Kent and Medway Safeguarding Adults Board

Annual Report

April 2020 – March 2021

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

About us

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

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

Our Responsibilities

Our responsibilities include:

- developing and publishing a Strategic Plan to set out our priorities and how these will be met;
- assuring safeguarding practice continuously improves, to bring about better outcomes for those experiencing, or at risk of, abuse, ensuring that we make safeguarding personal, person centred and outcome focused;
- promoting multi-agency training;
- holding our partners to account, gaining assurance that effective safeguarding arrangements are in place;
- producing multi-agency policies and procedures, and monitoring their impact ;
- undertaking Safeguarding Adults Reviews to establish what happened, and what we can learn;
- producing an Annual Report to explain how we have achieved the priorities set out in our Strategic Plan;
- working collaboratively and with effective governance to promote wellbeing and prevent abuse and neglect;
- setting the strategic direction to protect and empower adults at risk across Kent and Medway.

Our Membership

In 2020 - 2021 our Board was led by an Independent Chair.

Our statutory partners are:

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

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

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

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

Our Structure

Our structure is set out on the next page. The terms of reference and membership for each group are reviewed annually, 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 to reduce duplication.

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

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

Medway Safeguarding Adults Executive Group (MSAEG)

This group brings together senior representatives from the key agencies responsible for the effective delivery of adult safeguarding in Medway. MSAEG works collaboratively to deliver the strategic priorities of the Kent and Medway Safeguarding Adults Board, strengthening local delivery, oversight and governance. KMSAB's Business Group is regularly updated on both Medway's and Kent County Council's progress.

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

The Board's Working Groups	Responsibilities
Communications and Engagement (CEWG)	The CEWG develops, and ensures organisations implement, a communications strategy across the partner agencies with the intention of raising awareness of the Board and 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)	Coordinates the commissioning, delivery and evaluation of the Board's multi-agency safeguarding adults training programme.
Practice, Policy and Procedures (PPPWG)	Reviews and updates the "Multi-agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway", and associated documents - maintaining a modern approach with a continuous review cycle.
Quality Assurance (QAWG)	Coordinates the delivery of quality assurance activity to evaluate and assess the effectiveness of safeguarding activities from our partner agencies, to safeguard and promote the welfare of adults at risk of abuse or neglect

Joint Exploitation Working group (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.

Section 2. Priorities and Achievements

This section details how we delivered against our priorities for 2020 – 2021. It is recognised that activity can cut across more than one priority. For example, Safeguarding Adults Awareness week met both the priorities for Prevention and Awareness.

Coronavirus (COVID-19) Pandemic

The impact of the Coronavirus pandemic during 2020 must be acknowledged. The virus and measures put in place to seek to control it, affected everyone, but particularly the most vulnerable in our society and those caring for them. In writing this report, Board members wish to acknowledge the devastating impact of this virus and express their condolences to those who have experienced the loss of a loved one or are managing the long-term effects of the illness and pandemic response. They also wish to thank all key workers who worked tirelessly and selflessly to support those who needed it most.

The government published the "Care Act easements: supporting guidance" which allowed local authorities to streamline assessment arrangements and prioritise care, if needed, so that the most urgent and acute needs were met. It is a credit to both Kent County Council and Medway Council that they did not need to enact these easements and were able to maintain their existing service offer.

In recognition that KMSAB agencies were at the forefront of the Coronavirus response, Board members met in March 2020 to determine what KMSAB work was able to continue and what needed to be put on hold, to allow staff to be deployed to frontline activity. It is testament to the partnership that, during this unprecedented year, members manged to make the progress set out in the remainder of this report.

Priority One: PREVENTION

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

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

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

What we have achieved

1. KMSAB Meetings and Related Coronavirus Response Meetings

Board meetings continued throughout the pandemic; they were held virtually through Microsoft Teams. When the pandemic was first confirmed, members were asked to provide assurance in relation to the following;

- How statutory safeguarding requirements would be met during the pandemic.
- Whether there had been any changes in the 'minimum' offer for adults at risk.
- How agencies would work together, with limited resource, to ensure the safeguarding function continued.
- How they would mitigate any potential increase in, and susceptibility to, risk factors such as pressure sores, crime, hunger, and any emotional deprivation which could be incurred by isolation.

In addition to the KMSAB meetings, Board members attended meetings established as part of the Emergency and Resilience response. Various group meetings, known as 'cells', such as the multi-agency and community cells, were established to coordinate the response across Kent and Medway.

A specific 'Safeguarding and Partnership Impact of COVID 19' meeting was established for key partner agencies involved in safeguarding, which offered the opportunity to provide updates, share intelligence and seek support to ensure they were able to identify and respond to those individuals who needed it most.

Example – how sharing intelligence made a positive difference

During a 'Safeguarding and Partnership Impact of COVID-19' meeting, the then Independent Chair of the KMSAB, Deborah Stuart-Angus, advised the membership that safeguarding leads in other counties had reported that some people attending COVID testing centres were using the opportunity (of being out of the house) to disclose incidences of domestic abuse.

As a result of this, support and information were made available at testing centres across Kent and Medway.

The Kent and Medway Clinical Commissioning Group also developed a domestic abuse training pack for colleagues working in vaccination sites across Kent and Medway. This was subsequently rolled out by NHS England and Improvement (NHSEI) across the south east region as a ''good practice'' document.

The Board's Business Unit developed and promoted a Coronavirus advice section on its website, providing a central repository and to share relevant information, advice, support and guidance in relation to adult safeguarding and the COVID pandemic. Key messages were also shared through the Board's newsletter.

Kent and Medway SAB - Coronavirus Advice (kmsab.org.uk)

2. KMSAB Review

The Care and Support Statutory Guidance states that Safeguarding Adults Boards must make arrangements for self-audit and peer review. To fulfil this obligation, in December 2020 members commissioned Siân Walker McAllister [1] to undertake a review of the Board. The methodology chosen was to hold informal interviews with 36 members, with differing levels of experience and engagement with the Board, who were asked what they felt worked well and any areas for improvement. The findings of the review were presented to KCC Cabinet and the Kent and Medway Safeguarding Adults Board in March 2021.

Strengths highlighted by the review included:

- Great team supporting the Board with considerable emphasis on great communication from them, providing information to partners.
- Kent and Medway having a joint Safeguarding Adults Board - and there is a demonstrable commitment for this to continue.
- Good partner engagement with particular strong engagement in the work of the sub-groups (and good engagement in the review).
- Good links with Community Safety.
- Great relationships across the partnership with an effective forum for multi-agency discussion.
- Good multi-agency attendance at the Board and its sub-groups.
- Positive responses on KMSAB training and the work of the working groups, and how they are developing the training offer
- Effective work plans.

The review made 12 recommendations for change, these included:

- Review the Board Structure with a tighter, smaller Executive Group.
- Ensure the right representation on the Business Group with senior strategic operational leaders.
- Additional resources for the KMSAB Business Unit.
- Establish a task and finish group to deliver how diversity and equalities issues are addressed by the KMSAB, with particular reference to the Kent and Medway demography and any specialist provision across both local authorities.
- Establish greater clarity within the Board structure, in terms of how the KMSAB works in partnership with the large number of NHS providers.
- Ensure better consultation with people with lived experience and consider how Healthwatch can support the Board to engage with those who have received a safeguarding intervention.
- Use a development day to present learning from data, from SARs and from this review to refresh the KMSAB Strategy, ensuring that aims and objects are achievable and deliverable. Utilise the output of this to frame the agendas for the KMSAB.

An action plan has been developed to address the recommendations, progress against this is reported to the Executive.

[1] At the time of the review Siân Walker, a registered social worker, worked as an Independent Chair of two Safeguarding Adults Boards for Lambeth in London and for Devon. She was also the Independent Chair of the Bath and NE Somerset Community Safety & Safeguarding Partnership. A former Director of Health and Social Care in the UK, Siân had 40 years' experience of working in social care in London, the South-West of England and in Wales, for local authorities and the supported housing sector.

3. Delivery of our Training Offer

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

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

During 2019, the Board's Learning and Development Working Group (LDWG) designed a new suite of face-to-face multi-agency training workshops. The contract for recommissioning this programme went out to tender in late 2019. Five new course topics were developed and a considerable amount of work subsequently undertaken, in conjunction with the successful training provider, to prepare for the delivery of these new courses from April 2020. However, due to the Coronavirus pandemic and associated national restrictions, the planned programme was suspended, and it was agreed that all immediate training should be offered as remote virtual sessions rather than be classroom based.

During the spring and summer of 2020, members of the LDWG, as well as the KMSAB Business Unit and other colleagues, continued to work closely with the selected training provider to mobilise the contract. Detailed course handbooks were developed for each of the modules, as well as a comprehensive learning agreement and 'on the day' evaluation form, all tailored to meet the requirements of online remote learning. The programme was finally launched to start in September 2020, using the Zoom video conferencing platform, with the following courses:

One day multi-agency safeguarding adults workshops:

- Adult Legal Literacy
- Domestic Abuse

Half-day multi-agency safeguarding adults workshops:

- Collaborative Working in Multi-agency Section 42 Enquiries
- Self neglect and Hoarding
- Exploitation

The training is funded for staff from statutory partner agencies which contribute financially to the operation of the Board, and proved very popular amongst multi-agency colleagues, with more than 700 applications for places. The workshop on Self neglect and Hoarding was the most popular and, to meet the demand for places, the Board Business Unit continued to liaise with the training provider, making adjustments to the planned timetable of workshops to reflect this trend.

For the seven-month timeframe from September 2020 to the end of March 2021 a total of 51 training workshops took place with 576 delegates participating. The tables below provide a summary analysis for this period:

September 2020 to March 2021 – analysis of attendance by agency	Total	Adult Legal Literacy	Domestic Abuse	Collaborative Working in Multi-agency Section 42 Enquiries	Exploitation	Self neglect and Hoarding
No of Workshops	51	9	8	11	10	13
Kent County Council	339	52	53	62	73	99
Medway Council	30	7	4	5	2	12
Health – combined	166	21	26	55	24	40
Kent Police and Kent Fire & Rescue Service	34	2	4	6	5	17
Other agencies	7	2	0	0	2	3
Delegate completed attendance	**576**	**84**	**87**	**128**	**106**	**171**
No of Applications for Training	712	108	112	155	128	209

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

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

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

4. 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. These are important elements of our training evaluation and quality assurance mechanism, which helps the Board maintain and improve the quality of the training provided.

One of the disadvantages of the virtual delivery has been a reduction in the number of on the day feedback forms completed and submitted. However, of the 264 returns received and analysed the increase in self-reported knowledge and skills, following course completion, is impressive. The Board is reliant on managers within each service to measure how this shift in knowledge impacts on service delivery and collaborative, multi-agency working in practice.

Knowledge and skills self-assessment

Quarter 3 (Sept to Dec)	Low	Satisfactory	Good	Excellent
Before the training	23%	49%	27%	0.5%
After the training	0%	7%	84%	9%

Knowledge and skills self-assessment -

Quarter 4 (Jan to April)	Low	Satisfactory	Good	Excellent
Before the training	20%	57%	23%	<1%
After the training	0%	10%	76%	15%

Analysis of feedback provided by delegates, six weeks following course completion, presents a similar positive picture, in relation to the quality of the training, increase in knowledge and how learning is embedded into practice. Some examples of the feedback received include:

- "It enabled me to recognise more easily when I need to raise a safeguarding because one of my patients is at risk or could be at risk of abuse".
- "Having an increasing number of safeguarding cases this training helps to reflect and see where I can improve my practice and the huge benefits of collaborative working".
- "Having improved my knowledge I feel I will be able to use what I have learnt in my practice on a daily basis."
- "I use the knowledge I gained in my everyday practice that also supports professional curiosity."
- "It has informed my day-to-day practice and refreshed my legal knowledge."
- "Used it to inform my supervision of my student and to provide learning examples."
- "I am currently working in the [team] and have found the learning from this course has improved my knowledge in this area and also enhanced my confidence that I understand and am able to effectively apply the legislation in my practice."
- "The course gave me time to reflect on my current practice and to think about what I'm currently doing and how I can improve that in the future."
- "I have completed some multi-agency enquiries and used the training as part of this. I have also spoken to colleagues about transitional safeguarding and non-statutory enquiries".
- "I have recently completed a safeguarding inquiry which involved liaising with other professionals and I was able to put things learnt into practice."
- "I am currently working in our team's safeguarding hub. We have received a higher number of safeguarding concerns in recent month which involve domestic abuse. The training has informed my knowledge and made me more confident asking questions I may have avoided before."
- "The information has enabled me to have a deeper understanding of the support needs for those who may be from different backgrounds - and to explore other areas of abuse that may be more prevalent within the backgrounds of those individuals. It has also provided a better knowledge base in seeking support and how best to consider the needs of those people and the families as a whole."
- "Cascaded information back to colleagues, discussed at team meeting regarding some clients we link with."
- "I have used this knowledge to impart on my colleagues at team meetings."

- "It has improved my understanding of different types of exploitation and has aided me when working with a client who has been a past victim."

5. 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" This document sets out: legal responsibilities in relation to adult safeguarding; arrangements for working together across Kent and Medway; and provides guidance on how to recognise and respond to actual or suspected abuse against adults at risk. "Making Safeguarding Personal", hearing the voice of the adult, is a central theme throughout the document.

The policy is supported by a number of additional policies, which are updated in accordance with a policy update schedule to ensure that they continue to incorporate relevant: legislative change; national advice; thematic learning from Safeguarding Adults Reviews, Complex Case Audits, Domestic Homicide Reviews and outcomes from Children's reviews.

Whilst some policy updates were put on hold due to the pandemic, the following documents were created/updated as they were linked to emerging Safeguarding Adults Review themes or legislative requirements, so to delay may have been detrimental.

Kent and Medway multi-agency resolving practitioner differences; escalation policy for referrals and adult safeguarding In response to the learning gained from ongoing Safeguarding Adults Reviews (SARs), the Practice, Policy and Procedures Working Group strengthened the existing document to cover differences of opinion when agencies are referring clients between each other. It emphasised that, in situations where the escalation process is required, the agency making the original referral should maintain case oversight until resolution is agreed. A flow chart was added for ease of reference.

Protocols for Kent and Medway to Safeguard Adults who are at Risk of Sexual Exploitation Modern Slavery and Human Trafficking This policy was reviewed and updated in accordance with the update schedule, and due to an ongoing project within KCC on Serious and Organised Crime. During the process, Practice, Policy and Procedures Working Group members linked in with members of both the Kent and the Medway Safeguarding Children's Partnerships as they were updating their "Safeguarding Children Who May Have Been Trafficked" guidance.

When Adults at Risk Abuse Each Other Protocol This policy was created to replace the previous "Additional Guidance for Health and Care Service Providers in Kent and Medway. When Adult (s) with Care and Support Needs or Support Needs Alone Abuse Each Other" document, following feedback from practitioners that it was no longer fit for purpose.

Managing Concerns around People in Positions of Trust (PiPoT)
It is a requirement of the Care and Support Statutory Guidance that all relevant Safeguarding Adults Board (SAB) partners must have policies and procedures, in line with those of Safeguarding Adults Boards, for responding to concerns against any person who works with adults, in either a paid or unpaid capacity, in positions of trust. Previously the Board's main policy document included a section on this, however due to changes in working practices and to offer more guidance for all agencies, the Board developed a stand-alone policy to set out agencies' responsibilities.

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

Putting policy, training and learning from SARs into practice - anonymised case example 1

A customer was referred to safeguarding following concerns for self-neglect and high levels of hoarding. They wanted help and support but didn't know where to seek this. The customer disclosed that they had poor mental health and had not engaged with services in the past. The Kent Fire & Rescue Service (KFRS) Designated Safeguarding Officer (DSO) who was assigned to the case worked with the customer to build a rapport, through weekly phone check ins. A Safe and Well visit was carried out.

The DSO worked with other agencies, chasing to ensure that the referral was allocated to a social worker. Adult social care carried out an assessment. A cleaning company came in to clear the property and make the environment much better for the customer.

A telephone call was received from the customer in Feb 2021. They wanted to thank KFRS. Through KCC, their house had been cleared and an industrial cleaning company commissioned. The customer said they would send some photographs to show the difference it had made to their home. The customer felt that 'everything has fallen into place' and, following an assessment, they were now being assisted with Kent Enablement at Home (KEaH). They now had a carer who attended daily to help with self-care needs.

The customer explained that they now had a social worker, who has been helping, and their diabetes medication is working well. Their diet is improving and the environment at home had been such a positive change. They also received support from community mental health as a result of the referrals submitted by KFRS. The customer reported feeling more positive and wanted to say thank you to KFRS for being persistent and getting them the help and support which had changed so much. The customer explained that they were in such a better place and "can't believe how my life has changed".
Kent Fire & Rescue Service

Responding to changes in legislation - a preventative safeguarding approach

A designate nurse from the Clinical Commissioning Group (CCG) explored whether any work was being undertaken nationally in respect of vulnerable groups and the EU Settlement Scheme (EUSS)'s right to remain deadline. Specifically she asked how/if health practitioners were being supported to identify and signpost vulnerable individuals who may need support with the application process. This was particularly important as the process was entirely online, which could prove difficult, and disadvantage some of the most vulnerable individuals.

The designate nurse produced a '7-minute bulletin' for providers and primary care services across the region which set out the issue, how vulnerable individuals may be impacted and how practitioners could signpost and support. The health bulletin was further adapted and shared with KCC and Medway Council and through the Kent and Medway Safeguarding Adults Board Newsletter - April/May 2021 newsletter.

This work was picked up at national level both by Health and at the National Chairs' Network.
Kent and Medway Clinical Commissioning Group

6. Prevent Duty across Kent and Medway

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

In September 2020, Kent County Council (KCC) and Medway Council received additional funding from the Home Office for local Prevent resources, bringing the addition of a second Prevent Education Officer and a Prevent Community Engagement Officer for Kent and Medway to support the other Prevent posts working to the KCC Prevent and Channel Strategic Manager. The team covers both KCC and Medway Unitary areas. Kent was also one of the original Dovetail pilot areas. The Dovetail pilot sought to test the efficacy and capability of local authorities taking responsibility for the administration and management of Prevent referrals suitable for Channel consideration and adopted Channel cases, which had previously been a Police function. The Dovetail arrangements came into effect in KCC in September 2016 and have continued beyond the original 12-month pilot.

Despite working remotely during the COVID pandemic, Prevent training continued to be delivered virtually in 2020 - 21 to a wide number of organisations. Concern has been expressed nationally in relation to extremism and radicalisation via online grooming, as vulnerable individuals may spend excess time online. It has been very important to ensure Prevent training incorporates this challenge, providing information to partner organisations to enable them to have the confidence to make a Prevent referral.

The Kent and Medway Prevent Team continued to deliver a wide range of activity throughout 2020 - 21 despite the new ways of remote working, as an example the Kent and Medway Channel Panel continued to meet virtually on a regular basis, and excellent attendance at the panel by partner agencies was maintained.

The Kent and Medway Prevent Duty Delivery Board (PDDB,) established in 2015, is the strategic partnership board that agrees levels of risk and coordinates Prevent activity across Kent and Medway. The PDDB connects to the KMSAB and other strategic partnership boards across Kent and Medway. PDDB also continued to meet as per its schedule in 2020/21.

Some of our Partner Highlights

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

Case Study of collaborative working

Mr A arrived in the (local) district during the winter and was taken into the winter provision of accommodation, delivered by the Council in partnership with the YHA and Catching Lives.

Staff at Catching Lives carried out extensive enquiries and discovered that Mr A was missing from home in a foreign country and that there was a forensic psychiatric history. Mr A was assigned to a member of the Rough Sleeper Initiative (RSI), a Council led partnership with Catching Lives and Porchlight.

The officer assessed Mr A to be acutely mentally unwell and raised concerns with Adult Safeguarding, Community Safety, Community Mental Health teams and previous professionals who were found to have had contact with Mr A in other authority areas. Mr A chose to return to sleeping rough but the RSI continued to maintain contact and as a result was able to facilitate an initial mental health assessment and a subsequent Mental Health Act Assessment, resulting in Mr A being admitted to hospital for treatment. Mr A had been suffering acute untreated mental illness for many years but is now safe and receiving essential care with the RSI remaining involved in order to ensure that a full course of rehabilitation continues to be provided.

Local District Council

Ashford Borough Council (ABC)	Dementia Friends sessions are embedded as part of the corporate induction programme for all new staff and some ABC officers are trained as Dementia Champions who can deliver the training internally as well as to partner organisations. The Designated Safeguarding Officer is a Home Office accredited 'Workshop to Raise Awareness of Prevent (WRAP)' trainer and this can be delivered to relevant staff who carry out site visits or are customer-facing as part of their role (this can also be delivered to partner organisations).
Ashford Borough Council (ABC)	The Lifeline Service, Additional Support is a service provided by the ABC Monitoring Centre. Operators' safeguarding knowledge has been improved through bespoke training and this has encouraged referrals and support for our clients. Additional welfare calls to clients have also been instigated as part of the COVID-19 response, which were not only key during times of social isolation, but also gave clients an opportunity to raise any concerns.
Ashford Borough Council (ABC)	Collaborative working remains strong with virtual partnership meetings such as: District Contextual Safeguarding; Ashford Vulnerabilities; Complex Adolescent Risk Management (specific to a murder case); Kent Safeguarding Children Multi-Agency Partnership's District Council Safeguarding Leads Meeting; MARAC (multi-agency risk assessment conference for domestic abuse); and Ashford Community Safety Unit and Community Safety Partnership. This has ensured that knowledge, skills and information is shared and that our communities are listened to. Although adolescent, a good example of this is the multi-agency work carried out around a gang related murder, not only in respect of criminal justice but also in safeguarding those families affected.
Canterbury City Council	In addition to the mandatory 'Basic Awareness Adult Safeguarding' training for all front-line staff, the Council has focused this year on Adverse Childhood Experiences (ACE) and trauma informed practice. ACE Ambassadors have been recruited and are rolling out training to front-line staff. The aim is to have a fully trained ACE Aware front-line workforce who are confident in responding to vulnerability. Consideration of ACEs will also be given in service development to better understand the impact of trauma on communities.

Canterbury City Council	The Assisted Moves Scheme was developed as a response to support vulnerable adults who were living in Council properties that were too large and unsuitable for their needs. For many of these adults there were multiple barriers to them moving such as hoarding, and physical and mental health problems. This scheme works with tenants to help them overcome barriers and move to accommodation that better suits their needs. Feedback from the Scheme has been overwhelmingly positive.
Dartford & Gravesham NHS Trust (DGT)	DGT invested in DGT carers who were specifically employed for the care and support of patients. They were able to sit and talk to patients and get them shopping. DGT also created the Compassionate Care Team, having recognised that patients were in hospital and may not have any visitors. The team supported patients to make phone calls or Zoom calls.
Dartford Borough Council (DBC)	The DBC Safeguarding Policy is a living document and continuously reviewed to ensure it remains up to date. The Policy was last updated in June 2021. This was in response to actions identified in DBC's Self-Assessment Framework (SAF) submission to the KMSAB, which identified the importance of raising awareness to staff of signposting carers to carer's assessments and of signposting adults with care and support needs to advocacy services, where appropriate. The 'managing allegations against staff' process within the Policy was also updated to ensure it aligned with the KMSAB's Managing Concerns around People in Positions of Trust (PiPoT) Protocol. The Safeguarding Policy had previously been updated in February 2021 to ensure that the escalation procedure was aligned with the updated KMSAB's 'Resolving Practitioner Differences: Escalation Policy for Referrals for Adult Safeguarding'.
Dartford Borough Council (DBC)	DBC uses a tiered approach to safeguarding training to ensure that all staff receive the most appropriate training that is proportionate and relevant to their roles and responsibilities. There are three categories of safeguarding training – A, B and C. These categories are based on specific roles and also on the level of contact staff have with children and adults at risk in their day-to-day job. Additional training is also provided where a need is identified. For example, Prevent awareness training was recently delivered to approximately 40 attendees. Modern slavery awareness training is ongoing and training is planned in other key areas and is constantly reviewed by the Council's Safeguarding Steering Group.
Dartford Borough Council (DBC)	The Safeguarding Steering Group is a group of DBC designated safeguarding leads. The group provides a platform for the discussion of all aspects of safeguarding issues and ensures liaison and, where appropriate, joint working internally between DBC Departments/Directorates and externally with Kent County Council's Children's Social Services and Adult Social Services Departments. The Group includes the monitoring of safeguarding referrals as a standing item on its quarterly agenda. The local Team Manager for Safeguarding Adults is an external representative on the Safeguarding Steering Group and provides a valuable contact to discuss and solve any day-to-day operational issues that may arise between DBC and the local Adult Social Services Teams. This representative is a key contact to forward any concerns where, for example, DBC has not received an update on whether a safeguarding referral has been actively considered, and to discuss any other issues with regards to referrals.
Folkestone and Hythe District Council (F&HDC)	As a result of the COVID-19 Pandemic, F&HDC led the County in its response by implementing three community hubs across the district to support vulnerable adults (both shielding and non-shielding). Examples of support given include; engagement by volunteers with all of the adults on identified lists providing befriending, addressing loneliness and mental health concerns, in addition to supplying emergency food parcels, collecting medication, etc. Figures of adults supported are below – this work commenced in March 2020 (current totals shown):

	• GP surgery calls made – 26250 • (CEV) Shielded patients contacted – 9867 • Food provision (incl. shopping baskets, hot meals and free food parcels from the hubs) 68437
Gravesham Borough Council (GBC)	The Council's Safeguarding Policy details the GBC 'Safeguarding Pledge' ensuring all staff are aware that the safeguarding of children and vulnerable adults is everyone's responsibility. The policy details clear instruction of the reporting of concerns and key points of contact within the council.
Gravesham Borough Council (GBC)	Due to the pandemic, face-to-face training was put hold, with all staff accessing the online training in both adult and child safeguarding via the Kent Safeguarding Children Multi-Agency Partnership's website. To add an element focused on safeguarding in a council officer's role, staff also watched the videos produced by Haringey Council, available on YouTube. Feedback from staff has been that these were really helpful in applying a safeguarding perspective to their roles
Gravesham Borough Council (GBC)	The Community Safety Partnership (CSP), which was previously a combined Gravesham and Dartford group, has been separated this year, with each district now having their own. The meetings are interactive and well attended with partners helping shape agendas, which can involve discussions and intelligence around child sexual exploitation, safeguarding awareness and local concerns, etc. Importantly, the CSP develops a network of key officers amongst local agencies, helping remove barriers and aid effective working towards the safeguarding theme. Many CSP projects, from taxi licencing and training to addressing domestic violence and other risk issues, are delivered in the borough through a variety of collaborative projects, groups and initiatives. One such initiative is the multi-agency meeting addressing Violence Against Women and Girls (VAWG). GBC bid for, and received, funding for this 3-year project to address and reduce violence against women and girls through youth projects, direct support, etc. Meetings are quarterly.
Healthwatch	Both Healthwatch Kent and Healthwatch Medway had concerns raised from their helpline in relation to 'hidden harm' and these were escalated with the relevant providers such as the South East Coast Ambulance Service and NHS Hospital Trust along with the Kent and Medway Clinical Commissioning Group.
Healthwatch	Healthwatch has representation at many boards and meetings including: Rough Sleepers, Carers Partnership; local Community Faith Forum; and Voluntary Sector Leaders meetings. This provides the opportunity to share any safeguarding information that may be relevant to those organisations and to hear any concerns from those organisations, which can, in turn, be raised to the Kent and Medway Safeguarding Adults Board.
Kent Community Health NHS Foundation Trust (KCHFT)	At the start of the Coronavirus pandemic, the safeguarding team developed a weekly safeguarding update. This well received resource, aimed to raise awareness of: key areas of concern prompted by the pandemic; support services available; and new guidance. It progressed to an established monthly newsletter with sections on: general safeguarding; updates on existing and emerging safeguarding topics; themes, learning from incidents and case reviews; sharing of multi-agency information; and promotion of internal and external training. The newsletter is shared with all staff via service leads and on the Trust's intranet. This virtual way of promoting awareness further supported key campaigns during the pandemic such as "at home should not mean at risk" and access to support for victims of domestic abuse.

Kent Community Health NHS Foundation Trust (KCHFT)	Internally the Trust worked closely with both the Mortality Review Team and Learning Disability LeDeR Team to ensure that mortality reviews undertaken had considered the criteria for SAR. This helped to ensure good inter-agency working was promoted, to provide a seamless service to the service user, recognising that by changing practice it can prevent harm to the service user.
KCC - Kent Community Warden Service	The Kent Community Warden Service (KCWS), based in communities, provides a proactive and visible presence to improve residents' quality of life and promote stronger and safer communities. The KCWS met the challenges of the pandemic from the outset. Able to use local knowledge, the Community Wardens ensured those most vulnerable were supported with essential needs during the first lockdown. Wardens liaised with charities, food banks and pharmacies and made vital deliveries of food, medication and personal protective equipment (PPE), and connected residents and communities with services and support. Sightings of Wardens brought comfort to residents and their welfare checks to isolated, lonely individuals, were lifelines. This news article captures a Warden's work during the pandemic: Kent County Council community warden shares what it's like working during coronavirus crisis (kentonline.co.uk)
Kent County Council (KCC)	KCC Adult Social Care and Health (ASCH) has provided many varied training opportunities for staff over the last year and has worked proactively and dynamically to ensure that training was accessible via various virtual platforms, providing consistent learning and development to staff during the pandemic. Some of the courses provided by KCC included - domestic abuse training with the KCC commissioned domestic abuse provider, Mental Capacity and Safeguarding for the Designated Senior Officers, self-neglect with Suzy Bray, Section 42 Safeguarding Enquiries and transitional safeguarding, all of which are in-line with current legislation, guidance and reflect the themes highlighted within the Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHRs). Courses are quality assured by both staff and senior managers, including the Level 3 Kirkpatrick Model (one of the key planks of learning and development that gives a sense of the impact of a training intervention).
Kent County Council (KCC)	KCC also worked very closely with the Kent Integrated Domestic Abuse Service (KIDAS) to provide a virtual conference 'Domestic Abuse: It's Everybody's Business comprising of 16 days of virtual events to inform, educate and inspire action. Many aspects of domestic abuse were covered, including 'coercion and control', which has also been highlighted as a theme within Domestic Homicide Reviews (DHRs). Over 4,266 multi-agency colleagues were able to attend the event and the feedback received showed a high satisfaction rating of excellent/good, stating that the conference was useful to their work or personal life, many feeling they had an increased understanding of domestic abuse.
Kent County Council (KCC)	KCC continued to support Dementia Friendly Communities through The Design and Learning Centre during the pandemic. Virtual Dementia Friendly Community Meetings were held in some areas, often reaching a wide audience, and initiating projects that eased the isolation.
Kent Fire & Rescue Service (KFRS)	The Safeguarding Manager delivered modern slavery training to all Designated Safeguarding Officers, Call Representatives, the 'Safe and Well' team and Building Safety. This was a train the trainer package from Stop the Traffik.
Kent Fire & Rescue Service (KFRS)	The KFRS Collaboration Team worked alongside other partners in Kent and Medway, especially last year during the outbreak of COVID-19 when more joint working with other agencies was exercised. For example, delivering hot meals in conjunction with Age UK and working with NHS, and delivering training for care home staff within Kent.

Kent and Medway CCG (KMCCG)	In addition to the training provided to KMCCG staff, the safeguarding team provided safeguarding training to approximately 1800 primary care colleagues through online and bespoke webinar training events. The use of virtual events with primary care was very well attended and colleagues reported that this mode of delivery made it easier for Practices to engage.
Kent and Medway CCG (KMCCG	The KMCCG safeguarding team also provided collaborative preventative support and guidance with regard to: the ethical dilemmas of testing; vaccinating adult residents in care homes who did not have mental capacity to give consent; advising about associated potential ligature risks of personal protective equipment (PPE); and additional support to the vaccination hubs with regard to safeguarding supervision. The team also ensured that communication of guidance was undertaken and additionally raised awareness and confidence for teams to respond better to Domestic Abuse.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	Self-neglect is discussed in all adult safeguarding training and the multi-agency policy and protocol for managing self-neglect and hoarding is accessible from the KMPT safeguarding intranet. Bite-size training, video/webinars and other self-neglect resources have been added to the KMPT internal ''iconnect' safeguarding adults page for easily accessible information. The referral rate identifying self neglect during the pandemic (when people had been less visible and modes of working were adapted to meet the pandemic guidance) evidenced the responsiveness of front line staff and thoughtfulness in their practice, and they were responding to self -neglect and hoarding concerns in line with policy.
Kent and Medway NHS and Social Care Partnership Trust (KMPT)	The KMPT safeguarding team developed a 'Make Safeguarding Personal' leaflet to meet the needs of staff and patients when discussing safeguarding, both proactively and in response to abuse. This leaflet is included in the patient welcome pack, and is accessible for all staff to request copies or to download. The leaflet explains what safeguarding is and what 'Making Safeguarding Personal' looks like.
Kent Police	Dedicated Hate Crime Teams have been established on each Division to ensure that vulnerable victims who are targeted and subjected to crime are provided with a bespoke and first-class service dependant on their individual needs.
Kent Police	Operationally, investigations are managed by the Divisionally based Vulnerability Investigation Teams (VIT). In total, there are 205 officers and 4 police staff working within the VIT Vulnerable Adult/Child teams in Kent. In order to ensure that staff and officers are appropriately trained to investigate crimes against adults at risk, a perfect training profile has been introduced with a target of 75% of those working in the VIT to be nationally accredited detectives. This has been a real focus of Divisions and Kent Police Learning and Development, and has seen the levels rise from 29% to 66%.
Kent Police	Dedicated Vulnerable Adult Police Community Support Officers (PCSOs) are based in Community Safety Units on each Division, who can offer guidance to officers on local or community-based advocacy services. PCSOs have been a vital line of communication to adults at risk living in the community. Normally their work involves visiting those they know are at risk in the community and offering signposting advice or making referrals. During COVID they adapted to ensure that COVID associated risks were managed, but that contact was still maintained with those at risk. This adaptation included use of phone calls or virtual calls to adults at risk, and strengthened liaison with community support groups, to ensure consistent advice was given or risks identified. Where Community Policing involvement is beneficial, vulnerable people can be referred for discussion and monitoring at the multi-agency District Vulnerability Panels, which allows for action to be set and results monitored to ensure that positive change is being effected.

Kent Police	Proactive visits to families most at risk of domestic abuse were conducted as a response to COVID and concerns regarding hidden harm. The cohorts for these visits were identified through business analysis and coordinated by the Domestic Abuse Manager in the strategic Protecting Vulnerable People Command. This work was repeated in December 2020, when over 130 couples or victims were seen, and their welfare established. Due to feedback from victims these visits will continue in the future beyond COVID-19.
Kent Police	Launch of the dedicated County Lines and Gangs Team (CLGT) - the CLGT provides a proactive and preventative capability to reduce the harm caused to Kent communities from the criminality connected to 'County Line' Class A drug supply. The Team focuses not only on combatting the supply of drugs (and therefore the vulnerabilities due to drug abuse) but also on identifying adults who are being exploited or may be victims of cuckooing. Proactive visits to those believed to be at most risk of cuckooing are completed by the Community Policing Teams to offer intervention and support to those at risk of abuse.
Maidstone and Tunbridge Wells NHS Trust (MTW)	The level of Kent Adult Safeguarding Alert Forms (KASAFs) raised by Trust staff increased during the pandemic and so staff were continuing to fulfil their obligations under the Care Act 2014 in relation to highlighting to the local authority their concerns about adults at risk. The number of Deprivation of Liberty Safeguards (DoLS) applications completed by staff increased by 236 to 537 during the pandemic.
Maidstone and Tunbridge Wells NHS Trust (MTW)	The MTW Named Nurse for Safeguarding Adults liaised with the KCC KARA project team (the KARA service provides vulnerable people with virtual care and support via video carephones), enabling the start of the roll out of KARA Tablets on hospital wards so that social care colleagues could continue with their safeguarding duties, albeit remotely. Going forward, It is hoped each of the wards will have a static KARA Tablet so that social care colleagues can engage effectively with adults at risk when they are inpatients at MTW.
Maidstone and Tunbridge Wells NHS Trust (MTW)	Even within the COVID pandemic, in the last year training levels remained consistently above 90% compliance for Levels 1 and 2 safeguarding adults; this is within the Trusts current compliance level set at 85%. Quality assurance of training delivery is via participant feedback and through the activity in MTW in relation to raising safeguarding alerts, responding to concerns and completing robust investigations into safeguarding concerns raised about hospital practice. The Named Nurse for Safeguarding Adults built a Mental Capacity Act E-Hub, which is a resource available to staff on the MTW learning and development platform to further staff's knowledge about applying the Mental Capacity Act (2005) into their practice. Webinars have been recorded at Level 3 for safeguarding adults, MCA and DoLS for staff to access
Medway Community Healthcare (MCH)	MCH is working with the Medway and Swale Integrated Care Partnership and Healthwatch Medway in regard to views and experiences of patients on discharge processes. MCH Customer Experience Team is also considering how to ensure the voice of the adult at risk of harm is heard when seeking feedback on services provided.
Medway Community Healthcare (MCH)	As part of the new clinical records system used by Medway Community Healthcare, the views of carers are considered during the assessment process, including a fuller mental capacity assessment window which prompts clinicians to seek the views of carers and also prompts them to consider making an application for a carer's assessment to access carer support.
Medway Community Healthcare (MCH)	Throughout the height of the pandemic, fear caused some individuals to disengage with services. Medway Community Healthcare was aware of this and implemented a list to flag high risk vulnerable adults, to ensure they were not forgotten and support could still be provided. This was also added as an alert on the clinical record to

	ensure consistency throughout services. There was also an increase in communication with local authority partners and referral to the integrated locality review to increase collaborative working.
Medway Council	Social care staff have access to monthly supervision, which was conducted remotely during this year. The staff teams across the 3 localities are divided into hubs with each hub having a senior social worker to provide the supervision, they then have supervision with the team manager. The senior social workers in the safeguarding hubs meet with the operational safeguarding lead monthly, to share information and learning and for group supervision.
Medway Council	The views of the adult at risk are sought and considered throughout the safeguarding intervention. At the concern stage, the individual is asked what action they want to take in relation to the safeguarding concern (if they lack capacity around this an appropriate representative will be asked). At the enquiry stage it is confirmed with the individual that they are aware the concern has been raised and they have consented to this. Independent advocacy is arranged as required (Care Act guidance). It is confirmed that the individual has been asked about any desired outcomes from the investigation. The outcomes are recorded. The desired outcomes can be changed. At the closure stage it is confirmed that the individual has been asked about any desired outcomes from the investigation. The individual is asked if the desired outcomes were achieved. For concerns where others may be at risk the individual's desired outcome may not be actioned. Compliance with asking people about their views is measured on the adult social care dashboard. Quarter 3 2020 - 21 showed 76% of adults at risk were asked about their desired outcome and 88% had the desired outcome fully or partially met.
Medway Council	People making unwise decisions continues to be a challenging area for practice where this leads to risk to the person. Medway Council has developed an internal high-risk panel, the purpose being to have senior management oversight of those known to adult social care who are assessed as being at high risk.
Medway NHS Foundation Trust (MFT)	A restriction on visitors and those accompanying vulnerable patients was applied, which created additional challenges as staff could not liaise with families and carers as they would previously have done. The introduction of 'Skype Angels', to support patients in communicating with their families, helped patients and families feel connected. In addition, the learning disability nurses provided vital liaison between doctors, patients and carers during this time, supporting best interest decision making and ensuring the Mental Capacity Act was adhered to for those with a learning disability.
Medway NHS Foundation Trust (MFT)	The safeguarding team was invited to be a member of the ethics committee to provide support and advocate for patients during the pandemic. This allowed patients to have representation to ensure that their rights were upheld at a time of difficult decision making.
Medway NHS Foundation Trust (MFT)	During this time all face-to-face training was stopped and was moved to e-learning. The training compliance across the Trust remains above our key performance indicators; which has been a huge achievement during such challenging times. In addition to e-learning, staff have been encouraged to attend the KMSAB multi-agency training opportunities delivered via video conferencing.
Tonbridge and Malling Borough Council (TMBC)	The TMBC new policy for taxi drivers requires all drivers to undertake safeguarding training within 12 months, and all new drivers must take a safeguarding course before receiving their licence.
Tonbridge and Malling Borough Council (TMBC)	Community safety meetings take place weekly, with police and partner agencies, to share concerns. Safeguarding, hoarding, exploitation, and vulnerable adults are standing items on the agenda. TMBC has a Safeguarding Task Group which meets quarterly to share relevant safeguarding information, and minutes of these meeting

	are discussed at Management Team and cascaded to all teams. A monthly Vulnerable Persons Board (which is linked to the community safety partnership, with Borough Council reps attending), ensures that appropriate information in relation to vulnerable people can be shared. A Rough Sleepers Task and Finish Group also meets to identify rough sleeping in the borough and look at what actions/support can be offered to help them into accommodation and off the streets.
Tunbridge Wells Borough Council (TWBC)	Annual refresher training is delivered by two practicing social workers who provide training on safeguarding as a substantive part of their role; they have common-sense checked the internal training TWBC provides and provided comments/suggestions for improvement.
Tunbridge Wells Borough Council (TWBC)	Relevant webinars and online training have been attended by other members of staff – for example, the 12 days of domestic abuse training that was organised by Look Ahead Care and Support was attended by members of the housing team, and in February and March 2021 the health team provided sessions on Making Every Contact Count, also attended by several members of the housing team.
Tunbridge Wells Borough Council (TWBC)	A local hotel in Tunbridge Wells made the decision to remain open, when most other hotels had closed, in order to provide accommodation for rough sleepers. The manager of the hotel worked closely with the housing team at TWBC to ensure the guests had food. A local charity, Tunbridge Wells Street Teams, provided an evening meal each night for the residents. During this time, two schemes set up by Maidstone BC's housing team for homeless people across the 4 West Kent councils, were also in place. A nurse who specialised in providing support to rough sleepers, visited the residents at the hotel to ensure they were linked in with a GP and otherwise able to access healthcare. A team of mental health specialists provided a similar service to the hotel guests. This continued throughout the lockdowns, as did support from the rough sleeper outreach teams who are employed by Porchlight.
Virgin Care	A new guidance under safeguarding was released in 2019 - 'Working With People Who Are Reluctant To Engage'. Colleagues found working with this guidance helpful as it is used alongside the self-neglect policy to support service users with complex needs. This policy is due to be reviewed in 2021 - 22.
Virgin Care	Ligature and Self harm risk management policy was launched in January 2021, this policy supports colleagues in the inpatient units to identify and assess patients appropriately when risk of self-harm is identified. This policy came into force following a KMSAB SAR recommendation.

Priority Two: AWARENESS

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

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

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

What we have achieved

1. National Safeguarding Adults Awareness Week - 16 – 22 November 2020

Kent and Medway Safeguarding Adults Board members 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 following themes were highlighted during the week:

- Monday – Safeguarding and Wellbeing
- Tuesday – Adult Grooming
- Wednesday – Understanding Legislation
- Thursday – Creating Safer Places
- Friday – Organisational Abuse
- Saturday – Sport & Activity
- Sunday – Safeguarding in Your Community

Unlike previous years, the pandemic response meant that the Board was mainly reliant on social media, such as Twitter and Facebook, to raise awareness. A social media content plan, setting out the messages to be sent by partner agencies' communication teams, was developed and shared.

Following the campaign, the Communication and Engagement Working Group (CEWG) reviewed the social media analytics. Unfortunately, due to the pressures of the pandemic response, not all agencies were able to report on their analytics. However, of the analytics that were returned, a total of 56,478 impressions (number of times the content is displayed) and 1075 engagements (likes, shares, comments etc) were reported.

Although analytics did not evidence huge engagement, a large number of people/services had been reached. Members of the CEWG identified that there was a notable increase in engagement with posts that included details of the new KMSAB website and specific posts around grooming. It is not clear if the increase in engagement was due to the wording of these posts or due to the subject matter.

Other areas of targeted awareness raising during the week included:

- Sharing a short film produced by Mencap which included Covid-19 Q&A session for adults with Learning Disabilities.
- Regular circulation of safeguarding bulletins to community groups and staff
- Dissemination of leaflets and posters.
- Targeted Hubs to support volunteers/staff with escalating safeguarding concerns.

Example 'tweet'

Ann Craft Trust – Twitter Statistics for Safeguarding Adults Awareness Week

12 Million+ people reached through hashtags, over twice as many as 2019

3000+ individuals and organisations talked about the week on twitter

7000+ tweets made using the hashtags on 23 November alone.

2. Promotion of Communication and Engagement Toolkit

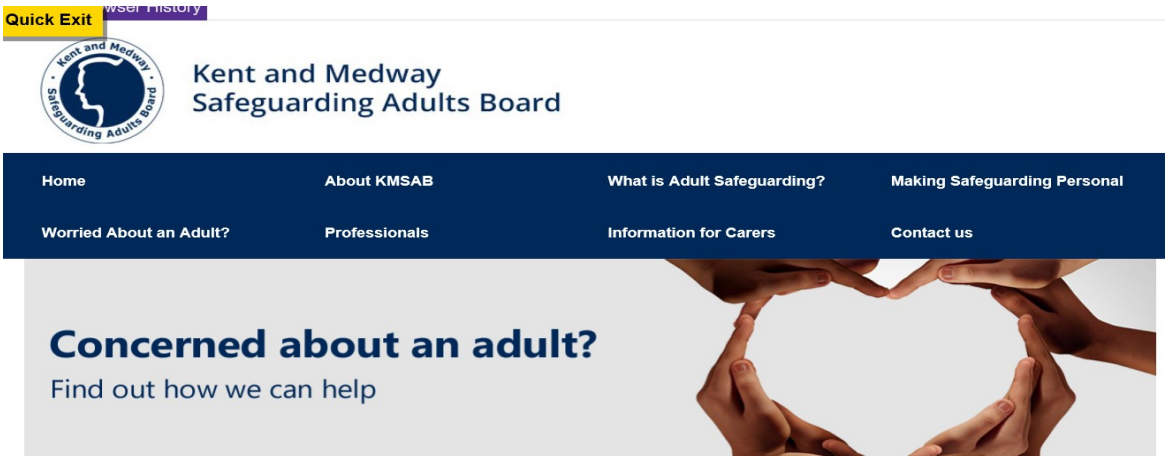
To support safeguarding adults awareness week and to enable agencies to raise awareness of adult safeguarding during the pandemic, the Communications and Engagement Working Group continued to update and promote their Communications toolkit. This included:

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

3. New Safeguarding Adults Board Website

The new Kent and Medway Safeguarding Adults Board website was launched as part of safeguarding adults awareness week. This significantly improved the accessibility and availability of Board information, as previously information was on different pages on Kent County Council's website, making it hard for practitioners and members of the public to find.

A formal accessibility audit was undertaken by the KCC Digital Accessibility Team to ensure the website was compliant with the accessibility duty. As at November 2021, the home page has been accessed 494,006 times.



4. Independent Chair's Safeguarding Adults Awareness Briefing

Two 'virtual' safeguarding adults awareness briefings, hosted by the Independent Chair of the Board Deborah Stuart Angus, were held in October 2020. The briefing sessions were aimed at non-partner organisations who work closely with their local communities (e.g. charities, faith organisations, advocacy, businesses). Again, the emphasis was on raising awareness about the types of abuse, channels for reporting concerns, and to encourage agencies, organisations and businesses to evaluate their internal processes to safeguard adults at risk. Case studies were used to generate discussion and to help embed the knowledge shared. The events attracted over 60 attendees and feedback received during and after the event was very positive.

> "Thank you to everyone involved in bringing the briefing, I found it very valuable and is an important part of our safeguarding training and awareness. Please pass on my thanks and I look forward to the next one."

5. Newsletter

The Board's business development and engagement officer continued to produce and circulate a monthly newsletter sharing updates in relation to: Board activity; Covid guidance and support; and relevant local and national safeguarding information. Covid specific articles included:

- Details of the 24-hour mental health crisis text service
- Public Protection - COVID-19 Scams and Guidance
- Counter Terrorism Police – Radicalisation and COVID-19
- Adolescent to Parent Violence during COVID-19
- supporting autistic people and people with learning disabilities,

- Domestic Violence and Abuse: Safeguarding during the COVID-19 crisis,
- Alcohol Change UK – Supporting the most vulnerable drinkers during COVID-19

Over 290 people subscribe to the KMSAB newsletter, with many cascading this further within their organisations.

The newsletter is also one of the tools used to share findings and themes arising from Safeguarding Adults Reviews, Domestic Homicide Review and other relevant reviews. We do not wait until SARs are published to share any identified areas for improvement, as this would lead to unnecessary delay.

Example newsletter article to share SAR/DHR learning - published January 2021

Are you requesting Carers' Assessments?

Carers' assessments have been a prevalent theme within Safeguarding Adult Reviews (SARs) and it is vital, especially during the COVID-19 pandemic, that carers are receiving the support that they need before they reach crisis point. Caring for someone covers different things, including:

- Helping with washing
- dressing
- eating
- Taking them to regular appointments
- Medication
- Housework
- Financial Support
- Keeping them company when they feel lonely or anxious

A person is entitled to a carers assessment in their own right, even if the person that requires care does not get any help from the council. For more information on support for carers, how to request a carers assessment and useful links and resources, visit the KMSAB website.

6. Engagement with local communities

The KMSAB is continuously pursuing ways to engage with service users, carers and the public. The ambition is to provide ways for them to influence the work of the Board and empower and enable them to contribute to safeguarding in Kent and Medway. Whilst this remains a top priority for the Board, it is also an area of challenge. Many approaches have been trialled, but the impact of these have been hard to quantify.

Members of the Communication and Engagement Working Group have recognised that within the organisations/communities they represent there is a great deal of activity being undertaken to raise awareness of adult safeguarding at a local level, but this can be difficult to capture. Members developed a form for agencies to complete when such awareness raising has taken place. The information can then be considered at the working group to identify any gaps.

In addition, the self-assessment framework (SAF) developed by the quality assurance working group includes the following questions:

- How does your agency take into consideration the views of those at risk of abuse and neglect and how and when is this information analysed?

- What are the themes and trends from feedback and how has this information been used?
- Can your agency demonstrate that service users are invited and supported to attend S.42 meetings? (Local Authorities Only)
- How are messages and feedback from staff and service users reported to the Working Groups and the Board?

The SAF process is covered in the next section of the report.

Healthwatch Kent and Medway and the Advocacy People have begun discussions with other Healthwatch areas to consider best practice and the potential development of a 'citizen's panel'.

7. Translated KMSAB leaflet – How to recognise and report abuse.

The Board's main leaflet, which explains how to recognise and report abuse, was translated into the 18 languages most commonly spoken across Kent and Medway, to help all communities raise awareness of the signs of abuse and how to report it. The leaflet is also available in easy read.

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

8. Some of our Partner Highlights

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

Safeguarding Messaging on Prescription Bags - Working with health partners, Kent Police developed bags for use by Pharmacies when delivering medication. This was introduced at the beginning of the first lockdown, when many other services were closed and only essential shops and pharmacies were open. The messages focused on crimes that people may be more vulnerable to due to the pandemic. This advice included guidance around courier fraud and how to seek help around domestic abuse.	
Ashford Borough Council (ABC)	The newly identified Modern Slavery and Human Trafficking Safeguarding Officer completed the Council's Modern Slavery statement and an action plan was put together; this has included a passionate, specialist councillor (member) Group. Completed tasks from the action plan include: Modern Slavery referral guidance produced and shared with staff, elected members and parish councillors; an article in the Council's magazine (distributed to the whole borough); and a Kent Police presentation at an Ashford Community Safety Partnership meeting.
Ashford Borough Council (ABC	The Council's internal 'Smart Hub', which all staff and elected members have access to either via a desktop and/or mobile phone app, has a page outlining that Safeguarding is Everybody's Business and which contains various information such as: who the themed safeguarding leads are; how and where to make a referral; and has links to our safeguarding policy and other sources of information. Specific safeguarding awareness raising articles are also posted on the Smart Hub.
Canterbury City Council	The communications team continue to use social media platforms to reach residents in the District. Posts this year have included short awareness raising videos on domestic abuse and cuckooing and avoiding scams for the elderly.
Canterbury City Council	The resettlement team provides information in Arabic, for Syrian families, on who to contact. They also arranged for PCSOs to visit to talk about services and reporting hate crime.

Canterbury City Council	The Council's resettlement team spoke to a number of refugees who were hesitant about the COVID vaccine, having read social media posts that worried them, to better understand their concerns. The team and a voluntary sector partner (Canterbury Welcomes Refugees) arranged for the Chair of the Mosque, who is a medical doctor, to lead a question-and-answer session in Arabic. As a result, vaccinations have been taken up across all refugee families the Council supports. Having heard about this example of good practice, Kent Community NHS Foundation Trust has approached us to assist with an area of low vaccine take up elsewhere in the District.
Dartford Borough Council	DBC has produced a safeguarding poster, which is displayed around DBC's offices. The poster reminds staff that safeguarding is everyone's responsibility; where to find the procedures for reporting concerns; and, the contact details of members of the Safeguarding Steering Group if advice is required on a safeguarding matter. KMSAB posters and leaflets are also displayed in DBC's Civic Centre reception area.
Dartford Borough Council	The impact of Covid has raised concerns that vulnerable people and people with limited contact with the outside world, due to social distancing and self-isolation, may be at an increased risk of abuse. DBC has promoted national and Kent-wide campaigns, both internally through the Intranet and externally through posters and social media, in order to raise awareness of the risks of different types of abuse and the support available for victims – including for domestic abuse, radicalisation, modern slavery, and Covid scams.
Dartford Borough Council	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. The Elders Forum meetings have been postponed over the last year due to the impact of the Covid pandemic, however it is hoped they will resume in the future. Despite this, some initiatives have been communicated and shared with members of the Forum, such as fraud prevention advice from Kent Police, and free crafting courses which were offered by KCC. In 2020, DBC also carried out an initiative to hand deliver puzzle book packs to approximately 2,000 residents over the age of 70, who live alone.
Dover District Council	We work with minority groups to raise safeguarding awareness, for example, controlling migration funded project to build community cohesion between Roma and British communities in Folkestone Road Area.
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
Gravesham Borough Council	Local work on 'violence against women and girls' 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 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.
Healthwatch	Mental Health Forums received this feedback following support given from the team - "We have forged a stronger relationship with Victim Support in relation to signposting around services for customers affected by Hate Crime and Safeguarding issues where we have some correlation with BAME customers".
Kent Community Healthcare NHS Foundation Trust (KCHFT)	KCHFT's safeguarding service facilitates an annual safeguarding conference, this includes a range of speakers from partner agencies, including lessons learnt from case reviews and practical demonstration of topical safeguarding issues i.e. self-neglect. The delivery is varied to support a wide range of learning styles.

Kent Community Healthcare NHS Foundation Trust (KCHFT	The safeguarding team has raised awareness of the impact of Coronavirus pandemic on individuals and families through various mediums including question-and-answer virtual sessions, blogs, bespoke updates and within training. Key thematic topics included domestic violence and abuse, risks of isolation, self-neglect, hoarding, exploitation and the importance of application of Mental Capacity Act in practice, especially the challenges of its application in practice during the pandemic and use of virtual assessments. Staff were provided with Prevent updates as released and an annual Prevent briefing was published.
Kent Community Healthcare NHS Foundation Trust (KCHFT)	KCHFT was commissioned to deliver Covid Vaccination programme in Kent and Medway through mass vaccination centres. This included development of safeguarding processes and ensuring the workforce was safeguarding aware and had robust process in place for identification and reporting.
Kent Community Healthcare NHS Foundation Trust (KCHFT)	Self-neglect consultations from staff to the safeguarding service have continued to rise from 60 in 2016/17, to 112 in 2018/19 to 126 in 2019/20 and 130 in 2020/2021. This demonstrates an increase in staff recognising and acting upon concerns of self-neglect, following continued efforts to raise awareness of this topic across the organisation.
Kent County Council	The Kent Community Safety Team led on the review and refresh of the Kent and Medway Domestic Abuse Services website, working with partners to ensure the directory of services and content was up to date and provides the best experience for visitors to the site. During 2020/21 the refreshed website moved onto a new platform to make it more user friendly. The public facing element of the website went live in November 2020, in-line with the 16 Days of Activism Against Violence Against Women and Girls (VAWG). In addition to the above, throughout the COVID-19 pandemic the website was updated with changes to services to ensure those in need had access to current and up to date information on service provision in the county.
Kent County Council	In order to improve engagement, KCC launched the "Kara" service as part of our response to the pandemic and to support other priorities such as Winter Pressures. Kara enables KCC to continue to deliver elements of care and support to residents remotely, connect people with their friends and family safely and securely, as well as enable the ability for us to continue to work with providers and partners across the county.
Kent County Council	We started rolling-out video carephones to many of our residents to enable us, and care providers, to continue to deliver elements of care and support to residents remotely. The video carephone allows a person to stay in touch with care workers, family members and other approved services through a video call. Only approved responders who have access to the system can use the video carephone. The carephone is a tablet device that has a SIM card to make it instantly usable, even for people with little or no WiFi connection. Over 2,000 devices have been sent out, not only connecting people to their paid care services, but also to friends or family members.
Kent Fire and Rescue Service	To raise the awareness to our customers about partnership working and the types of situations and incidents whereby we identified safeguarding concerns, the Engagement team and Safeguarding Manager have created a 'Together Video' showing collaborative working. This has been published on Kent Fire and Rescue Website and shared on numerous social media platforms to reach our customers. The video is available here.
Kent and Medway CCGs	The CCG organises Primary Care Protected Learning Time events, these events are always well received and reached approximately 1800 people in 2020. The event covers topical safeguarding issues such as Mental Capacity Act in Pandemics, Mental Capacity Assessment and Do Not Attempt Resuscitation, Liberty Protection Safeguards, Domestic Abuse and Think Family. Feedback from the events showed the value of these events and how they are appreciated by our primary care colleagues. This is a significant

	increase in uptake of training in this area from the previous 12 months.
Kent and Medway CCGs	As part of Safeguarding Adults Awareness Week the CCG authored daily safeguarding bulletins on different topics and disseminated across CCG staff and distributed social media content.
Kent and Medway CCGs	Development of multi-agency toolkit for all front-line staff to help support young people and adults where exploitation is suspected.
Kent and Medway CCGs	During the COVID-19 response the CCG had a multiagency care home cell. The CCG safeguarding team assisted in the provision of support directly to care home cells, including input on planning of systems to enable remote assessment, sharing of national guidance across providers /primary care /care homes and CCG, and supporting rapidly developing COVID-19 response systems to include Mental Capacity Act statutory guidance for staff going out to undertake swabbing and later consent to vaccinations, along with ligature risks of personal protective equipment and do not attempt CPR, This work has increased the safeguarding team's input into the engagement work with care homes and resulted in a Designate being identified to support care home work going forward.
Kent and Medway NHS and Social Care Partnership (KMPT)	KMPT has a Partnership and Engagement team which engages with patients and the community to get involved with a wide and diverse range of activities. The patient voice supports KMPT in improving or developing services. Patients and the public can register their interest in joining on the public facing webpage.
Kent Police	**Launch of AWARE principle** – AWARE (Appearance, Words, Activity, Relationships and dynamics, Environment) is 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.
Maidstone and Tunbridge Wells NHS Trust	In safeguarding adults week 2020 we took this as an opportunity to raise awareness with staff. The Named Nurse for Safeguarding Adults recorded a short video that was communicated out to staff on our usual communications platforms and social media. Good use was made of the "Ann Craft Safeguarding Materials" with daily communications throughout the week publicised in the Trusts edition of the staff briefing – The Pulse. The Named Nurse for Safeguarding Adults authored a question and answer section about safeguarding adults for the Governance Gazette, this included information about what MTW staff are good at in relation to safeguarding adults, what would we like to improve, and asking what is the one change in practice that would make the biggest difference and a piece about applying the Mental Capacity Act into their practice.
Medway Community Healthcare	Medway Community Healthcare has dedicated safeguarding pages on the staff intranet with all links to KMSAB page and relevant documentation, tools and referral forms. The page is managed by the Safeguarding Team and updated regularly. The Safeguarding Team has also produced short bulletins throughout the pandemic to ensure staff are not bombarded but still made aware of safeguarding information in a bitesize format. The KMSAB newsletter is disseminated throughout the organisation via the Communications team.
Medway Community Healthcare	Medway Community Healthcare has a social value working group that was established in the wake of the COVID-19 pandemic as an emergency response to support MCH and the wider community. During the pandemic, the group helped to coordinate volunteers to respond to the demand for support across the NHS, as well as working with Medway Voluntary Action to help recruit volunteers to support the wider community response.
Medway Council	In January 2021, in response to a Medway Safeguarding Adult Review, an audit was

	completed of those people where Medway had received more than 3 contacts, that had been closed, in a 6- month period. The outcome was that most contacts had been managed appropriately.
Medway Foundation Trust	The Head of Safeguarding chairs a monthly operational safeguarding meeting attended by matrons, security and therapy staff. This meeting not only shares information regarding current and ongoing safeguarding cases but also learning from reviews, outstanding actions and the support required to ensure that learning takes place. This meeting continued virtually during the pandemic and enabled the sharing of information for attendees to take back to their teams, this included the expected rise on Domestic Violence, mental health and self-harming cases as lockdowns eased. This meeting provides support, supervision and guidance in addition to being a point of escalation.
Sevenoaks District Council	Safeguarding cards were produced to raise awareness of key safeguarding issues for all staff.
Tonbridge and Malling Borough Council	Staff from several Council teams delivered emergency food parcels throughout the lockdown periods. On one occasion a disabled gentleman was found to have had a fall from his wheelchair and had been unable to call for help. The staff member called an ambulance and supported him until the paramedics arrived. Following his stay in hospital, his housing needs have been reassessed and he has been allocated suitable housing that better meets his needs.
Tonbridge and Malling Borough Council	Community development meetings have been held virtually with partners working in our deprived communities. Action plans are in place to support vulnerable people and assist them engage with services.
Tonbridge and Malling Borough Council	The weekly Community Safety meetings (virtual) also enable shared learning and discussion of cases with all partners (police, KFRS, KCC, Porchlight, etc).
Tonbridge Wells Borough Council	The Safeguarding Operational Lead has presented reports to the Council's Overview and Scrutiny Committee and Covid Recovery Panel about homelessness, which has included information about adults at risk of homelessness and those at risk of self neglect through hoarding and what actions TWBC is taking to safeguard these vulnerable groups.
Virgin Care	The Covid-19 pandemic lockdown made it difficult to undertake the safeguarding awareness week in the usual way we normally do however, we used various platforms and the new way of meeting, which is the virtual approach, to reach out for the safeguarding awareness. members of the public were not involved in the last year's awareness, but the workshops held virtually helped colleagues and equipped them to understand their safeguarding responsibilities and by doing so they were able to promote safeguarding to the wider public.
Virgin Care	The community hospitals and all service user areas have posters of how to report abuse, some posters were taken down due to infection control policy on covid-19 pandemic but safeguarding posters such as domestic abuse posters and the KMSAB report abuse posters remained visible to service users who are able to visit clinical areas.

Priority Three: QUALITY

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

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

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

What we have achieved

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

As a Board, one of our main responsibilities is to hold our partners to account. This involves gaining assurance that safeguarding arrangements are in place, that they are effective and they deliver the outcomes people want. It also involves respectfully challenging partners. During 2020/2021 Quality Assurance Working Group (QAWG) members implemented the quality assurance framework, which sets out the measures and tools we use to measure effectiveness of partners' safeguarding activity.

The tools detailed in the framework include:

Annual Self-Assessment Framework (SAF)

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

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

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

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

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

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

The 2020/21 SAF was due to be sent to agencies for completion in March 2020, but this was delayed due to the pandemic and was instead circulated in January 2021. The submission deadline was also extended until 30 April 2021.

To ensure that they were seeking assurance from the most relevant agencies with a responsibility for safeguarding adults, Board members reviewed the agencies required to complete the SAF. This led to the additional inclusion of the 12 district/local councils. North East London NHS Foundation Trust and G4S, increasing the number of returns from 16 to 30.

The 2021 SAF was comprehensive and included the following sections:

- **Participation –** Standards include:
  - the availability and accessibility of adult safeguarding information.
  - how agencies take into consideration the views of those at risk of abuse or neglect and how this information is used to improve services.
  - How staff are made aware of advocacy services.
  - How agencies assure that they meet their legal obligations so that carers are referred for a Carer's Assessment, or the need for a Carer's Assessments is highlighted to the Local Authority (SAR finding)
- **Leadership –** Standards include**:**
  - Whether there are accountable leads for safeguarding and the impact they make.
  - Whether the organisation has and escalation policy and if this incorporates the new KMSAB escalation policy (SAR finding)
  - How well the organisation participates with, and promotes, the work of the Board, how messages from the Board are disseminated and how the impact of this is measure/evidenced.
  - How are messages from staff and service users are reported to the working groups.
- **Service Delivery and Effective Practice –** Standards include:
  - How the organisation ensures that commissioned, subcontracted, agency or locum services are compliant with KMSAB Safeguarding Adult Policy and Procedures.
  - How the organisation identifies people who may have challenges in transitioning between services and what is in place to manage and support this (SAR Finding).
  - How the agency takes into account the potential increased vulnerability of previously looked after children in provision of care? (SAR finding)
  - What self-harm risk controls are in place (SAR finding)
- **RECRUITMENT AND SUPERVISION –** Standards include:
  - Whether safer recruitment policies and procedures in place, are monitored and the frequency of any staff vetting checks.

- What the criteria is for carrying out and recording management oversight for individuals who are at risk of harm.
- Whether the organisation has a clear policy in place for dealing with allegations against people who work, in either a paid or unpaid capacity, with adults with care and support needs.
- Whether the agency has a Whistle-blowing Policy and how systems and processes encourage staff to raise concerns about internal provision and/or performance.

- **Training** - **Standards include: -**
  - 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, DHRs and Child Safeguarding Practice Reviews in order to integrate learning into practice and training.
  - What process/training is in place for employees to enable them to identify any potential allegations against staff.
- **Performance Management – Standards include:** -
  - How the agency uses safeguarding performance data and other feedback to inform safeguarding or other strategy and service delivery.
  - How the organisation uses safeguarding performance and quality information to hold services to account.

Annual Agency Reports

All KMSAB partner agencies are required to complete an annual agency report to detail actions taken to improve effectiveness, identify good practice and issues for their organisation over the previous 12 months. The 2019/2020 report also sought information on how agencies were delivering the three priorities of awareness, prevention and quality, as set out in the Board's strategic plan.

A total of 31 reports were submitted by the deadline of July 2020. Quality assurance working group members reviewed the submissions, highlighting areas for clarification, good practice, and areas of concern to be raised to the Board.

Members were impressed with the good practice examples provided and these were included in the 2019/2020 annual report.

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

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

It is important to reiterate that the Board and its working groups do not wait until a SAR is complete to begin to make improvements identified as the review progresses. For example, a recurring theme from

SARs is the need to 'hear the voice of the adult' and embed 'making safeguarding personal'[2]. This information was shared with all the working groups, resulting in the practice policy and procedures working group developing a dedicated webpage on the new Board website, providing guidance and links to useful resources. This was promoted by the communication and engagement working group and re-iterated in all the training modules. The quality assurance working group's SAF included standards to measure how successfully this approach had been embedded.

3. Sharing of Good Practice

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

Examples of 'making safeguarding personal' making a difference to an adult at risk

Examples of good practice include:

The Community Nursing Team were incredibly responsive to a complex and high-risk case where a patient was making unwise decisions regarding their health care and treatment. The team followed KMSAB Self-Neglect policy and proactively coordinated care in a multi-agency way to reduce risk where possible. The team were patient centred throughout and ensured they made safeguarding personal, they involved the patient every step of the way and the patient described feeling thankful and appreciated that the team cared.
Kent Community Health NHS Foundation Trust

The Respiratory Nursing Team were responsive to a high-risk concern where a patient who lacked capacity regarding a particular health decision, was in turn placing themselves and others at significant risk. They supported the patient in a caring and sensitive way, applying the principles of the mental capacity act in practice. They coordinated and led both best interest and multi-agency meetings and as a result the risk was resolved
Kent Community Health NHS Foundation Trust

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

4. Evaluation of Level One and Two Safeguarding Adults Training

KMSAB partner agencies are required to deliver level one and two (foundation) adult safeguarding training which is aligned to their professional bodies' competency/capability framework, or should they not have one, the Board's competency framework. Whilst the Board does not hold responsibility for level one and two training, the Learning and Development Working Group (LDWG) does have a quality assurance function, as level one and two training should equip those attending subsequent KMSAB training with a sufficient and consistent knowledge base. Due to the pressures of the pandemic, partners were not able to formally evaluate their level one and two training, using the Board's standards tool. They did however, provide a verbal update at a learning and development working group meeting.

5. SAR methodology

Due to the pressures of the pandemic and the number of safeguarding adult reviews being managed by the Board, members of the Safeguarding Adults Review Working Group (SARWG) trialled different methodologies to expediate the learning, whilst still retaining a rigorous process. SAR working group members will be updating the SAR policy in 2021/2022 and will use the evaluation of these trials to inform this.

6. Some of our Partner Highlights:

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

Ashford Borough Council (ABC)	The Council's Lifeline service is accredited through the professional body; Telecare Standards Authority and was audited in February 2021; a pass was received.
Canterbury City Council	The new KMSAB self-assessment tool and follow up peer review endorsed the good practice we already have and challenged us to identify areas where improvements can be made.
Canterbury City Council	As a result of working through the list of vulnerable adults, a number were identified with significant unmet support needs. The Council formed a cross service working group to review cases and ensure robust appropriate measures were taken to safeguard them. The key themes were: • Mental health – for some with existing mental health issues these worsened during lockdown as people found it harder to access ongoing support and medication. Others were experiencing stress and trauma as a result of the pandemic. • Elderly people with care needs that hadn't been identified were referred into relevant statutory services for Care Act assessments and support. • Financial hardship, exploitation and cuckooing were variously referred to appropriate support All cases were followed up with welfare calls to ensure no one 'slipped through the net'.
Canterbury City Council	The elected members have been robust in requesting further information around safeguarding data throughout the pandemic to better understand the Council's responses.
Kent Community Health NHS Foundation Trust	Safeguarding referrals audit - An initial audit was developed to review processes involved as part of the safeguarding consultations duty line, this has resulted in the processes being refined and a follow-on audit looked at the quality of referrals in to social care. Key areas of good practice included; the adult at risk or their representative was consulted about the referral, safeguarding referrals were completed electronically, there was clear

	reference to 3- part eligibility criteria in referrals, and an incident report was completed following a Safeguarding referral.
Kent Community Health NHS Foundation Trust	The safeguarding peer review audit showed for adults that there is evidence that following the audit there is improved assessment of need, sharing of information with partners to ensure timely and appropriate support, compliance with Care Quality Commission domains and that learning has been embedded into practice following CR/SCR/SARs and DHRs. The audit also showed there is evidence of good understanding of what constitutes safeguarding concern, self-neglect, MCA and consent. The majority of staff knew how to contact the KCHFT safeguarding duty line and sought support about safeguarding concerns. Those who submitted data evidenced compliance to demonstrate learning from reviews or that practice is developing and meets quality standards. A new capacity assessment was completed for each intervention where the person lacked capacity to consent, best interests meetings were documented in majority of cases. Another improvement and impact of training and advice for front line staff was regarding MCA assessments with 93 per cent documented who was involved in the decision making.
Kent Community Health NHS Foundation Trust	In 2020/2021 KCHFT Specialist safeguarding team provided 617 consultations to staff through a dedicated duty line and processed 427 adult safeguarding referrals raised into the local safeguarding process, 349 adults safeguarding referrals raised by KCHFT staff alone. The main category of abuse raised was neglect, followed by the category of self-neglect.
Kent County Council	KCC Adult Social Care has a safeguarding competency framework in place to ensure that adult social care staff are fully equipped to identify, and have the right skills to support, adults at risk. The framework consists of levels from A-D, and it includes the requirement to discuss Safeguarding within supervision. This framework is for everyone (registered and unregistered) who has contact with adults within the Adult Social Care and Health Directorate and staff are required to evidence their developing competence, using the observed practice approach.
Kent County Council	The KCC Strategic Safeguarding and Quality Assurance Manager chairs our internal strategic County Safeguarding Group meeting, which provides a forum and clear governance route for raising any safeguarding issues and sharing intelligence with senior colleagues within Safeguarding and Adult Social Care. An Assistant Director and Service Manager's from each Service area (Mental Health, Older Persons and Physical Disabilities, Learning Disabilities and Sensory Services), Strategic Safeguarding, Performance, Commissioning and Deprivation of Liberty Safeguards attend.
Kent County Council	KCC Adult Social Care undertook a "Peer Challenge" in November 2020. This was not an inspection but rather an external assessment by critical friends who have experience of delivering an equality/diversity agenda in their own councils. However, it provided vital feedback to inform future activities. The peer review was undertaken by the Local Government Association (LGA), using the LGA's Equality Framework for Local Government. A strength identified within the review was in relation to Adult Social Care having a good understanding of the makeup of the community including ethnic minorities such as asylum seekers, Gypsy, Roma and Travellers, the Nepalese community and the different Asian communities in Gravesend and North Kent. The team and others know where the pockets of disadvantage are as well as the trends around other needs such as mental health, autism and learning disability and rural isolation.
Kent Fire and Rescue Service	Every three 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.
Kent and Medway CCGs	Designates continue to support the Adults Health Reference Group (HRG); the overarching purpose of the HRG being to provide a means for safeguarding health leads and commissioners across the Kent and Medway health economy to collaborate and share good practice, consider emerging themes from statutory reviews and case law. The Designates also utilise 7-minute briefings to share learning and information. These briefings are shared by the Designates with the providers in their portfolios. The briefing are also shared with GP Practices via the weekly GP bulletin, 7-minute briefings are uploaded to the safeguarding web page as a resource for all to access.
Kent and Medway CCGs	The participation of Designated Nurse/Professionals in the 'Serious Incident' (SI) panels has been reviewed and strengthened with the introduction of a safeguarding / SI database designed to identify SIs with a primary safeguarding element and those where safeguarding concerns were identified as a secondary or unidentified element of the SI. The database allows the Designates to theme and trend the safeguarding elements of SIs by category, provider and outcome. This data informs quarterly returns to NHSEI and provides triangulation with other sources of soft data related to an organisation's safeguarding competence, risk and good practice. The data can be used within the QRGs as evidence that improvements are needed, at Safeguarding Committees to challenge perceptions of safeguarding practice, to strengthen assurance and to celebrate areas of good practice or where organisations have made sustainable change to practice.
Kent and Medway NHS and Social Care Partnership (KMPT)	An independent internal audit by TIAA (audit company) on consent was completed in January 2021. The objective of this review was to establish the effectiveness of the processes in place within the Trust regarding obtaining consent from patients. The review included the process for consent for diverse patient groups, consent to treatment under the Mental Health Act (MHA) and for where a person lacks mental capacity to make an informed decision, or give consent. The assurance level applied was 'reasonable assurance', this level is from one of the four categories which can be applied, No, Limited, Reasonable, Substantial. Meeting this level of assurance is an achievement reflecting the MCA training and consent training which is delivered by the safeguarding team.
Maidstone and Tunbridge Wells NHS Trust	The Trust completes a quarterly report to the CCG to provide evidence against key performance indicators that have been developed Kent wide. These are scrutinised by the Trust's Strategic Safeguarding Committee and by the Designated Nurses for Safeguarding within the CCG.
Medway Community Healthcare	Medway Community Healthcare uses the CCG Safeguarding Metrics document to measure safeguarding activity. This document includes numbers of referrals made, training compliance, DoLs applications, SAR involvement, contacts to the safeguarding team and attendance at MARAC amongst other parameters. This information is shared and discussed at the Quality Assurance Committee and with commissioners
Medway Council	We 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.
Medway Council	Adult Social Care has a safeguarding dashboard to monitor performance. This is scrutinised by senior managers. If any issues are identified then an action plan will be agreed to address this, for example, audit activity, learning sessions. This forms part of our internal assurance process.
Medway Foundation Trust	The Chief Nursing and Quality Officer has initiated divisional assurance reporting into the quarterly Safeguarding Assurance Board. This has not been affected by the pandemic. The Trust uses the safeguarding board escalation policy as required. Most escalations do not progress beyond the informal escalation route.
Virgin Care	Safeguarding activities are measured through different means and by auditing all our clinical services. We conduct annual safeguarding audit, monthly clinical governance

	score card, we recently added our consent and mental capacity audit question to our annual health record audit. The business unit quality strategy is reviewed quarterly with the contribution of the safeguarding lead.
Virgin Care	Non- concordance personalised care plan is put in place to support individuals who may or may not lack capacity, so that they are involved with their care and support and guidance is given with their decisions.

Section 3. Safeguarding Adults Reviews

3.1. Criteria for Conducting a Safeguarding Adults Review

KMSAB must arrange for there to be safeguarding adults review 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.

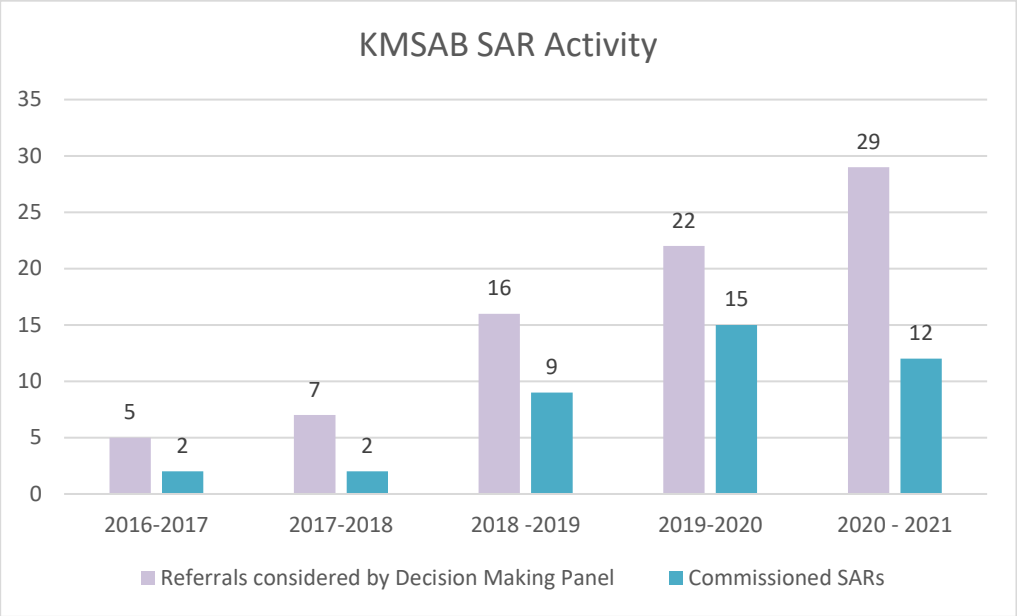
KMSAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include 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 case referred for a Safeguarding Adults Review meets the criteria, a multiagency decision-making panel, chaired by a member of the SAR working group, is convened when a new referral is received. Each agency brings a summary of their involvement, these are considered to assess if the referral meets the criteria for a SAR or whether any other review or action is required. The recommendation of the panel is sent to the Independent Chair of the KMSAB for a final decision.



The KMSAB received 29 new SAR applications between April 2019 and March 2020, of these:

- 12 SARs were commissioned
- 17 cases 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. In many cases, the additional information evidenced that agencies did work together, so the criteria was not met.

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

Harrold Garrett

Harold, aged 66 at the time, was admitted to hospital in January 2018 after suffering a fall and a suspected bleed to the brain. His medical and psychological needs were complex in that he was alcohol dependent, smoked and had dementia-like symptoms, with episodes of aggression, confusion and agitation. His needs were such that he was attended by a Registered Mental Nurse on a one-to-one basis whilst in hospital. By early February 2018 he was considered to be well enough, medically at least, to be discharged from hospital. The placement identified for him was a nursing home specialising in looking after those with acute dementia. Harold at that time had no clear diagnosis of dementia, although he was exhibiting some of the symptoms. It was apparent very early on that this placement was unsuitable and after four weeks he was asked to leave. Staff took him to the Housing Department where he was accepted as homeless. Within hours he was admitted to psychiatric care and remained so until he died.

Malcolm Foreman

Malcolm Foreman, a white British male aged 42 was found deceased in a wooded area near his home. He had reportedly been diagnosed with illnesses related to psychosis in 2000 and had sporadically engaged with health and welfare services for eighteen years. Leading up to his death, Malcolm's mother had raised concerns on numerous occasions regarding Malcolm's mental health. Despite at least ten welfare checks being undertaken by a variety of agencies Malcolm had not engaged with services.

Thematic Case Review

This Safeguarding Adults Review related to four individuals, where self-neglect was considered to be a factor in their death. Each had been found deceased at their home addresses. As very little information was known about these individuals it was agreed that a combined thematic SAR should take place. Pre-pandemic, a practitioner event was held, where agencies who knew the individuals, and other relevant agencies, met to discuss the key lines of enquiry and consider ways to work with people who may be self-neglecting, who may refuse services and to discuss ways to raise awareness to prevent self-neglect.

Denise

Denise was a 62-year-old lady residing in Town A. She had a medical history of type 2 diabetes treated with insulin. She also had retinopathy (an eye condition that can cause vision loss and blindness) and chronic kidney disease, both of which are recognised complications associated with diabetes. Due to the lack of information each agency had over a two-year period prior to her death, the chronologies demonstrated earlier information to support the review. It was clear that Denise had become isolated and disengaged from society; however the reasons for this were not clear to each agency nor were they explored.

John

John was a 62 year old man living in Town C when he was found deceased. He had a medical history of hypertension and an eye condition, 'Pigment Dispersion Syndrome', which can cause a form of glaucoma for which he was receiving repeated medication. John was noted to consume high volumes of alcohol, sometimes stating he was an alcoholic. John was known to environmental health due to complaints about the state of his property.

Betty Taylor was aged 91 years and her daughter **Susan Taylor**, was 63 when they were found deceased in their home in August 2018 On 11 October 2017 Kent Adult Social Care contacted Susan and Betty's neighbours as they had expressed concerns to the police that they had not seen Mrs Taylor for some time. It was reported that Mrs Taylor had recently had an accident, where she had told the neighbours that she had fallen in her house a couple of weeks earlier, however she still had bruises on her face. The neighbours felt that Mrs Taylor was "in a bit of a state" and she needed some attention. The neighbours were advised to ask for her consent for a referral. A little later the neighbour called adult social care back to explain that he went to see Mrs Taylor to tell her of the referral and she stated that she did not want any help from social services. She refused to give him her contact number or GP details. The adult social care worker demonstrated good practice by phoning GP surgeries in the area to establish the surgery Mrs Taylor was registered with. Had they persevered with speaking to a GP they may have established a greater concern however they emailed the GP surgery with the details they had been given regarding Mrs Taylor having a fall. Unfortunately, no further action was recorded and the contact was closed 11 October 2017.

As very little information was known about these individuals it was agreed that a combined thematic SAR should take place. Pre-pandemic, a practitioner event was held, where agencies who knew the individuals, and other relevant agencies, met to discuss the key lines of enquiry and consider ways to work with people who may be self-neglecting and ways to raise awareness to prevent self-neglect.

Robert Bolton

Following a threat to take his own life in 2012, Robert was supported in different settings within the community until 2016. In March 2016, after concerns raised about his declining wellbeing, a Mental Health Act assessment was arranged. Robert did not engage, so a section 135 warrant to gain access was progressed and he was subsequently detained in hospital, initially under section 2 for assessment and later section 3 for treatment. This was recorded as non-engagement to treatment, delusional disorder and depressive episode which was in remission. Robert remained in hospital for six months until September 2016 when he was discharged to a temporary placement, supported by the local Community Mental Health Team (CMHT). In December 2016 he moved into supported accommodation. He continued to be supported by family members, CMHT, and local support services. In January 2019 Robert died by suicide.

Trevor

Trevor, a white British male, was aged 51 when he died by suicide in June 2019. He had suffered for some years from a number of physical and psychological problems and was significantly disabled, having had both legs amputated. Trevor had little family contact since the death of his wife 'Jennifer' in 2012 and was reliant on agencies and one close friend for support. By all accounts, Trevor was a quiet and unassuming man who liked to live independently and, latterly at least, did this beyond his safe capabilities. He was not someone who demanded help and he received less help towards the end of his life than he needed.

Ian

Ian, a white British man aged 54, lived alone. He was separated from his wife and had no immediate family living nearby, he did not seem to have any close friends. He died by suicide on 6 March 2019. Ian was known to services as he was a former Class A drug user who had been diagnosed with long standing physical and mental health problems which included leg ulcers, depression and anxiety. He was undergoing treatment for all these conditions at the time of his death.

Gordon Fields

Gordon's wife died in 2012, following which his granddaughter moved into the property, with her husband and child, to provide care for her grandfather. Gordon died on the 29 June 2019, he was aged 69. He had been admitted to hospital on 20 June 2019 in a severely malnourished state with multiple ulcers on his right leg. His left leg was badly ulcerated with maggots present and was described by the hospital as "non-viable". He was very poorly and passed away a few days later.

Simon

Simon was a white British male, who died due to sepsis, pneumonia and malnutrition. He was 61. His mother had previously been to his GP to outline her concerns regarding Simon, she advised that he had falls, was extremely unkept, unable to go to the shops and she believed he was self-neglecting.

Consequently, a referral was made by the Health and Social Care Coordinator, based at the GP practice, and the staff from Intermediate Care Team visited Simon. The Intermediate Care Team was concerned with the appearance of Simon, the odour coming from the property and Simon's refusal for them to look at his leg wounds. Advice was given to the Intermediate Care Team staff to submit a safeguarding referral to the Local Authority, liaise again with the GP and raise this case at the multidisciplinary team (MDT) hub. When the local authority Central Referral Unit received the safeguarding referral, they acted immediately by liaising with the local community health trust staff. Contact was made to Ambulance Service who visited Simon on 6.9.2019. Tragically, on 09.9.2019 Simon was found deceased at his property.

3.5. SAR Priority Learning

In recognition of the number of the number of SARs the Board was progressing, the Independent Chair of the Board hosted a meeting with the independent SAR authors leading the reviews. The intention of the meeting was to establish the priority work-steams for the Board in relation to addressing the lessons learned. The following priority areas were identified:

- **Legal literacy, Mental Capacity Assessments and fluctuating capacity**
- **Professional Curiosity and the voice of the person (include Think Family)**.
- **Agency collaboration/multiagency working**

A task and finish group developed an action plan to address these complex areas. The intention was to build on the work that had already been completed. The action plan was approved by Business Group members and actions have been allocated to working groups to progress.

3.6. SAR Recommendations

Other recommendations from the SARs, listed in section 4, include:

Recommendation/theme	Actions taken by the Board
Exploring barriers to engagement One of the common themes across Domestic Homicide Reviews, SARs and Serious Case Reviews is the issue of successful contact with a service user, to engage them in services. There may be a number of reasons why people choose not to engage, and professionals have a responsibility to work with individuals and to be inquisitive as to the reasons why people may not wish to engage.	• The SARWG, jointly with the Community Safety Partnership and Children's partnerships developed a learning document and circulated it widely. • Establishing people's communication preferences and any other barriers forms part of the 'professional curiosity and voice of the person' priority workstream.
Ensuring awareness and appropriate use of the "Multi-Agency Resolving Practitioner Differences - Escalation policy for Referrals and Adult Safeguarding". The intention of this policy is to provide a formal process for resolving differences and	• The Practice, Policy and Procedures Working Group strengthened the **Kent and Medway multi-agency resolving practitioner differences; escalation policy for referrals and adult safeguarding policy** to cover differences of opinion when agencies are referring clients between each other. It emphasised that in these

escalating concerns, should agencies not be in agreement with each other.	situations, if the escalation process is required, the agency making the original referral should maintain case oversight until resolution is agreed. A flow chart was also included for ease of reference. • The revised document was shared widely, including at the time the report was published and in the KMSAB newsletter. • The quality assurance working group developed a standard for the 2021 self assessment framework, requiring agencies to report on how they have shared this policy and how they know that this was effective and is being used. • The training providers were advised of the SAR findings and asked to refer to the updated document during training.
Exploring barriers to the use of the Kent and Medway Multi-Agency Policy to Support People that Self Neglect or Demonstrate Hoarding Behaviour Self-neglect is a factor in many safeguarding adult reviews. 'Self-neglect is an extreme lack of self-care, it is sometimes associated with hoarding and may be a result of other issues such as addictions. Practitioners in the community, from housing officers to social workers, police and health professionals can find working with people who self-neglect extremely challenging. The aim is to engage with people and offer all the support possible, without causing distress, and to understand the limitations to interventions if the person does not wish to engage.'[3]	• Members of the Performance Policy and Procedures working group held focus groups within their agencies to discuss the self-neglect policy, what works well and what can be improved. As a result of this a shorter 'practitioner's guide was developed, to complement the main document. The use and impact of this will be monitored by the QAWG. • The KMSAB training programme includes a module on self-neglect.
Recognising the rights of carers to a carers assessment. Carer stress and the impact of this, has been a feature of many reviews. The reviews found that not all agencies were aware that carers are entitled to a carers assessment even if the person they care for does not get any help from the council. Carers are entitled to an	• Communication relating to the carers has been sent to agencies and promoted using different media. The self-assessment framework included a requirement that agencies evidence how this information has reached staff. • The business unit developed and promoted a specific webpage for carers found here. The page includes links to useful links and resources for carers.

[3] SCIE Self-neglect: At a glance | SCIE

assessment in their own right and do not have to have the permission of the person they are caring for. A carers assessment provides the opportunity to consider what support may be needed to help someone in their caring role.	• Since the webpage was added, there have been 4753 'hits' to the page.
The importance of providing context and specific information when agencies request a police welfare check. Reviews found that expectations in relation to welfare checks vary. Professionals may request that Kent Police undertake a 'welfare check' on and adult at risk, to establish of the person is alive, breathing and conscious. Officers attending are not trained or equipped to carry out clinical assessments on the mental health or wellbeing of an individual, so it is important that professionals requesting the check have plans in place to provide an assessment and/or medical care once the individual has been located.	• Kent police is developing a framework, setting out clear expectations, to share with practitioners who contact Kent Police to request a welfare check. The framework will be followed by control room staff and will include a prompt to ask about the context of the request and will emphasise the expectation for the requesting agency to request feedback and follow up on actions.
The importance of making safeguarding personal and strength-based practice. A theme of many reviews, both within Kent and Medway, and nationally, is the lack of the individual's voice and wishes and feelings throughout contact with agencies. 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.	• The practice policy and procedures working group developed a Making Safeguarding Personal webpage for the KMSAB website. It includes links to best practice and further tools and guidance. It is available here • Since the webpage was added there has been 3347 'hits' to the page. • The self assessment framework sets out a standard on making safeguarding personal, assurance on how MSP is embedded is also sought in agencies' annual reports. • To further embed the learning and to build on the actions completed, Professional Curiosity and the voice of the person (include Think Family) have been identified priority SAR learning. •
Circulate the findings of a thematic SAR review by Alcohol Change: "Learning from Tragedies – an analysis of alcohol related safeguarding adults reviews" Although this recommendation was specific to one	• The document was circulated to all KMSAB and working group members, it also was added to the KMSAB newsletter, to reach a wider audience.

review, alcohol misuse is a feature of many of our reviews, so this was pertinent reading.	
The need for practitioners and others to know who to contact when someone is in a mental health crisis.	• Mental health crisis contact information was shared with Board and working group members, it was also added to the KMSAB newsletter. • Communication and Engagement working group members continue to raise awareness of this and other useful resources for the public and practitioners.
Transition between services and teams It is important that there remains continuity of care and support for individuals at risk who move between different districts, local authorities, or services. Equally, transition from children's services to adulthood needs to be delivered in a well-managed, coordinated and client focused way. Some of the SAR reviews identified issues in the transfer of care and support for the individuals concerned, especially if they moved frequently.	• Learning from SARs has been shared across the partnership. • To measure the impact of this, the 2021 SAF included the following standard: o How does your agency identify people who may have challenges in transitioning between services and what is in place to manage and support this. Prompts included: Transition between children and adult services, Continuity of Care for people who move across localities and/or defined areas of service. For example; how are people supported if they move frequently over several districts? • All agencies completing the SAF will need to provide sufficient evidence for this requirement to be graded green.
Supervision, Reflective Practice and Quality Assurance SARs have referenced the importance of agencies providing effective practice supervision and opportunities for staff to reflect on practice, both in a meeting with their manager or as a team. Agencies should have a quality assurance process to evaluate the extent to which supervision is applied consistently and makes a positive difference to the worker and for people who use services. Many SARs have also identified the need to improve recording of discussions on individual's care records.	• Learning from SARs has been shared across the partnership. • Statutory partner agencies have their own policies and guidance documents in relation to staff supervision. • To measure the impact of these, the 2021 SAF included the following standard: o What the criteria is for carrying out and recording management oversight for individuals who are at risk of harm. In particular, please advise how your performance framework arrangements ensure: • that safeguarding is a standing item in supervision and appraisal systems. • that staff are able to debrief for individuals with complex needs • Ensure safeguarding decisions are fully

	recorded •Oversight of risk
Awareness of KMSAB policies and procedures Whilst the SARs published during this period have not identified any issues of concern in relation to the content of the KMSAB policies and procedures, some have highlighted a lack of awareness of these multi-agency policies amongst frontline staff.	• The new KMSAB website has made it easier for practitioners and others to locate and access the KMSAB policies. • Agencies have been asked to highlight and promote the KMSAB policies and procedures. • The 2021 SAF asks agencies to explain how they have shared the KMSAB policies and procedures and how they measure that these have been received and understood by staff.
Safe discharge from hospital Several SARs have identified issues in relation to discharge planning and safe discharge of individuals with care and support needs from hospital. One author escalated this to the Board as a matter of concern, prior to the report being finalised.	• The Independent SAR Chair wrote to the 4 acute hospital trusts, 3 community trusts and the Director of Adult Social Services, for both Kent County Council and Medway Council. The letter outlined the concerns raised by the SARs and requested they attend an Extraordinary Meeting of the KMSAB to provide assurance and to detail any improvement activity.

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

It is recognised that it is easier to explain what action has been taken to address a recommendation than to evidence the impact these interventions make in practice. The quality assurance working group is mindful of this challenge and takes this into account when designing assurance tools. The good practice examples provided throughout this report provide one such measure.

Section 4. KMSAB Funding

The Kent and Medway Safeguarding Adults Board is funded by Kent County Council, Medway Council, Kent Police, Kent Fire & Rescue Service, Clinical Commissioning Groups and commissioned Health provider organisations. Each of these agencies made the following percentage contributions in 2020 - 2021:

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

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

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

	2018-2019 Agreed contribution (£000's)	2019-2020 Agreed contribution (£000's)	2020-2021 Agreed contribution (£000's)
KCC	**105.6**	**111**	**111**
Medway Council	**21.6**	**22.6**	**22.6**
Local Health Commissioners and Providers	**93.6**	**98.2**	**98.2**
The Office of the Police and Crime Commissioner	**36.7**	**38.6**	**38.6**
Kent Fire & Rescue Service	**4.3**	**4.5**	**4.5**
Reserve	**0**	**9**	**48.2**
Total	**261.0**	**283.9**	**323.1**

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

Appendix 1 - Safeguarding Activity

This section is provided by Kent County Council and Medway Council.

Background to Data

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

Data included in this report is consistent with the NHS Digital Safeguarding Adults Collection (SAC) for, 2018-19, 2019-20 and 2020-21.

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

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

National comparator data has been included, it is also available on the NHS Digital website.

New Safeguarding Concerns and Enquiries

Number of Safeguarding Concerns

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

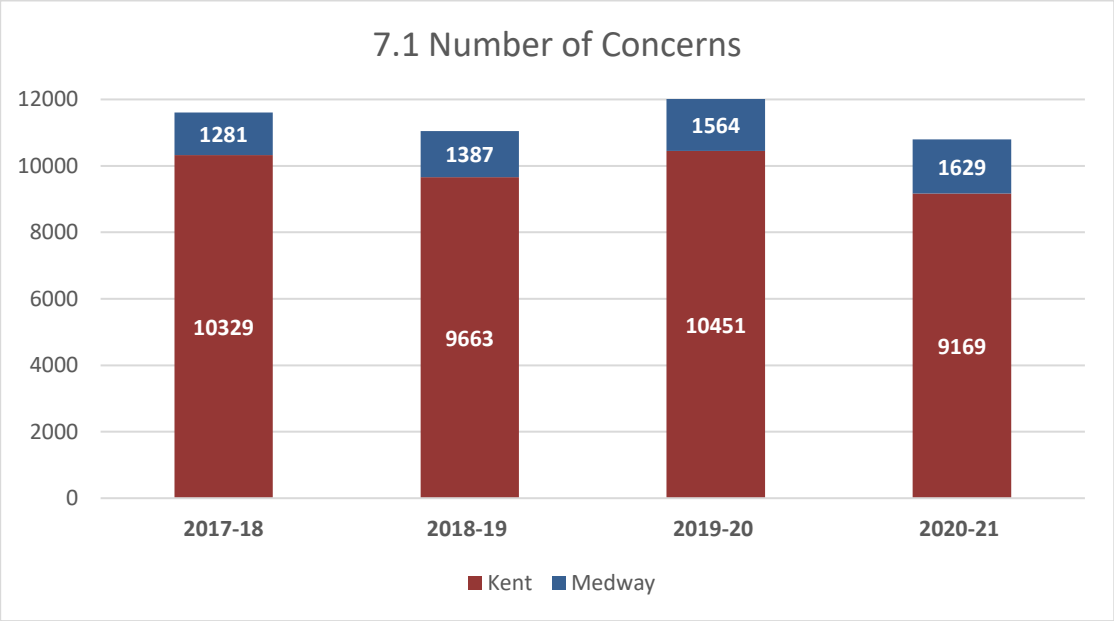


Fig 7.1: Number of Safeguarding Concerns received in Kent and Medway for 2020/2021

A total of 10,798 Safeguarding Concerns were raised across Kent and Medway during 2020/21, representing an overall decrease of 10.1%. Increases in the number of Concerns were observed in Medway (up 4.2%) whereas a decrease in Kent was seen (-12.3%).

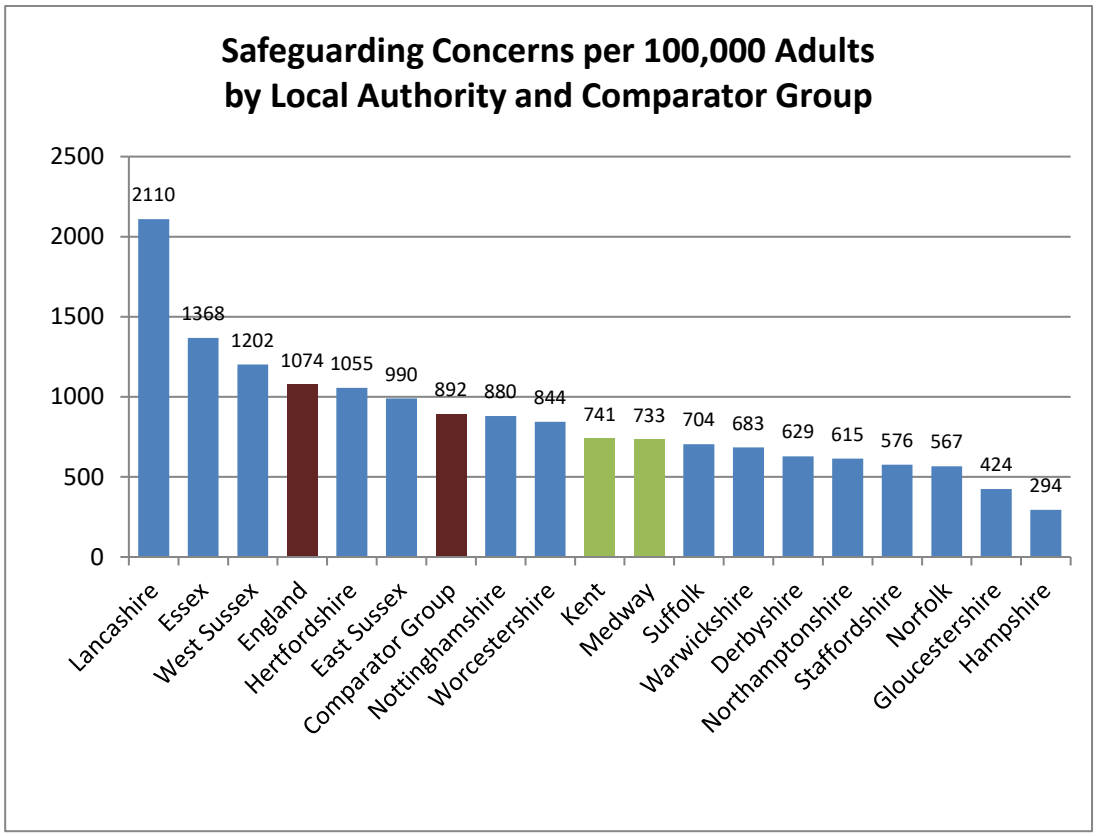


Fig 7.1a: Number of Safeguarding Concerns per 100,000 adults by Local Authority and Comparator Group
Source NHS Digital 2020-2021 Safeguarding Adults Collection.

Number of Safeguarding Enquiries and Rate of Change

6,127 new Safeguarding Enquiries were started in Kent and Medway during 2020/21, a 16.9% decrease from the year before.

- Kent - the number of Enquiries initiated during 2020/21 was down by 15.8%, 1030 less that the year before.
- Medway – saw a 25.5% decrease compared to the previous year, down by 216.

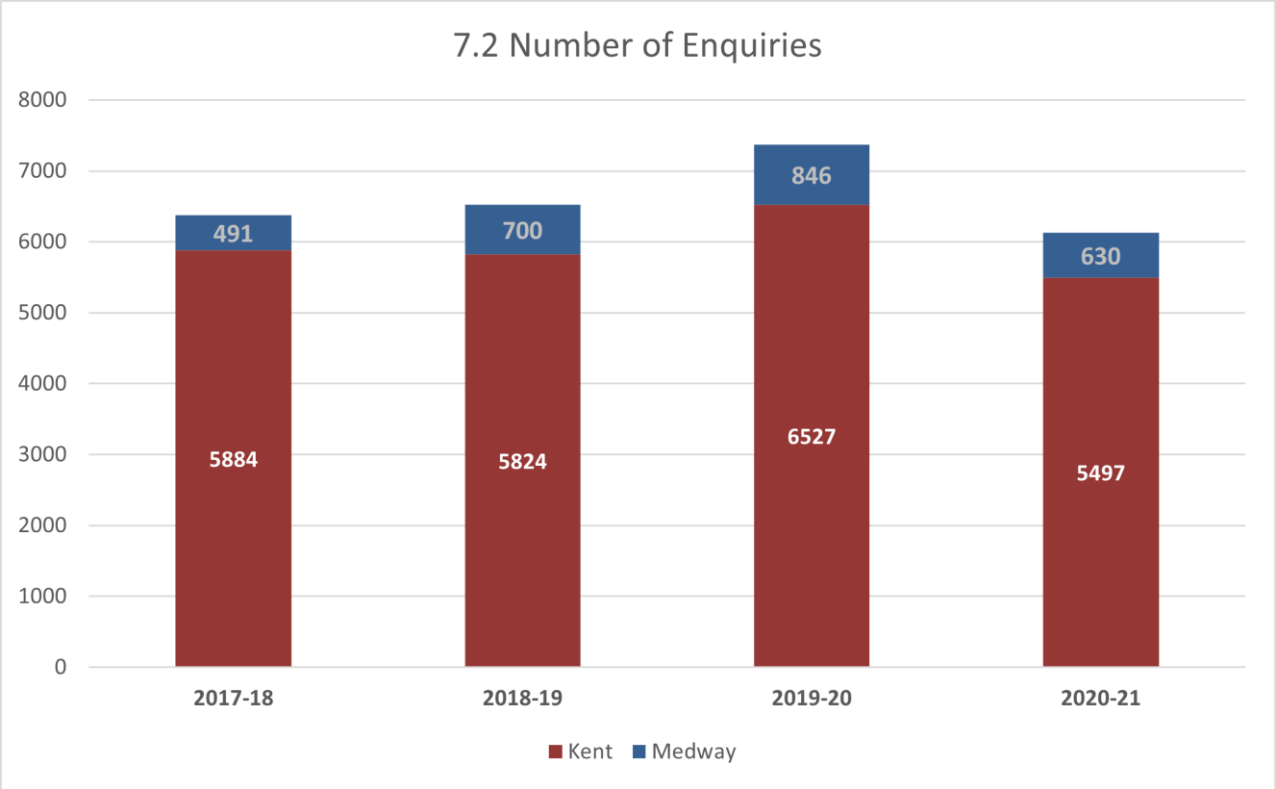


Fig 7.2: Number of Safeguarding Enquiries carried out in Kent and Medway for 2020/2021

The overall conversion rate for Kent and Medway (i.e. the proportion of Safeguarding Concerns that progress to Enquiries) has also decreased, from 61.4% in 2019/20 to 56.7% in 2020/2021.

National comparator:

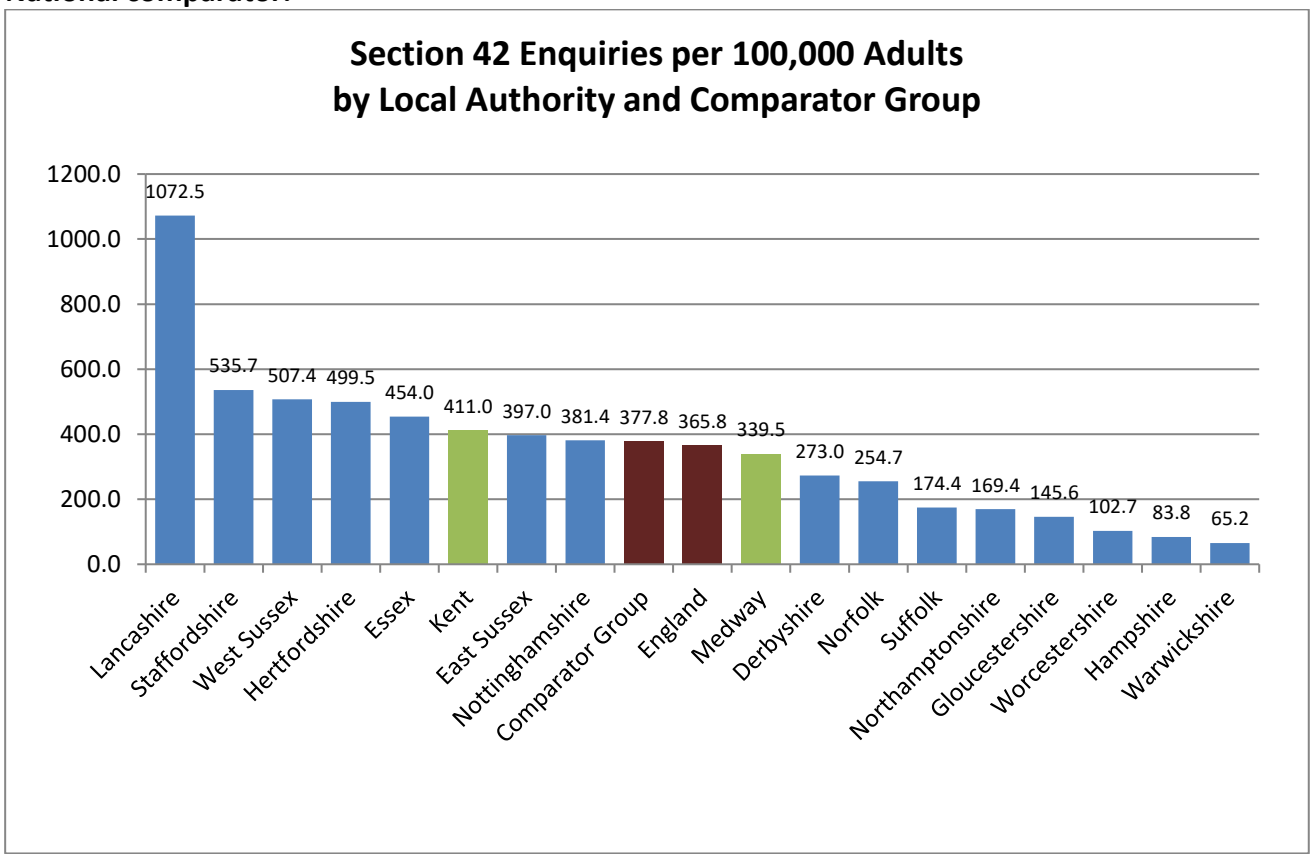


Fig 7.2a: Section 42 enquiries per 100,000 adults by Local Authority and Comparator Group
Source NHS Digital 2020-2021 Safeguarding Adults Collection

Age of People at Risk of Harm

In the past year, 42.8% of individuals involved in Safeguarding Enquiries fell into the 18-64 age banding, slightly down from 43.4% in 2019-2020. Within this banding, the highest proportion of adults are within the 55-64 age group with 11.7% (635 individuals) represented here followed by the 45-54 age group at 9.6% (520), consistent with last year. The 18-24 age band accounts for 7.3% (397 individuals), reflecting a slight increase of 0.4%.

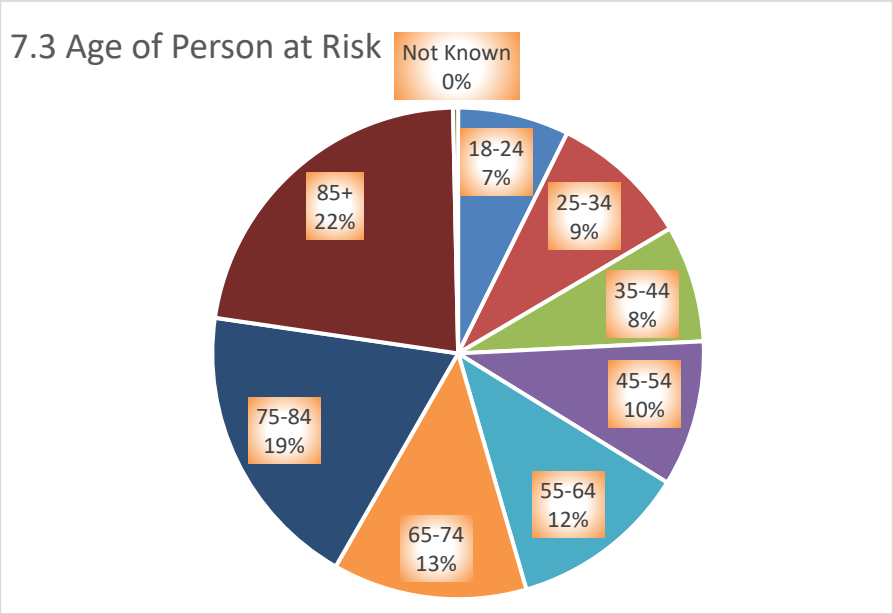


Fig 7.3: Age breakdown of people at risk of harm for 2020/21 in Kent and Medway
***NB:** Caution should be taken if comparing the 18-24 age group, as this age group represents a smaller age band than all other age bands*

The percentage of individuals aged over 65 has decreased by 2.2% compared to last year, distributed evenly between the three age bandings 65-74 (12.8%, 693 individuals, down 0.1%), 75-84 (19%, 1031 individuals, down 1.3%) and 85+ (22.4%, 1212 individuals, down 1%). The percentage of enquiries where the age of the person at risk of harm is unknown has remained level at 0.3% for the fourth consecutive year.

Gender of People at Risk of Harm

In 2020-2021 the highest proportion of people at risk of harm remains female, with a fractional increase of 0.3% observed (3,181) and a decrease in the male category of 0.6% (2,062). Individuals having a Not Known gender value recorded (including Indeterminate Gender) rose (0.3%) to 0.6% (33).

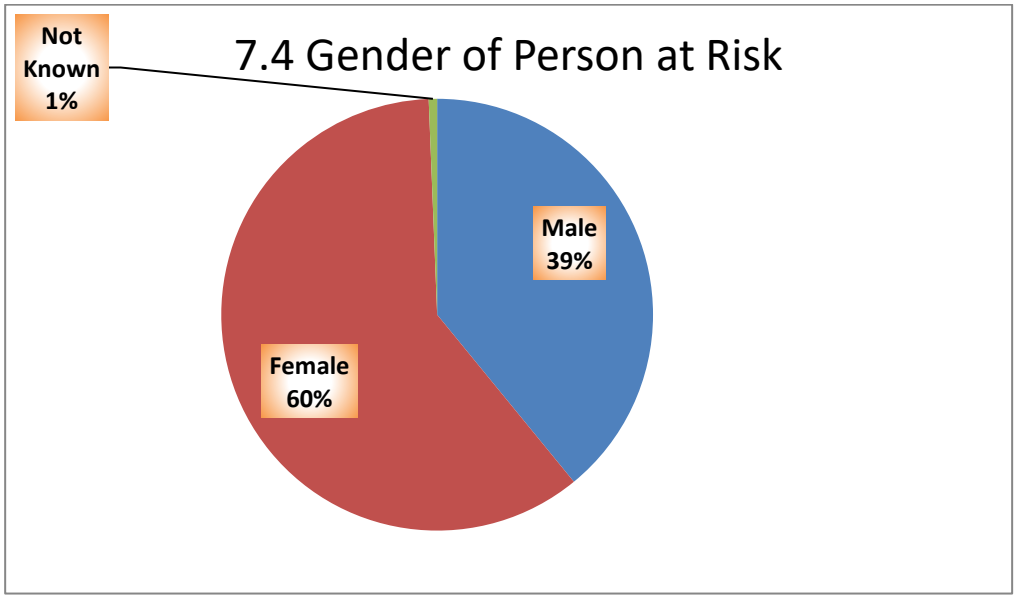


Fig 7.4 Gender of people at risk of harm for Kent and Medway in 2020-2021

Ethnicity of People at Risk of Harm

Of all the Safeguarding Enquiries initiated during 2020-2021, Enquiries related to people from a white ethnic background, have decreased by 493 compared to 2019-2020. An increase has been observed in the percentage of enquiries relating to people from a black and minority ethnic background, increasing 0.7% to 5.2% (figures in the table below). There remains a cohort of Enquiries where ethnicity data was unavailable (14.5%), however this has decreased by 165 compared to 2019/2020, and a continued improvement is expected to be observed for future reporting with the ongoing use of the Mosaic system.

Ethnic Group	2018-19 Number	%	2019-20 Number	%	2020-21 Number	%
White*	4,658	80.3%	4,729	79.8%	4,236	80.3%
BME **	232	4.0%	268	4.5%	276	5.2%
Not stated/ obtained	911	15.7%	929	15.7%	764	14.5%
Total	**5,801**	**100.0%**	**5,926**	**100.0%**	**5,276**	**100.0%**

Table 7.5: Breakdown of Ethnic Group for the periods 2018-19 to 2020-2021

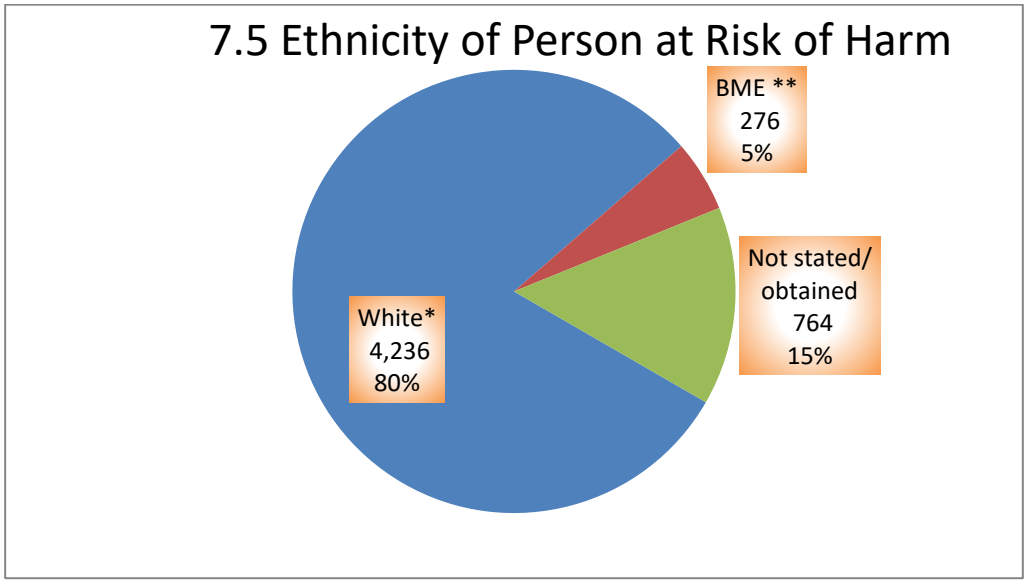


Table 7.5: Breakdown of Ethnic Group for the periods 2018/19-20 to 2020/21

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

Primary Support Reason of Person at Risk of Harm

As in previous Annual Reports, in both Kent and Medway the most prevalent support reason remains Physical Support. This is then followed by No Support Reason at the time of the alleged incident, with Kent and Medway reflecting 18.9% (996). The category No Support Reason is likely to relate to instances where the investigating authority is not providing direct support to the person at risk of harm and information on support needs is not captured; this category does represent a notable increase for both authorities when compared to 2019/20, highlighting a need to ensure that support needs of vulnerable individuals is captured.

Primary Support Reason	Kent	%	Medway	%	Aggregated
Physical Support	2,220	47.3%	258	44.3%	47.0%
No Support Reason	793	16.9%	203	34.9%	18.9%
Learning Disability	393	8.4%	44	7.6%	8.3%
Mental Health	839	17.9%	48	8.2%	16.8%
Memory & Cognition	275	5.9%	17	2.9%	5.5%
Social Support	83	1.8%	10	1.7%	1.8%
Sensory	86	1.8%	2	0.3%	1.7%
Total	**4,695**	**100%**	**582**	**100%**	**100%**

Table 7.6 Breakdown of Primary Support Reason (PSR) for the period 2020/21

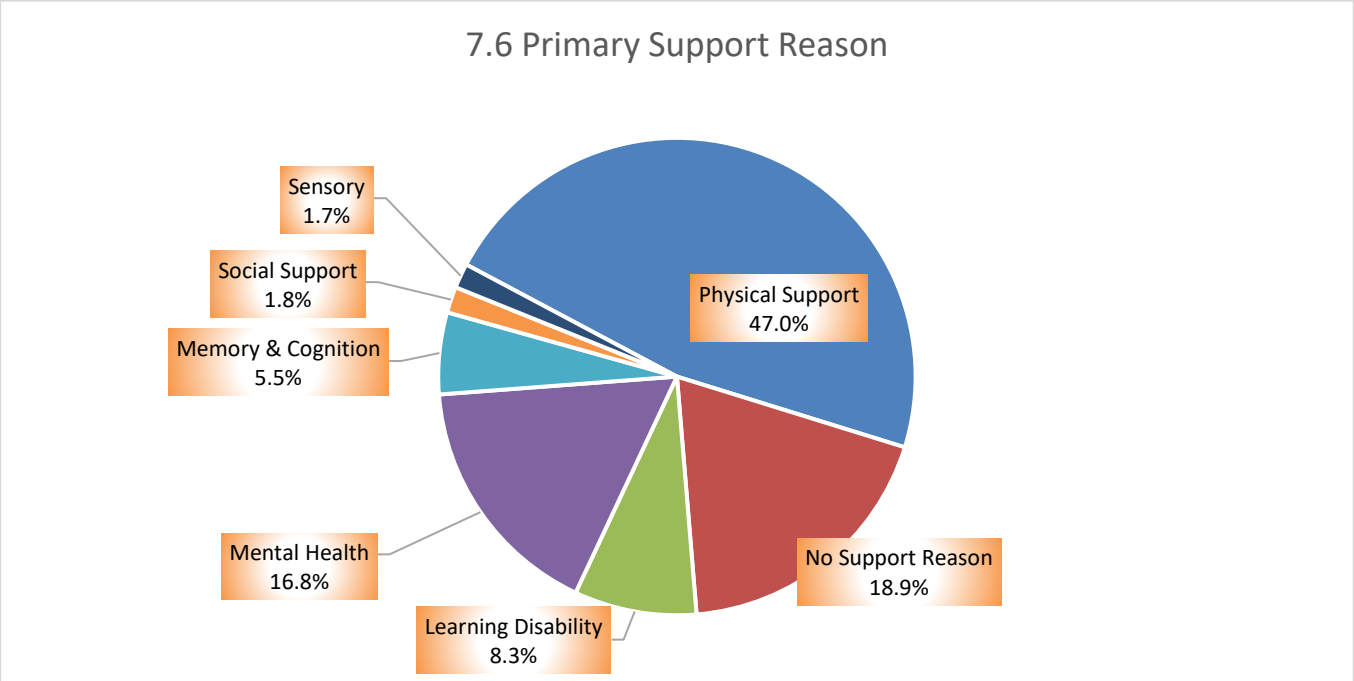


Fig 7.6 Breakdown of Primary Support Reason (PSR) for the period 2020/21 (aggregated)

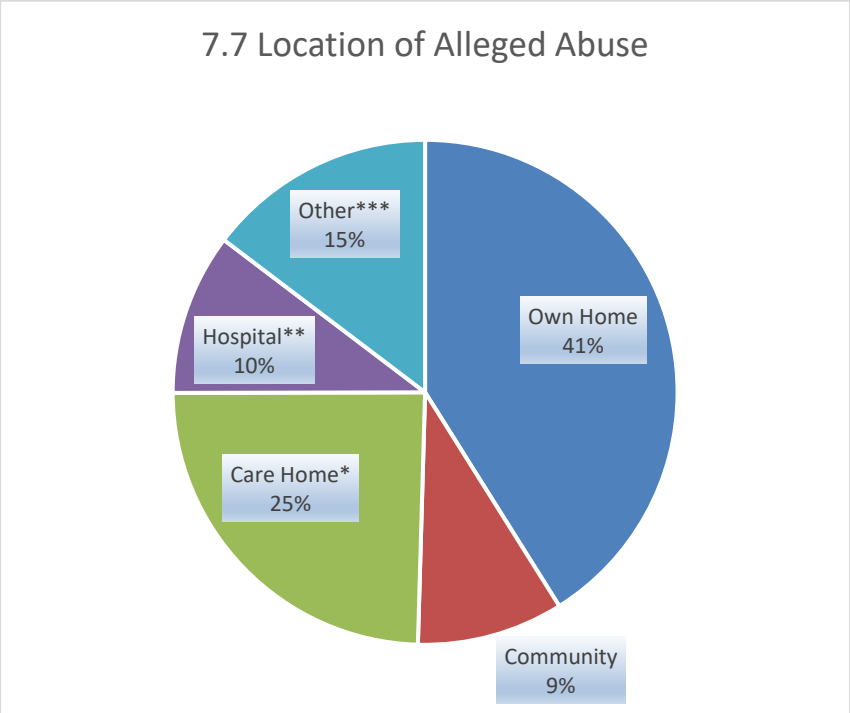
Location of Alleged Abuse

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

In 2020/21 the most prominent location for incidents of alleged abuse remained within the alleged victim's own home, representing 41.1% (2,658), although this figure has reduced by 250 compared to 2019/20. The care home setting is the second main setting of alleged incidences of abuse at 24.5% (1586), for a second year this has seen a consistent decrease.

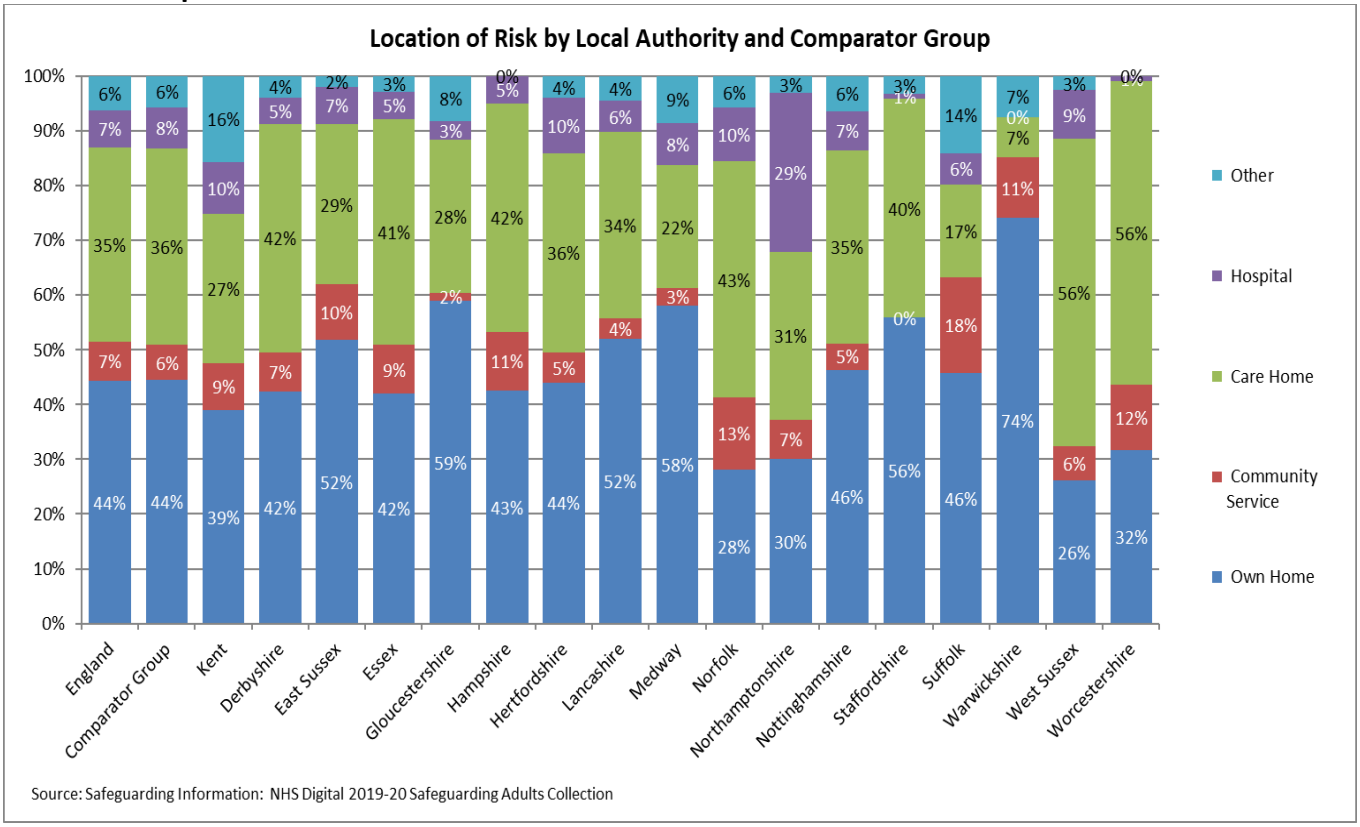
	2018-19		2019-20		2020-21	
Location	**Number**	**%**	**Number**	**%**	**Number**	**%**
Own Home	**3424**	**43.9%**	**2908**	**40.4%**	**2658**	**41.1%**
Community (excluding community services)	**257**	**3.3%**	**278**	**3.9%**	**283**	**4.4%**
In a Community service	**261**	**3.3%**	**310**	**4.3%**	**324**	**5.0%**
Care Home	**2423**	**31.1%**	**1925**	**26.8%**	**1586**	**24.5%**
Care Home - Nursing	623	8.0%	412	5.7%	313	4.8%
Care Home - Residential	1800	23.1%	1513	21.0%	1273	19.7%
Hospital	**450**	**5.8%**	**697**	**9.7%**	**670**	**10.4%**
Hospital - Acute	384	4.9%	398	5.5%	309	4.8%
Hospital - Mental Health	4	0.1%	252	3.5%	271	4.2%
Hospital - Community	62	0.8%	47	0.7%	90	1.4%
Other	**979**	**8.3%**	**1076**	**15.0%**	**950**	**14.7%**
Total	**7,794**		**7,194**		**6,471**	

Table 7.7: Location of alleged abuse for the periods 2018/19 to 2020/21



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

National comparator:



Category of Alleged Abuse

Based on concluded Safeguarding Enquiries, the most predominant type of risk overall has remained physical abuse over the past five reporting years, with a slight increase in this category for 2020/21 of 1.4%. However, looking at data individually, for Medway, Neglect and Acts of Omission is the highest category of Abuse (40%). Psychological Abuse has replaced Neglect and Acts of Omission as the second most prevalent type of abuse, accounting for 29.8%.

There has been a notable increase in the recording of Domestic Abuse in 2020/21, more than doubling as a proportion of Safeguarding Enquiries (an increase of 14.9%). This is likely to be attributable in part to increased awareness among staff of domestic abuse as a safeguarding issue, and to the improved recording of the embedded forms within the MOSAIC system meaning that this domestic abuse recording is more prominent, and recording continues to be improved as a result.

	2018-19		2019-20		2020-21	
Categories of alleged abuse	**Number**	**%**	**Number**	**%**	**Number**	**%**
Physical Abuse	2,661	34.1%	2,230	39.1%	2,297	35.5%
Neglect and Acts of Omission	2,092	26.8%	1,688	29.6%	1,716	26.5%
Psychological Abuse	1,470	18.9%	1,430	25.1%	1,931	29.8%
Financial or Material Abuse	1,407	18.1%	1,162	20.4%	1,258	19.4%
Sexual Abuse	397	5.1%	324	5.7%	312	4.8%
Organisational Abuse	187	2.4%	225	3.9%	231	3.6%
Domestic Abuse	244	3.1%	523	9.2%	1,169	18.1%
Self-Neglect	700	9.0%	393	6.9%	482	7.4%
Discriminatory Abuse	67	0.9%	55	1.0%	46	0.7%
Sexual Exploitation	54	0.7%	77	1.4%	74	1.1%
Modern Slavery	11	0.1%	10	0.2%	20	0.3%
	9290		**8117**		**9536**	

Table 7.8: Category of alleged abuse for the periods 2018/19 to 2020/21

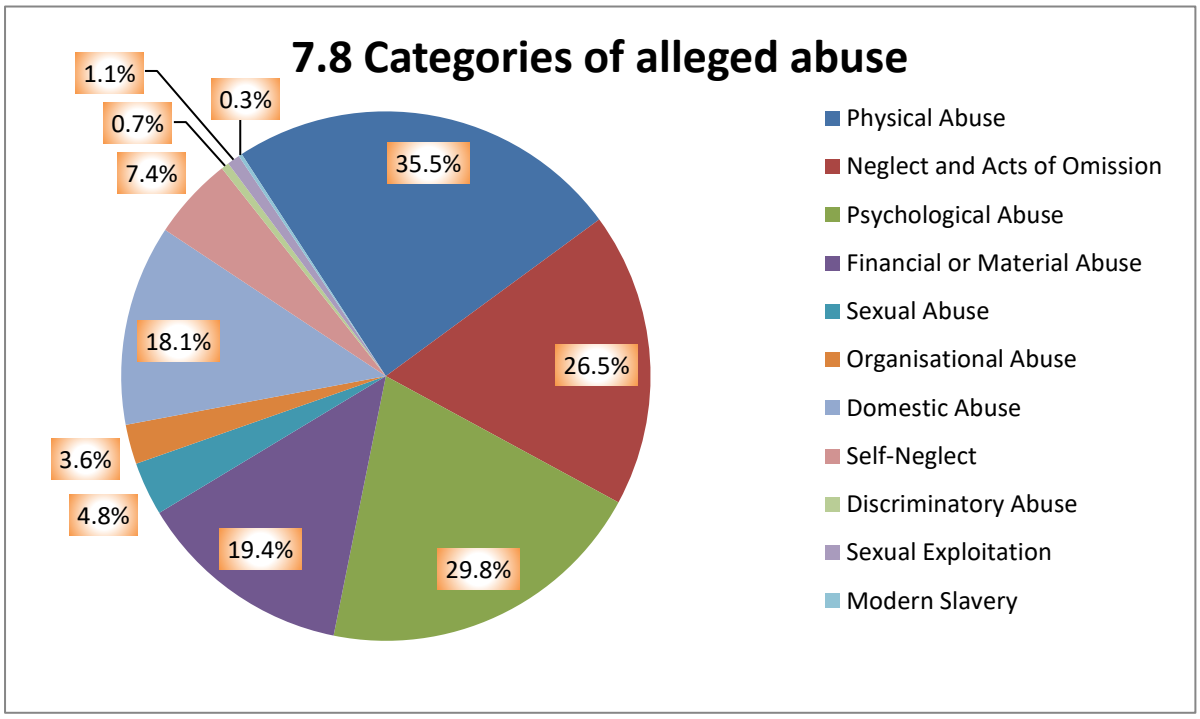


Fig 7.8: Category of alleged abuse, 2020/21

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

National comparator:

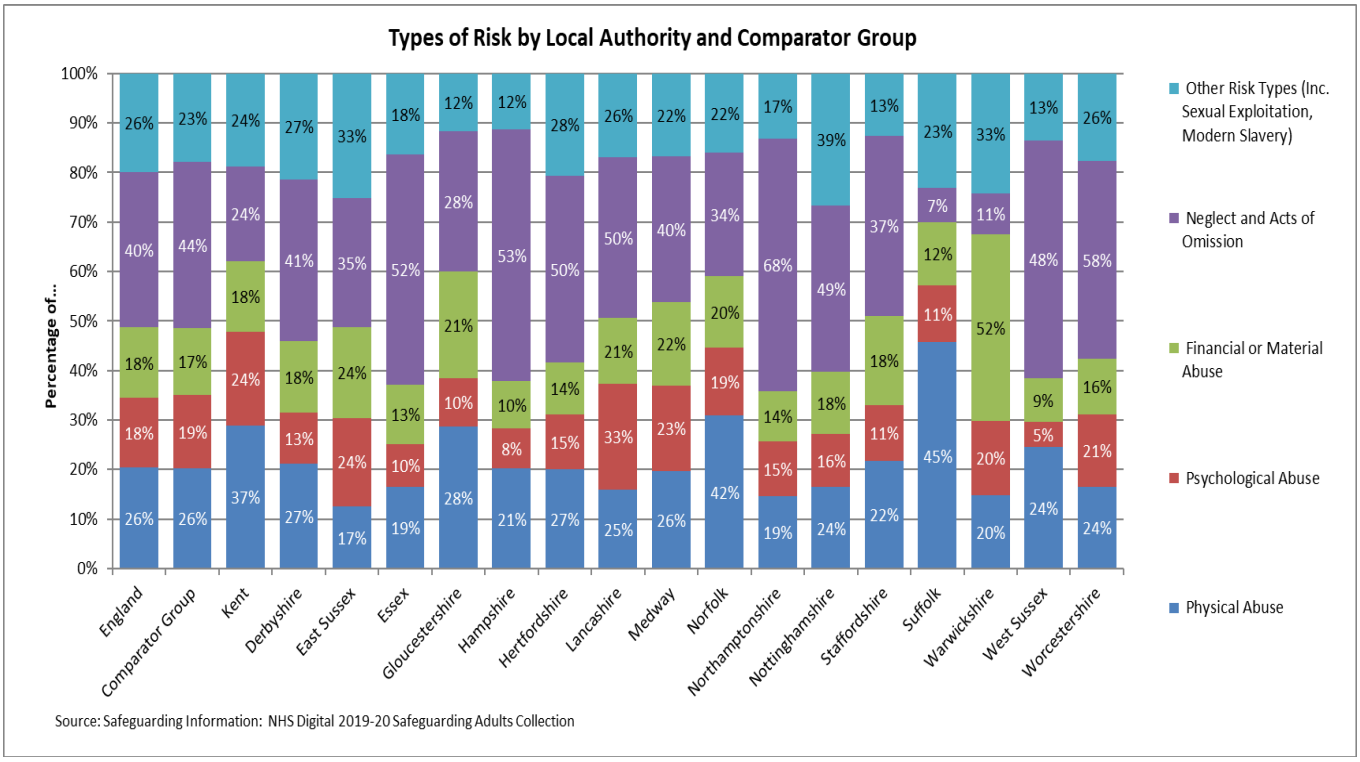


Fig 7.8a: Types of alleged abuse, by Local Authority and Comparator Group

Closed Referrals

Outcome of Closed Enquiries

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

	Kent		Medway		
Outcome	**Count**	**%**	**Count**	**%**	**Total**
Substantiated – fully	1912	29.8%	208	30.4%	2120
Substantiated – partially	147	2.3%	100	14.6%	247
Not substantiated	2118	33.0%	90	13.2%	2208
Inconclusive	1718	26.8%	218	31.9%	1936
Investigation ceased at individuals request	524	8.2%	68	9.9%	592
Total	**6419**	**100.0%**	**684**	**100.0%**	**7103**

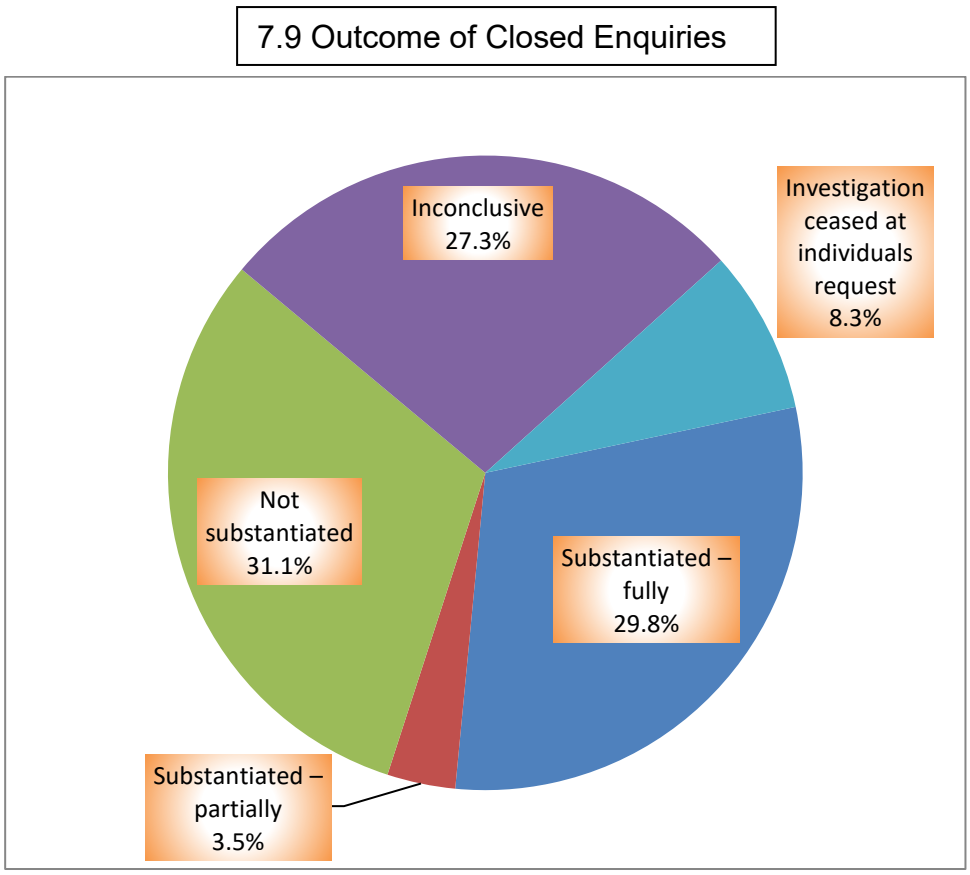


Fig 7.9: Outcomes for closed Safeguarding Enquiries 2020/21

It should be acknowledged that there are circumstances that a risk could remain; for example, in the case of an individual wanting to maintain contact with a family member who was the source of the risk (in such an example action could still be taken to refer a person to an alternative provision, such as counselling, should they wish it).

Risk Outcomes for Closed Enquiries

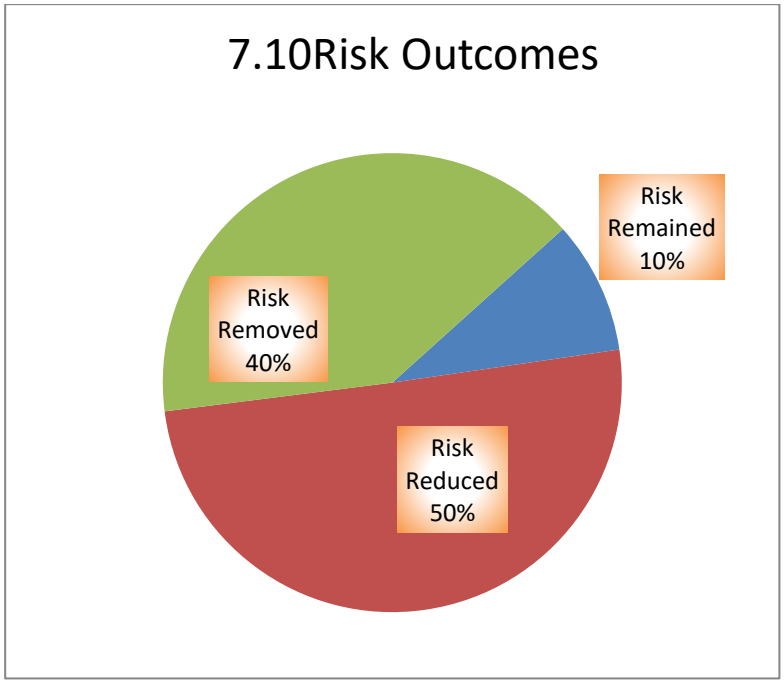


Fig 7.10: Risk Outcomes for closed Safeguarding Enquiries 2020/21

Fig 7.10 demonstrates that in both Kent and Medway the greatest proportions relate to risk being reduced or removed and this is consistent with previous reports. In Safeguarding Enquiries where a risk was identified the risk was either reduced or removed in 90% when the Enquiry concluded, with the majority (50%) falling into the Reduced category. In Kent, 38% saw the risk removed. In Medway, however, the split is far more even with 48.2% having a Risk Reduced outcome and 44.2% seeing the risk removed.

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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