Kent and Medway Safeguarding Adults Board

Annual Report

April 2021 – March 2022

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

About us

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

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

Our three core duties

The Care Act 2014 requires that the Board:

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

Our responsibilities

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

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

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

Our vision

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

Our mission

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

Board membership

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

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

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

Board structure

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

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

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

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

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

Our Board is supported by the KMSAB Business Unit

Section 2. Priorities and Achievements

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

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

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

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

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

What we achieved:

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

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

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

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

What we achieved:

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

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

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

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

Section 3. Safeguarding Adults Reviews

3.1. Criteria for Conducting a Safeguarding Adults Review

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

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

Or

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

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

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

3.2. Purpose of a Safeguarding Adults Review

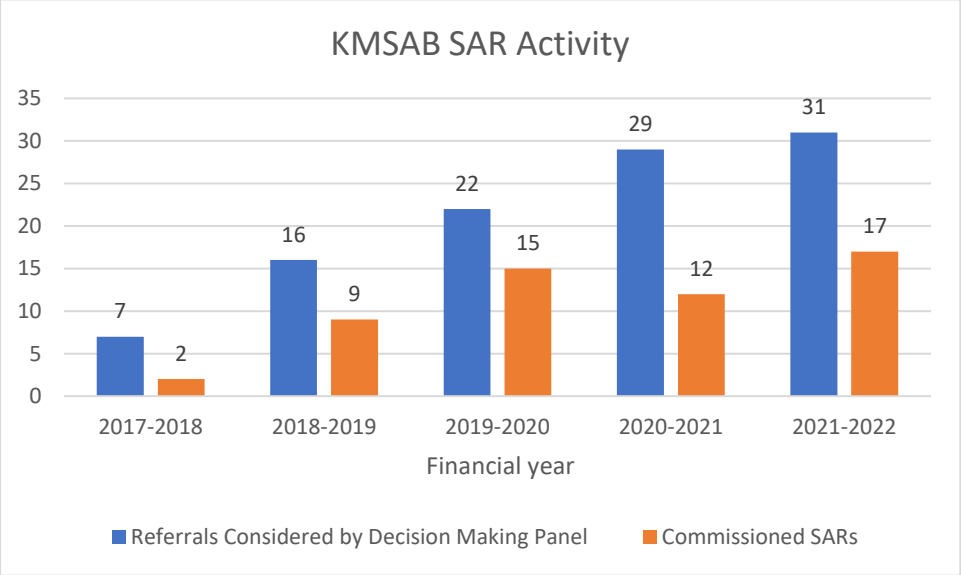
A Safeguarding Adults Review (SAR) is not an enquiry or investigation into how someone died or suffered injury and it does not allocate blame. It stands separately to any internal organisational investigation, or that from Police or a Coroner. The SAR scrutinises case and system findings and analyses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

3.3. Safeguarding Adults Review Activity

To ensure a robust and consistent process for determining whether a referral for a Safeguarding Adults Review meets the criteria, a multi-agency decision-making panel, chaired by a member of the SAR Working Group, is convened. Prior to the meeting, agencies who worked with the adult, are asked to complete a summary of agency involvement form, detailing relevant and proportionate information to inform the discussion and decision on whether the criteria for a SAR is met. The SAR decision making group consider the agency

involvement returns and the initial referral and assess whether the referral meets the criteria for a SAR, or whether any other review or action is required. The recommendation of the panel is sent to the Independent Chair of the KMSAB for a final decision.

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

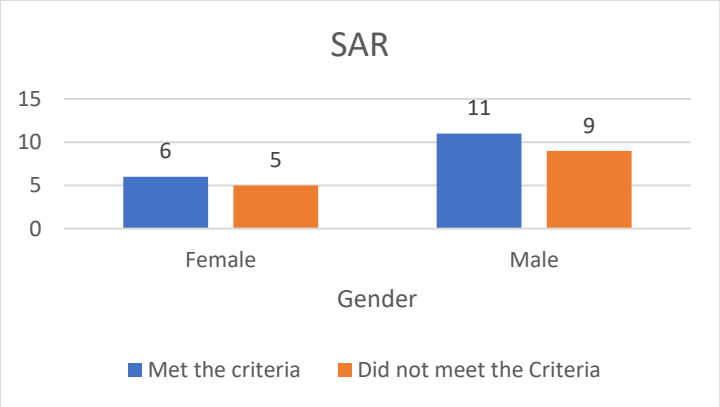


The KMSAB received 31 new SAR applications between April 2020 and March 2021, of these:

- 17 SARs were commissioned
- 14 did not meet the criteria and no further action for the Board was required

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

Gender - SAR applications received between April 2020 and March 2021

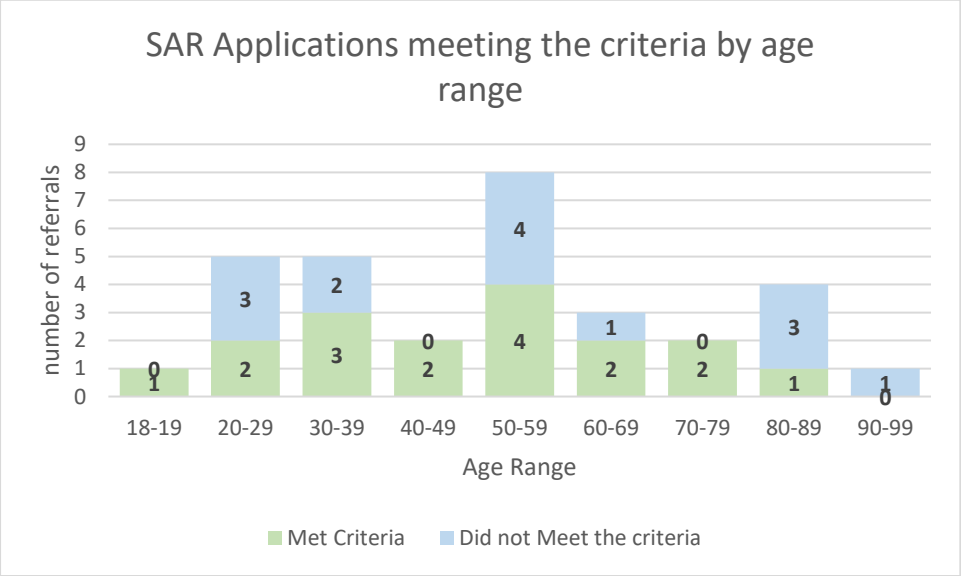


The conversion rate of application to commissioned SARs was 55% for both males and females.

Ethnicity - applications received between April 2020 and March 2021

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

Age – SAR applications received between April 2020 and March 2021



3.4. Completed Safeguarding Adults Reviews

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

All names are pseudonyms to protect the identity of those concerned

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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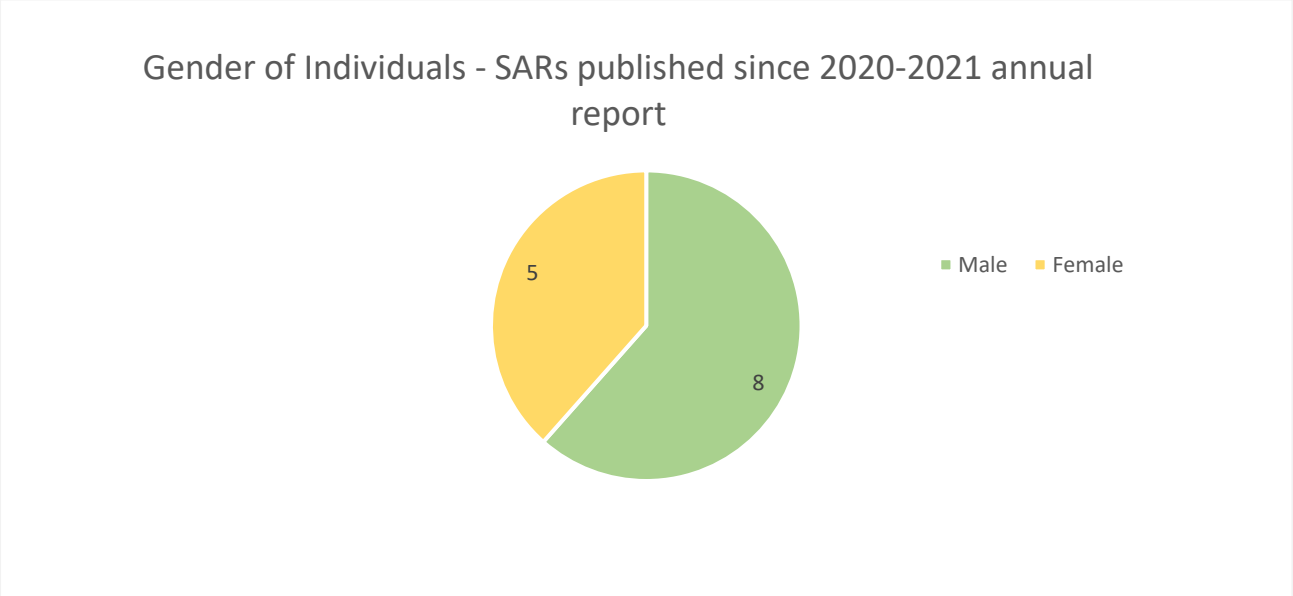
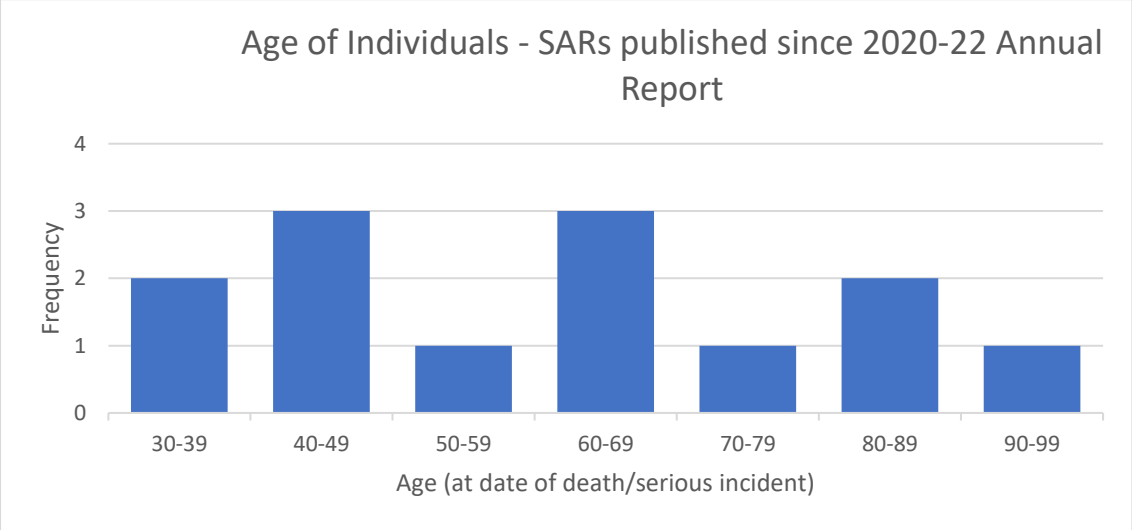
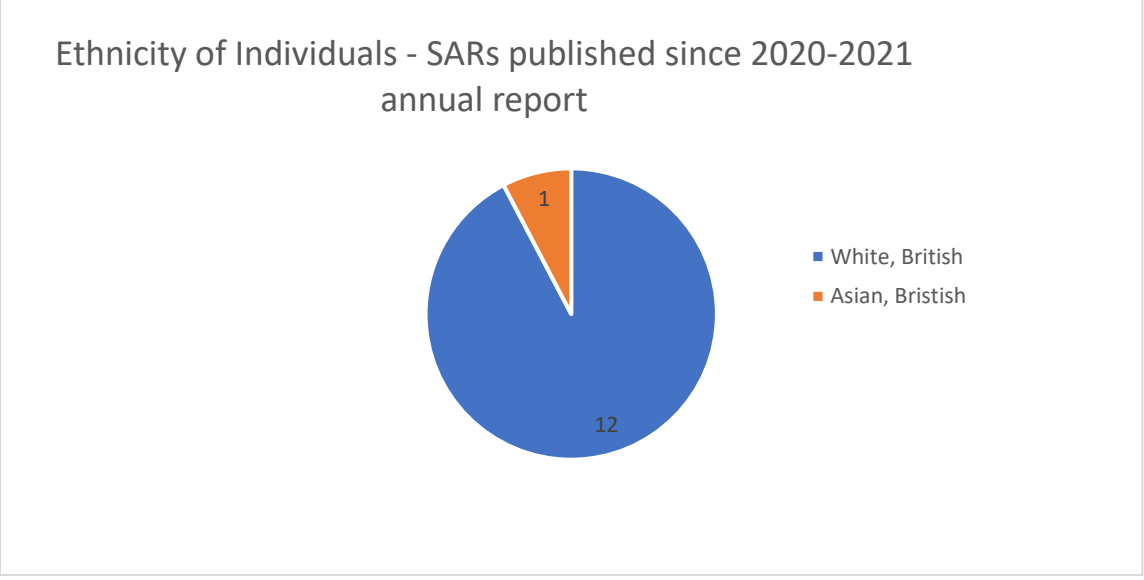

Gender of Individuals - SARs published since 2020-2021 annual report
5
8
Male
Female


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


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

Glossary of terms

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

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

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