Children's

individuals at risk of harm who decline services	partnerships, developed a learning document and circulated it widely. • The learning and development training specification has been updated, to ensure that each course includes the following learning objective: - consider culture, literacy and communication needs that may impact on an individual's access to adult safeguarding. • This theme has been raised at relevant meetings with key partners, to inform their work, for example commissioning activity. • Relevant KMSAB members were asked to review their agency's 'was not brought/did not attend' policy.
Multiagency working	• KMSAB policy and protocols provide clear guidance on multi-agency working and how to escalate concerns. • Relevant agencies commenced work to map multi-agency risk management forums/panels including governance, referral criteria and pathways, and how actions are progressed, so that gaps and areas for improvement can be identified and addressed. • The PPPWG produced a practitioner guide document, to outline the legal basis for sharing information. • A feature of effective multi-agency working is understanding each other's roles and responsibilities, to assist with this the LGA document on Safeguarding Adults - Roles and Responsibilities has been shared widely. • The Board's training offer includes a specific module on collaborative working in multi-agency Section 42 Enquiries. The importance of effective multi-agency working is featured in all other courses.
Referral Mechanisms - the different ways in which concerns are reported to the local authority and the consequences of this.	• In February 2022, the Independent Chair of the Board convened a meeting with relevant partners to discuss this theme. He requested that the statutory agencies and South-East Coast Ambulance Service work together to develop a consistent approach or an agreeable compromise which mitigated against the risks. • This theme has been raised nationally.
Legal Literacy	• The KMSAB training offer includes a module on legal literacy • Practice Policies and Procedures working group members updated the Multi

	Agency policy document to include situational incapacity and inherent jurisdiction • Practice Policies and Procedures working group produced a practitioner guide to outline the legal basis for sharing information • The Board Business Unit hosted an open session on the application of the Mental Capacity Act 2005 • The Board Business Unit hosted a SAR Learning event on "Improving Partnership Working – Managing Complexity and Capacity" • To measure how learning has been shared and embedded, the 2022 Self-assessment framework included the following standards: o The agency/organisation ensures that staff are aware of their legal responsibilities and powers to safeguard adults o Relevant staff working with adults at risk are aware of the legal powers of intervention (as referenced in the KMSAB self-neglect policy) and how and when to apply them. This includes Inherent Jurisdiction. o Consent is sought from the individual (where it is safe to do so) before a referral is made to adult safeguarding. Decisions on consent are well documented. o Relevant staff working with adults at risk are aware of the Mental Capacity Act and how and when to apply it. Decision making is recorded appropriately. o Decision making in relation to adult safeguarding is clearly recorded, justified and proportionate. o Staff are aware of the legal basis for sharing information and are confident in applying this to safeguarding adults.

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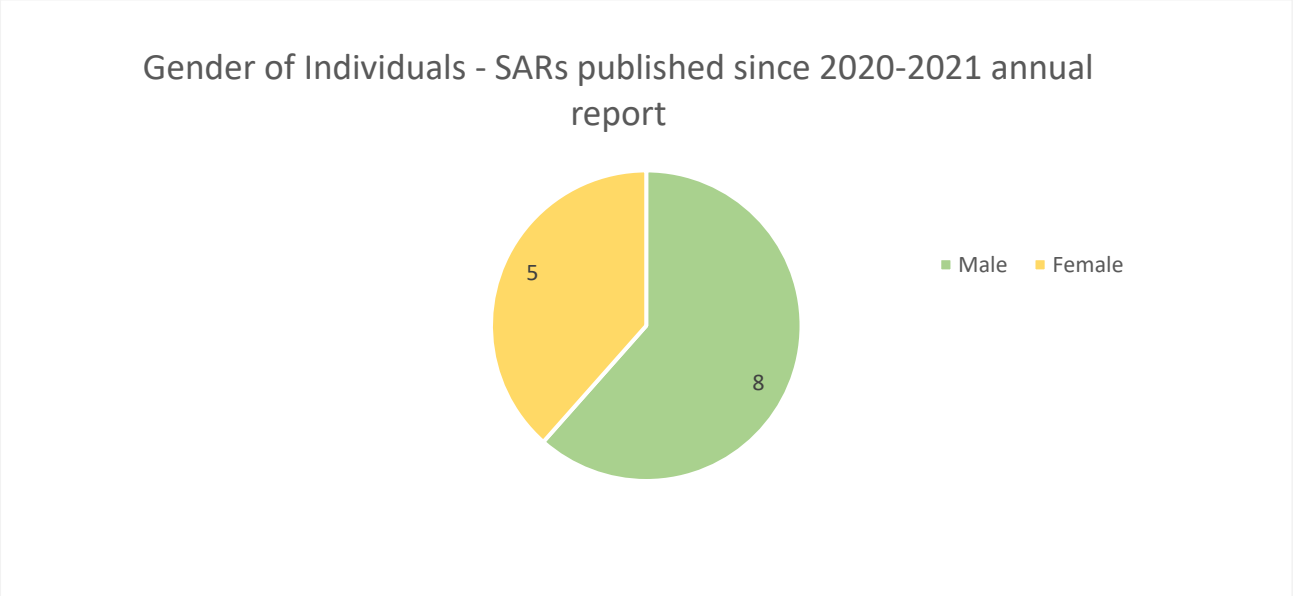
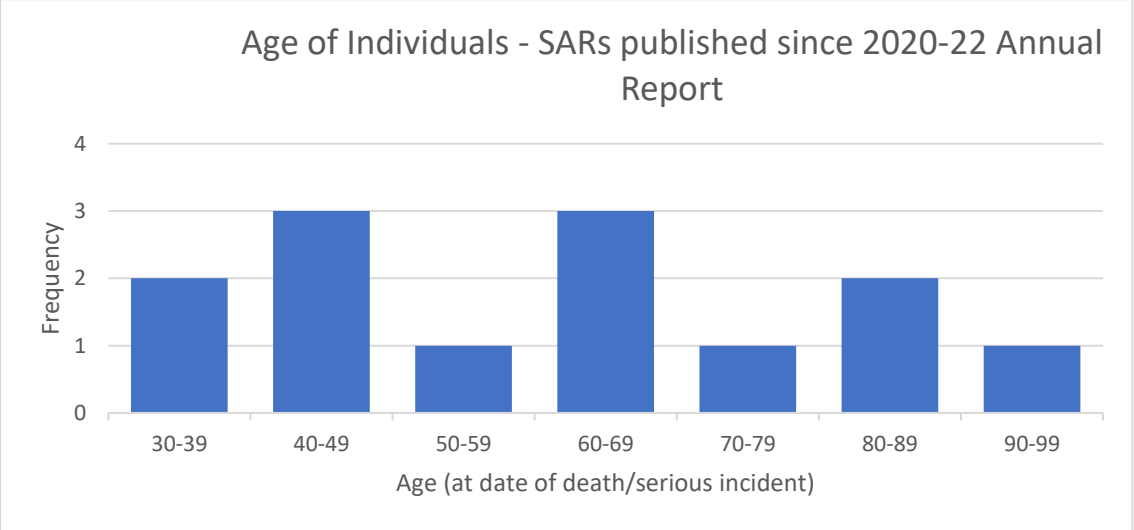
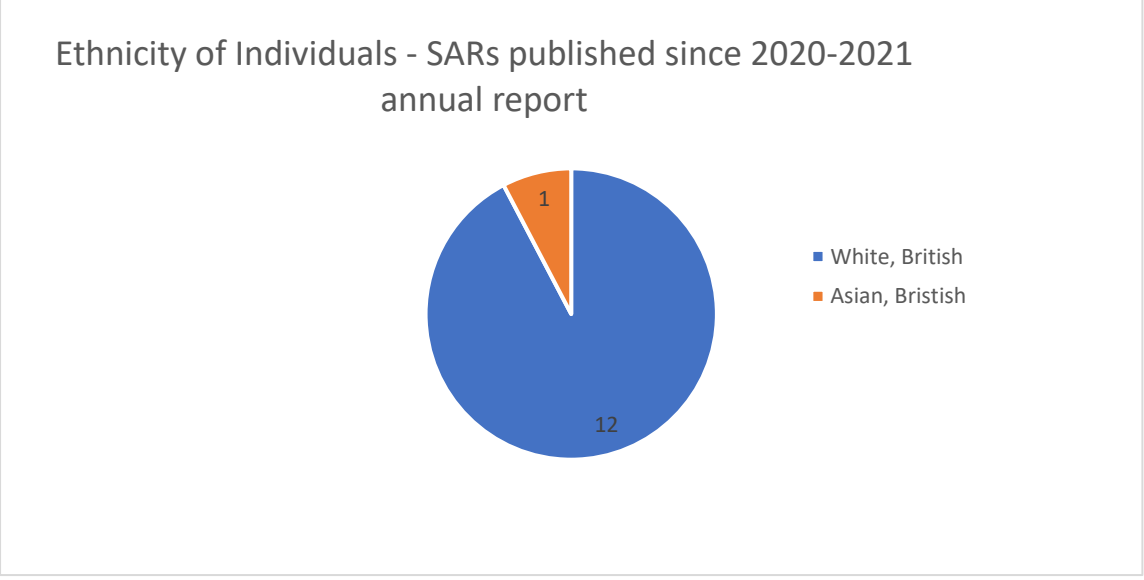

Gender of Individuals - SARs published since 2020-2021 annual report
5
8
Male
Female


Age of Individuals - SARs published since 2020-22 Annual Report
Frequency
4
3
2
1
0
30-39
40-49
50-59
60-69
70-79
80-89
90-99
Age (at date of death/serious incident)


Ethnicity of Individuals - SARs published since 2020-2021 annual report
1
12
White, British
Asian, Bristish

Glossary of terms

Care Quality Commission (CQC)	The CQC is the independent regulator of health and social care in England. They monitor, inspect and regulate health care providers to make sure they meet fundamental standards of quality and safety ensuring the best possible care for patients, service users and their family and friends. More information is available here
Clinical Commissioning Group (CCG)	During the timeframe covered in this annual report, Clinical Commissioning Groups were responsible for commissioning most of the hospital and community NHS services in the local areas for which they were responsible. Commissioning involves deciding what services are needed for diverse local populations and ensuring that they are provided. CCGs were dissolved in July 2022 and their duties taken on by the new integrated care systems (ICSs).
Clutter Score/Clutter Image Rating	The Clutter Image Rating has been developed to assist in identifying and sharing hording concerns. The images can be found here. More information on how to respond to self-neglect and hoarding concerns can be found here.
County lines	County lines is the name given to drug dealing where organised criminal groups (OCGs) use phone lines to move and supply drugs, usually from cities into smaller towns and rural areas. They exploit vulnerable people, including children and those with mental health or addiction issues, by recruiting them to distribute the drugs, often referred to as 'drug running'.
Cuckooing	Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation. It takes the name from cuckoos who take over the nests of other birds.
Discharge to Assess - D2A	Can be applied when people may still require care but are deemed to be 'medically fit' for discharge from hospital, in that their care and assessment can safely be continued in a non-acute setting. Short term, funded support is provided to enable the individual to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.
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.
Inherent Jurisdiction of the High Court	The ability of the High Court to make declarations and orders to protect adults who have mental capacity to make relevant decisions but are vulnerable and at risk from the actions/inactions of other people. More information is available here.

Integrated Care System	Integrated care systems (ICSs) 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 in available here.
Kent and Medway NHS and Social Care Partnership (KMPT)	KMPT provide secondary mental health services across Kent and Medway, both in the community and within inpatient settings. More information is available here
LeDeR	Research has shown that on average, people with a learning disability and autistic people die earlier than the general public, and do not receive the same quality of care as people without a learning disability or who are not autistic. LeDeR reviews deaths to find areas of learning, opportunities to improve, and examples of excellent practice. This information is then used to improve services for people living with a learning disability and autistic people. More information is available here.
Making Safeguarding Personal	Making Safeguarding Personal (MSP) is about professionals working with adults at risk to ensure that they are making a difference to their lives. Considering, with them, what matters to them so that the interventions are personal and meaningful. It should empower, engage and inform individuals so that they can prevent and resolve abuse and neglect in their own lives and build their personal resilience. It must enhance their involvement, choice and control as well as improving quality of life, wellbeing and safety.
Mate Crime	Mate crime happens when someone 'makes friends' with a person and goes on to abuse or exploit that relationship. The founding intention of the relationship, from the point of view of the perpetrator, is likely to be criminal. The relationship is likely to be of some duration and, if unchecked, may lead to a pattern of repeat and worsening abuse.
Mental Capacity Act 2005 (MCA)	The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The MCA is designed to protect and restore power to those vulnerable people who lack capacity. Capacity should also be assumed unless there is a reason to suggest otherwise, in which the MCA applies.
Multi-Agency Risk Assessment Conferences (MARAC)	MARAC is a multi-agency response to tackling Domestic Violence and Abuse. The role of the conference is to facilitate, monitor and evaluate effective information sharing to enable appropriate action to be taken in respect of Domestic Violence and Abuse. This means that risks are assessed and quantified and subsequently managed with an overall view to protect victims, their children and the general public.
Proactive Assessment Unit	The Proactive Assessment Unit (PAU) enables people to be assessed for their community care needs without staying in acute hospital beds.
Red (Risk Evaluation &	The RED process has been formalised (by KMPT) to ensure high

Decision) Board	quality safe care for people who are experiencing an acute mental health episode in the community and to promote consistency in the management and review of risks, and in the formulation of treatment plans. RED Board Meetings are daily multi-disciplinary clinical meetings reviewing patients identified as high risk and establishing immediate appropriate care planning and actions.
'Red Card'	A "Red Card" informs a patient they have been excluded from receiving any treatment by the Trust due to their often threatening and violent behaviour. People are still able to receive treatment where it is deemed by a medical practitioner as an emergency.
Section 42 Enquiry	An enquiry is any action taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.
Section 136	Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.
South-East Coast Ambulance Service (SECAmb)	Respond to 999 calls from the public, urgent calls from healthcare professionals and provide NHS 111 services across the region. More information is available here.

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Kent and Medway Safeguarding Adults Annual Report 2021-2022.

Appendix One – Safeguarding Data

Contents

Medway Data

1. Background to the data

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

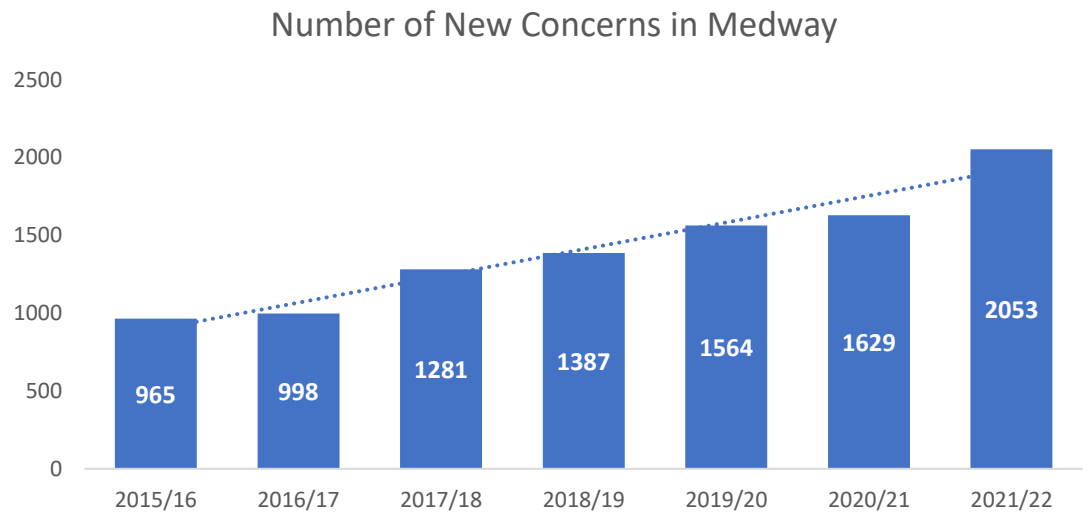
At the time of submission, the data had been submitted to NHS Digital as part of the annual statutory return for safeguarding adults the SAC (Safeguarding Adults Collection). The data submitted in the returns was awaiting validation so may be subject to minor amendment ahead of national publication

National and CIPFA comparator group data had not yet been published nationally so comparisons made below were made using 2020-21 data available.

2. New Safeguarding Concerns and Enquiries

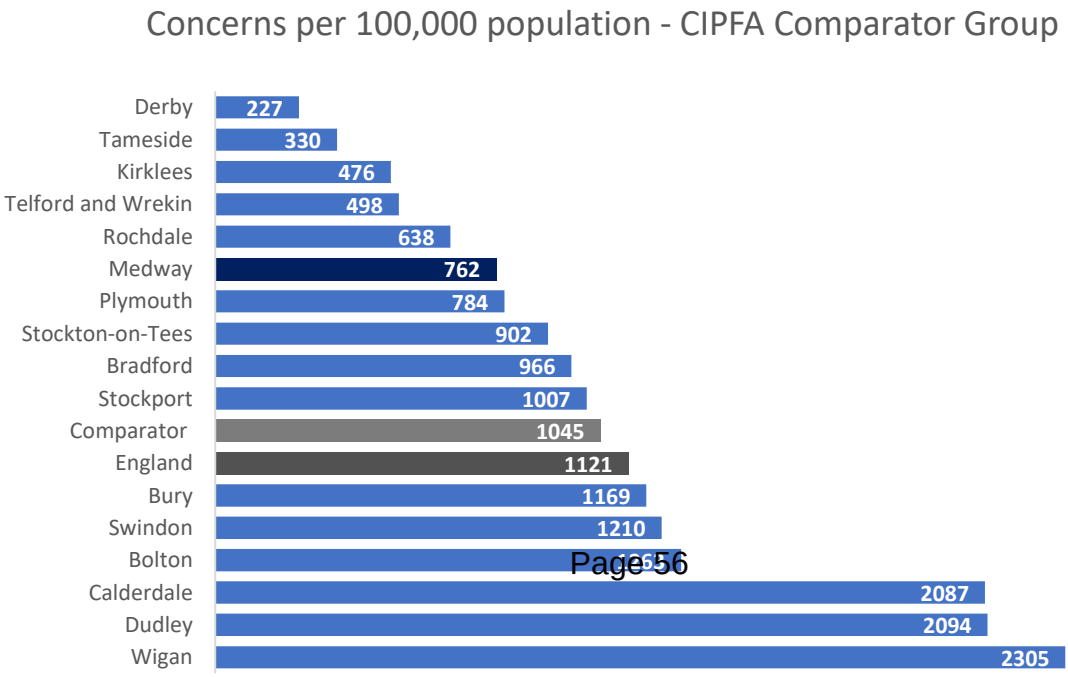
2.1. New Concerns

The following section looks at the number of new concerns and enquiries raised in 2021-22 and the demographics of individuals subject to a new safeguarding enquiry. The analysis covers annual trends and comparisons with other local authorities in Medway's CIPFA comparator group.



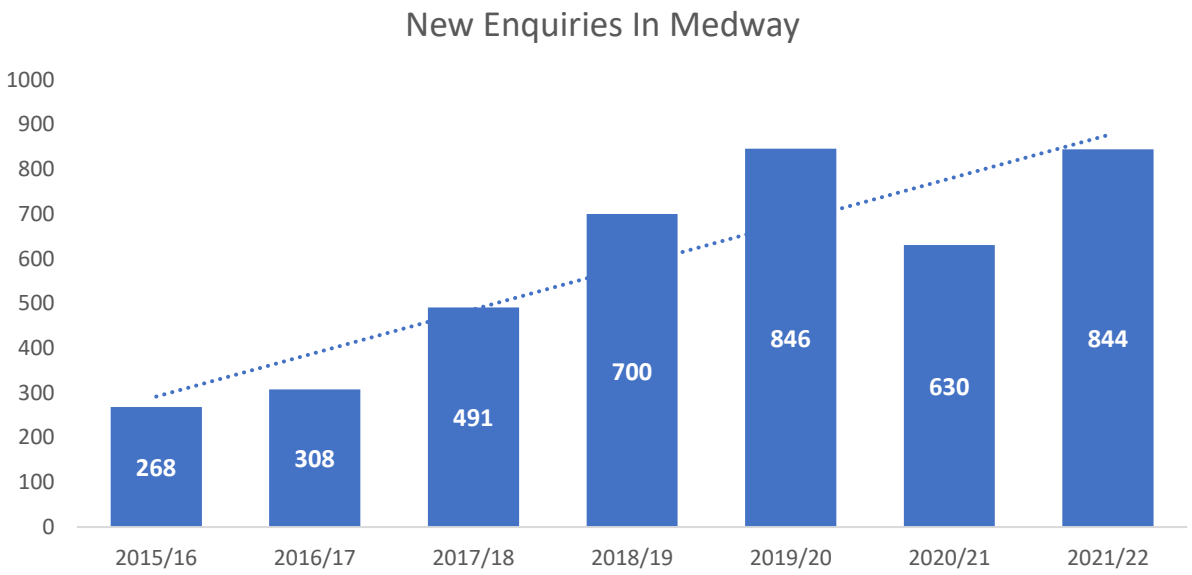
The number of new safeguarding concerns raised in Medway has seen a consistent increase since 2015-16 to 2020-21. However there has been a more significant increase, of 26%, from 2020-21 to the current reporting year (2021-22). The increase may be reflective of the easing of Covid 19 restrictions resulting in more face-to-face contact and identification of potential risk.

National data for 2021-22 is yet to be published however, analysis of previous reporting years shows there was a significant increase of 20% in concerns from 2018-19 to 2019-20 and then a 5% increase from 2019-20 to 2020-21. The figures from next reporting year will need to be carefully monitored to fully understand the impact of Covid 19 on incidence, reporting and recording of safeguarding concerns.



Medway ranked 6th out of the sixteen local authorities in the CIPFA comparator group for new concerns per 100,000 population in 2020-21. This was 32% below the figure seen nationally. Crime reports from the police or vulnerable adult alerts from SECAMB would be assessed before they are raised as a Concern. The outturn for 2021-22 in Medway is 956 per 100,000 which would see Medway ranked 8th, according to the available 2020-21 data from other authorities. The publication of the validated 2021-22 data will help understand Medway's new concerns in a national context.

2.2. New Enquiries

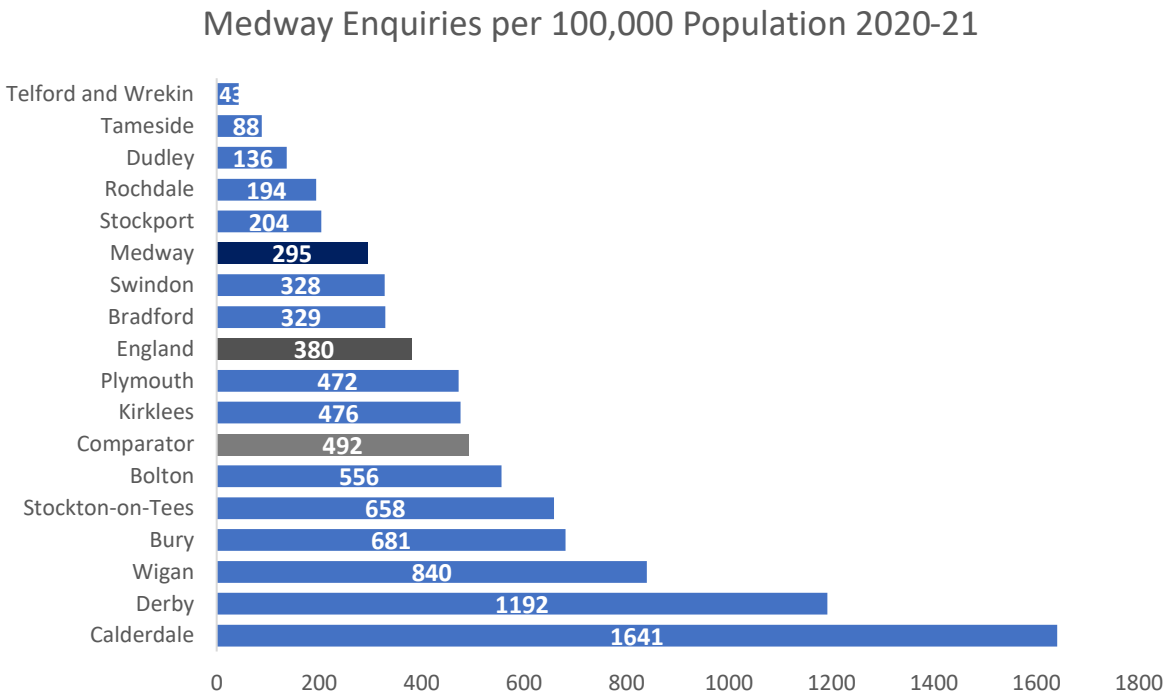


There has been a 34% increase in the number of new safeguarding enquiries raised from 2020-21. 2020-21 saw an 25% decrease from 2019-20 to 2020-21 so the increase seen in the current reporting year sees Medway return to the same figure seen before the Covid 19 pandemic. Again, careful analysis will need to be conducted to ascertain the true impact the pandemic has had on raising and recording of enquiries.

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

The proportions of enquiries that meet the criteria for Section 42 enquiry and those that are non-statutory have remained consistent in Medway from 2018-19, apart from in 2020-21, where the proportion dropped. The number of non-statutory enquiries remaining consistent, but the number of Section 42 enquiries decreased.

The high proportion of non-statutory enquiries is currently being investigated to ensure that these are all appropriate to be investigated as a safeguarding enquiry.



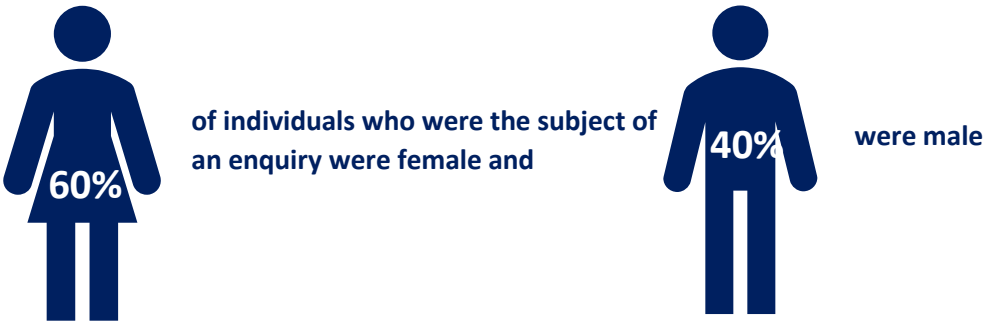
The 2020-21 of new enquiries per 100,000 sees Medway ranked sixth within the comparator group; 22% below the national figure. Medway's current enquires per 100,000 population would be 393 which would place Medway 8th according to the latest CIPFA data available (2020-21). The publication of the validated 2021-22 data will help understand Medway's new concerns in a national context.

2.3. Demographics of Adults at Risk

This section looks at the demographics of individuals subject to a new safeguarding enquiry in 2021-22.

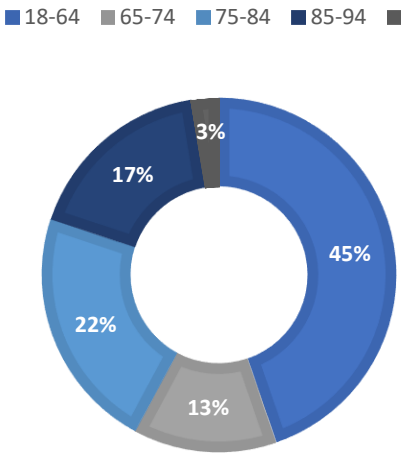
Gender

In 2021-22



There has been a consistent proportional split across genders in past reporting years

Age Group



45% of individuals subject of a new safeguarding enquiry were aged between 18-64 years. The remaining 55% were 65+ with the larger proportions of individuals within the 75-84 and 85-94 age groups jointly accounting for 35% of the total number of individuals.

Ethnicity

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

The proportional split across ethnic groups for individuals subject to a new enquiry has remained consistent over the three reporting years with between 89.5% and 84.3% being white.

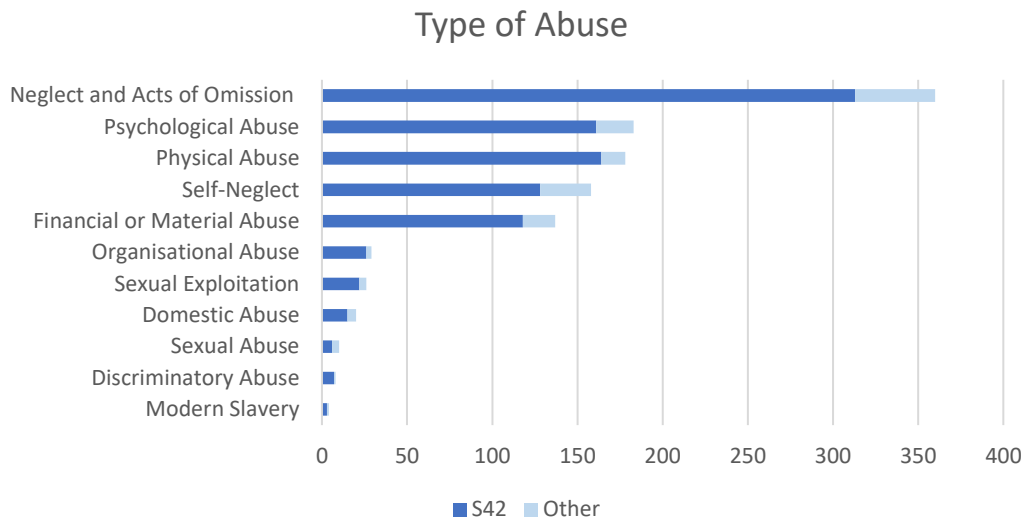
Primary Support Reason

Primary Support Reason	2019-20	2020-21	2021-22
Physical Support	42.6%	44.3%	45.3%
Sensory Support	0.3%	0.3%	1.0%
Support with Memory & Cognition	2.5%	2.9%	2.0%
Learning Disability Support	4.4%	8.2%	8.4%
Mental Health Support	1.4%	8.2%	7.2%
Social Support	1.4%	1.7%	2.6%
No Support Reason	43.5%	35.0%	33.5%
Not Known	0.0%	0.0%	0.0%

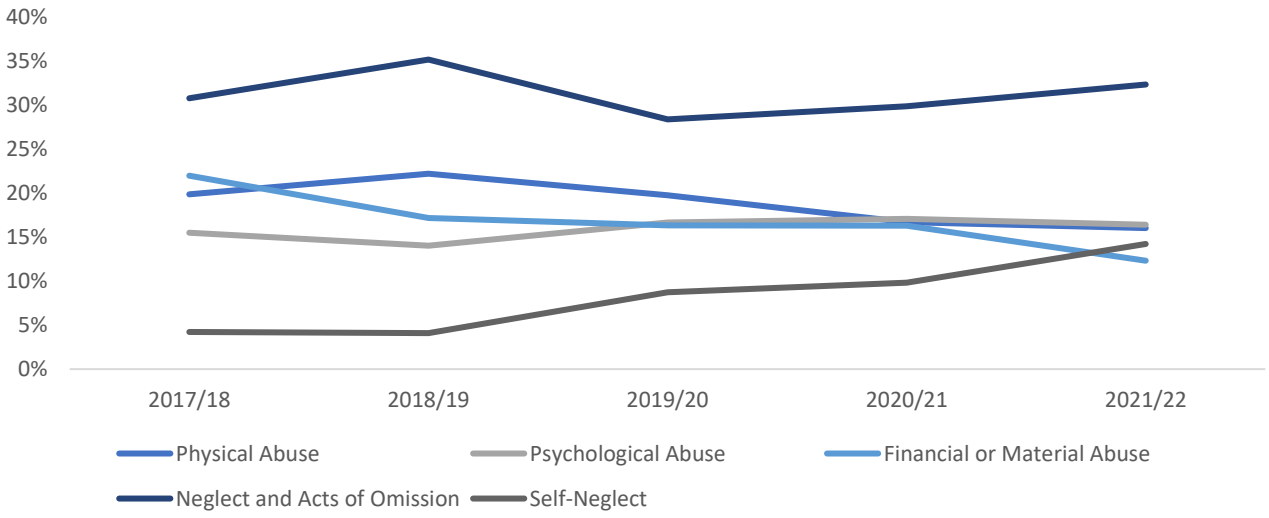
The most prevalent Primary Support Reason (PSR) over the past reporting years has been Physical Support. This includes both individuals who are supported by social services with their personal care or help with their access and mobility. The second most prevalent support reason is those who are not currently receiving direct support from Medway adults social care services. The proportion of individuals subject to a safeguarding enquiry who have a support reason of Learning Disability and Mental Health has increased in the past two reporting years.

3. Closed Enquires

3.1. Types and Location of Abuse

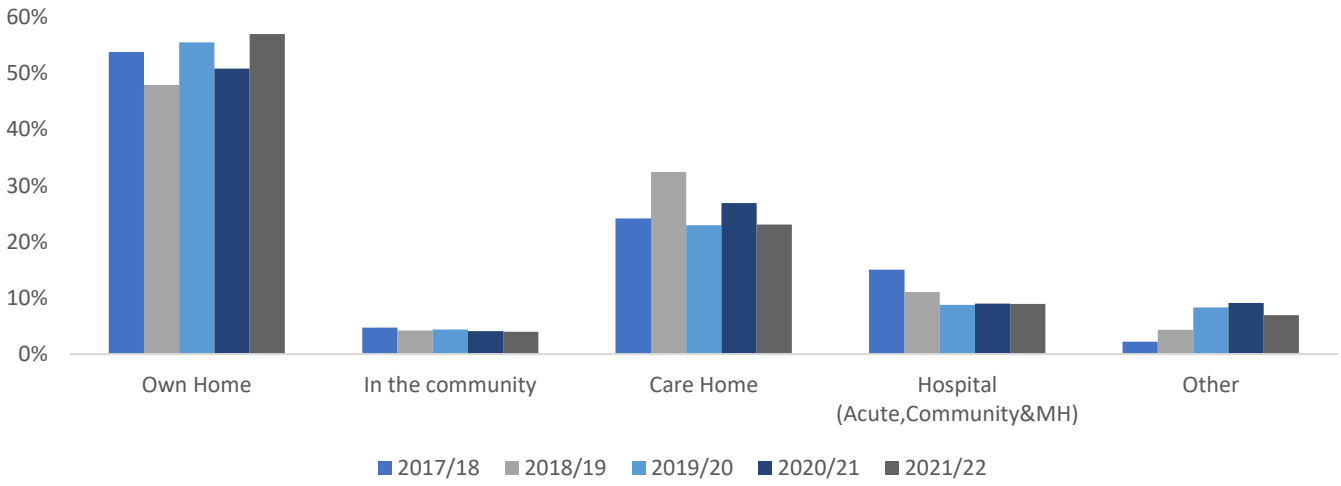


The types of abuse for closed enquiries in 2021-22 reveals that neglect and acts of omission was the most prominent reason presenting in safeguarding enquires. Psychological, physical abuse and self-neglect are the next most prevalent types of abuse reported.



Assessing the proportions of enquires related to the four main types of abuse over the past five years shows that neglect and acts of ommision have always made up the the highest proportion for types of abuse. It has averaged 31% of enquiries over the time period. Both physical and financial abuse have seen a decline in proportions since 2017-18. Phsyical abuse makes up 17% of enquiries in 2021-22 compared to 20% in 2020-21. Financial abuse saw a significant decline from 2017-18 and has remained at 16-17% since then.

There has also been a rise in the proportion of enquiries relating to self neglect with 14% of enquiries related to this compared to 4% in 2017/18. This is reflective of a seven fold increase in actual number of enquiries where the primary reason of abuse is self negelct.

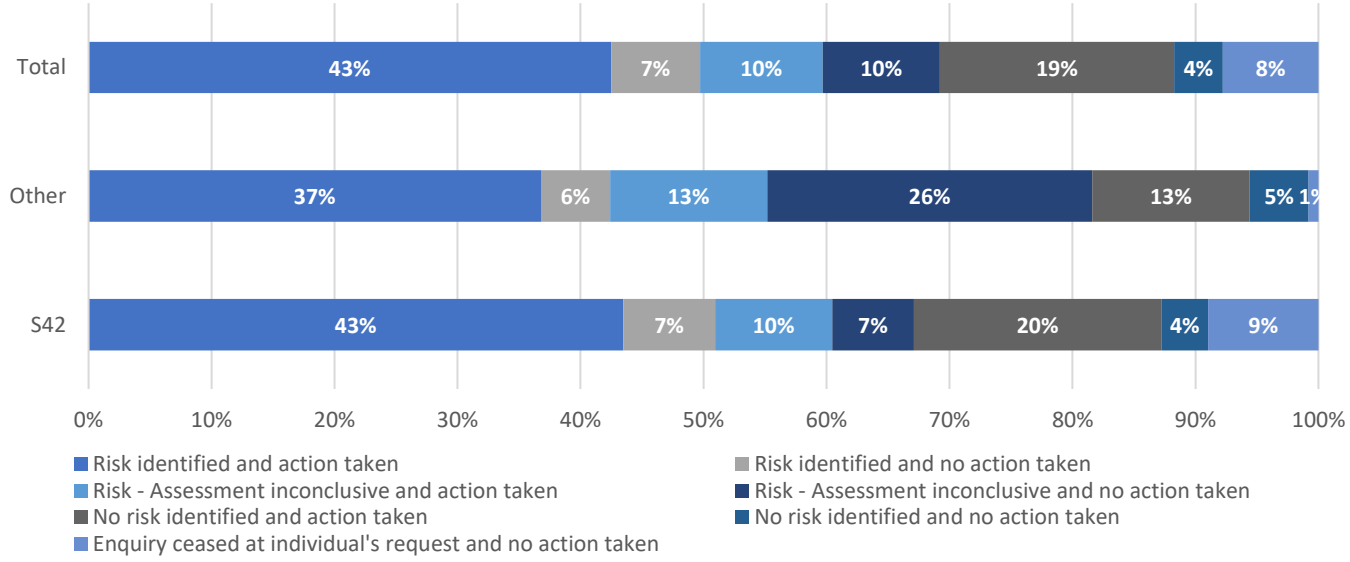


The most prevalent location of abuse has been in the victims own home. The proportion of incidents within hosptial settings has seen a declince since 2017/18 reducing from 15% down to 7% in 2021-22. There has been some fluctation in the proportions of safeguarding incidences in care homes. 2018-19 saw a peak of 32% but the average over the 5 years has been 26% with 23% of closed safeguarding enquiries having been recorded as happening within a care home.

4. Outcomes of Closed Enquiries

The following section looks at the outcomes for closed enquiries covering the identification of risk and actions taken. For those where risk was identified whether the risk remained or was reduced or removed. There are cases where risk will legitimately remain after a safeguarding enquiry has been completed e.g. an individual may want to maintain contact with a family member who was identified as a source of risk.

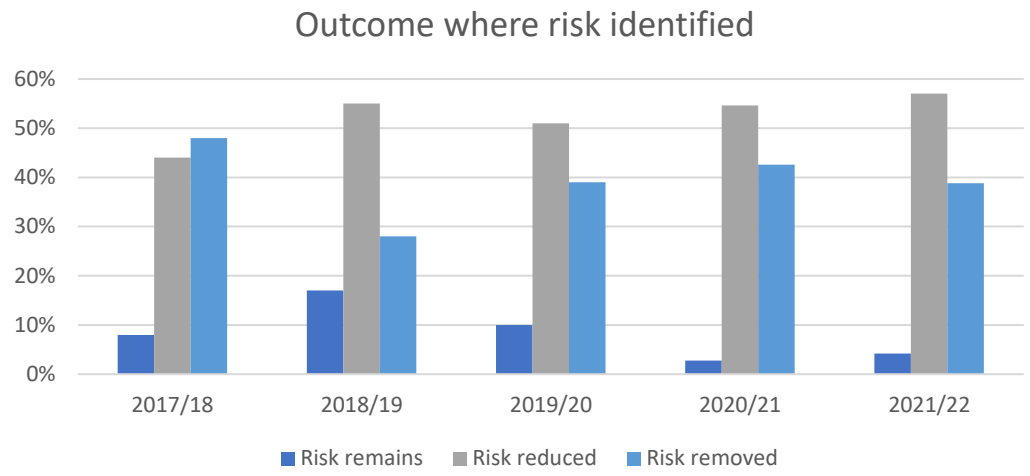
4.1. Identification of Risk



In 2021/22 50% of all closed Enquiries had a risk identified (substantiated) and 23% had no risk identified, this is in line with last year's figures of 51% and 24%. 39% of non-statutory Enquiries were inconclusive compared to 17% of S42.

72% of closed Enquiries had action taken in 2021/22 whether a risk was identified or not, up from 64% in 2020/21.

4.2. Outcome



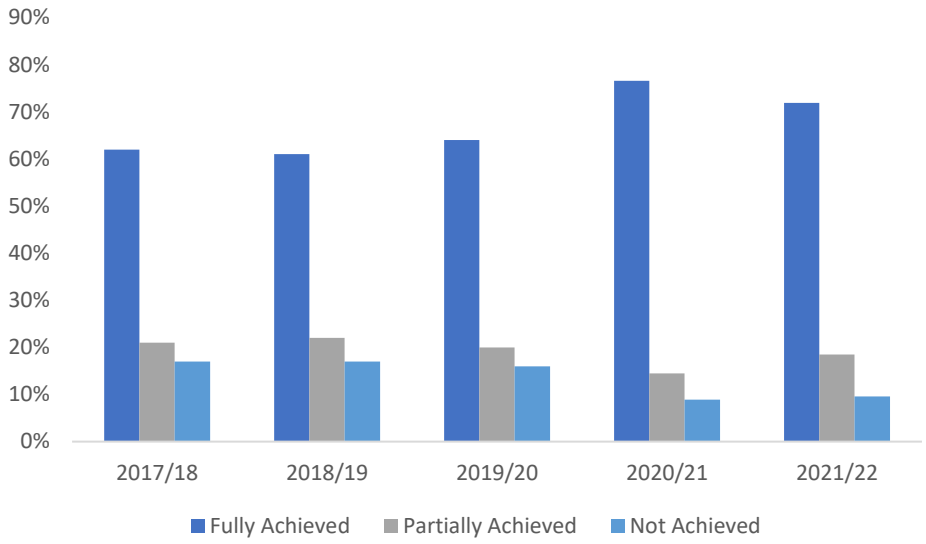
Where a risk was identified in a closed enquiry, 39% saw the risk removed and in 57% of cases the risk was reduced. In the remaining 4% of cases the risk remained, compared to in 3% of cases in 2020/21. This still represents a significant reduction in the proportion of cases where risk remained from 2017-18 to 2019-20 where the risk remained in 8%-17% of cases.

4.3. Making Safeguarding Personal

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

For any safeguarding enquiry, an individual or their representative is asked what their desired outcome of the investigation would be. Over the past 3 years an average of 74% of individuals (or their representative) were asked and expressed outcomes. An average of 22% were not asked and the remaining 4% were not recorded.

In 2021-22 for those who did express outcomes:



Over the past five years there has been a consistent decline in the proportion of those asked for their outcomes where those outcomes were not achieved and higher proportions of cases where the outcomes were fully achieved. In 2021-22 71.9% of individuals had their outcomes fully achieved, 3.8 percentage points above the currently available 2020-21 national figure of 68.1%.

Kent County Council Data

5. Background to the data

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

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

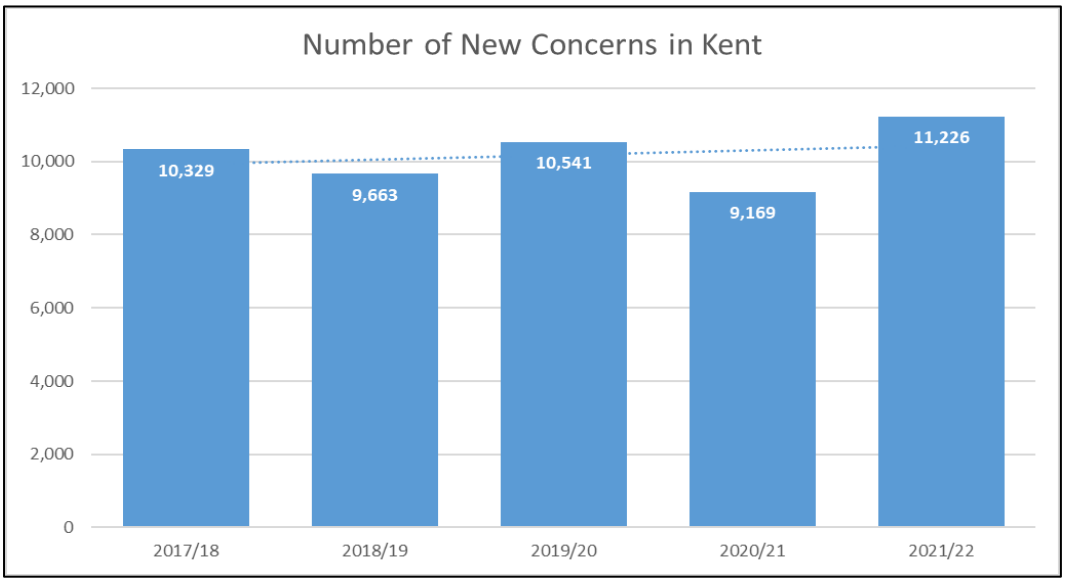
6. New Safeguarding Concerns and Enquiries

The following section looks at the number of new concerns and enquiries raised in Kent for 2021-22 and the demographics of individuals subject to a new safeguarding enquiry.

6.1. New Concerns

The number of safeguarding concerns received has increased on the previous year, however, the increase is more in line with the pre-pandemic trend. In March 2022, a new online form for reporting Safeguarding Concerns was launched, leading to an increase in activity for that month compared to the previous year.

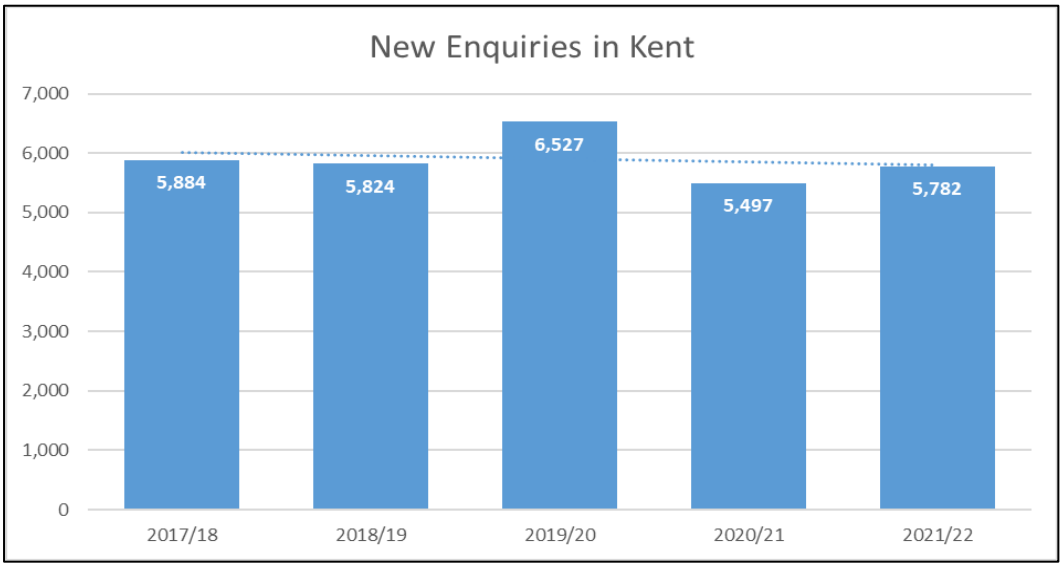
Chart 1: The number of new safeguarding concerns received, by Kent, each year from 2017/18.



6.2. New Enquiries

There was an increase in the number of Safeguarding Enquiries started in 2021/22, compared to the previous year, however they remain lower than the pre-pandemic figures. KCC Adult Social Care and Health (ASCH) implemented a series of improvements in 2021/22, in relation to the safeguarding process and practice, ensuring that the Safeguarding Enquiries that progressed were in line with Care Act (2014) legislation, or signposted appropriately, to provide alternative support to the person concerned.

Chart 2: The number of new safeguarding enquiries commenced, by Kent, each year from 2017/18.



6.3. Demographics of Adults at Risk

This section looks at the main demographics of people subject to a new safeguarding enquiry in 2021/22.

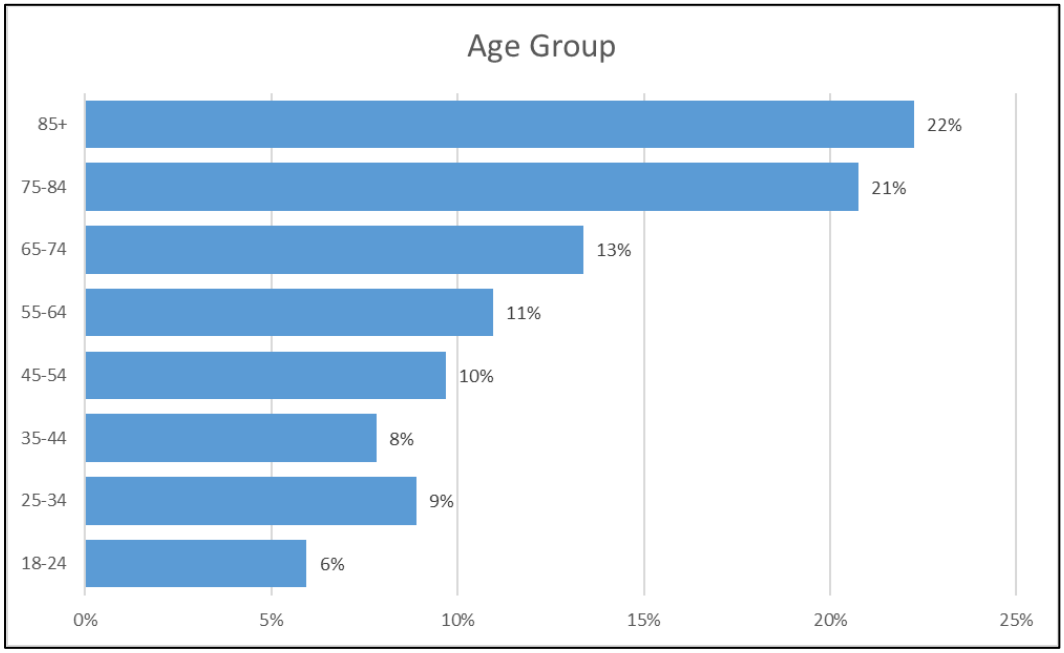
6.3.1. Gender

Proportionately there was a small increase in the number of males compared to the previous year, however 58% were female and 41% were male (there were some whose Gender was unknown).

6.3.2. Age Group

The proportion split of age has not significantly changed on the previous year. The highest proportion of people were aged 75-84 years old (21%) and aged 85+ (22%)

Chart 3: The proportion split of peoples ages, in 2021/22.



6.3.3 Ethnicity

There has been little change to the Ethnicity profile; and the proportion of unknown Ethnicity remains high at 14%.

Table 1: Ethnicity

Ethnicity	2020/21	2021/22
Asian or Asian British	1.8%	1.6%
Black, Black British, Caribbean or African	1.6%	1.5%
Mixed or multiple ethnic groups	1.0%	1.1%
White	80%	81%
Other Ethnic Group	0.8%	0.6%
Unknown	15%	14%

6.3.4. Primary Support Reason

There has been an increase in the proportion of people with no support reason following increases in the volume of risk assessments being completed when a concern has been received. This is to ensure decision-making is recorded appropriately when a concern is not progressed to section 42 enquiry and has led to a higher amount of people involved in an 'enquiry ' (a progressed concern) who have had no support reason identified. Concerns that are not progressed to a full enquiry are unlikely to have a Primary Support Reason recorded on Mosaic.

Table 2: Primary Support Reason

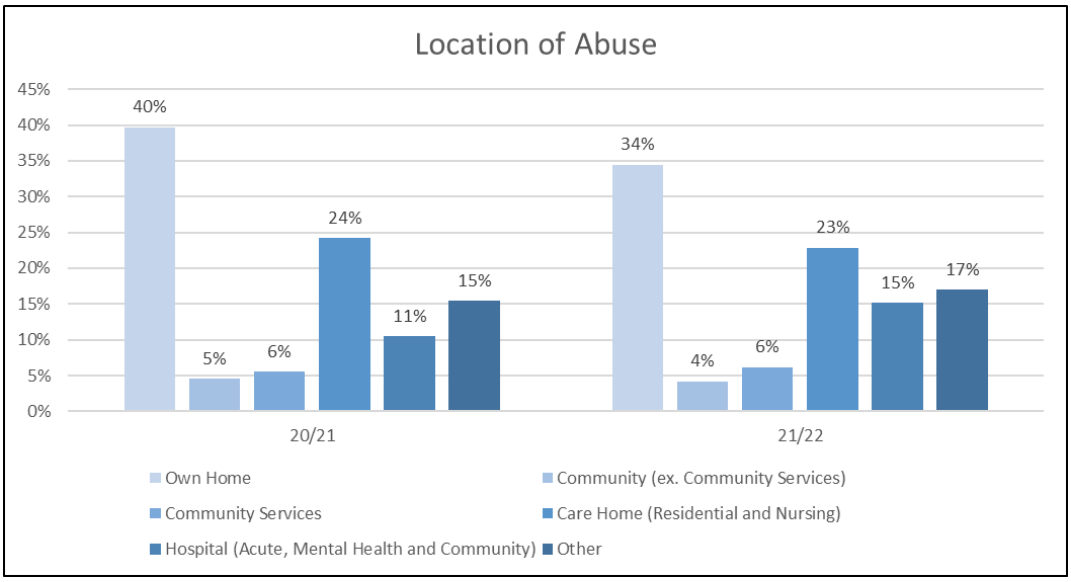
Primary Support Reasons	2020/21	2021/22
Physical	47%	44%
Learning Disability	8%	7%
Mental Health	18%	16%
Memory & Cognition	6%	6%
Social Support	2%	1%
Sensory	2%	1%
No support reason	17%	25%

7. Closed Enquires

7.1. Location of Abuse and Types

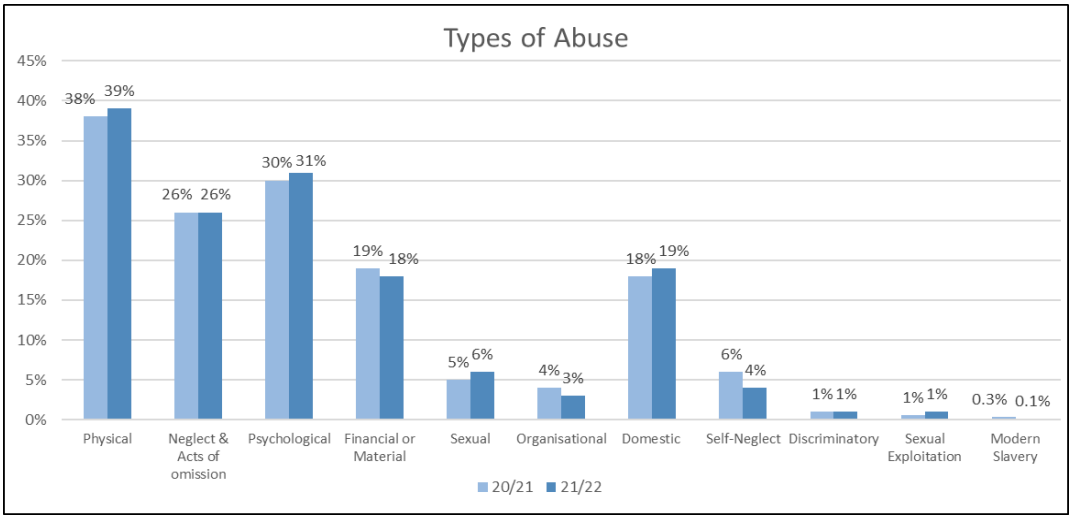
There were decreases in the amount of people who have a location of alleged abuse in their own home or a care home, these are concluded enquiries that may have been initiated during the COVID-19 pandemic. The increase in hospital location of abuse was due to an increase in enquiries being closed in a Mental Health setting as a result of additional resource within the safeguarding function.

Chart 4: The Location of abuse, 2020/21 compared to 2021/22



Physical abuse remains the highest category of alleged abuse, which is consistent with previous years. It is also of note that Physical Abuse and Neglect and Acts of Omission are the two highest categories of abuse identified in neighbouring authorities according to the SAC report. There was a slight change with Self-Neglect, largely due to changes in the way people who were identified as self-neglecting were assisted by Adult Social Care.

Chart 5: Types of Abuse, 2020/21 compared to 2021/22



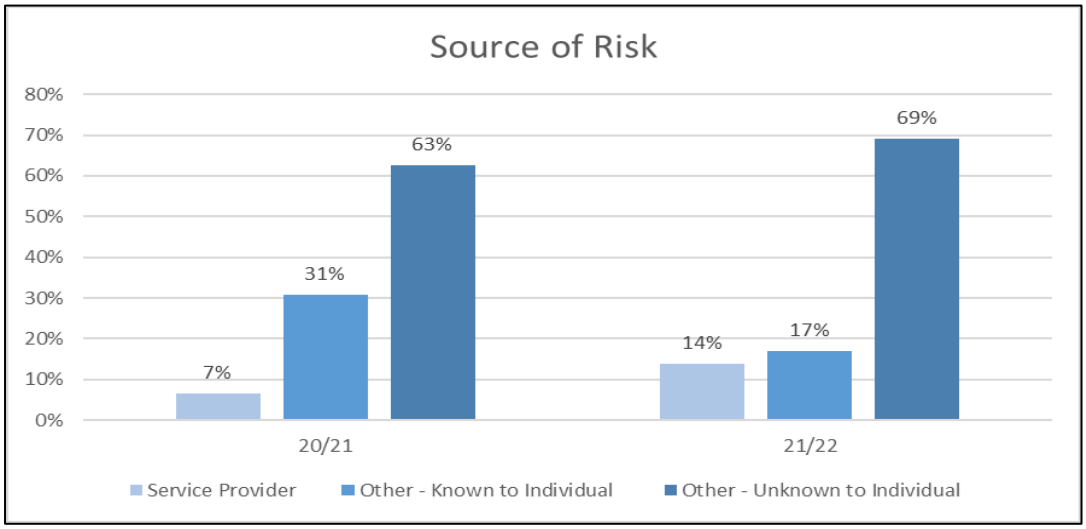
8. Outcomes of Closed Enquiries

The following section looks at the outcomes for closed enquiries covering the source of the risk. For those where risk was identified, whether the risk remained, was reduced or removed. There are cases where risk will legitimately remain after a safeguarding enquiry has been completed e.g. an individual may want to maintain contact with a family member who was identified as a source of risk.

8.1. Source of Risk

Changes made in the recording of safeguarding enquiries have led to improved recording of the source of risk and through having a more robust recording mechanism the volumes of no risk recording has decreased leading to shifts in the source of risk proportions.

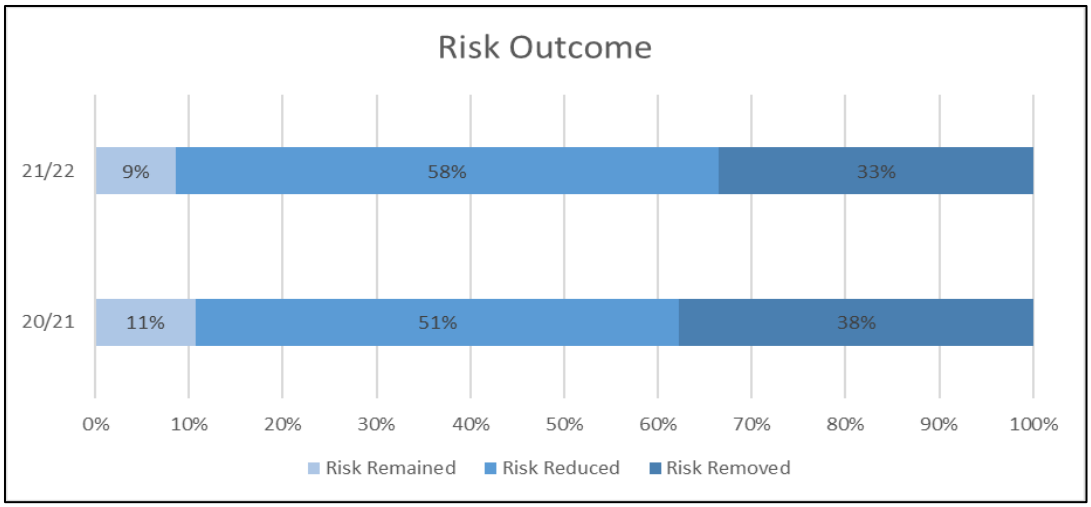
Chart 5: Source of risk, 2020/21 and 2021/22



8.2. Risk Outcome

Although the proportion of those with a 'risk removed' has decreased to 33%, more have had their ‘risk reduced’ leading to a decrease in those with a ‘risk remained’ at only 9%

Chart 6: Risk Outcomes 2020/21 and 2021/22.



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Kent and Medway Safeguarding Adults Annual Report 2021-2022.

Appendix Two – Partner Highlights

Contents

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

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

1. Prevention

Agency	Example
Ashford Borough Council (ABC)	ABC's Safeguarding Lead Officers group received training on the Mental Capacity Act (MCA) 2005. The session was delivered by the KCC Manager for MCA and DoLs (Deprivation of Liberty Safeguards).
Ashford Borough Council	All Ashford Borough Council licensed taxi and private hire drivers are required to complete safeguarding training and provide proof of this prior to being issued a licence. It is recommended that they complete Blue Light Safeguarding training.
Ashford Borough Council	Collaborative Partnership Working: Ashford Borough Council are a key agency in collaborative partnership working. A number of ABC officers work in partnership with other agencies, such as the Police, as part of their day-to-day role. This can include joint visits, multi-agency initiatives, partnership meetings and panels. Partnership meetings include: • Ashford District Contextual Safeguarding Meetings • Multi-agency risk assessment conference (MARAC) • Channel panel, where individuals who are identified as being vulnerable to radicalisation are referred to. • Ashford Adults Vulnerability Panel – multi-agency meeting organised by the Police • Ashford Community Safety Unit
Canterbury City Council	Opportunities to increase learning from experts in adult safeguarding have been taken up with a particular focus on mental health, including: • KMSAB Open Forum attended by safeguarding leads who cascaded useful information about the Mental Capacity Act 2005 • Specialist training: Adult Safeguarding & Homelessness: Foundations for Positive Practice delivered by Prof. Michael Preston-Shoot • Bespoke session "Understanding mental health conditions" delivered by a clinical psychologist. In addition, elected members have received an Adult Safeguarding Basic Awareness briefing session.

Canterbury City Council	The Council participate in a number of multi-agency forums that contribute to adult safeguarding including: • Canterbury Vulnerability Panel co-ordinated by the Police. This multi-agency group addresses individual complex safeguarding issues which will have an impact on the wider community, such as cuckooing and exploitation. As a result of meetings, safeguarding referrals and action plans are co-ordinated and comprehensive. During 2021/2022, 28 people were supported by this panel.
Canterbury City Council	Working with Kent Fire and Rescue Service and the Royal British Legion, Canterbury City Council Armed Forces Community Covenant Champions set up a Veterans Hub last year at one of our Neighbourhood Centres. The Hub provides a space where those who served can access information, support and take part in activities that support mental health and wellbeing.
Canterbury City Council	The Rough Sleepers Initiative team take an assertive outreach approach which has embedded safeguarding adults practice throughout. The team focus on harm reduction, drug & alcohol use and discussions on how to keep safe. All staff are naloxone epi-pen trained and have worked in partnership with Forward Trust to train clients so they are able to safely use Epi pens on themselves, and others, should there be an overdose.
Dartford & Gravesham NHS Trust (DGT)	The DGT has continued to deliver face-to-face 'Family Focused' training for the past year in conjunction with the safeguarding children's team, albeit that the classroom sizes have been reduced as a result of COVID-19. The aim of the training is to ensure that staff are aware of the whole safeguarding agenda, their roles and responsibilities and the interface between them. The training consists of the use of Virtual Reality (VR) technology in order to give a richer experience, adding some additional context to the day and a 'lived experience'. The training also includes a session from the Mental Health Lead Nurse and the Independent Domestic Violence Advisors, which adds richness to the training and follows the themes from the VR experience. The training has good feedback and is well received by all trust staff. The quality of safeguarding referrals and enquiries has improved following this training. The role of the Safeguarding Adults Boards is discussed and how to access the website is shared during the training day.
Dartford & Gravesham NHS Trust	DGT has recently purchased three bespoke webinars that are accessible on the Trust intranet with the aim of improving staff understanding of the Mental Capacity Act and its application. These including Mental Capacity, Fluctuating Capacity and communication.
Dartford Borough Council	Recent SARs have highlighted the need for carers to be signposted to carers' assessments and support where appropriate. As a result, DBC's Safeguarding Policy has recently been updated to include this information and a briefing has been drafted to raise awareness to staff.
Folkestone and Hythe	Safeguarding policy and procedures - this policy was updated in November 2021 and went through a rigorous council scrutiny process. All key members were able to input to the production of the policy and changes were made accordingly. In addition, the findings of the Board's self-assessment framework (SAF) peer review were incorporated into the revised policy. The revised policy places additional emphasis on topics such as: Safeguarding Adults, Prevent, Modern Day Slavery, Mental Capacity Act, Deprivation of Liberty Safeguards, Domestic Abuse, Mental Health, Hoarding.
Folkestone and Hythe	KMSAB newsletters and other updates are shared with the council's Designated Officers and the members of the Safeguarding Steering Group, who can then disseminate the information amongst their teams as required. The Corporate Leadership Team signposted to the extensive work of KMSAB, resulting in adult safeguarding becoming a mandatory eLearning course across the organisation from 2021/22 onwards.

Folkestone and Hythe	One aspect of our work has been to support our community hubs in delivering ongoing assistance to vulnerable people experiencing difficulties in reconnecting back into society by continuing with loneliness/isolation befriending calls, and also helping in hardship. The community hubs helped in making sure people stayed warm through the winter, and were receiving adequate food and heating, and therefore not self-neglecting.
Gravesham Borough Council (GBC)	In addition to the Adult Safeguarding Level 1, Child Safeguarding Level 1, and Modern Slavery and Human Trafficking online training, the Lead Safeguarding Officer has developed a GBC-specific briefing delivered face-to-face to review the council's Safeguarding policy and procedures.
Gravesham Borough Council	A Gravesham specific multi-agency collaboration is the Gravesham Vulnerability Panel (GVP) and Organised Crime Groups meeting. This monthly meeting co-ordinated and hosted by GBC, chaired by the Police. The purpose of the GVP is to provide a partnership response to areas of vulnerability and associated crime and its impact on local communities. The GVP takes referrals from officers within the council, police, and partner agencies for vulnerable adults, with the following aims: • Provide an effective local response to issues related to areas of vulnerability in Gravesham; • Develop and implement multi-agency plans, specifically tailored to support and meet the needs of individuals, victims and communities affected by areas of vulnerability; • Raise awareness, amongst partner agencies and within local neighbourhoods, of the areas of vulnerability and the impact on individuals and communities; and • Carry out joint activity to develop techniques and identify interventions to deter people (particularly those under 21 years) from being drawn into serious and organised criminality.
Gravesham Borough Council	Modern Slavery Working Group. A multi-agency group focussed on an action plan to address Modern Slavery in Gravesham. It is well attended and partners have requested this is expanded to include more of the county and more partners.
Heathwatch	Healthwatch is continuing to work with The Advocacy People in setting up a "Citizen's Panel" to ensure that safeguarding information is reaching the public in a way that is understandable. The panel will also be able to share real life experiences.
HM Prison Service	Kent Surrey and Sussex prisons group provide all staff with Suicide and Self Harm (SASH) training which incorporates the identification of those who are vulnerable to the exploitation of others. Vulnerable individuals are also referred to our weekly Safety Intervention Meetings (SIM) where a behavioural plan can be formulated with the advice and assistance of our mental health team, psychology department and specific senior staff member who is allocated as a case manager.
Kent County Council (KCC)	During 2021, KCC Learning and Development provided training for over 3,500 colleagues, which included various subject matters such as; Safeguarding adults' basic awareness, Section 42 Safeguarding Enquiries, Mental Capacity Act, Domestic Abuse, Transitional Safeguarding, and self-neglect awareness. KCC also has a suite of e-learning material accessible to all staff. In addition, the Practice Postcards produced by the KCC Practice Development Officers (PDOs) in Adult Social Care and Health, are all available on the Kent Academy (learning resource). The postcards' themes are in-line with issues highlighted within Safeguarding Enquiries, and various safeguarding adult reviews (SARs) and Domestic Homicide Reviews (DHRs), for example, topics such as substance misuse, suicide, homelessness, self-neglect, and transitional safeguarding. This learning resource is promoted within Team meetings, in the Adult Social Care bulletins and on our intranet page. A series of team talks were delivered between November 2021 and January 2022

	which are now being converted to video for colleagues to access. The team talks covered areas such as Human Rights from a Deprivation of Liberty Safeguards (DOLS) perspective, Introduction to Liberty Protection Safeguards Progress and Undertaking Mental Capacity Assessments.
Kent County Council (KCC)	The vision for Adult Social Care is changing and in 2021 the work to make this a reality started to take shape. The 'Making a Difference Everyday' approach focusses on three pillars which outline the overarching areas of development within Adult Social Care and the basis for how we work. In line with 'Making a Difference Every Day', in March 2021 the work began on person's voice priorities – our building blocks to help us embed and share people's experiences and stories as part of our standard way of working. This work included creating a core co-production group of people that will influence our priority projects, scheduling 'springboard' surveys to open up key discussion themes to a wider audience and promoting our People's Network to raise awareness of how to get involved in social care. In addition, we launched a 'living library' of people's voices and their feedback. In July 2021, during National Co-production Week, the "Your Voice" network was launched. The network is co-production in practice, putting the person's voice at the heart of how we develop services, to ensure we deliver consistent, high quality person-centred and innovative support to those that need it. There is a specific work stream focussing on the review and redesign of the delivery of safeguarding; this will include ensuring that the person is seen, to enable their voice to be heard.
Kent County Council (KCC)	The Kent Adult Carers Strategy 2022 to 2027 was drafted and sent out for consultation. An estimated 148,341 adults aged 16 and over provide unpaid care each week across our county. Therefore, KCC reached out for views from the people of Kent to ask "have you ever looked after an adult relative or friend? Or do you support people in your work that have unpaid caring responsibilities?" It was vital to hear people's thoughts on the new strategy which describes how we plan to work with all our partners to make welcome changes towards improving the experiences of unpaid adult carers.
Kent Community Health NHS Foundation Trust (KCHFT)	In 2021/22, KCHFT launched its 'Nobody Left Behind - People, Equity, Diversity and Inclusion Strategy' and 'Nobody Left Behind Charter' with a pledge to zero tolerance to abuse, discrimination and microaggression; supporting people to recognise the signs of abuse and how to seek help without fear of negative consequences.
Kent Community Health NHS Foundation Trust	KCHFT delivered on its promise to successfully deliver a mass vaccination programme to the population of Kent and Medway as one of the interventions to disrupt the Coronavirus pandemic. This included safeguarding arrangements to ensure staff responsible for delivering the vaccination programme were trained to recognise, respond and escalate any safeguarding concerns.
Kent Community Health NHS Foundation Trust	The Trust has a dedicated specialist safeguarding service to support the organisation with meeting its safeguarding duties, in line with national and local legislation and guidance, and to promote the key safeguarding principles. Staff can access a dedicated safeguarding consultation duty line for specialist support, advice and guidance, safeguarding supervision and training. The safeguarding team further supports staff with complex safeguarding cases, professional escalation and referrals into social care.
Kent Community Health NHS Foundation Trust	The Trust continues to support staff to raise awareness of self-neglect and the importance of supporting people who demonstrate self-neglect or hoarding behaviour via a multi-agency approach. The Trust has seen a 50% rise in calls into the KCHFT duty line related to self-neglect compared to the last 2 years, which demonstrates good awareness and provides opportunity for relevant actions to be taken to support the patient and staff to complete relevant referrals for support,

	working collaboratively with partner agencies, completion of risk assessments and patient support.
Kent Police	In 2021, Kent Police introduced a Strategic Detective chief inspector (DCI) role that has a dedicated portfolio of Child Protection and Adult Protection. The role also includes oversight of the Central Referral Unit whose role is to manage multi-agency safeguarding referrals and notifications. The number of referrals to Adult Social Care and NHS Mental Health Services processed through the Central Referral Unit decreased in 2021. This reduction may be due to the impact of COVID-19 during 2021, however it also reflects a better understanding of thresholds for referrals to partner agencies due to ongoing training.
Kent Police	Kent Police Mental Health Team has improved the collection and use of data, to deliver enhanced training, ensuring the appropriate intervention is made when dealing with people in crisis, and works closely with KMPT (Kent and Medway NHS and Social Care Partnership Trust, NELFT (North-East London Foundation Trust) and the NHS CCG. This work has resulted in better outcomes for vulnerable people by the reduced use of police powers of detention under Section 136 of the Mental Health Act 1983. Kent Police continue to use the dedicated 836-advice line, which provides clinical advice for front line officers prior to making decisions to detain individuals. The Kent Police Mental Health Team is supporting partners to review policies, processes, and practices to improve the quality of service to patients. The Strategic Partnerships Superintendent continues to co-chair the "Urgent Care Oversight Board" with KMPT which monitors the delivery of a number of improvement projects which will see continued change and improvements in the service provision. This includes the creation of a 24/7 crisis function for adults during 2022 via NHS 111.
Kent Police	Kent Police also continued to implement the AWARE principles (Appearance, Words, Activity, Relationships and dynamics, Environment). These are designed to support the development of professional curiosity in identifying vulnerability in both children and adults. This principle can be used in any context and provides guidance around signs to look out for and be aware of to identify early safeguarding opportunities and support voice of the child and voice of the vulnerable adult information gathering within Kent Police. Force wide training on the AWARE principals will be delivered to all front line staff by the end of 2022.
Kent Police	In January 2022, Kent Police launched the Tackling Violence Against Women and Girl Strategy to underpin the principles of the government's Violence Against Women and Girls Strategy (published in September 2021). It lists five key areas in which Kent Police will drive change: • Holding Offenders to Account • Supporting Victims • Keeping you Safe • Our Culture • Strengthening the system The document is available publicly here.
Kent Police	Kent Police Learning and Development has developed a new Adults at Risk Course. This week-long course builds on the basic Safeguarding Training all officers receive and reinforces the need for specialist investigators to work with other agencies. The aims of the course are: • To promote collaborative working to achieve best practice in relation to the vulnerable adults who fall within the remit of the multi-agency adult safeguarding and/or criminal investigation system. • To enable students to apply the principles and values of vulnerable adults to operational situations In 2021/2022, a total of 74 Detectives completed this enhanced training.

Kent Police	Kent Police continued with carrying out 'Hidden Harm Visits' which are proactive visits to families most at risk of domestic abuse. These were initially conducted as a response to Covid and concerns regarding hidden harm during lockdown, however due to positive feedback from victims these visits continued. The plan is that they continue into the future but will be managed by the newly formed Proactive Domestic Abuse Teams on each division.
Kent Fire and Rescue Service (KFRS)	Safeguarding training has recently been reviewed. We have re-written the eLearning packages for children and adult safeguarding for all employees and volunteers. This is classed as mandatory learning for all employees and volunteers with an expected completion date of May 2022. Completion rates are monitored robustly. This is also a safeguarding package included within the induction for any new starters in the Service.
Kent Fire and Rescue Service (KFRS)	In October 2021, the Safeguarding Manager and Customer Safety Lead attended The National Fire Chief's Level 3 and Level 4 Safeguarding Train the Trainer. Our 2020/2021 training plan, delayed by COVID, has been written with reference to the intercollegiate document. Different levels and roles within the fire service have been identified as requiring different levels of safeguarding training and level 3 sessions have seen the attendance of the Chief Fire Officer, Area Managers, Directors, Assistant Directors, Corporate Management Board, Duty Group Managers, Designated Safeguarding Officers, and strategic personnel with safeguarding responsibilities.
Kent Fire and Rescue Service (KFRS)	In September 2021, a full time Safeguarding Officer was appointed as it has been recognised that the demand has increased. We have seen an increase in safeguarding cases for hoarding, self-neglect and mental ill health with threats or attempts to end life. We have also retained the Designated Safeguarding Officer position (currently 17) which is a specialism in addition to their role within the service. KFRS has increased the amount of Station Manager roles with safeguarding as a specialism to 11 to provide out of hours support. Support for colleagues who identify a safeguarding concern is available 24/7.
Kent and Medway Clinical Commissioning Group (KMCCG)	In addition to the training provided to KMCCG staff, the safeguarding team has provided safeguarding training across primary care through online and bespoke webinar training events. These will be further repeated in June and July 2022, capturing the 192 GP practices across Kent and Medway. The use of virtual events with Primary Care is very well attended and this mode of delivery appears to have produced increased engagement.
Kent and Medway Clinical Commissioning Group (KMCCG)	In West Kent, primary care safeguarding lead forums were established and ran throughout 2021-22, offering practice leads the opportunity to share learning, discuss case learning and share new and evolving safeguarding practice. The team is now looking to establish these forums across Kent and Medway, following positive engagement and feedback by the primary care workforce. KMCCG also offer as required support and informal supervision to some provider safeguarding teams.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	KMPT safeguarding training is reflective of both the Adults and Children's Intercollegiate Documents. These statutory frameworks are followed with the inclusion of local learning from Safeguarding Adult Reviews (SAR), Child Serious Case and Rapid Reviews, and Domestic Homicide Reviews (DHR) to enable continued reflective learning and development. Supplementary Domestic Abuse, Stalking and Harassment (DASH RIC) training, and bite-size topical safeguarding sessions have been delivered to compliment the statutory training. Hidden harm and increased risk to people stemming from a reduction in face-to-face contacts and increases in video technology contacts has been reflected in policy and training to support staff to understand hidden harm and how to respond and adapt practice to keep people safe. KMPT policies and training reflect the need to be risk and person centred in the decision of contact types. Safe mode of routine enquiry is discussed within

	induction safeguarding training and subsequent levels, in addition to resources to support safe routine enquiry accessible on the safeguarding KMPT intranet page, to mitigate risk associated with different modes of contact in response to the pandemic. The safeguarding training compliance was a significant achievement in 2021 and 2022. There is evidence that the move to virtual training in response to the pandemic has not impacted on safeguarding functions, and that safeguarding adults is embedded into KMPT culture, with alerts/referral rates evidencing commitment from KMPT staff to recognise and respond to safeguarding, thus enabling a multi-agency approach.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	Self-neglect, a common theme within Safeguarding Adult Reviews (SARs), is discussed in all levels of adult safeguarding training. The KMSAB Multi-Agency Policy and Protocol for Managing Self-Neglect and Hoarding is accessible to staff on the KMPT Safeguarding Intranet page, in addition to bite-size training, video/webinars and other self-neglect resources. The referral rate identifying self-neglect evidences front line staff's responsiveness, and thoughtfulness with people that are self-neglecting to enable a multi-agency approach in-line with policy and good practice.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	KMPT is committed to supporting carers. KMPT teams, with the permission from patients, will always seek to involve carers and other friends and family in our programmes of support. This includes consultation on the decisions made about care and treatment. KMPT activity seeks the views and engagement of carers and promotes how people can gain access to a carer assessment on our public facing webpage.
Maidstone and Tunbridge Wells NHS Trust (MTW)	Staff have the opportunity to discuss and debate issues and cases with the Named Nurse for Safeguarding Adults via a Teams meeting to further their understanding and exploration of the subject matter in both Safeguarding Adults and Mental Capacity. These 'talk with the expert' sessions are offered monthly from March through to November each year and are proving popular for practitioners to discuss particular cases, learning from the Webinars or learning from practice.
Maidstone and Tunbridge Wells NHS Trust (MTW)	MCA and DOLS learning requirements have been mandated for staff to complete every 3 years, as opposed to having been a one off requirement within the Trust. In the drive to improve competence and confidence amongst staff to apply MCA/DOLS into their practice, the Trust has taken the decision to reset the training compliance for this subject back to zero and all relevant staff have been notified that they need to complete their MCA/DOLS training in the near future to become compliant. We expect compliance rates to be on an upward trajectory over the next year with the Trust reaching the compliance target of 85% by July 2023. Staff will then be required to refresh this training every 3 years, seen as especially important due to the changes in relation to Liberty Protection Safeguards going forwards.
Maidstone Borough Council (MBC)	Safeguarding training is mandatory and an audit was undertaken to ensure all staff complete e-learning. Training has been developed and delivered with an external agency after collating staff responses around safeguarding and gaps in knowledge and confidence levels. This was measured by a questionnaire measuring confidence and knowledge both before and after training.
Maidstone Borough Council	MBC also developed a counselling service by working in partnership with Mid Kent Mind for adults who present with self-neglecting behaviours such as hoarding.
Medway Community Healthcare (MCH)	Information relating to the work of KMSAB and adult safeguarding, including themes from SARs, policy updates and learning events, are communicated to staff and the general public through a variety of means including: • MCH social media accounts • Internal quality assurance meetings • Intranet and internet content

Medway Council	Medway commissioned bespoke 'The Role of the Inquiry Officer' and 'The Role of the Designated Safeguarding Officer' training, this has been quality assured using the KMSAB Training Delivery Observation Sheet. This includes mental capacity, unwise decisions and how an assessment under section 11 of the Care Act can be utilised. To support practice, in light of findings from Safeguarding Adult Reviews, training has been delivered on Strengths Based Practice and Developing / Use of Professional Curiosity. All training is initially quality assured via attendee feedback, with further quality assurance activity as required.
Medway Council	The internal High Risk Panel continues to support practitioners working with individuals where there are barriers to engagement, who make what appear to be unwise decisions and live with a high level of risk. This supports practitioners and ensures senior management are aware of these individuals. Work has started on operational guidance for staff where individuals do not engage and how MOSAIC (IT system) can be used to ensure that there is management oversight where interventions are closed due to non-engagement.
Medway Foundation Trust	The Trust Executive team commissioned bespoke Board level training delivered in October 2021 by Bond Solon, this training included the Non-Executive Directors for the first time.
Medway Foundation Trust	There have been a number of webinars and online conferences promoted and accessed during this time, of particular benefit to safeguarding and to the wider workforce was a series of webinars from Alcohol Change UK which included Lessons from Safeguarding Adult Reviews, by Professor Michael Preston-Shoot
Probation Services	Our pan-Kent Safeguarding Team continue to offer support, guidance and signposting for any frontline practitioners who have adult safeguarding concerns or who want to discuss whether or not to make a referral. Our pan-Kent Safeguarding Bulletin has regularly provided frontline staff with details of the current offer from the Safeguarding Team. All staff are regularly trained in all aspects of safeguarding. This includes group training, one to one support in supervision and via our Quality Development Officers.
Probation Services	We have People on Probation Forums on a regional basis as well as local arrangements to ensure the "voice" of the service user is heard so we can make the necessary improvements into our operational delivery.
Sevenoaks Council	Understanding and responding to self-neglect remains an ongoing priority and there is recognition of the risk of self-neglect increasing, therefore, we have appointed a Hoarding Co-ordinator in partnership with Peabody, funded through the Better Care Fund.
Sevenoaks Council	A Homeless Risk Management group responds to concerns relating to a group of individuals who are homeless and have additional vulnerabilities relating to mental health and/or substance misuse. Through multi-agency information sharing and support with West Kent Housing and Kent County Council, risks to rough sleepers/homeless were considered and have resulted in a 'Housing First' supported housing model being delivered.
Swale Borough Council	Swale Borough Council has its Safeguarding Policy in place that is regularly reviewed – the last review being December 2021. An internal audit has also been completed recently with a 'sound' assurance level.
Swale Borough Council	Collaborative working is carried out using the Swale Vulnerability Panel which was set up several years ago, and despite Covid, this has remained a very well attended meeting with effective results in helping vulnerable people of Swale. We have had a case where the client would not engage with agencies and we utilised KCC wardens to build a relationship and assist in mental health, housing and social care to offer help and assistance.

Thanet District Council	Thanet District Council has a dedicated Safeguarding team that is embedded within the Community Team who carry out all safeguarding duties. This Safeguarding team, although embedded within the Community Team, also works alongside Kent Police Community Safety Unit and Multi-agency Task Force (MTF).
Thanet District Council	The Safeguarding Forum is chaired by the Community Services Manager and representatives from each department within the council. Discussions are had around safeguarding cases, serious case review, Domestic Homicide Reviews, emerging trends, training, policies, PREVENT, projects and any concerns/issues with regards to safeguarding. All those who sit on the safeguarding forum are trained to a higher level.
Tonbridge and Malling Borough Council (TMBC)	TMBC has a Safeguarding Policy and Reporting Procedure. This has been sent to all staff via NetConsent (which only allows access to computer files once the policy has been read and agreed).
Tonbridge and Malling Borough Council	Our policy for taxi drivers requires all drivers to undertake safeguarding training within 12 months. All new drivers must take a safeguarding course before receiving their licence.
Tonbridge and Malling Borough Council	Weekly Community Safety meetings take place, with Police and partner agencies, to share concerns. Safeguarding, hoarding, exploitation, and vulnerable adults are standing items on the agenda. A monthly Vulnerable Persons Board (which is linked to the Community Safety Partnership with Borough Council reps attending), ensures that we're sharing information in relation to vulnerable people. A Rough Sleepers Task and Finish Group meets to identify individual's rough sleeping in the borough and look at what actions/support can be offered to help them into accommodation and off the streets. An on-call Duty Officer is available 24/7 to support and assist vulnerable people with emergencies.
Tonbridge and Malling Borough Council	SARs/DHRs are standing items at the quarterly internal safeguarding meeting, to raise awareness and understanding of the issues with staff.
Tunbridge Wells Borough Council	Case management supervision within the Housing Needs Team takes place monthly, with the Senior Housing Options Advisor reviewing the caseload of the Housing Options Advisors, which includes many vulnerable single adult applicants, enabling the discussion of any complex cases, identification of any safeguarding concerns and the appropriate actions required. Weekly team meetings and bi-weekly complex case discussions are also utilised as an opportunity to discuss cases and prevent escalation, by identifying support services to refer vulnerable at risk clients into.

2. Awareness

Agency	Example
Ashford Borough Council	The Council's Website has a page specific to safeguarding which outlines what to do if people are concerned someone is suffering abuse. It also contains links to the Council's Safeguarding Policy, the KMSAB website, modern slavery and preventing extremism. It has a link to the leaflet how to protect yourself from abuse in a number of alternative languages. During the period covered by this report, there were 330 unique page views for the ABC Safeguarding page.
Ashford Borough Council	Engagement with residents in Independent Living Schemes: These include various events that residents and others from the local community can attend and enjoy, such as coffee mornings, all with the aim to tackle social isolation and loneliness. This can also give residents the opportunity to raise any items of concern.

Ashford Borough Council	Voluntary Sector: The Council has a Funding & Partnership Officer who supports the voluntary sector in all areas of their work such as assisting them in safeguarding best practice, training and policies. Additional to this, the Council works closely with Ashford Voluntary Centre who take a lead in connecting with the vast voluntary community organisations in Ashford and who again will promote best practice, highlight opportunities and will refer any issues
Canterbury City Council	Raising Awareness of Modern Slavery: The council took part in a multi-agency Operation in July 2021. Partners from Kent Fire and Rescue Service, Kent Police, and representatives from Stop the Traffic as well as the Gangmasters and Labour Abuse Authority had 2 days of operations checking nail bars and car washes in the Canterbury District. As a result, the team engaged with over 80 individuals. The council's Environmental Health and Private Sector Housing teams and Kent Fire and Rescue Service also supported action due to a fire safety issue.
Canterbury City Council	Raising Awareness of Safeguarding with Refugees and Afghan Nationals for those families that we have resettled into homes in Canterbury: we provide casework support and will include running through the role of the Police, how to report crime and support with any issues. For the Afghan nationals residing locally, we have run sessions on Rights, Responsibilities and the Law and this covers reporting crime, including Hate Crime, Modern Slavery, Forced marriage. We also invite the Community Liaison Officer and a uniformed PCSO to meet families and talk to individuals to help break down any issues of mistrust, so people will feel safe approaching the police.
Canterbury City Council	Raising Awareness of Safety for Student: Canterbury has a large student population. The Council's Community Safety Unit joined partners to deliver the Safer Autumn Campaign over Freshers Week and reached over 3000 students.
Dartford Borough Council (DBC)	DBC hosts an Elders Forum, which is a means of two-way communication with the elder community and provides information specifically relevant to this higher risk group.
Folkestone and Hythe	Grounds Maintenance staff received bespoke face-to-face safeguarding training.
Folkestone and Hythe District Council	We participate in many events e.g., adult safeguarding week where stalls are set up in the town centre with partners and information is distributed to the public on all aspects of safeguarding.
Gravesham Borough Council	The KMSAB newsletters and KSCMP (children's partnership) newsletters are shared with Safeguarding champions and on to their teams. In addition to the adopted policy, the Lead Safeguarding Officer provides regular updates on the safeguarding agenda to the council's nominated service 'champions', promoting awareness across the authority.
Gravesham Borough Council	Local work on Violence Against Women and Girls (VAWG) highlighted the importance of hearing from women and girls in the Black, Asian and ethnic minority communities regarding safeguarding issues that impact them, so the annual "Listen to Our Voices" conference was organised; feedback from the questionnaire completed by attendees has driven the agenda for the following year each time. Attendees are speaking up more as the years go on. Translators are available at the conference to ensure that all can share their voice.
HCRG (formerly Virgin Care)	In the last year, HCRG Care Group joined together with other agencies in the Kent and Medway area to promote Safeguarding Week. The Ann Craft Trust Nationwide Safeguarding Adult's Week campaign facilitated conversations around the theme 'creating safer cultures'. The national HCRG Care Group safeguarding team produced a short video for the safeguarding week with the overarching theme 'be curious, do your bit', whilst locally had a specific cultural safety message for each day to encourage colleagues to have a safe and open culture.

Healthwatch	There are regular engagement meetings held with all providers across Kent & Medway to share any concerns or compliments that the public are sharing with us. Any learning that takes place from Serious Incidents is disseminated with staff. Both Healthwatch Kent & Healthwatch Medway along with Mental Health Forums will contribute to any quality assurance processes to offer an independent patient / public view. If we have information shared with us from patient experiences, this can be utilised as part of the lessons learnt process.
Kent County Council (KCC)	In July 2021, KCC Adult Strategic Safeguarding teamed up with multi-agency Kent Community Safeguarding Partnership to raise awareness of the issues of Domestic Abuse in our older population and continued to raise awareness as part of Safeguarding Adults Awareness Week. The Strategic Safeguarding Unit (SSU) delivered a virtual internal conference for all staff within the Local Authority. The event was titled "Domestic Abuse - a Kent Perspective" was held on 10th November 2021 and featured presentations on Domestic Abuse in our Older population, Domestic Abuse Act, Commissioning and Kent Analytics and Male Domestic Abuse. This event was attended by over 200 colleagues, and included themes highlighted within Safeguarding Adult Reviews and Domestic Homicide Reviews and promoted guidance such as the multi-agency Domestic Abuse Policy. The feedback was really positive and helped to continue to increase the awareness around these vital issues.
Kent County Council (KCC)	The wider multi-agency campaign for Safeguarding Adults Awareness Week 2021 – "Creating Safer Cultures", was also promoted within Adult Social Care bulletins and on the staff intranet site. KCC Communications Team shared the campaign on various social media sites such as Facebook and Twitter which reached over 18,000 people, with people sharing the posts and commenting on the content. In addition to the above, KCC also promoted various other campaigns all to help raise awareness with colleagues and the residents of Kent. Some of the campaigns, included 'Mental Health Awareness Week' – promoting Live Well Kent, Explore Kent and One You Kent services which reached over 70,000 people in May 2021; 'Release the Pressure' Suicide Prevention campaign in September 2021 reaching nearly 20,000 people; and 'Know Your Score' Alcohol Awareness campaign - Nov '21 which reached over 30,000 people. The subject matters promoted are again sympathetic to the themes within the Safeguarding Adult Reviews and therefore our online campaigns were a great opportunity to continue to raise awareness. KCC awareness raising was so successful that, in 2021, the KCC Stakeholder Engagement Team's work was shortlisted and won a silver award in the IESE Public Transformation Awards for communications in the adult social care directorate.
Kent County Council (KCC)	KCC Strategic Safeguarding are now producing "7-minute briefings" for all staff, to highlight the themes within the reviews and to provide related guidance and tools. In addition, Team Talks are being delivered internally to various Team within KCC, which promote the work of Safeguarding, the Kent and Medway Safeguarding Adults Board, and useful resources. The feedback received so far has really been very positive and helped to increase the awareness of the Board.
Kent Community Health NHS Foundation Trust	The Trust has dedicated safeguarding and mental capacity link workers and uses the regular meetings to share and disseminate safeguarding updates, campaigns and learning. The sessions are enhanced by guest speakers to support collaborative working and understanding of differing services roles/responsibilities/referral processes and include case discussion with a supervision format.

Kent Community Health NHS Foundation Trust	The awareness of safeguarding themes is raised through various mediums including virtual sessions, blogs, bespoke updates, link workers and within training. Key thematic topics in 2021/22 included self-neglect, domestic violence and abuse and exploitation. The Trust supported awareness raising of the national safeguarding awareness week including social media campaigns, information on the intranet site, blogs each day to suit the themes of the week, a link worker meeting that focused on specific themes, and virtual drop in sessions on the theme of mental health and well-being and adult grooming. The impact of the awareness raising can be seen through the data comparison capturing internal safeguarding consultation contacts.
Kent Community Health NHS Foundation Trust	Mental Capacity Act training has been adapted to provide a more practical approach to learning, using case specific discussions and includes upcoming changes on the Liberty Protection Safeguards Programme. To meet the needs of specific staff groups, mental capacity assessment workshops are offered for new staff induction, staff working with children and young people and also for staff working with adults. This practical approach helps staff feel more confident when conducting an assessment and providing support to patients and families; making sure that the patient is at the centre of the decision making and staff are following the key principles of mental capacity assessment legislation.
Kent Community Health NHS Foundation Trust	In 2021/2022, KCHFT safeguarding team provided 927 consultations to KCHFT staff through a dedicated duty line and processed 442 adult safeguarding referrals raised into the local safeguarding process, with 347 adults safeguarding referrals raised by KCHFT staff alone. The main category of abuse was neglect, followed by self-neglect, domestic abuse, financial abuse and physical abuse.
Kent Police	The Dedicated Child Protection/Adult Protection Strategic DCI holds a number of meetings across the force with Operational Safeguarding Leaders, Safeguarding Co-ordinators and the Vulnerable Adult Intervention Officers to ensure that they are all kept up to date with developments in the work of the KMSAB and partner agencies and to ensure that any operational issues can be addressed at a strategic level. The newly launched Crime Academy acts as a repository for this learning and information and shares it via SharePoint Intranet pages and develops suitable continuing professional development inputs.
Kent Police	With the increase in Terrorism Threat level in November 2021 to SEVERE, there was a renewed focus on Vulnerability to Radicalisation (V2R). This has now been incorporated as the “14th Stand of Vulnerability”. It is recognised that those with other vulnerabilities may have increase vulnerability to radicalisation. In response, Kent Police held a series of internal session for staff which reached over 300 members of staff. This aligned with the launch of the Crime Academy V2R page.
Kent Fire and Rescue Service (KFRS)	Externally using our social media Communication and Engagement team have been able to post information about various support and signposting available. One of the service’s ‘together’ videos was published on Kent Fire and Rescue Service website and through social media channels. This showcased the work that KFRS do in the safeguarding team and how we work with partners to ensure that when a concern is identified we work closely with other agencies to ensure that person is supported.
Kent and Medway Clinical Commissioning Group (KMCCG)	Internal feedback from the work undertaken during adult safeguarding awareness week included: “Thank you to the Safeguarding team for bringing this to all of our attentions, such an important area and so often overlooked” “Congratulations on a successful week”. “I am really pleased to see us raising awareness about the National Safeguarding Adults Awareness Week. Safeguarding is everyone's responsibility both in our workplace roles and our home lives.”
Kent and Medway Clinical	KMCCG designates also participate in local health safeguarding panels. Participation in these meetings enables KMCCG to work collaboratively with the NHS Trusts and

Commissioning Group (KMCCG)	the relevant Local Authority in exploring the progress of open section 42 enquiries and ensuring Making Safeguarding Personal (MSP) principles are followed.
Kent and Medway Clinical Commissioning Group (KMCCG)	Kent and Medway CCG have, through the communications and engagement working group, participated in supporting the KMSAB social media content plans and the promotion of Safeguarding Adults Awareness Week. Contributing to the development of material for the week and supporting the roll-out of social media content across Facebook and Twitter during the week itself, reaching 3737 people with 316 views of the multi-agency video that was produced.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	KMPT has Safeguarding Champions represented in each care group to ensure that resources, themes and learning is shared in a timely way. Themes are shared through public mechanisms such as Twitter and Facebook, or internal processes such as during the trust-wide Safeguarding meeting, and within relevant care group meetings. The KMPT communication team support with the dissemination of information for a collective response in recognising and responding to safeguarding theme.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	Mental Capacity Act training is mandatory for KMPT front line practitioners. Within training, unwise decisions and best interest are discussed with scenario-based discussions. KMPT staff are committed to ensuring that decisions are person centred, with opportunities to discuss choices including unwise decisions. Mental Capacity is a key area of continuous development in the preparation of the introduction of Liberty Protection Safeguards.
Maidstone Borough Council	All relevant updates are shared with staff to support in how to raise a safeguarding concern internally and externally. Posters are shared on social media platforms, and most recently, shared on the Ukrainian support page on the MBC website after receiving the translated information.
Medway Community Healthcare	Inpatient Units have been encouraged to create safeguarding -themed pinboards for easy access to safeguarding information for all staff, patients and their carers. In addition, specific information to safeguarding is included in local induction for agency staff on inpatient units.
Medway Community Healthcare	A new electronic record system has been implemented during 2021/22, this has allowed us to implement recommendations from SARs including means of monitoring referrals for carers assessments and referrals to advocacy services other than IMCA (Independent Mental Capacity Advocate).
Medway Foundation Trust	Safeguarding adults awareness day was spent with 'trolley dashes' to wards and departments promoting the internal safeguarding team, the KMSAB and resources available and distributing leaflets to staff and public. Other promotional methods used throughout the year have been the use of the Trust safeguarding intranet webpages, the Trust global bulletin sent out to all staff via email, the safeguarding operational group for members to cascade to their teams and social media. Not only using the Trust social media platforms but creating the Trust twitter account @mftsafeguarding #seriousaboutsafeguarding #SAS.
Sevenoaks Council	All staff receive online training. We have a new training hub for the Council and there are 3 safeguarding courses on there that are compulsory for everyone. Frontline staff and managers receive in-house training from Designated Officers with training accreditation. Since the last report we have run 7 training sessions.
Sevenoaks Council	Safeguarding Cards were re-produced in 2022 to raise awareness of key safeguarding issues for all staff.
Thanet District Council	The Safeguarding Forum disseminates emerging themes and concerns on a district, county and national level to their teams. This runs alongside information given via our internal web pages, discussion pages and standing agenda items.

Thanet District Council	Safeguarding Champions disseminate safeguarding information to their teams and have safeguarding as a set agenda item on their team meetings. Here they can discuss up to date news and information and for the team to raise concerns they have with safeguarding issues.
Thanet District Council	The Community Team also has a community development role embedded into it, which allows for a well-rounded team with a holistic approach. The community development role within the team allows us to directly work with all different parts of the community, these communities can include BAME, LGBTQI+ and those of different faiths, which are historically hard to reach. The community team builds these relationships and safeguarding training is offered as well as information on what to do or where to go if they are worried about an individual. PREVENT is also discussed. We give information of contact details should they wish to contact us directly to discuss concerns, we in turn give advice and/or refer to relevant agencies. The Community Team carry out an annual residents perception survey on information they have locally and what information they need.
Tonbridge and Malling Borough Council	Homes for Ukraine Scheme – A small team has been set up to respond to this, offering support and advice where necessary to host families and Ukrainian refugees. In addition to home checks, we have organised a Ukrainian Welcome Evening in partnership with Tonbridge School, where partner agencies (Police, Department of Work and Pensions, Community Wardens, Health, Housing, Citizens' Advice Bureau etc) were able to offer advice and support. Safeguarding leaflets in Russian and Ukrainian have been distributed to all host households and to people attending the welcome evening.
Tunbridge Wells Borough Council	Safeguarding training covering both adult and children's safeguarding is provided to all new starters who join the Council. These training sessions take place bi-monthly and are held virtually. They are mandatory for all new starters as part of their induction and probation. During 2021-22, there were 38 new starters to the Council attended the safeguarding training.

3. Quality

Agency	Example
Ashford Borough Council	Details of lessons learnt from SARs and DHRs are shared with Safeguarding Lead Officers as well as partner agencies, which can then be disseminated to relevant team members. This also includes sharing details of lessons learned seminars. The Designated Safeguarding Officer is not only a WRAP trainer (raise awareness of PREVENT), but attends Channel Panels from which relevant feedback is disseminated. The cases are reviewed to ensure that ABC imbeds learning from them into its policy and processes. An example was improving staff knowledge around the Care Act 2014 which has been addressed by specific training to key staff.
Ashford Borough Council	A quarterly safeguarding update report is provided to senior managers (Management Team) which details the number of referrals each quarter and the type of referral e.g., adult, child, domestic abuse etc. The report also includes a chart detailing figures for previous quarters so any large increase in referrals or concerning trends are identified. Details on the number of staff that have received both Level 1 and Level 2 safeguarding training is also included.
Ashford Borough Council	Following the KMSAB Self-Assessment peer review meeting, various improvements have been made.

Canterbury City Council	Recording and reviewing safeguarding activity: The Council has a centralised recording system for all safeguarding concerns. All records are reviewed by the team of Designated Safeguarding Officers at least every two months to ensure that actions taken were appropriate and timely and to follow up outcomes of referrals.
Canterbury City Council	Implementation of new safeguarding concerns reporting system: Together with Sevenoaks District Council, a new reporting system has been commissioned. The system is now being piloted and will then be adopted by the majority of Districts in Kent. The system will enable the Council more efficiently manage safeguarding concerns but also: • Provide automatic links and prompts to documents such as the Kent & Medway Self Neglect & Hoarding Procedures; • Prompt recording of outcomes and impact of actions taken; • Analyse the types of concerns, responses etc which will enable us better target training and development; and • Share data with other Districts to see if there are any emerging trends in Kent.
Dartford Borough Council	DBC's Safeguarding Guidelines for External Providers builds due regard around safeguarding into contracts using a tiered approach based on the level of contact the external provider will have with children and adults at risk and the type of service being procured. Contract monitoring arrangements are in place where DBC reserves the right to check external providers' safeguarding arrangements at any time, on reasonable notice. External providers are also expected to regularly review and update their safeguarding policies to ensure they capture the most recent legislative and compliance requirements and up-to date guidance.
Gravesham Borough Council	Each department within the council has its own Safeguarding Champion. There is a shared email address for this group so questions can be asked and issues raised. These champions feedback on safeguarding issues within their areas. This information is used to highlight training needs, develop training, and escalate issues if necessary.
Kent County Council (KCC)	As part of our quality assurance measures, KCC reviewed their Safeguarding Adults' Competency Framework. The Framework is for all staff (registered and unregistered), who have contact with adults within Adult Social Care and Health to help provide a consistent good standard of practice. Staff are required to evidence their developing competence, using the Observed Practice approach.
Kent County Council (KCC)	In 2021/22, work began on the Adult Social Care Practice Framework. This Framework focuses on the person, their family, and the community they are part of. The aim is to support people to live the life they want to live in a place they call home and to build communities where everyone belongs. The Framework also focuses on supervision, encouraging a culture of learning, incorporating a strengths-based approach towards supervision, reflective discussion in a multi-skilled group, and promoting personal development.
Kent Community Health NHS Foundation Trust (KCHFT)	During 2021/2022, KCHFT became the first community health trust (non-mental health NHS trust) to sign up to the Triangle of Care (TOC). Being members of the TOC demonstrates a real commitment to working with carers to make sure they are recognised as an integral part of the care planning process and are involved in decision-making about service development. The Triangle of Care is a national scheme which promotes a three-way partnership between the patient, carer and clinicians where carers are involved and supported. By signing up, the Trust and its services make a pledge to find out who cares for the patient and record this in the notes, attend training in carer awareness and engagement, have clear processes for sharing information with carers, have a carer champion in the team, provide carers with a warm introduction to the service and help carers access support for their own needs.

Kent Police	The Serious Case Review Team worked with the Protecting Vulnerable People Department to develop training for SAR panel members to ensure that attendance is effective during the review process and setting of recommendations.
Kent Police	The Protecting Vulnerable People Command has a Governance and Scrutiny Team. Whose role includes assessing the quality of safeguarding across the force. Examples of Scrutiny that have been carried in 2021/2022 relevant to adults at risk are: • Adult Protection Referrals – Identified good practice in decision making, considering capacity and gaining consent. It also showed an improvement in the capturing and sharing of Voice of the Vulnerable Adults but identified that the capturing of family members and other agency involvement needed improvement. This has led to a revisit of the AWARE Principles and the planned relaunch in 2022. • Domestic Abuse Reports – Showed that where incidents involved an adult with care and support needs this was always identified and an appropriate referral for support was highlighted to Central Referral Unit. However, the reports sometimes lacked the wider holistic picture around the individual and focus on that individual incident. Again, this had led to the relaunch of AWARE. • Achieving Best Evidence Interviews (video recorded statements that can be entered in evidence at court) – overall the quality of interviews was found to meet the legal evidential standards however some areas for development were identified with regard to victim engagement or the planning process. This has led to the Crime Academy working with the reviewer to develop ongoing CPD for those trained in conducting ABE interviews.
Kent Fire and Rescue Service (KFRS)	Every 3 months a comprehensive safeguarding report is completed for Corporate Management Board. Data is reviewed for the previous 3 months on how many safeguarding cases were opened, which ones are still open providing justification, and how many cases were closed. We look at details of what the outcome of the safeguarding case was i.e., referral to mental health, adult social care, child social care or safe and well visit. There is detail of quality assurance procedure and if cases were re-opened what was the reason and how many were closed with satisfied actions first time. Each week a report is compiled of all the cases that week and Designated Safeguarding Officer (DSO) Team Meetings take place each month to discuss high risk cases. Speak Out Policy is in place for highlighting concerns. Safeguarding Manager reviews case load of DSOs and ensures that identified actions are carried out in a timely manner and cases are reviewed on a regular basis providing support for the DSO and customer whom the concern is about.
Kent and Medway Clinical Commissioning Group (KMCCG)	The Safeguarding team has also produced a safeguarding toolkit for primary care to support embedding of safeguarding practice. This has been rolled out and promoted to all practices across Kent and Medway.
Kent and Medway Clinical Commissioning Group (KMCCG)	NHS contracts obligate providers to report on safeguarding activity and policy as standard. The specific safeguarding requirements are detailed within Schedule 4 of the provider contract as a metric. The Designate function is to review the safeguarding metric, best practice and learning and summarise findings ensuring any identified risks are escalated to the Provider Executives via the Quality Review Groups (QRG) and the Governing Body of the CCG via the Quality, Safety and Safeguarding Committee. Where risks or poor performance are identified the Designate team request and monitor a remedial action plan via the QRGs.

Kent and Medway NHS and Social Care Partnership Trust (KMPT)	KMPT are committed to ensure that care plans are person-centred and need-driven to support safe person-centred recovery from mental ill health. Working with patients to develop care plans is core business in health and recovery frameworks. The KMPT Transformation Team, as part of the quality account priority on improving care plans, produced and disseminated a staff survey and Service User feedback to understand some of the thoughts, ideas and barriers around creating person-centred care plans to improve quality of care. These ongoing initiatives to strive to improve care delivery evidence KMPT's commitment in providing the right care and support that enables safeguarding and recovery reflecting the holistic needs of patients. This initiative is a great example of collaborative working with clinical and operational staff working together with patients to drive positive change within KMPT.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	Audits during 2021 have been utilised to establish whether the voice and wishes of patients are evident in safeguarding referrals and patient records. The audit objectives were to seek assurance that KMPT staff are complying with Making Safeguarding Personal (MSP) as promoted in the Care Act 2014, and Kent and Medway Safeguarding Adult Board's Protocols and Guidance; To establish whether the quality of referrals made by KMPT staff enables the local authority to identify the category of abuse, the adult at risk's wishes and views, circumstances/vulnerabilities thus enabling them to make effective safeguarding enquiries based on referrals made by KMPT staff. The quality of safeguarding referrals audited provides overall substantial assurance that staff are effectively raising safeguarding concerns appropriately. Most referrals made were robust and identified the safeguarding concerns that were subject of the referral. Obtaining consent has shown a marked improvement from the last safeguarding referral audit in 2019 and has moved from reasonable assurance to substantial. Matters of immediate risk were addressed and the think family approach to safeguarding applied.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	All safeguarding activity is captured on the DATIX system which reports activity to care group managers, service managers, the safeguarding team and Directors to ensure a measurable, transparent and responsive approach to safeguarding.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	An independent audit on KMPT safeguarding functions was completed in August 2021. The objective of this review was to establish the effectiveness of the processes in place within the Trust. The outcome of this external scrutiny was positive and demonstrates the diligence and commitment of the safeguarding team and KMPT in maintaining safe and effective safeguarding functions during a pandemic when staff were tested in adaptability and resource.
Maidstone Borough Council	We are currently in the process of developing a virtual platform for feedback to be given within all departments so we can learn from the positive and negative experiences that individuals have had. We are also spearheading the domestic abuse journey mapping exercise which has been shared at several domestic abuse and housing forums across Kent. During the creation of the journey map, we will be looking to speak with survivors and gain feedback on how they were responded to and how they felt safeguarding enquiries were managed by MBC.
Medway Community Healthcare (MCH)	MCH use the Adult Safeguarding: Roles and Competencies for Health Care Staff, the intercollegiate document, as a competency framework for safeguarding adults' practice. Compliance is monitored via monthly performance reporting and through the appraisal process. Further work is being undertaken in relation to a specific MCA competency framework that will be implemented as a mandatory requirement for all staff alongside current clinical competency frameworks.

Medway Community Healthcare	The safeguarding team monitors contacts to the safeguarding team, safeguarding referrals, DoLs applications/authorisations, compliance with training, attendance at group supervision, IMCA referrals and MARAC contribution/ attendance. This information is submitted to the Clinical Commissioning Group on a quarterly basis. In addition, a quarterly report is presented to our internal Quality Assurance Committee which highlights both activity and risk.
Medway Council	We have adapted and use the KMSAB safeguarding competency framework to ensure our staff have the required knowledge, skills, values, and experience to undertake their roles, in collaboration with strategic partners. We have developed a competency framework for our social care officers (non-registered staff) to ensure they have the right knowledge and skills. This includes the KMSAB safeguarding framework which is a core competency.
Probation service	The Probation Service is audited externally by HMIP (Her Majesty's Inspectorate of Prisons) as well as the national Operational Assurance Group. We undertake regular internal audits for all matters safeguarding.
Swale Borough Council	Swale Borough Council completes a quarterly performance report to its senior management team on its safeguarding work. This includes the number of safeguarding concerns raised to the safeguarding team, the category of issue, referrals made and the outcome of these, and level of training compliance. This report also monitors any actions from internal/external audits and any appropriate actions linked to learning reviews. A recent internal safeguarding audit took place with a 'sound' assurance rating – second highest rating. All actions identified from this are now complete. We also actively participate in audits run by the Children's Partnership and Adults Board to improve our local response.
Tonbridge and Malling Borough Council	Work on safeguarding is regularly audited, with recommendations/actions for improvement highlighted and monitored. An internal Safeguarding Audit has just been completed.

From: Ben Watts, General Counsel

To: Adult Social Care Cabinet Committee – 18 January 2023

Subject: **Work Programme 2023**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Standard item

Summary: This report gives details of the proposed work programme for the Adult Social Care Cabinet Committee.

Recommendation: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **NOTE** its work programme for 2023.

1.1 The proposed work programme has been compiled from items on the Forthcoming Executive Decisions List, from actions arising from previous meetings and from topics identified at agenda setting meetings, held six weeks before each Cabinet Committee meeting, in accordance with the Constitution, and attended by the Chairman, Vice-Chairman and the Group Spokesmen. Whilst the Chairman, in consultation with the Cabinet Member, is responsible for the final selection of items for the agenda, this report gives all Members of the Cabinet Committee the opportunity to suggest amendments and additional agenda items where appropriate.

2. Terms of Reference

2.1 At its meeting held on 27 March 2014, the County Council agreed the following terms of reference for the Adult Social Care and Health Cabinet Committee: - '*To be responsible for those functions that sit within the Social Care, Health and Wellbeing Directorate and which relate to Adults".*

3. Work Programme 2023

3.1 Following the most recent meeting of the committee, an agenda setting meeting was held at which items for this meeting were agreed and future agenda items planned. The Cabinet Committee is asked to consider and note the items within the proposed work programme, set out in the appendix to this report, and to suggest any additional topics they wish to be considered for inclusion in agendas for future meetings.

3.2 The schedule of commissioning activity which falls within the remit of this Cabinet Committee will be included in the work programme and considered at future agenda setting meetings. This will support more effective forward agenda planning and allow Members to have oversight of significant service delivery decisions in advance.

3.3 When selecting future items, the Cabinet Committee should give consideration to the contents of performance monitoring reports. Any 'for information' or briefing items will be sent to Members of the Cabinet Committee separately to the agenda, or separate Member briefings will be arranged, where appropriate.

4. Conclusion

4.1 It is vital for the Cabinet Committee process that the Committee takes ownership of its work programme, to help the Cabinet Member to deliver informed and considered decisions. A regular report will be submitted to each meeting of the Cabinet Committee to give updates of requested topics and to seek suggestions of future items to be considered. This does not preclude Members making requests to the Chairman or the Democratic Services Officer between meetings, for consideration.

5. Recommendation: The Adult Social Care Cabinet Committee is asked to **CONSIDER** and **NOTE** its work programme for 2023.

6. Background Documents

None.

7. Contact details

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ADULT SOCIAL CARE CABINET COMMITTEE
WORK PROGRAMME 2023

Item	Cabinet Committee to receive item
Verbal Updates – Cabinet Member and Corporate Director	Standing Item
Work Programme 2022/23	Standing Item
Key Decision Items	
Performance Dashboard	Sept 22, Nov 22, March 23, May 23
Draft Revenue and Capital Budget and MTFP	Annually (January)
Risk Management: Adult Social Care	Annually (March)
Annual Complaints Report	Annually (November)

15 MARCH 2023 at 2pm		
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item
5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item
6	Learning Disability and Autism Alliance	Key Decision
7	Interpreting Framework for People who are d/Deaf or Deafblind Contract Award	Non-Key Decision
8	Independent Advocacy Services and Mental Health Assessment Services Contract Award	Key Decision
9	Rates Payable and Charges Levied for Adult Social Care Services 2023/2024	
10	Performance Dashboard	
11	Risk Management: Adult Social Care	
12	Work Programme	Standing Item
17 MAY 2023 at 2pm		
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item
5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item
6	Performance Dashboard	
7	Work Programme	Standing Item

6 JULY 2023 at 2pm		
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item
5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item
6	Work Programme	Standing Item

ITEMS FOR CONSIDERATION THAT HAVE NOT YET BEEN ALLOCATED TO A MEETING	
Down Syndrome Act 2022	Suggested by Mr Ross (ASC CC 1/12/21) – TBC but approx. between Nov 2022 and May 2023
Adult Social Care Workforce and Recruitment/Careers Pathways	Suggested by Mr Streatfeild at ASC CC 18/01/22, discussed at ASC Agenda Setting 18/05/22 - TBC after ASC Away Day in July
Bespoke Support Service – Service Update	Suggested by Mr Streatfeild at ASC CC 18/5/22 – mid 2023
Kent Enablement at Home - presentation on work being done	Suggested by Mr Meade at ASC CC 18/5/22
External Community Opportunities for People with Learning and Physical Disabilities Update - positive impacts of the service on users	Suggested at ASC CC 31/3/22
Social Prescribing – Evaluation and Progress	Suggested by Mrs Hamilton at ASC CC 13/7/22
Dementia Strategy	Deferred from November 2022 agenda
DOLS (transition of service)	Approx. September 2023
Transition from SEND – inc. cost implications, joint ASC/Integrated Care Partnership Paper	March 2023 (Mr Streatfeild 17/11/22)