Kent and Medway Safeguarding Adults Board

Annual Report

April 2022 – March 2023

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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:

- 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.
- 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, considering any specialist training that may be required, and identifying mechanisms for monitoring and reviewing the implementation and impact of training.
- Holding partners to account to gain assurance that effective safeguarding arrangements are in place.
- Producing multi-agency policies, procedures and strategies for protecting adults and monitoring their impact.
- Working collaboratively, and with effective governance, to promote wellbeing and prevent abuse and neglect.
- 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.
- Formulating guidance about the arrangements for managing adult safeguarding, and dealing with complaints, grievances and professional and administrative malpractice in relation to safeguarding adults.
- Evidencing how KMSAB members have challenged one another and held other boards to account.
- Balancing the requirements of confidentiality with the consideration that, to protect adults, it may be necessary to share information on a 'need-to-know basis'.
- Determining arrangements for peer review and self-audit.

Board membership

Independent Chair:	Andrew Rabey
Statutory Partners:	Kent County Council Medway Council Kent and Medway Integrated Care System Kent Police
Other partner agencies:	Advocacy People Dartford and Gravesham NHS Trust Department of Work and Pensions 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 (now Town and Country Housing) South East Coast Ambulance Service 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 groups for people with lived experience.

Board structure

Kent and Medway Safeguarding Adults Board – **Executive Group**
Delivers the responsibilities as set out on page 3 and 4.

Kent and Medway Safeguarding Adults Board – **Business Group**
Responsibilities: • Hold the Working Groups to account for the delivery of the strategic plan and their annual work plans, by scrutinising update reports, monitoring progress and identifying and addressing gaps or risks. • Accountable for decision making to implement the Strategic Plan and work plans. • Receive update reports from other 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 feedback from practitioners or those with lived 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 safeguard the welfare of children and adults at risk.
Safeguarding Adults Review (SARWG)	Delivers the Board's 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 – 2022 -2025 Strategic Plan

Development of the strategic plan

In accordance with the Care Act 2014, Safeguarding Adults Board's must produce a Strategic Plan which sets out how the Board and partner agencies will prevent adults with care and support needs from the risk of abuse, or neglect and support and promote their wellbeing.

During 2022 Members of the Kent and Medway Safeguarding Adults Board drafted the Strategic Plan 2022 - 2025, having used evidence and intelligence to identify the key priorities. The Board then sought to consult on the Strategic Plan to ensure that it fulfilled the statutory duty, met the needs and expectations of Kent and Medway residents, and promoted a partnership approach to the delivery of the Plan.

Public Consultation

Prior to the consultation starting, the Board's communication and engagement working group was consulted, and the Board Business Unit worked closely with the KCC consultation team, to identify and develop appropriate tools to support the consultation.

The key stakeholders identified were:
All residents of Kent and Medway, in particular:

- people with a lived experience of adult safeguarding
- Carers groups and organisations
- Voluntary and community sector
- Faith groups
- Groups supporting people with physical and mental health disabilities.
- Board partner agencies

The following tools were developed to support the consultation:

Resource	Detail
Strategic Plan 2022 – 2025 Consultation document	The KMSAB Strategic Plan for 2022 – 2025 and supporting documentation were made available online and as a Word document.

Easy read KMSAB Strategic Plan 2022 – 2025	An easy read version of the plan and supporting questionnaire were developed by a specialist organisation, this included testing of the document by user groups.
Large print	All consultation material was made available in large print versions.
Social media content plan and graphics	A social media content plan and assisting graphics were developed to raise awareness of the consultation on agencies' social media channels.
Guided discussion document	The guided discussion tool was developed for partner organisations to use in meetings, public engagement events, advisory groups and user forums, to facilitate a discussion and gather feedback on the Strategic Plan. Board members were asked to add the KMSAB strategic plan to the agenda of relevant meetings taking place during the consultation period and utilise the tool to collate feedback.
Posters	Posters promoting the consultation were designed for partner organisations to print and display in public facing spaces, in accordance with their agencies' policies on this, such as infection control.
Introductory video by the Independent Chair of the KMSAB	The Independent Chair of the Board, Andy Rabey, produced a brief video message to introduce the Strategic Plan and encourage people to complete the consultation questionnaire.

The consultation was live for a period of eight weeks, taking place between 26 April to 20 June 2022. All consultation material was shared with partner agencies for onward dissemination. Regular reminders were circulated by email as well as at Board and working group meetings. Additionally, details of the consultation were included in the Board's newsletter, which has a distribution list of approximately 350 individuals. The newsletter is also further disseminated by those receiving it. Other promotional activity included:

- An invite to engage with the consultation was sent to individuals registered with the engagement platform, who expressed an interest in Adult Social Care, Community Safety, Public Health and Wellbeing and General interest (6,309 individuals)
- A press release
- A promotional banner on kent.gov and Let's talk Kent homepage.

It was identified that the subject matter could be difficult and emotionally triggering for some people to talk about and that some individuals may not be able to access documents online. To help counter this, partner agencies were asked to identify and facilitate discussions with individuals/groups that they work with, and/or their staff groups. A guided discussion document was developed to support these conversations and to provide consistency.

There were 973 total visits to the consultation webpage with 747 of these being unique visitors to the webpage. There were 409 document downloads from the consultation webpage in total. The table below highlights the number of downloads of each resource from Let's talk Kent.

Table 1. Downloads of each resource

Engagement Tool	Visitors	Downloads/views
Strategic Plan Document	260	364
Consultation Questionnaire - Word version	15	21
Equality Impact Assessment	9	9
Equality Impact Assessment Supporting information	6	8
KMSAB draft Strategic Plan - Easy Read	3	3
Equality Impact Assessment Supporting information - Large Print	2	4
Andy Rabey introducing the KMSAB Strategic Plan Consultation	48	48
Total	343	457

A total of 67 consultation responses were received. In addition, four completed guided discussion documents were submitted, with a total number of 60 individuals consulted by this method. Bringing the total number of respondents to 127. The full consultation report is available on this link. For comparison, the consultation on the 2019-2021 Strategic plan elicited 28 responses.

The Final KMSAB Strategic Plan 2022 – 2025

The final strategic plan, and easy read version are available here. The plan includes:

The operating environment

This section sets out the national and local context which influences and impacts on the work of the Kent and Medway Safeguarding Adults Board and its partner agencies. These include, legal, regulatory, policy and financial factors.

Our vision

The agreed vision is to "Protect and prevent adults with care and support needs from the risk of abuse, or neglect; supporting and promoting their wellbeing, with all partners working together effectively, ensuring that the safeguarding system is always improving through learning".

The Board at a glance.

This section sets out the Board arrangements, including the purpose, membership and working groups.

Approach to partnership working

This section sets out the 'three lines of defence model' which the Board works to. It places an emphasis on the organisational operational management responsibilities, as distinct from the strategic multi-agency safeguarding accountabilities.

- **Tier 1 – Operational** – The operational delivery of safeguarding activity sits with each organisation, as the 1st tier. That is, the expectation that each organisation will meet the various requirements placed on them by relevant laws, regulations, guidance, and professional standards connected with the exercise of their own responsibilities and accountabilities, alongside their own assurance arrangements.

- **Tier 2 – Board/System** - The effectiveness of the overall safeguarding system in protecting adults at risk of abuse or neglect, is the collective responsibility of all partners through the Board, informed by the principle of collaborative working.

- **Tier 3 – Independent Assurance** –scrutiny from relevant independent regulatory or statutory bodies (such as the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services' (HMICFRS), Office for Standard in Education (OFSTED), Healthwatch, NHS England NHS Improvement).

Top three priorities

1. Promoting Person Centred Safeguarding – putting adults at the centre of our work
2. Strengthening system assurance – checking that organisations are working well together to support adults
3. Embedding improvements and shaping future practice – helping the organisations we work with to keep getting better

Objectives

The strategic plan lists 14 objectives which detail how the Board plans to deliver the three priorities between 2022-2025.

Promoting Person Centred Safeguarding	1. Raise awareness of adult safeguarding to ensure that people understand what abuse is, how to recognise the signs and how to seek help. 2. Enable residents of Kent and Medway to voice their opinions on the work of the Board. 3. Ensure the voice of the person (or their representative) who has been involved with our safeguarding system is heard in respect of their safeguarding experience. 4. Seek assurance that each partner agency's workforce demonstrates 'professional curiosity and has processes in place to allow them to reflect on their practice and receive appropriate supervision.
Strengthening system assurance	5. Establish a mechanism to identify system issues and risks to provide assurance to Kent and Medway residents that effective safeguarding arrangements are in place. 6. Improving public understanding of the roles and responsibilities of partners.

	7. Improving interagency understanding of the roles and responsibilities of other partner organisations. 8. Agencies discharging their respective responsibilities to safeguard people. 9. Ensure effective Board to Board/Partnership arrangements. 10. Ensure an effective functioning Board with appropriate support structures.
Embedding improvements and shaping future practice	11. The voice of the person is listened to, and there is evidence their wishes are respected. 12. Learn from experience and have a workforce that is knowledgeable and confident in the application of their safeguarding adults roles and responsibilities. 13. Develop the right balance between support and challenge, aimed at system improvement. 14. Partners will be able to contribute to safeguarding at regional and national level.

Included in the strategic plan is a list of the actions that will be taken, over the coming years, to meet the objectives and key indicators of success and impact.

The final section sets out the Board's communication and engagement principles.

Section 3. Priorities and Achievements

This section details how we delivered against our new strategic priorities for 2022 – 2023. It is recognised that activity can cut across more than one priority.

Promote Person Centred Safeguarding – What we achieved:

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:
	  ○ Exploitation and county lines
	  ○ Self-neglect
	  ○ Creating safer organisational cultures
	  ○ Elder abuse
	  ○ Domestic abuse in a 'tech-society'
	  ○ Safeguarding in everyday life
	More information on these themes is available here.
	
	• To support agencies in promoting the week, the Board's communication and engagement working group developed a social media package and a toolkit of awareness raising materials.
	• KMSAB partner agencies participated in the week by sharing the social media messaging and hosting events within their agencies.
	• The Kent Community Safety team hosted an online seminar exploring the theme of harmful practices and cultural competency, over 160 people attended with 96% of respondents rating it as excellent, very good or good.
	• Public facing events included attendance at coffee mornings, one stop shops, community centres and information stands at supermarkets and shopping centres.
	• There were 3524 visits to the KMSAB webpages during the week, with 1147 clicks to the "worried about and adult?' pages for the public. This included 191 views to the 'report abuse' page and 956 visits to the 'useful resources for the public' page. 896 views were received on Tuesday 22 November, the theme of this day was 'self-neglect'. This was the highest number of views per day, of the week.

KMSAB Open Session on Predatory Marriage	• As part of Safeguarding Adults Awareness Week, the KMSAB hosted an open session on Predatory Marriage, led by Daphne Franks, who has lived experience of the issue. Attendance included representatives from the Kent and Medway registrar services. • Feedback included: *"I just wanted to say how interesting and thought provoking the event for Predatory Marriage was yesterday evening. The work that Daphne Franks has undertaken is inspirational and I would like to promote further within KCC to continue to raise awareness*." "Just a quick email to say thanks to you and the Board for the event last night

	regarding “Predatory Marriage”. The lived experience of Daphne and her family was heart-breaking to hear, and I am glad to know that the law has moved on a little in the last 10 years and the knowledge around complex capacity questions is spoken about more often. I will be looking to produce a small information precis of the event for internal circulation.” • Following the event, the Board shared a 7 minute briefing on the subject, and added the information to the newsletter, to support agencies in disseminating the message. • The Manager of the KCC Registrar service advised that Daphne’s presentation has been shared with the Kent registrars and is now embedded within their training.
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 was listed in the KMSAB Annual report for 2021/2022. • Additionally, the leaflet was used and adapted by other Boards and partnerships such as Oldham SAB and Shropshire Safeguarding Community Partnership. • The Communication and Engagement working group developed a social media content plan to share messaging, in Ukrainian, on how to recognise and report abuse. An example post:  • The KMSAB Business Unit attended an information event, hosted by the charity 'Medway Help for Ukrainians', where the Ukrainian KMSAB leaflet was shared to provide information on how to recognise and report abuse to Ukrainian nationals and their hosts.

Translated leaflets	• The KMSAB is committed to having its information leaflet, on how to recognise and respond to abuse, available in all the languages which are most commonly spoken in Kent and Medway. • During 2022-2023, agencies were consulted and advised that the following languages were required: ○ Dari, Pashto, Lithuanian, Arabic, Tamil, Albanian and Kurdish • Translations were commissioned and the leaflets were shared with partners, made available on the KMSAB website and promoted through the newsletter and at events. • The leaflet is currently available in English, Easy Read, British Sign Language Accessible and 26 other languages.

Engagement with local communities	• During 2022/2023, a brief article, titled "*Are you concerned about an adult*?", continued to be included in every edition of *Medway Matters*, a community magazine delivered to 120,000 homes across Medway.
	• Members of KMSAB and the Business Unit hosted a stand at the Kent Police Open Day on 3 July, where 10,000 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 1000 people visited the stand and engaged with the facilitators. Highlights of the website data, following the event, include:
	  ○ 241% increase in views to the KMSAB website during July
	  ○ All pages received an increase in visits
	  ○ 175% increase in visits to the 'useful resources for the public page' (435 from 158)
	  ○ Report abuse for public saw 249**%** increase for the rest of July (412 from 118)
	• As part of their work, the Independent Chair of the Board, Board Manager and the Board's Business Development and Engagement Officer, continued to hold introductory sessions with charities, voluntary sector and other community leads. This also includes meetings with advocacy leads, faith leaders, homeless services, the prison service and organisations representing people with lived experience.
	• The Independent Chair of the Board volunteers as a member of the diocese safeguarding advisory panel, their role is to support and advise the diocese of Rochester on safeguarding for their congregation and wider membership.
	• Safety in Action Day - The Medway Task Force held a Safety in Action Day on Sunday 24th July at the Chatham Dockyard in Medway. The event was aimed at members of the public to share the work that agencies are doing to protect the community. The Kent Fraud Protect and Prevent team attended a stall to share advice on how to protect themselves from fraud, along with information on how to recognise the signs of abuse and how to report concerns.
	• Members of the KMSAB Communications and Engagement Working Group and the Business Unit occupied a stand at the Ashford College Freshers Fayre, to speak to young adults about the signs of abuse and how they can report it. During this time, information was shared with trainee nurses, social workers and people from Ukraine who are now living in Kent

Meetings with Healthwatch	• In addition to attending Board meetings, Healthwatch leads met with the Independent Chair of the Board and the Board Manager regularly throughout the year. These meetings provide the opportunity for Healthwatch to provide insights into information that they have received on key areas of safeguarding. • It was agreed that Healthwatch would analyse feedback in relation to specific themes identified in SARs, and emerging issues. The first thematic analysis was in relation to people's experiences of NHS hospital discharge from 1 December 2021 to 30 November 2022.
Promotion of Communication and Engagement Toolkit	• To support Safeguarding Adults Awareness Week, and to enable agencies to raise awareness of adult safeguarding throughout the year, 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 used on social media to catch attention). The toolkit was added to the KMSAB website to enable all agencies and stakeholders to access the content.
Support for Carers Week	• As support for carers and carers stress was identified as a theme in Safeguarding Adults Reviews and Domestic Homicide Reviews, the Communication and Engagement Working Group produced materials to support the 'national carers week' campaign. These were shared by KMSAB partner agencies. Following the campaign, there was an increase in visits to the KMSAB webpages: Carers Week 2022 (6-12 June 2022) ○ The 'support for young carers' page saw a 109% increase from May-June ○ The 'support for carers' page saw a 54% increase from May – June ○ The 'useful links and resources for carers' page saw a decrease of 70% in views from May-June but a 55% increase from June to July. ○ Although there was a decrease to the 'useful links and resources for carers' page from May-June, there was a 2206% increase to the Carers Week 2022 information during the same time frame, with a total of 1314 views.
Consultation on the Board's Strategic Plan	• As detailed in section 2 of this report, the KMSAB ran a 6 week consultation, seeking feedback on the Board's Strategic Plan to ensure that it fulfilled the statutory duty, met the needs and expectations of Kent and Medway residents, and promoted a partnership approach to the delivery of the Plan.
Family Involvement in Safeguarding Adults Reviews	• The KMSAB is committed to involving individuals, their representatives, family members and friends when undertaking safeguarding adults reviews, to gain an understanding of their experiences and views of safeguarding. At each terms of reference meeting, SAR panel members will determine who should be contacted to be involved in the review, how to facilitate this contact, and what support may be required to enable them to contribute. It is only in exceptional circumstances, for example, where there are no next of kin details, where no contact is attempted. Of the SARs published

	since the last annual report, detailed in section 4, 50% included the views of the individual or those close to them. It is important to recognise that whilst every effort is made to approach the subject sensitively and supportively, some individuals indicate that they do not want to be involved, and their wishes are respected. • The SAR information leaflet for individuals, families, friends and carers, which details the review process, was updated during 2022, to incorporate different SAR methodologies.
Tricky friends Animation	• The KMSAB adapted Norfolk's Tricky Friends animation which was designed to help people to understand what good friendships are, when they might be harmful, and what action they can take if they have concerns. The animation is also available in British sign Language.
Advocacy People – development of a citizens panel	• The Advocacy People launched a campaign to find people with lived experience of adult safeguarding, to share their stories, and contribute to creating a new approach to safeguarding. The aim of the project was to draw on individual's experiences and use this to inform the work of the Board. Unfortunately, despite much promotion, no individuals offered to take part in the panel. Subsequently, the KMSAB members agreed to continue to make use of existing forums to seek the views of people with lived experience of safeguarding.
Culturally Competent Practice	• Members of the KMSAB raised awareness of culturally competent practice. This was supported by the training provider, who ensured that this was reflected in training modules. • The update of the KMSAB's main policy document included a new section on culturally competent practice, which referenced supporting resources.
Small Concertina Awareness Raising Leaflets	• Practitioners advised that they would benefit from a credit card sized concertina leaflet setting out how to respond to adult safeguarding concerns, which they could share with members of the public. The communications and engagement working group members agreed the content for the leaflet. The Board business unit sought funding, from the KCC Community Safety Unit, for the design and printing of 2000 copies.

Strengthen System Assurance

What we achieved:

Quality assurance framework	• During 2022-2023, 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.

Self-Assessment Framework	• 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. • To allow agencies time to undertake any improvement activity to meet any standards rated red or amber, it was agreed that the 'full SAF', which was last issued in 2021, would be completed every two years. A shorter, thematic SAF would be completed in the intervening years, with a focus on measuring the impact of learning from safeguarding adult reviews and other priorities identified by the Board. • The 2022 thematic SAF focused on the following priority standards: ○ **Legal literacy** ▪ The agency/organisation ensures that staff are aware of their legal responsibilities and powers to safeguard adults. ▪ 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. ▪ 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. ▪ 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. ▪ Decision making in relation to adult safeguarding is clearly recorded, justified and proportionate. ○ **Self-Neglect** ▪ 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. ▪ The communication needs of individuals are taken into account when engaging with them. ○ **Person centred Practice** ▪ Making Safeguarding Personal is understood and applied within safeguarding practice. The individual or

	their advocate is involved throughout. If this has not been possible, the reasons are clearly documented. ▪ The 'think family' approach is applied when working with individuals. Think Family is an approach to help practitioners consider the parent, the child and the family as a whole when assessing the needs of individuals and when planning care packages and or/support. ○ **Embedding learning from safeguarding adults reviews** ▪ Learning from relevant reviews is shared with staff and there is a mechanism in place to measure the impact of this on practice/increase in knowledge. ▪ For agencies involved in hospital discharge arrangements. 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. ▪ Staff are aware of the legal basis for sharing information and are confident in applying this to safeguarding adults. • To support the launch of the SAF, the Board manager hosted a briefing session for agencies. The session covered how to complete the SAF, the rationale for the standards, and provided an opportunity for questions and peer support. • Agencies were required to assess how well their organisation was achieving each standard/requirement, using a red, amber, green (RAG) rating. They were also required to provide supporting evidence and complete an action plan for any requirements graded red or amber, detailing how compliance would be achieved. Outstanding actions were 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 were required to present their completed SAF analyses and evidence to a panel of 'peer' reviewers. • Of the 406 standards (29[1] agencies x 14 standards) initial returns indicated a 76% achievement rating (green), with 23% rated amber and 1% red. Following the peer-review, there was a 73% achievement rating (green), with 27% rated amber and .2% rated red. • The difference between agency's gradings and peer review ratings can mostly be attributed to; differing thresholds, the peer review panel requiring more evidence, or agencies considering a standard was not applicable, which the panel felt was applicable.

[1] Although 30 agencies were asked to complete the SAF, one submission was delayed and therefore is not included in these figures.

	• By June 2023[2] there was an 87% completion rate, with 13% (54) requirements remaining amber. Members of the QAWG will continue to receive updates until the standards are met. If the standards are not met after 18 months, the Independent Chair of the Board will escalate with the relevant agency leads.
Roles and responsibilities	• A referral is the gateway into a service that a professional or the individual has identified that they need. A referral without the right information can result in time wasted, health and/or social care needs deterioration, reactive escalation and most importantly the right support not being offered. In response to learning from SAR referrals and reviews, members of the Safeguarding Adults Review Working Group developed a guide for practitioners, setting out what makes a good referral and the key points that need to be considered when completing a referral for a service. • The KMSAB partnered with the training provider, DCC-I, to create an introductory e-learning module. The module provided a basic introduction to topics such as the Care Act 2014, safeguarding principles, the well-being principle, and the Mental Capacity Act. The training was publicised and made available on the KMSAB website. • The KMSAB promoted and raised awareness of the "Safeguarding Adults, roles and responsibilities in health and care services" guide. The guide was created by the Directors of Adult Social Services (ADASS), the Local Government Association, NHS England, the Care Quality Commission and the Association of Chief Police Officers. The document provides clarity on the roles and responsibilities of the key agencies involved in adult safeguarding. The aim is to ensure that the right things are done by the right people at the right time, by working within their own agency and with partners. • The need for robust record keeping, to evidence defensible decision making, is a feature of many safeguarding adults reviews, without this it can be hard for those involved in the review to evidence what actions were taken and the rationale for these. The KMSAB continued to raise awareness of the significance of good record keeping, including sharing this document produced by the social care institute of excellence. As detailed in the section above, defensible decision making formed part of the 2022 SAF, to measure how agencies were embedding this learning. • During 2022, Kent County Council ended their consultation process for adult safeguarding, which offered partner agencies the opportunity to discuss safeguarding concerns and issues with the local authority to assist them in making the decision on whether to submit a safeguarding concern form. Instead, agencies were encouraged to consult with their safeguarding leads, as was the established process in Medway. To support the change, the KMSAB promoted the national guidance on "Understanding what constitutes a safeguarding concern". The aims of this framework are to support a whole range of sectors and organisations in making appropriate referrals of concerns to adult social care, by promoting a consistent and shared understanding of what constitutes a safeguarding adults concern. Legal literacy was measured in the 2022 SAF.

[2] All 30 agencies had completed their SAF by this time.

	• Analysis of the 2021 self-assessment framework responses identified that not all agencies were clear on the different types of statutory advocacy services available to support individuals across Kent and Medway. In response to this, the Advocacy People developed a flowchart setting out the process for statutory advocacy for Independent Mental Capacity Advocates (IMCA), Independent Care Act Advocates (ICAA) and Independent Mental Health Advocates (IMHA). An open session was also arranged by the Board business unit, offering an introduction to the advocacy offer and the opportunity to ask questions. Subsequently, there was an increase in the number of agencies that were able to demonstrate that they had achieved a green rating for this standard.

Agency Audits	• As part of the Board's Quality Assurance Framework, agencies are asked to present relevant audit activity and findings to the quality assurance working group, to provide assurance and inform future KMSAB activity. During 2022-2023 the following audits were presented:
	  ○ Medway Community Healthcare – Mental Capacity Assessment Audit
	  ○ Medway Foundation Trust –LeDeR audit

Joint SARs and DHRs	• Within Kent and Medway, the responsibility for undertaking Domestic Homicide reviews, where the criteria is met, sits with the community safety partnership (CSP). Where it is expected that a referral may meet the criteria for both a SAR and a DHR, the KMSAB business unit and the CSP team liaise closely with each other. If the criteria is met for both reviews then a joint SAR/DHR is commissioned. To date, 3 joint reviews have been commissioned, of these, the Board led two reviews and the CSP led one. • The commissioning of joint reviews is not only cost effective, but also facilitates stronger partnership working and understanding. • Where a safeguarding adults review involves an individual who was known to children's services, then the children's partnerships (Kent or Medway) in addition to the respective agencies, will be invited to contribute to the review. This allows for a holistic, person centred review and for learning to be shared across the partnerships in a timely way.
Legal basis for sharing information	• To support agencies in delivering their statutory duties, and to address findings from safeguarding adults reviews, the KMSAB produced and promoted a short guide on "the legal basis for sharing information". This was an extract of guidance developed by London ADASS. • To ensure that this information was embedded, the 2022 self-assessment framework included the following standard, "Staff are aware of the legal basis for sharing information and are confident in applying this to safeguarding adults."
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 over the previous 12 months. The report also provides the opportunity to highlight safeguarding priorities and any areas of challenge.

	• A total of 28 responses were submitted. These reports were peer reviewed by 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.

Effective Board to Board/Partnership arrangements	• Monthly meetings take place between the Managers of the following partnerships:
	  ○ Community Safety Partnership
	  ○ Kent Safeguarding Children Multi-Agency Partnership
	  ○ Medway Safeguarding Children Partnership
	  ○ Domestic Abuse Partnership
	  ○ KMSAB
	• The meetings provide an opportunity for peer support and to share good practice, priorities, key learning, and intelligence. This information is then triangulated to identify areas for joint working. It allows for the sharing of resources and messages across the partnerships, to ensure consistency and reduce duplication.
	• Update reports from the Kent and Medway Health and Wellbeing Boards, Community Safety Partnerships and Safeguarding children's partnerships are received by the Business Group. The purpose of this is to share learning and identify areas for joint working and development.
	• The Joint Exploitation Working Group is a joint subgroup of the Medway Safeguarding Children Partnership (MSCP) and the Kent and Medway Safeguarding Adults Board (KMSAB). Both Kent and Medway Community Safety Partnerships (CSPs) and the Kent Safeguarding Children Multi Agency Partnership (KSCMP) are also part of the group. It is a well-attended meeting, the areas of work overseen by the group are set out in section 1 of this report.
	• In 2022, the JEG introduced a quarterly contextual safeguarding report, covering both Kent and Medway, which informs partners of any patterns and trends covering issues such as emotional well-being, domestic abuse, missing children, county lines and serious youth violence. Members provide updates on how they use this information to keep practitioners informed on the changing picture of contextual risks and to understand how partners are mitigating these.

Escalation policy	• Members of the Kent and Medway Safeguarding Adults Board are clear that whenever a practitioner, agency or service has a concern about the action or inaction of another, this must be addressed, and any challenges conducted in a professional and respectful manner. • During 2022 the Board's escalation policy was reviewed, updated, and shared with practitioners. The 2023 SAF will include a standard to measure how this has been embedded in practice.
KMSAB Executive Meetings	• The Board Executive Membership met on 4 occasions in 2022-2023. 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: ○ Tackling violence against women and girls strategy ○ Review of safeguarding processes – East Kent Hospitals University Foundation Trust ○ Section 42 referral process and adult social care restructure – KCC ○ NHS safe and wellbeing review programme ○ Impact of cost of living pressures and safeguarding ○ ICB strategic plan ○ Suicide thematic review ○ Roles and responsibilities ○ Serious violence duty ○ Care Quality Commission – Assessment framework for local authority assurance • In addition to the executive meetings, the statutory members of the Board met on 2 occasions to discuss resourcing and KMSAB priorities.
New SAR policy	• The Board's safeguarding adults review (SAR) policy was completely re-drafted to incorporate different methodologies for undertaking reviews. The revised document followed the format of the Board's main policy document, with sections for policy, protocols and guidance, it was also cross referenced against the national SAR quality markers. The updated policy has been well received by all agencies and adds greater consistency and rigor to all stages of the SAR process. • Supporting documents, such as the SAR referral form and summary of agency involvement forms were also revised to ensure that they provided the most relevant information to support decision making and to identify key learning. • The revised policy and supporting documents are available on the Board's website.
Prevent Duty	• The KCC and Medway Prevent team deal with Prevent/Channel referrals and deliver extensive work to prevent radicalisation across Kent and Medway as part of the UK counter terrorism strategy CONTEST. Innovative work is being delivered in relation to the threat of online extremism, providing support to adults, parents, carers and individuals who have been identified as being vulnerable to radicalisation. This includes delivering Prevent training to KMSAB partners, ensuring that organisations understand new and emerging threats. • The Kent and Medway Prevent Duty Delivery Board provides the strategic oversight across our area. Work is focused on promoting person centred safeguarding, ensuring appropriate and timely support is provided to those at risk of radicalisation. In February 2023, a hybrid conference on tackling Hateful Extremism across Kent and Medway was held and over 250 in person or online delegates attended. A further conference will be held in February 2024. All KMSAB partners have a Prevent duty as outlined in the Counter Terrorism and Security Act 2015.

Embed Improvement and Shape Future Practice

What we achieved:

Delivered our Training Offer	• The Board offers multi-agency training, predominantly for staff from the statutory sector. In response to feedback, learning from SARs and a course content review, all half-day courses were increased to full day courses with the modules focusing on the following priority areas:
	  • Adult safeguarding legal literacy
	  • Domestic abuse, including a focus on stalking and harassment, harmful practices, female genital mutilation (FGM) and honour-based crime
	  • Collaborative working in multi-agency Section 42 Enquiries
	  • Self neglect and hoarding workshop
	  • Types of Adult Exploitation - including cuckooing, modern slavery, 'mate' crime and county lines
	• Between April 2022 – March 2023, 57 workshops were held, with 703 delegates participating.
	• The training providers, DCCi, increased the number of places available on each course from 15 to 22. This enabled the learning and development working group to extend the learning offer more widely, to GPs, local councils and charities.

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.

Kent and Medway Safeguarding Adults Board Policy and Procedures	• Members of the Practice, Policies and Procedures Working Group reviewed and significantly updated the Board's main policy document, "Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway" , which all Board members and relevant partners are required to work to.
	• The policy is supported by a number of additional policies, which are updated in accordance with a policy update schedule.
	• During 2022/23, Members completed their review and revision of the following documents:
	  ○ Kent and Medway Multi-Agency Resolving Practitioner Differences; Escalation Policy for Referrals and Adult Safeguarding
	  ○ Kent and Medway Multi Agency Policy and Procedures to Support People that Self-Neglect or Demonstrate Hoarding Behaviour

	○ Managing Concerns around People in Positions of Trust (PiPoT) • 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.
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. • To improve how the Board responds to learning from SARs, Board members agreed to work to a thematic approach for action plans. The actions to address each theme were determined by members of the SARWG, co-opting other practitioners with subject matter experience/expertise where required. This approach enabled reviews to build on already established learning and allowed time for previously identified actions to embed in practice. They key themes are shared with the Board's working groups, so that these can be incorporated into their work programmes.
Sharing of Good Practice	• Safeguarding Adults Reviews are a critical tool to help identify areas for improvements. 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.
SAR Video and Reflective Learning Briefings	• It is acknowledged that individuals have different learning styles and preferences. To accommodate this, the Board piloted a video approach to sharing learning from SARs. The author of the Elizabeth Eastly review created and presented a 10 minute summary of the review process and findings. • Members of the Communication and Engagement working group will undertake analysis to measure the effectiveness of this approach. If the findings are positive, more videos to accompany SAR reports will be produced. • In addition to the full overview report, Independent SAR Chairs produce a reflective summary briefing. This briefing distils the key learning from the review and poses reflective questions for practitioners to consider themselves, or in team meetings/other training.
KMSAB Open Sessions	• The Board Business Unit continued to deliver quarterly 'KMSAB open forum sessions', providing an opportunity for anyone with an interest in adult safeguarding to hear from people with a lived experience of safeguarding, and other subject matter experts. The following sessions were held in 2022-2023: ○ Deaf awareness and adult safeguarding ○ Adult safeguarding where chronic alcohol dependency is a factor

	○ Advocacy and adult safeguarding ○ Preparation for safeguarding adults awareness week, briefing sessions ○ Predatory Marriage.
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 350 people/agencies subscribe to the KMSAB newsletter (a 20% increase from 2021/2022), with many cascading it further within their organisations.
Regional and National Forums	• The Independent SAR Chair attends the national SAR Independent Chair Network and Chairs the regional meeting of Independent SAR Chairs and Safeguarding Adults Board (SAB) Managers. • The Board Manager attends the regional meeting and also attends the national SAB Manager's network. • These network meetings are extremely beneficial and provide the opportunity to share information, best practice, learning and work on joint projects. They also provide the Boards with a stronger national voice, should they wish to escalate concerns to relevant government departments.
Theft and Fraud within Families	• Members of the quality assurance working group received a presentation on the "all parliamentary report on theft and fraud within families", which aims to prompt discussion of financial abuse within families and the need to work more effectively together to prevent the abuse and harm that it causes. • The report was also shared in the newsletter, with a request to spread awareness amongst safeguarding partners, and others, about the issue and prompt greater collaboration.
Safeguarding Adults Review Learning Events	• The Board, in collaboration with the training provider DCCi, delivered the following workshops to share the learning from safeguarding adults reviews: ○ Improving partnership working – managing complexity and capacity – 180 delegates attended this session. ○ Understanding Self-Neglect and Supporting Good Practice. 2 sessions were delivered on this topic to coincide with the launch of the revised self-neglect and hoarding procedures. 181 delegates attended in total. ○ Overcoming Barriers to Engagement. 144 delegates attended this session. • The sessions encouraged attendees to work collaboratively, reflect on good practice and develop a solution focussed approach. • Through engagement in the sessions, members co-produced a guide to working with complexity, self-neglect, substance misuse and mental capacity. Which is available on the Board's website. • Feedback received indicated that the sessions were valuable, both in terms of content and in providing multi-agency

	networking opportunities.
Work with SAR Chairs	• The Board Business Unit, and the Chair of the LDWG met with the Independent SAR Chairs to discuss emerging themes within SARs/SAR applications. These themes included homelessness and the commissioning of specialist placements. • Independent SAR Chairs provided intelligence that the issues surrounding homelessness, including the lack of appropriate supported housing, social housing and the concerns around hospital discharges when someone is identified as homeless, are also common themes in other areas they are completing reviews for. • The Chairs found the joint meeting beneficial. To enable them to continue to provide peer support and share themes, a secure Microsoft Teams page was set up. To maintain confidentiality, case specific details are not shared or discussed.
Multi-agency risk management framework (MARM)	• In response to SAR findings and recommendations, a task and finish group was established to provide assurance that current practice and procedures are sufficient in relation to co-ordination of a multiagency response to adults as risk, or whether an additional tool/process, such as the MARM framework would be beneficial.

Section 4. Safeguarding Adults Reviews

4.1. Criteria for Conducting a Safeguarding Adults Review

Mandatory SAR

Provision 44 of the Care Act 2014 sets out the criteria for Safeguarding Adults Reviews as follows:

An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

> (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, **and**
>
> (b) condition 1 or 2 is met.

Condition 1 is met if—

> (a) the adult has died, **and**
>
> (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

> (a) the adult is still alive, and
>
> (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect

Discretionary SAR

An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs)[3]

More information on the SAR process is available here.

4.2. Purpose of a Safeguarding Adults Review

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

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

As detailed in section 3 of this report, the Safeguarding Adults Review policy was completely redrafted and relaunched during 2022/3. The new policy was designed to ensure greater clarity, consistency, and a focus on establishing the lessons in a timely and rigorous way, without compromising on quality. In line with national findings and best practice, the intention is to build upon any previous learning in a systematic way and focus on the delivery of improvement outcomes and measuring the impact of changes. As part of this, the document distinguishes between single agency practice learning and system learning.

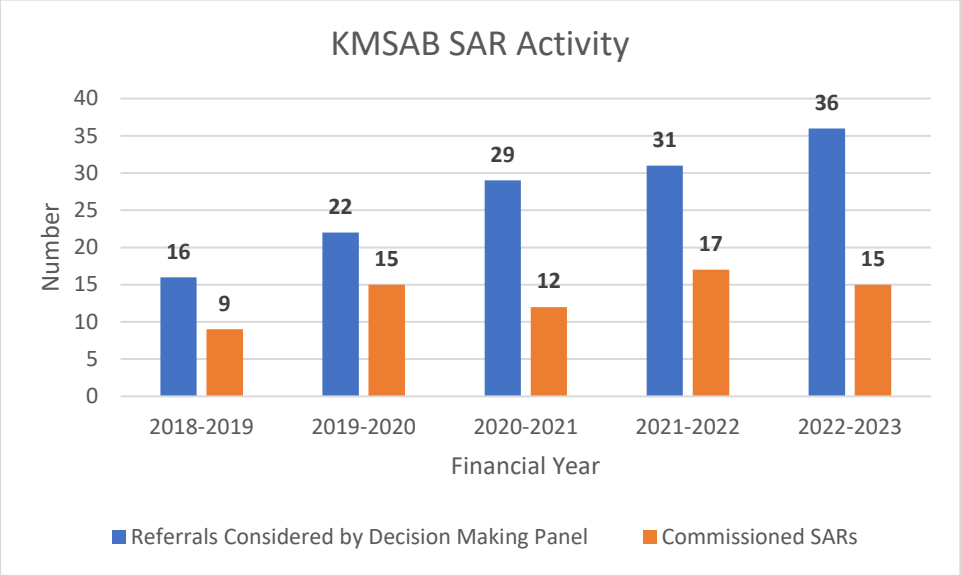
4.3. Safeguarding Adults Review Activity

To ensure a robust and consistent process for determining whether a referral/application for a Safeguarding Adults Review meets the criteria, a multi-agency decision-making panel, chaired by a member of the SAR Working Group, is convened. Prior to the meeting, agencies who worked with the adult, are asked to complete a summary of agency involvement form, detailing relevant and proportionate information to inform the discussion and decision on whether the criteria for a SAR is met. The SAR decision making group consider the agency involvement returns and the initial referral and assess whether the referral meets the criteria for a SAR, or whether any other review or action is required. The options for the panel are as follows:

- Commission a mandatory SAR (as detailed in 3.1)
- Commission a discretionary SAR (as detailed in 3.1)
- Criteria not met- should the panel members agree that a situation does not meet the criteria, but consider there to be single agency learning, they can recommend that the relevant agency conduct an internal review. At the end of the review, the agency will be asked to share relevant findings with the Safeguarding Adults Review Working Group.

The recommendation of the panel is sent to the Independent Chair of the KMSAB for a final decision.

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



The KMSAB received 36 new SAR referrals between April 2021 and March 2022, of these:

- 15 SARs were commissioned.
- 21 did not meet the criteria and no further action for the Board was required.

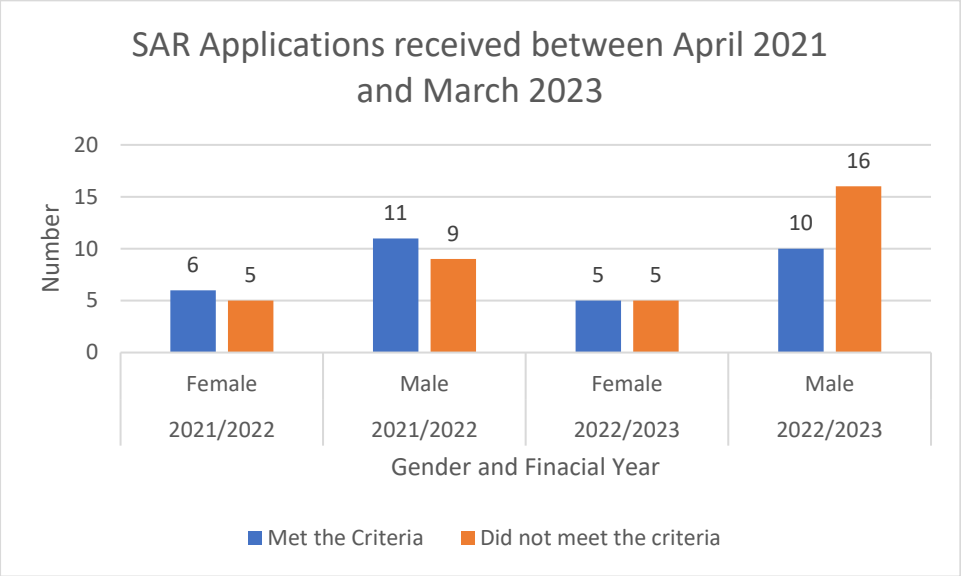
The summary of agency involvement returns allow members to consider information that may not have been available to the person who made the SAR referral, and, in many cases, the additional information evidenced that agencies did work together, so the criteria was not met.

Gender - SAR applications received between April 2021 and March 2023[4]

There continues to be more SAR referrals for males, including people who identified as male. Of the 36 SAR referrals received between April 2022 and March 2023, 72% were for males and 28% for females. In 2021/2022 the proportion was 35% female to 65% male.

The gender breakdown of SARs commissioned remains consistent, with approximately a third of commissioned reviews relating to females and two-thirds to males.

2022/23	Referrals (Number)	Referrals (Percentage)	SARs commissioned (Number)	SARs Commissioned (Percentage)
Male	26	72%	10	67%
Female	10	28%	5	33%
2021/2022				
Male	20	65%	11	65%
Female	11	35%	6	35%



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

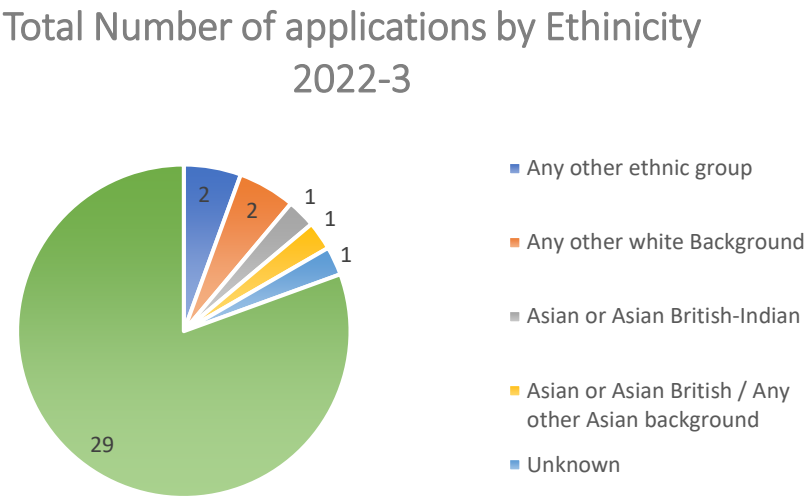
In 2021 – 2022, the conversion rate of referrals to commissioned SARs was 55% for both males and females. In 2022-2023 the conversion rate was 50% for females and 38% for males.

Ethnicity - applications received between April 2022 and March 2023

The SAR referral form contains a field for ethnicity information. Under the revised SAR procedure, the SAR core panel is asked to validate this information when reviewing the summary of agency returns, to ensure that information is recorded and that it is accurate.

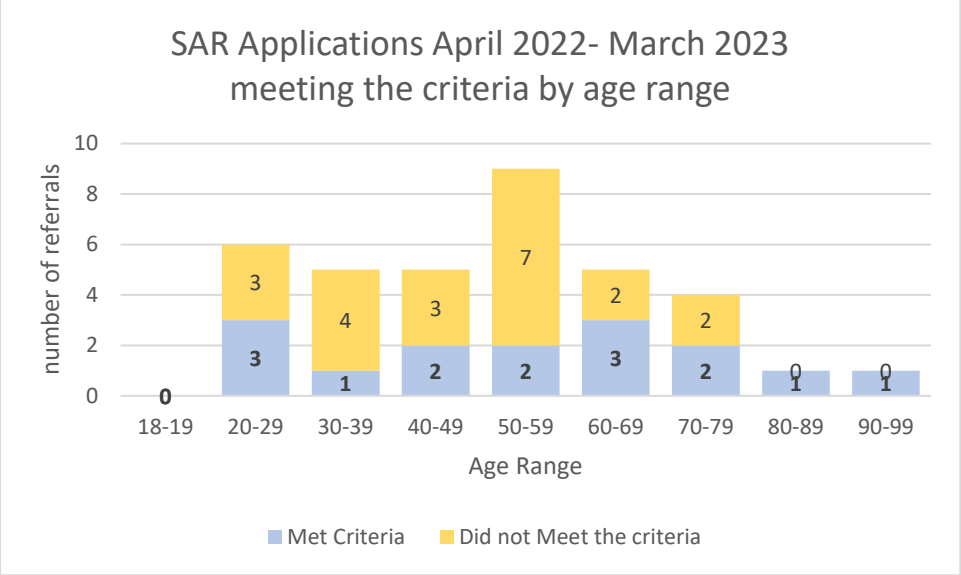
Of the 36 referrals received, 80.5% of the individuals were 'White British-English', 5.5% 'Any other white background', 5.5% 'Any other ethnic group', 3% 'Asian or Asian British – Indian', 3% Asian or Asian British / Any other Asian background, and 3% 'unknown'. 93% of the SARs commissioned were in relation to individuals who were white British/English.

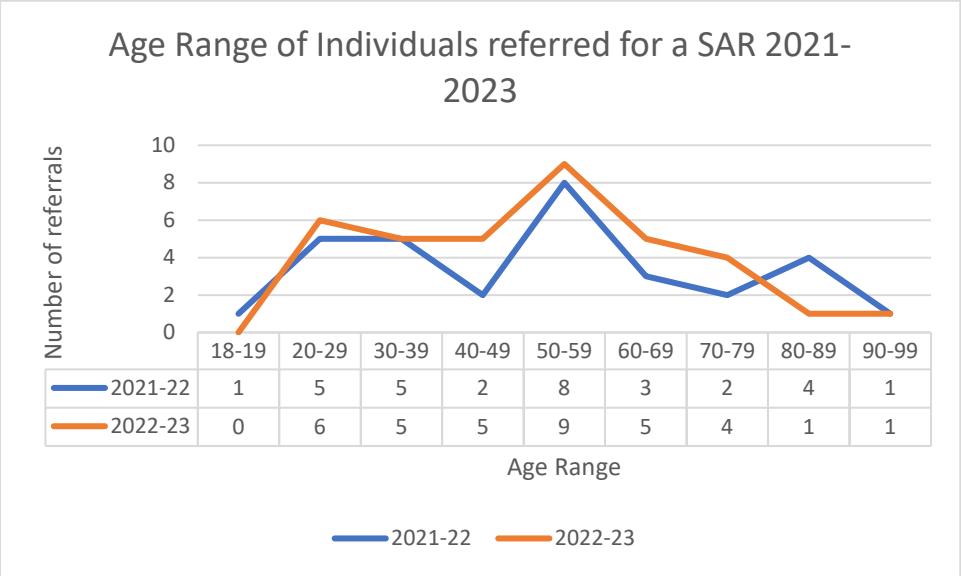
Ethnicity	Total Number of applications	Number of referrals meeting the criteria	Percentage of referrals meeting the criteria
Any other ethnic group	2	1	50%
Any other white background	2	0	0%
Asian or Asian British-Indian	1	0	0%
Asian or Asian British / Any other Asian background	1	0	0%
Unknown	1	0	0%
White British/English	29	14	48%



Age – SAR applications received between April 2022 and March 2023

Of the SAR referrals received, as with the previous year, the most frequent category was the 50-59 age range. Possibly due to the low numbers, there is little variation in age for the SARs commissioned during this reporting period.


SAR Applications April 2022- March 2023 meeting the criteria by age range
number of referrals
10
8
6
4
2
0
0
3
3
4
1
3
2
7
2
2
3
2
2
0
1
0
1
18-19
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90-99
Age Range
Met Criteria
Did not Meet the criteria


Age Range of Individuals referred for a SAR 2021-2023
Number of referrals
10
8
6
4
2
0
18-19
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90-99
2021-22
1
5
5
2
8
3
2
4
1
2022-23
0
6
5
5
9
5
4
1
1
Age Range
2021-22
2022-23

4.4. 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 and Methodology	Background	Findings/Recommendations
Rosie and Emma Published: 19 July 2023 **Traditional review**	Rosie, a white British female, was 24 when she died by suicide. Between 2011 and 2013 she had been looked after by the local authority on three occasions, following this, she was supported by the 18+ care leavers service. Her personal advisor described her as always beautifully presented and like a "little Amy Winehouse". Significantly, in January 2020, Rosie experienced the loss of her partner to suicide. A number of agencies reflect the impact of this loss on Rosie, and she was informally admitted to an inpatient unit for 4 days, having attempted to take her own life. In addition to the emotional trauma of this loss, Rosie also lost her home and went to live with a friend on discharge from hospital. Following her inpatient stay, Rosie was discharged to the Community Mental Health Team (CMHT) and met with a consultant psychiatrist who diagnosed her with Emotional Unstable Personality Disorder (EUPD), Post-Traumatic Stress Disorder (PTSD) and social anxiety. Rosie attempted suicide on 24 May 2020 and died as a result of this on 25 May 2020. Rosie's last recorded contact with services was on 21 May 2020. Emma, a white British female was 21 when she died by	Learning related to: • **Suicide prevention** - KMSAB should work with public health teams in Kent and Medway to ensure that the Kent and Medway Suicide and Self-harm Prevention Strategy 2021-2025 includes key findings from this Safeguarding Adults Review including understanding of suicide risk on a population-wide as well as an individual basis for people who: • have survived adverse childhood experiences • are using drugs and alcohol and have co-occurring mental health needs. • live nomadic lives with few fixed points and had little stability, economically, socially, or of accommodation • have experienced recent and ongoing trauma through loss of loved ones and friends, relationship breakups, homelessness and physical and sexual assaults. • **Think family -** Agencies involved in this review should introduce a "Think Family" approach and support

	suicide. Emma first became known to KCC Specialist Children's Services in 2004 when she was aged 5 years, having experienced abuse and neglect from her biological family. Emma and her siblings were made subject of a Child Protection Plan. They were placed in foster care together, where she remained until she was 18. Emma's personal advisor described her as 'very spiritual, creative, colourful, bubbly and independent". In May 2019, aged 20, Emma abandoned her tenancy, the reason for this is not clear. Following her leaving her tenancy Emma experienced frequent housing instability. The day before Emma's PA learned about the tenancy being abandoned, Emma was detained for her safety under section 136 of the Mental Health Act, having told her GP that she was actively suicidal. This followed an attendance at Accident and Emergency, eight days before having taken an overdose of paracetamol. Emma described herself to professionals as a 'sex worker'. During the period covered by the review, Emma was known to services following overdoses, self-harm and suicide attempts. Emma died by suicide on 2 July 2020. Her last recorded contact with services was on 1 July 2020. The rationale for a joint review was that it allowed a focus on similarities and differences and the approaches taken by services to engage and support Rosie and Emma. In this way, themes, patterns, systemic factors and processes could be identified. Agencies who knew Rosie and Emma were required to write separate Independent Management Reports and chronologies for each, to ensure that the focus remained on them as individuals.	practitioners to consider, for instance, how background information can be obtained from family members or friends that will help to identify risk and approaches to take to increase engagement; how to identify whether family or friends are protective factors or not, and how to work with family or friends in protection planning and providing ongoing support. • **Multi-Agency working -** KMSAB partners should examine the Camden Core Team model, the Plymouth and Bristol practice models and the work by Sandwell Metropolitan Borough Council, which provide examples of system change approaches for working with people like Rosie and Emma.

Pablo Published: 8 June 2023 **Day review**	*"Pablo was unique and passionate – he felt different to other people and wanted acceptance" (Pablo's mother)* Pablo, a white British male, was a musician and an artist. Growing up, Pablo and his mother were subjected to domestic abuse. Pablo's mother reported that this affected him deeply. Records indicate that Pablo had a diagnosis of bipolar affective disorder, paranoid schizophrenia and schizoaffective disorder – along with a history of drug and alcohol abuse. Mental health services were involved with Pablo from 2011 until his death. There are numerous reports of Pablo self-harming, which resulted in Emergency Department attendances. He was reported as being non-compliant with medication prescribed for his mental health and had poor concordance with his mental health needs. During periods of psychosis Pablo did not trust anyone, however he was never violent or confrontational – he preferred not to be around anyone due to the paranoia. His family also argued that he was not suicidal, but rather was experiencing delusions which led him to take actions which endangered his life. Pablo was in his early thirties when he went missing from a hospital in Town A, Kent. On the day he went missing, Pablo had left the hospital's Emergency Department whilst he was under supervision, due to being in an acute psychotic episode. Pablo's body was recovered some months later having been found on the coastline of the English Channel.	Learning related to: • **Safeguarding and Managing Risk Tool (SMaRT plus) -** The review has raised questions about the use of SMaRT tools, which require analysis. The need for learning around these tools is not unique to Hospital Trust 1. Other Trusts in Kent and Medway have been developing processes to aid the use of SMaRT tools. It is recommended that Hospital Trust 1 link in with these Trusts to share learning. • **Self-discharge/absconding from hospital -** All Safeguarding Adult Reviews in Kent and Medway which involve patients self-discharging or absconding from hospital will be collated, along with data from each Hospital Trust – to be shared with the Kent and Medway Integrated Care Board, to highlight the issue across Kent and Medway Hospital Trusts. • **Quality of Referrals -** Staff must be reminded of the importance of including pertinent points and using suitable language when making interagency referrals – this was also identified in SAR Elizabeth Eastley. Referrers must state clearly what the issue is and what they require of the agency they are referring to. • **Documenting defensible decision making** - Staff from all agencies should be reminded that decisions and the rationale behind decisions must be recorded clearly. • **Co-occurring conditions** – The findings from this review are to be used to inform the work of the Board's co-occurring conditions task and finish group.

Brian Published: 22 May 2023 **Traditional review**	Brian was a 49 year old single white male who lived alone in a coastal resort town in Kent. He was a tenant in District Council accommodation at the time of his death. Brian lived with mental health issues, including anxiety and preoccupied thoughts. Brian had a history of self-neglect when he increased his intake of alcohol and/or non prescribed drugs. Brian was found dead in his flat on 22 September 2021 by the police. It was evident he had been dead for some time. A Coroners' Inquest recorded an open verdict as it was not possible to determine the cause of death.	Learning related to: • **Practice/defensible decision making-** Adult social care was asked to ensure that parameters be set in relation to what the expectation for delivering, or meeting, an action that is deemed "urgent" are. As a guide, responding to an "urgent" action should whenever possible be measured in days, rather than weeks. • **Multi-Agency working /Information sharing** - KMICB should clarify the procedure and protocol for "just to let you know" correspondence sent by Health and Social Care Organisations. Relevant and contextual information should be included. Specifically, where there is an expectation the GP will take some form of action, this should be made explicit. KMPT and KCC Adult Social Care should consider introducing a working protocol that before services are withdrawn because there is a belief the other organisation is now taking the lead; the relevant organisation should obtain this confirmation before the withdrawal of services is approved. All Health and Social Care agencies should view Housing Authorities as key safeguarding partners and should be encouraged to involve them when individuals are tenants of their properties. (Subject to the permission of the individual). • **Safe-Discharge** - The NHS Hospital Trust should continue to explore their current initiative to review hospital

		discharge procedures for vulnerable patients into potentially unsafe home environments, with social care partners and other relevant agencies. • **Self-Neglect -** All Safeguarding agencies should publicise and implement a training and awareness programme for their staff now the new multi-agency self-neglect protocol is approved. KMSAB have been proactive in this regard and have self-neglect as part of their multi-agency training offer.
Brett Published: 18 May 2023 **Traditional review**	Brett, a white British male was 49 years when he died. His bother said that, when he was well, Brett was a fun loving person who loved a laugh and was easy going. Brett was a scout leader. His brother said that Brett loved being a leader in the scouts but when his mental illness started, he had to give it up. Brett's brother stated that after this Brett's depression got worse and he could see him shrinking as a person and that it was very sad to watch. Brett had a long history of psychotic illness, diabetes and self-neglect when unwell. Brett was referred to the Kent and Medway NHS and Social Care Partnership Trust (KMPT), in September 2020 by his brother, due to concerns that Brett's mental state was deteriorating, and as a result his ability to take care of himself was diminishing. Brett was also an insulin dependent diabetic and there were concerns that he was not managing this well. Brett was under the care of his local Community Healthcare	Learning related to: • **Self-Neglect -** The Kent and Medway Safeguarding self-neglect and escalation policy have both undergone a recent extensive and robust review. It is recommended that the KMSAB carries out a qualitative review with partner agencies to provide assurance that their staff are working towards the policy. This can be evidenced in the Board's Self-Assessment framework**.** • **Escalation -** The Kent and Medway Safeguarding Adults Board to consider carrying out an audit of practitioners in relation to their use of the self-neglect policy to identify if the escalation policy is being utilised when the self-neglect policy isn't working. • **Multi-Agency working** - Following the completion of this SAR a practice note guidance is to be produced highlighting the importance of recognising the complex needs of patients, both physical and mentally, and the

	Trust for his diabetes management. Brett was known to various services and issues of self-neglect were mentioned by services, however limited safeguarding referrals were made, and none in relation to possible self-neglect, until Brett was admitted into hospital for the last time. In October 2020, Brett was found unresponsive by his brother at his home address. An ambulance was called, and he was admitted to hospital. Sadly, Brett later died in hospital.	need for a multi-agency response through pre-established Multi-disciplinary meetings**.** There has been an identified need to strengthen communication between services to reduce gaps with regards to ownership and the utilisation of the escalation process. Assurance is to be gained that the communication between primary care and secondary care services is clear with regards to ownership and responsibilities. Agencies to raise awareness around the understanding of when a person has serious health conditions that the practitioner knows where they can refer the individual to, ensuring that the right agency is involved with that individual, including making use of GP MDT meetings. • **Diabetes management** - The SAB to commission a leaflet for adults, families and carers of adults with diabetes to identify the significant impact of mismanagement of diabetes care and the linkage with mental ill-health. Agencies are to highlight the link between certain serious medical conditions, such as diabetes, and the associated mental health problems and also the impact of managing mental health conditions can have on an adult's physical health. • **Carers** - A review is to take place regarding referrals for Carer's assessments to identify gaps within the system.

		• **Person centred/strength based practice** – Adult Social Care to roll out the new core skills framework/training (new practice framework) for staff which has been set up based on a strength-based approach, using families, friends and networks to support the person. • **Domestic Abuse** - A reminder learning bulletin/ information graphic is to be sent out to all agencies highlighting sibling on sibling domestic abuse and the appropriate referral and support mechanisms available.
Peter Published: 2 May 2023 **Practitioner Event**	Peter was a 74-year-old white British man. He was known to be living between his own home and that of his neighbour and friend, Susan. Professionals visiting him only saw him at Susan's home. Little is known of Peter's history. He appears to have been a private individual who developed a co-dependent relationship with Susan. During the review it was identified that their relationship was recorded as neighbours, friends, partners or as a married couple. In February 2021, Peter was admitted to hospital. On this occasion an ambulance attended Peter at Susan's address following an NHS 111 call for chest pain. When the ambulance clinicians arrived, they found Peter barely conscious with an ongoing chest infection and likely sepsis and possible Covid-19. He was noted to have numerous abrasions, swelling, infected wounds, cellulitis, and oedema to both legs. He was unable to speak properly with crew due to symptoms, was unkempt in old clothes, no personal hygiene maintained and unable to mobilise without help. Peter was conveyed to	Learning related to: • **Self-Neglect and Hoarding -** There were early indicators of potential self-neglect identified by single agencies. This would have been strengthened had there been images shared to enable interagency assessment. Therefore, it is recommended that the clutter image rating, with a full description of the room where the individual is mainly living, is shared with relevant agencies to underpin the assessment of risk for the individual. • There is evidence that Kent Fire and Rescue Service demonstrate good practice in this area, and it is recommended that they share their training across agencies. • **Multi-Agency working -** There was a multidisciplinary team meeting (MDT) to share concerns about Peter. This would have been improved by the inclusion of voluntary agencies and if it had been achieved earlier. It is

	hospital and an ambulance concern form was submitted to KCC Adult Social Care stating that it was unclear what the patient's home state was, but due to his appearance it was clear he was unable to care for himself effectively and the crew were unsure if his home environment was safe for him to return to. He was admitted to hospital for three days. When he was discharged home, there was no social care support set up as Peter declined a care package. There was community health input established. However, G4S (patient transport) made a safeguarding referral as Peter's house was found to be uninhabitable when they transported him home. He was noted to be unkempt and went to Susan's as he said he was waiting for his house to be cleaned. The community nursing team visited Peter weekly, at Susan's home, to provide wound care to his leg. They also made a referral for a short-term community nursing team to provide personal care, and meals twice a day for Peter and Susan. It is reported that they both declined personal care which led to a delay in support being delivered. The safeguarding referrals made in February did not meet the threshold for statutory safeguarding involvement, however, a referral to KCC Kent Enablement at Home Service (KEAH) was made. Once this was in place, Peter was discharged from the *short term* community nursing team. The community nursing team continued to provide wound care. During this time the GP visited the home and saw Peter to be unkempt and made a referral to the Community Trust for assessment. Kent Fire and Rescue Service (KFRS) conducted a safe and well visit for Susan. There were reports of declining KEAH support on occasions, saying he was	recommended that there is a review of how the Integrated Care System Primary Care Network Multi-Disciplinary Team Framework is monitored to ensure that primary care led MDTs include all relevant agencies. • **Safe-Discharge** - The discharge planning included the offer of a care package and the referral to community nurses. This would have been strengthened if the information about the concerns had been considered to enable a home visit to be undertaken to assess where Peter would be living. • **Referral Forms -** It is recommended that SECAmb review how their crews can make safeguarding referrals in line with the KMSAB policy procedures and practitioners guidance. There should be an audit of the outcomes for SECAmb concerns shared to identify further learning and this should be presented as a report to KMSAB. • **Carers -** It was known by some agencies that Peter was a carer, but often either he or Susan would refuse support. This would have been improved if there had been a consistent understanding of the needs of Peter both for himself and as a carer. It is recommended that the KMSAB review what guidance there is for all agencies to be able to identify those who are in a caring role but have specific needs of their own.

	not happy with the service and that he had a friend who was able to shop for him. By April 2021, there were increasing concerns that Peter was not coping. Prior to his hospital admission in February, he had been independent and was able to provide care for Susan. A multidisciplinary meeting was held on 22 April 2021. On 23 April 2021, SECAmb attended a 999 call for Peter and conveyed him to hospital, they contacted adult social care with concerns. Peter died in hospital on 2 May 2021	
Robin Published: 19 April 2023 **Traditional review**	Robin, a white British male, was 27 years old when he died, in August 2020. Robin's family reported that Robin was diagnosed, at the age of six years old, with Autistic Spectrum Disorder. When he was a teenager his family report that his self-care was poor, and he began to severely neglect himself. They reported that when Robin was 15 years old, he received a diagnosis of schizophrenia. As a young adult, Robin was moved to an intensive supported residential adult setting following a period in Psychiatric hospital, which was arranged by Mental Health Services, and then was moved to supported living accommodation. Robin lived alone at the time of his death and had a wish to be independent, Robin's mother tried to maintain contact with Robin, but he struggled to access help from his family or other agencies, most likely as a result of his mental ill health. In late August 2020, during an unrelated Police call to a property in the area, a large quantity of milk bottles was noticed on Robin's kitchen table and there were a large	Learning related to: • **Section 117 Aftercare - legal literacy and information sharing -** There is a need to ensure that section 117 aftercare and support responsibilities are recorded accurately on ICB, KMPT and Local Authority computer recording systems, where individuals are transferred back to Kent following an out of county mental health hospital admission. System checks need to be in place to ensure that individuals are accurately registered so that legal responsibilities for aftercare services to the individual are clear. When an individual is discharged to the care of their GP the risk of not engaging with medication/treatment plans should be carefully noted and informed, along with the status of section 117 arrangements. Where the responsibility for section 117 is to be handed over to the GP, this should be pre-agreed within a Care Programme Approach (where a CPA is required and deemed to be

	number of flies noticed within the property. Neighbours advised that Robin had not been seen for over a week. Enquiries through the Housing Association revealed that they had not been able to contact Robin for a matter of months. The next morning, entry was gained to the property by Kent Fire and Rescue Service (KFRS) and sadly Robin was found to have died, his body being in an advanced state of decomposition. Milk cartons, drinking vessels and alcohol bottles were found in the property. Unopened mail was found dated June and August 2020. The Coroner's inquest report states that 'post mortem decomposition has inhibited any conclusions as to the medical cause of death'. The conclusion remains an open one.	appropriate). This should include the likely relapse indicators, as well as there being an agreed plan to ensure that any mental health deterioration is accurately assessed. • **Not taking medicine** - GP practices to review persons who are not engaging with their medication for any mental health conditions so that relapse indicators can be considered and assessed. This is to include careful consideration of any individuals entitled to section 117 status. • **Specific actions for housing provider/association** - The Housing Association to ensure that staff are equipped, through training and support, to use their professional curiosity at all times in practice to safeguard their tenants. The housing provider needs to be aware and competent in their care and support responsibilities. Workers need ongoing support and training about how to be vigilant about adult safeguarding including self-neglect and hoarding behaviours when observed. • **Self- neglect and hoarding** – Good practice and awareness was demonstrated by the Central Referral Unit of KCC who would not initially authorise the safeguarding closure due to concerns for Robin's welfare and wanting to ensure that the operational team followed the self-neglect policy and arranged a multi-agency professionals meeting. There remained a recommendation for all agencies to

		ensure that staff are competent in using the self-neglect protocols and when a multi-agency meeting should be convened. • **Barriers to engagement -** Agencies to robustly consider how to better engage with hard to reach individuals and evaluate themselves on how they communicate with such individuals, reflecting on a) How flexible is your service provision to individuals with autism, learning difficulties and mental health issues? b) How aware is your service/ agency of what other services do to support individuals with ASD, learning difficulties etc? • **Multi – Agency working -** The Safeguarding Adult Board to seek assurance that there is consistency in Kent and Medway about the role and functioning of Community Safety Partnership meetings, with clear terms of reference and governance arrangements understood by partner agencies regarding the discussion of vulnerable adults, and how this fits into Kent and Medway safeguarding procedures.
Thomas Published: 12 April 2023 **Traditional review**	Thomas, a white British male, was aged 27 when he died. Thomas experienced a difficult early life and was taken into care at the age of 5 years old, due to significant concerns within the family unit, including substance misuse and domestic abuse. Thomas had a diagnosis of borderline personality disorder, bi-polar disorder, features of anxiety disorder and Emotionally Unstable Personality Disorder. His mental ill health was believed to be exacerbated by the use of drugs and other	Learning related to: • **Safe Discharge -** The discharge of patients from mental health hospitals as well as acute hospitals needs to be carefully considered in each case, drawing on all the relevant and proportionate knowledge of historical risks known. Multi-agency working is essential in cases of complexity where an individual is known to a number of agencies. and the hospital needs to ensure that the appropriate agencies are invited to the discharge planning

	psychoactive substances. Thomas had been known to Mental Health services since 2012. His history documents a number of challenges including drug and alcohol misuse, suicidal ideation, mental health hospitalisation, self-discharge from hospital, self-neglect, housing crises and periods of non-engagement with services. Thomas had been a victim of violence and also had offences for assault, burglary, public order, shoplifting, vehicle crime, dating back to 2011 which included serving a prison sentence for 2 years. Thomas also suffered with a leg injury which had been ongoing and unresolved for a number of years for which he was taking pain killers on an ongoing basis. When Thomas was found by the Police, drug paraphernalia was also found at the scene which, when examined later, revealed traces of cocaine, heroin, cannabis and spice (synthetic cannabinoid). There was some medication (Diazepam) on the bedside table, which still had some tablets in the foil wrapping. The Record of Inquest revealed the cause of death to be drug related; specifically Multiple Drug Toxicity.	meeting. KCC adult social care need to be included at an early stage in discharge planning where it is likely that there will be an ongoing role for support going forward. • **Information sharing** - Greater information sharing is required as currently there continues to be complexities due to different recording databases being used across agencies as well as uncertainty around information sharing protocols between them, regarding vulnerable adults. The KMPT Independent Management Report has highlighted ongoing concerns around KMPT's inability to promote the use of community safety partnership meetings due to requiring clarity on information sharing and governance agreements. The SAB need to clarify these information sharing arrangements for all agencies in order for community contextual safeguarding approaches to be enabled in a transparent way**.** • **Homelessness and housing options** - Housing options and needs for adults who are homeless or at risk of being homeless following discharge from mental health units requires more careful and critical evaluation in all cases in order to ensure that the right support is linked to the accommodation type. It is acknowledged that this is a national challenge. Where a vulnerable adult requires alternative housing in the community, this needs to be sought in a proactive,

		timely way in order to avoid unnecessary stress and uncertainty to the individual concerned. Building strong links with community housing teams and support services is essential for professionals. • **Multiagency working** - Professionals need also to make the most of technology to enable remote meetings in a timely manner, as highlighted from the pandemic practices, in order to avoid meetings being unnecessarily cancelled as occurred in this case. Multi-agency meetings could be made easier in this way, which should assist in professionals coming together to discuss complex cases like Thomas also. • **Transition** - Transfer of services between areas e.g., Community Mental Health Teams, Adult Social Care, GP practices, based on residence needs to be carefully considered, and transitions to be planned to avoid unnecessarily destabilising of an individual's mental health further. Clearly there are resource implications for agencies in considering possible delays in transfers and it would require flexibility amongst services to best meet an individual's needs.
Alice Published: 12 April 2023 **Traditional Review**	Alice, a white British female, was aged 84 when she sadly took her own life by drowning in the river just outside her home. Alice had lived with her husband, Fred, in sheltered accommodation. The couple had some friends, and were well known in the housing complex, but there was no known wider family. The housing manager was invited to contribute to the review, he advised that Alice and Fred were pleasant and friendly to others. He described Fred as having adored Alice,	Learning related to: • **Wellbeing Principle and impact of loss -** All agencies to reinforce the importance of wellbeing, and the impact of wellbeing on mental and physical health. For Alice her husband's dementia, her feelings of loss and concerns about her own health led her to take her own life. Listening and understanding the concerns of the individual to ensure that they are heard and understood

	he would "wait on her hand and foot". When he became ill with dementia, she apparently found it hard that their roles were, effectively, reversed. She became the carer and he the cared-for and she struggled with this. They were popular in the building and other residents became increasingly concerned for Alice and tried to assist by inviting her to join in activities. For whatever reason, she rarely did and became increasingly isolated. In early 2019 Alice received a scam telephone call. This was the start of a number of such calls that led to Alice being defrauded of some £5000 over the following year. The scam knocked Alice's confidence. Up until a few months before her death, she and Fred had managed to go out for drives and for coffee. They had a dog which Alice used to walk regularly around their home. Her isolation became more profound when the Covid pandemic began, in March 2020. Several agencies were involved in supporting the couple, but over the period of Covid this was more difficult than usual. It is also notable that the situation for both Alice and Fred deteriorated very rapidly over the few weeks prior to her death.	can be invaluable. • **Impact of financial abuse -** Agencies to promote awareness of the impact of financial Abuse and scamming with the emphasis on the effects on the mental health and confidence of the victim. • **Carers -** Those caring for others in their own homes should have their own care and support needs considered to ensure that they are given as much support as possible in their; sometimes, new, unfamiliar and developing roles.
Folade and Bola **Traditional review**	The SAR in respect of Folade and Bola was not published for reasons of anonymity.	Learning related to: • **Barriers to engagement** • **Referral Forms** - KMSAB partners to review the various safeguarding referral forms used across Kent and Medway. The review is to consider the content, format and language of the forms with a view to moving forward towards a consistent approach**.** • **Multi-agency working -** That the Integrated Locality

		Review role in relation to people with complex mental health is reviewed to ensure its effectiveness.
Ken Published: 21 March 2023 **Day review**	Ken, a white British male was aged 63 when he died. A SAR referral was submitted following the outcome of the inquest into Ken's death. The Coroner concluded that Ken "died at [hospital] on 4 March 2019 of 1a pneumonia with abscesses 1b cellulitis with ulceration 1c peripheral vascular disease. This could be natural causes, but it is rendered unnatural by issues in relation to omissions and failure of care. There were two admissions to hospital when he had hypernatremia and sepsis but on 10 February, he was discharged home alone with leg ulcers and no home assessment and no Community Nurse which, together with a lack of nutrition on his second admission, probably accelerated his death." Ken had a father, brother, a daughter, and he had named an ex-partner as his next of kin when he was admitted to hospital. Ken had cared for his father from 2017 until June 2018, when his father was placed in a care home. According to the GP records, there were intermittent issues between 2013 until August 2017. It was noted that Ken was unable to work, due to epileptic fits, poor compliance with medication and drinking alcohol. In 2017, Ken had his first presentation with the GP regarding the eventual diagnosis of Peripheral Vascular Disease (reduced circulation of blood to a body part other than the brain or heart, caused by a narrow or blocked blood vessel). In January 2018 Ken was seen by the vascular team, they undertook scans and tests and diagnosed extensive stenosis. In January 2019 Ken attended a minor	Learning related to: • **Self-Neglect** - Review the self-neglect training package to reflect learning from SARs and the research in practice report (2020). This should include GP Practice Nurse training. Consider running a multi-agency update day, focusing on self-neglect to support practitioners to work together through the challenges. Build on the work done following other SARs in relation to how the self-neglect policy sets out who can lead a multi-agency discussion to ensure that the responsibilities for self-neglect are accepted across the multi-agency network. KMSAB should seek assurance from system leaders about how they are ensuring there is the capacity within their services to address the growing demands in relation to self-neglect. • **Person centred approach/barriers to engagement** - The KMSAB should ask Healthwatch for support in gaining feedback from the community about the use of holistic assessments within short appointments/episodes of care and how services gain feedback from those who do not 'engage' with services. • **Specific Action for GP/Barriers to engagement -** GP practice staff must be literate about access to funds or services for individuals in need of financial support,

	injuries unit and was found to have necrosis of wounds. He was referred and admitted to hospital with sepsis, hypernatremia and encephalopathy. He was discharged home on 10 February. The referral to the community nurses was not completed. It was noted in the hospital records that his friend would be supporting him. When he arrived home, there was no-one there. The family was contacted for a key. G4S (hospital transport) were concerned the home was not habitable, there was no bed. They reported to the hospital and were advised that Ken would need to go to A&E. G4S made a safeguarding referral and Ken was left at the property. 5 days later, Ken's daughter found him on the floor of the property and called an ambulance. The ambulance crew attended the home, made a safeguarding referral due to the state of the environment and Ken's condition. They conveyed him to hospital where he was diagnosed with sepsis, assessed as malnourished and unable to care for himself. Ken died in hospital on 3 March 2019.	including circumstances in which people can access free prescriptions. The CCG/ICS should ensure that Primary Care Networks/Integrated Care Partnerships have plans in place to demonstrate how they address the wider issues in their practice populations that impact on health. GP Practices should be able to explore why patients, known to have specific care and treatment needs, are not engaging with the service**.** • **Information Sharing -** Between services run by different organisations there must be an agreed approach to how clinical information can be shared effectively to benefit the care and treatment of the patient accessing the different services. • **Safe – Discharge -** KMSAB should receive reports about the impact of the Integrated Discharge System to ensure that there is evidence of improved outcomes for patients being discharged from hospital. This should include consideration of how poor transfer of care concerns can be raised by non-health staff where they do not amount to a safeguarding concern. • **Specific recommendation in relation to patient transport services -** Patient transport services need to have safeguarding policies that enable their workers to make rapid decisions about risks identified when transporting patients. • **Carers -** How do staff access supervision in identifying, and providing support, to address the needs of carers? How does the KMSAB gain assurance about this?

Laurence Published: 15 February 2023 **Traditional review**	Laurence was a white male, born outside the United Kingdom (UK) but who had been a resident in the UK for approximately 10 years. Laurence passed away at the age of 45 years old, in a Kent hospital. Laurence is described by his mother as having been a 'wonderful guy' who had a 'heart of gold' and would 'do anything for anyone'. She described how Laurence was outgoing and had a strong work ethic. He was always in work or searching for work if he was not employed. At the age of 18 years old he was involved in a serious road accident in his birth country which resulted in him being in hospital for a 6-month period. As a result of this accident, he lost the hearing in one of his ears and suffered a frontal lobe brain injury. The SAR referral raised concerns about physical as well as financial abuse, experienced by Laurence over a significant period of time, by a non-related resident living in the same property. The referral also raised concerns regarding self-neglect, as a result, primarily, of chronic alcohol dependency. The referral highlighted Laurence as a vulnerable individual who had multi-faceted health complexities which included; a significant brain injury following an assault in 2011 where he suffered life changing issues; epilepsy, Type 2 diabetes and significant alcohol dependency. In the years prior to Laurence passing away he was, on occasions, living on the streets, due to being fearful to return to his own rental property. Laurence was admitted to hospital at the beginning of February 2020, in a very poor physical state. The hospital	Learning related to: • **Multi-agency working/Information sharing** - There is a need for more robust proactive thinking and action in convening multi- agency meetings to avoid complex multi-faceted cases falling through the net of adult safeguarding procedures. Housing providers have a key safeguarding role to play, alongside their colleagues in social care, health and the Police, in keeping people safe. They are well placed to identify people with care and support needs at risk of abuse, share information and work in partnership to coordinate responses. A more co-ordinated approach between housing and other agencies to share information would have been very useful in this case and would have brought to light previous historic concerns raised by neighbours over a period of time, which in turn would have influenced the action taken by agencies and led to better practice in safeguarding. • In cases where information is being shared across separate Police departments/teams, as well as cross-agency, officers need to ensure that they are not overly reliant on limited recorded information of an incident to assess the risk of the situation. The Police to be mindful, where they were not individually present at an incident, that this may mean that details about a visit to a property are lost or not extensively recorded, resulting in the severity of the risk being potentially diluted in communications. Furthermore, historical information

	raised concern regarding self-neglect and the 'emaciated' physical condition that Laurence was in at the time of admission. Laurence passed away in hospital one month later, on the 8 March 2020, having never recovered following his admission. The cause of his death is recorded as Aspiration Pneumonia, Liver Cirrhosis (alcohol related) and Type 2 Diabetes as a contributory factor.	used may mask the emergence of new issues and risk related to the individual, impacting the effectiveness of information sharing, and hampering efforts to establish a better understanding of the individual's vulnerability. • **Self-Neglect** - KMSAB to monitor the application of the Kent and Medway Self-Neglect Policy and Procedures to ensure that this is being applied and utilised appropriately and consistently, as it was intended. • **Person centred practice** - Professional practice needs to be 'effective' with more consideration to the efficacy of signposting and referring individuals on to services. Agencies to avoid over-ambitious signposting when working with vulnerable persons and consider whether advocacy is required. Consideration needs to be more in line with 'walking with people' to a service (Preston-Shoot (ADASS report), 2020, p.16) and more follow–up put in place by agencies, compared to simply 'referring on' and 'signposting'. • **Legal Literacy** - There is a need to ensure ongoing safeguarding literacy through training amongst all agencies. Professionals need to be competent in knowing when and how to raise a safeguarding alert, and a referral for a Care and Support needs assessment, as well as when to consider and instigate multi-agency self-neglect policy and procedures. Housing authorities and associations need to be clear and

		competent with statutory guidance on how and when to seek advice regarding adults at risk and ensure that all staff have sufficient training on how to recognise vulnerability in tenants. • **Contextual Safeguarding** - the need to ensure a greater contextual safeguarding approach in working with adults who are vulnerable that can look to incorporate all community contacts who could contribute to safeguarding and supporting individuals in the community. This is to be inclusive of working with charities, drop-in services and such like, as well as family members and friends. Training for homeless drop-in centres to be made available and kept up to date, possibly through the local housing authority. • **Documenting Defensible Decision Making** - Record keeping and decision making needs to be defensible by all agencies. Recording needs to be in line with individual agency policies and procedures. Managerial supervision should also be documented, where sought. • **Carers** - multi-agency partners must review how assessments of carer needs are undertaken and raise wider awareness of the need to refer for formal carer assessments. • **Alcohol/substance dependency** - In cases where alcohol or substance related vulnerabilities are evident, the police should be alive to the fact that individuals who are

		regularly intoxicated should not be considered less at risk purely because of the frequency of their intoxication. Any immediate risks associated with their intoxication, including when and how best they can be interviewed, should be factored into decisions made about their care and safety. • Kent Police to consider and be mindful to best practice guidance (e.g. College of Policing) which allows for the taking of initial accounts and statements from individuals, who allege being the subject of a crime but who are intoxicated at the point of contact. • **Referral Forms -** The KMSAB to consider the use of a more unified Safeguarding Referral multi-agency form to be used by all agencies, when raising adult safeguarding concerns.
Elizabeth Eastley Published: 9 January 2023 **Traditional Review**	Elizabeth Eastley was a 72-year-old, white British female. She was resident in self-contained sheltered accommodation. On 17 June 2019, Elizabeth was found deceased in her flat by the accommodation's Scheme Manager. It is believed she had been deceased for some days. She had lived in the accommodation for just over a year and had been allocated the property following an application from housing via the homelessness process. Very little was known about Elizabeth when she applied for housing, she was not registered with a GP. Her previous settled address had been in another county, decades before. She had been using a post office box address for post in a third	Learning related to: • **Legal Literacy** - It is recommended that all agencies responding to people at risk are aware of the available legislation and are confident of their own decision-making protocols and procedures. Including how to escalate concerns when a partner agency's response does not appear to be proportionate to the individual's needs. • **Specific action for housing provider** (legal literacy and KMSAB policies and procedures)- Housing provider staff to receive training on Mental Capacity Act awareness and on Kent & Medway Safeguarding Adult Boards Self-Neglect and Escalation policy and procedures.

	county for many years. Most of the questions about her past and how and why she came to be in Kent remain unknown. The review found that Elizabeth had lived in a hotel for over eight years, when this was sold, she was re-housed temporarily in another hotel by the local housing team, whilst her application for housing was progressed. She remained in this hotel for 18 months. The hotel manager, and the scheme manager where her postal address was, described Elizabeth to be well educated, well-spoken and very secretive. During the 18 months that Elizabeth was resident at the hotel she wrote regularly to the homeless and housing options teams. The letters became increasingly confused in nature. She also wrote to the hotel manager, indicating that she thought she needed to pay for the accommodation and that she would be returning to the previous hotel once it had been renovated. When offered a place in sheltered accommodation, Elizabeth wrote to the homeless officer, stating that she would not be staying for long, so didn't want to take up a property that someone else could have. No safeguarding concerns were raised about Elizabeth's state of mind and wellbeing. Elizabeth was reluctant to move to a new placement which had been identified for her and allocated by home choice. After the placement had been made, Elizabeth wrote a letter of a very concerning nature. As she had already been accommodated, the letter was scanned and saved on file. It has been confirmed that had this been seen by an officer, a safeguarding concern would have been raised. Elizabeth wrote daily to the new scheme manager, she	• **Specific action for local council** (person centred practice and embedding of policy and procedures) - Town A staff to follow their safeguarding policy and employ a person-centred approach, particularly when responding to homeless applications.

	wrote that she was expecting money from her solicitor and believed she was living in a hotel. Enquiries found that the solicitor did not represent Elizabeth, they had also received letters and were concerned. At the housing scheme Elizabeth slept in the communal living room, her belongings remained in boxes in her sparce room. She took food from the communal fridge and left notes for the cost to be added to her hotel bill. Elizabeth declined help and to register with a GP. The scheme manager made a referral to adult social care, which led to a referral to Kent and Medway NHS and Social Care Partnership Trust's (KMPT) community mental health team. Elizabeth had been known to these teams for less than three months prior to her death.	
Leon Published: 12 December 2022 **Practitioner event**	Leon was a 31-year-old white British man. He had lived alone since 2016, following a period of four years when he lived with his mother as he had struggled to live alone due to his drug and alcohol misuse. He had a dependency to drugs since his early teenage years, when he had been subject to a child protection plan. In 2014, his GP records showed he had a diagnosis of mental and behavioural disorders due to multiple drug use and use of psychoactive substances. Leon also experienced physical illness, with a persistent abscess. He reported to professionals that he had an eating disorder. In 2018 Leon stopped taking his antipsychotic medication, without seeking clinical advice, due to weight increase and he reported feeling better not taking them. In early 2019, Leon was in contact with addiction support services, his GP and other agencies. He was having 4 week reviews of his methadone prescription. By August 2019, there were increasing concerns about Leon's	Learning related to**:** • **Self-neglect** - It is recommended that all relevant agencies completing the KMSAB annual agency report, include how they have acted in relation to their initial response to self-neglect situations. • **Alcohol/substance dependency and legal literacy -** It is recommended that agencies must have arrangements in place, e.g., guidance, to support frontline workers in supporting individuals, who have long term addictions, specifically in relation to MCA and Advanced Care Planning**.** • **Multi-Agency working** - It is recommended that additional guidance for the multi-agency safeguarding adult policy and procedures is developed in terms of the wider legal frameworks available to support early interagency intervention for those with care and support needs due to addiction or self-neglect.

	wellbeing. The Pharmacy reported to the Addiction Support Service recovery worker that Leon appeared unwell. Leon also reported to his recovery worker that he was unwell and needed to be in hospital. He reported that he was not eating. The outcome was for a home visit planned for 3 September 2019. On 3 September 2019, the Addiction Support Service worker found no answer at the flat. Leon later contacted the worker and reported that he had no food for 14 days and was asking for medical attention. Leon's father visited and called 999 as Leon was not able to move, was jaundiced and very poorly. The ambulance crew, in consultation with the Single Point of Access assessed that Leon had the capacity to refuse to go into hospital. The plan was for a follow up within 72 hours and a safeguarding referral. The following day, Leon agreed to be admitted to hospital. He was assessed as self-neglecting, had not eaten for 20 days, had an abscess and pressure ulcers. His flat was deemed uninhabitable. Consideration was given to admission to hospital for a mental health act assessment. Subsequently it was deemed that he did not require an admission and had insight into his self-neglect. Leon had returned to his flat by the latter part of September 2019. The local authority attempted a home visit to complete a care needs assessment, Leon was found unresponsive and was admitted to hospital. Whilst in hospital Leon expressed concern about being discharged, due to the state of his flat, managing stairs and shopping. His family reported that he could not cope. During this period there were several services involved in attempting to support Leon. In	It is recommended that a multi-agency meeting is held to assess the risks for the individual themselves when they have been removed from a GP practice due to violence.

	November 2019, Leon became more aggressive when in contact with his GP. This resulted in him being de-registered and placed, by NHS England Primary Care Support, to a new practice. At this time the Local District Council Housing Team followed up their safeguarding concern with KCC adult social care and were informed that the concern had been assessed as not meeting the Section 42 criteria. This led to the Local District Council Housing Team making a second safeguarding referral in relation to poor mobility, not eating and utilities turned off. The outcome was a plan for a joint assessment between mental health and KCC. In December 2019, Leon self-referred to the Emergency Department where he was seen as pale and limping. He had a wound to his heel which was cleaned, dressed and he was given antibiotics. However, Leon did not attend the follow up appointment at the Urgent Treatment Centre. This was not looked into as he was deemed to have capacity. Later that month, Leon was found to have missed 3 days of methadone. It was considered unusual for him not to attend the pharmacy. This resulted in communication between the pharmacist, recovery worker, GP, and Leon's father. The recovery worker visited the home but there was no answer. They contacted Leon's father who had a key but when he visited, he found the flat was locked from inside. He contacted the police who entered the flat and found Leon deceased.	
Phyllis **Traditional Review**	The SAR in respect of Phyliss was not published for reasons of anonymity.	**Multiagency Working -** To review the Multi-disciplinary team process and consider keeping cases open if the risk to an individual has not decreased as a result of the actions agreed in the MDT**.**

		Alcohol dependency - Kent and Medway SAB to consider the roll out of training/awareness with regard to functional capacity and alcohol use. **Self neglect** - Remind agencies to use the Self-neglect policy and to ensure that there is awareness that this applies to people who can't, or won't, care for themselves. **Fire Safety** - Agencies should support Kent Fire and Rescue Service (KFRS) where a safe and well visit has taken place and equipment has been provided. There should be interagency communication to ensure that the equipment is being used. If circumstances change and/or the equipment needs to be re-issued then agencies must contact KFRS to report this. Where equipment is refused, agencies should work together to determine best support arrangements.

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.

It is acknowledged that, due to the covid pandemic and other factors, some of the reviews published over this reporting period relate to more historic incidents. However, the KMSAB does not wait until a report is concluded to share and act upon themes and findings. The inter-relationships between the working groups and the role of the business group enables themes to be raised from SAR decision making stage onwards. These are then addressed in each working groups' work programmes. Previous annual reports have identified the work that has taken place to address the recommendations made in the SARs listed above.

The table below provides a summary of 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
Multi-agency working and information sharing This theme was a feature in (11) 79% of the SARs published during this period. In addition, it is acknowledged that this will be a theme in all reviews as for a mandatory Safeguarding Adults Review (SAR) to be commissioned, it must meet the criteria set out in the Care Act 2014, this includes the condition that *"there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult*".	• KMSAB policy and protocols have been strengthened to provide clear guidance on multi-agency working and how to escalate concerns, including the self-neglect policy. The self-assessment framework seeks assurance from agencies that these policies are shared and understood by relevant staff. • Relevant agencies have 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 included 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. • Although outside of this reporting period, the KMSAB has agreed to develop a Multi-Agency Risk Management Framework, as these have been identified as good practice in other areas.

Identifying and responding to self-neglect and hoarding
 	
This theme was a feature in (8) 57% of the SARs published during this period.
	• 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.
	• The KMSAB Training Programme included a module on self-neglect and hoarding, the module was extended from half a day to a full day's training.
	• The Kent and Medway Multi-agency policy and procedures to support people that self-neglect or demonstrate hoarding behaviour was reviewed in relation to the 'lead agency' procedure and was launched in September 2022. Although after the reporting period for this annual report, the accompanying quick guide was reviewed and updated, to reflect the changes made to the main document.
	• The Board hosted two safeguarding adult review learning events which focused on self-neglect and hoarding.
	• National safeguarding adult awareness week included a dedicated day for self-neglect – Tuesday 22 November 2022.
	• The annual agency report included the following requirement: *all agencies to include how they have acted in relation to their initial response to self-neglect situations.*

Safe-discharge from hospitals This theme was a feature in (5) 36% of the SARs published during this period	Board members are aware of the national and local pressures in relation to hospital discharge and have sought updates through related meetings. In addition, safe discharge falls under priority 5 of the Kent and Medway Integrated Care Strategy**.** • 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 ICB 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. • Healthwatch Kent and Medway conducted a thematic analysis of all feedback received by Healthwatch Kent and Healthwatch Medway concerning people's experiences of NHS hospital discharge from 1 December 2021 to 30 November 2022. As this was mostly from people who contacted Healthwatch proactively, there was a bias towards the negative, accounting for 31 of the 32 pieces of feedback received. • In addition, Healthwatch spoke to ten carers with recent experiences of their loved one being discharged from hospital and 15 professionals from the NHS, social care and the voluntary sector who work with carers or could influence changes in their support. They produced this report and accompanying actions. What happens when the person you care for is discharged from hospital? | Healthwatch Kent
Carers, including raising awareness of a carers right to a formal carer's assessment. This theme was a feature in (5) 36% of the SARs published during this period	• 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? This measure will also be included in the 2023 SAF. • 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. A further joint event is planned for November 2023, to coincide with National Safeguarding Adults Awareness Week. • Communication and Engagement Working Group has supported and raised awareness of 'carers week' June 2023 and produced a social media content plan for all agencies to utilise.
Legal literacy This theme was a feature in (4) 29% of the SARs published during this period.	• 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 reviewed and further updated the escalation policy and raised awareness. • 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.

Working with individuals who are dependent on alcohol or substances. Including co-occurring conditions This theme was a feature in (4) 29% of the SARs published during this period.	• 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). • Alcohol Change's research documents; "Learning from Tragedies – an analysis of alcohol related safeguarding adults reviews" ; "The Blue Light Approach: Identifying and addressing cognitive impairment in dependent drinkers", and "How to use legal powers to safeguard highly vulnerable dependent drinkers", were circulated to all KMSAB and working group members, and included in the newsletter and KMSAB webpages, to reach a wider audience. • In October 2022, Mike Ward from Alcohol Change delivered an open session on alcohol dependency, providing more information on the research listed above. • The Board has commissioned a thematic review of SARs where alcohol dependency is a factor. • The Practice Policies and Procedures Working Group has established a co-occurring conditions task and finish group. • The Communications and Engagement Working Group helped to promote alcohol awareness week 2023. • The 2023 SAF will include the following measure: ○ The organisation promotes awareness of co-occurring conditions (mental health and substance/misuse) and demonstrates processes and person centred practice to overcome any potential barriers to engagement.
Barriers to engagement - how to work with individuals at risk of harm who decline services This theme was a feature in (3) 21% of the SARs published during this period. **Person Centred – Strength based**	• As part of the Board's work to address the theme of barriers to engagement, working groups have also focused on ways to increase engagement, such as making safeguarding personal and making information accessible. For example, the Practice, Policies and Procedures Working Group members developed a dedicated page on the KMSAB website. The Board's how to recognise and report abuse literature has been translated into 26 different languages, in addition to a British Sign Language version, as well as an easy read guide. • The Board hosted a safeguarding adult review learning event on barriers to engagement, as part of this event, delegates co-produced a good practice guide, which was shared with agencies.

practice.
This theme was a feature in (4) 29% of the SARs published during this period
	• The quality assurance working group asked member agencies, through their self-assessment framework return, to evidence the following:
	  ○ The communication needs of individuals are taken into account when engaging with them
	  ○ Making safeguarding personal is understood and applied within safeguarding practice and that the individual and/or their advocate is involved throughout
	  ○ The 'think family' approach is applied when working with individuals
	  ○ 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
	• The KMSAB facilitated open sessions which included 'deaf awareness and safeguarding' and 'working with people with alcohol dependency'.
	• The new KMSAB strategic plan made "promoting person centred safeguarding" a priority area.
	• As part of the annual agency report 2022-2023, agencies were asked to describe what they have done to achieve priority 1, of the previous strategic plan, which includes to listen to the voice of the adult and make sure that safeguarding is personal wherever possible. Good practice examples are included in Appendix 2.

Quality of referrals **referral mechanisms** - the different ways in which concerns are reported to the local authority and the consequences of this. This theme was a feature in (4) 29% of the SARs published during this period.	• 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. • The Safeguarding Adult Review Working Group developed a one page guide on what makes a good referral and why the content of a referral is so important, this was promoted through communication and engagement activity Why the content of any Referral is so important (kmsab.org.uk)

Defensible decision making This theme was a feature in (3) 21% of the SARs published during this period.	• All KMSAB training modules cover defensible decision making and the importance of accurate recording. • When reviewing and updating policies and procedures, the Practice, Policies and Procedures Working Group ensure that defensible decision making is included. • The 2022 Self-Assessment framework included the following standard: ○ Decision making in relation to adult safeguarding is clearly recorded, justified and proportionate.

Glossary of terms

Autistic Spectrum Disorder	Autism is a lifelong developmental disability which affects how people communicate and interact with the world. Autistic people may: • find it hard to communicate and interact with other people • find it hard to understand how other people think or feel • find things like bright lights or loud noises overwhelming, stressful or uncomfortable • get anxious or upset about unfamiliar situations and social events • take longer to understand information • do or think the same things over and over Autism is known as a "spectrum" disorder because there is wide variation in the type and severity of symptoms people experience. More information is available here.
Aspiration Pneumonia	Pneumonia is swelling (inflammation) of the tissue in one or both lungs. It's usually caused by a bacterial infection or a virus. As well as bacterial pneumonia, there are other types of pneumonia, including aspiration pneumonia– caused by breathing in vomit, a foreign object, such as a peanut, or a harmful substance, such as smoke or a chemical. More information is available here.
Bipolar affective disorder	www.nhs.uk "Bipolar disorder is a mental health condition that affects your moods, which can swing from one extreme to another. It used to be known as manic depression." More information is available here.
Care Programme Approach	The term Care Programme Approach (CPA) describes the framework that supports and co-ordinates effective mental health care for people with severe mental health problems in secondary mental health services. In 2008 the Department of Health issued national guidance in the form of documentation entitled 'Refocusing the Care Programme Approach' with the aim of providing a wider focus for all service users which ensures consistency and ensuring that the focus is centred upon a good quality of care. More information is available here.
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
Cirrhosis	Cirrhosis is scarring (fibrosis) of the liver caused by long-term liver damage. The scar tissue prevents the liver working properly. More information is available here.

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.
CONTEST Counter-terrorism strategy	The aim of CONTEST is to reduce the risk from terrorism to the UK, its citizens and interests overseas, so people can live freely and with confidence. More information is available here.
Emotionally Unstable Personality Disorder	Emotionally unstable personality disorder (EUPD) is also known as borderline personality disorder. It is commonly characterised by pervasive instability of interpersonal relationships, self-image and mood and impulsive behaviour. More information is available here.
Integrated Care Board (ICB)	A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the Integrated Care System area.
Integrated Care System	Integrated care systems (ICS) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. More information is available here.
Kent Enablement at Home (KEAH)	Kent Enablement at Home (KEAH) is managed by Kent County Council. It is for people who need support to regain their independence after a medical or social crisis. The service helps adults to do more for themselves at home, by learning or re-learning skills that make them feel safe and happy in their own home. Enablement is a time limited service which is provided free of charge, for up to 6 weeks.
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.

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-Disciplinary Team (MDT) – Primary Care	A multidisciplinary team (MDT) is a group of health and care staff who are members of different organisations and professions (e.g., GPs, social workers, nurses), that work together to discuss the care and treatment of individual patients. MDTs are used in both health and care settings.
Necrosis of wounds	This is where the wound tissue has died and is no longer viable so cannot heal, this tissue is normally cut away until viable tissue is exposed to allow healing.
Personality disorder	A person with a personality disorder thinks, feels, behaves or relates to others very differently from the average person. There are several different types of personality disorder and symptoms vary depending on the type of personality disorder. Mixed personality disorder refers to a type of personality disorder that does not fall into the ten recognised personality disorders. More information is available here.
Peripheral Vascular Disease	Peripheral Vascular Disease, also known as Peripheral Arterial Disease (PAD), refers to the development of narrowing and blockage of the arteries of the limbs and can lead to pain the legs when walking or foot sores. In severe cases it can lead to infection and ultimately amputation.
Prevent	The aim of the Prevent Strategy is to stop people becoming terrorists or supporting terrorism. Prevent tackles all forms of extremism – including both Islamist extremism and far right threats. Prevent has 3 key objectives: • respond to the ideological challenge of terrorism • support vulnerable people and prevent people from being drawn into terrorism • work with key sectors and institutions to address the risks of radicalisation.
Psychosis	www.nhs.uk "Psychosis is when people lose some contact with reality. This might involve seeing or hearing things that other people cannot see or hear (hallucinations) and believing things that are not actually true (delusions)". More information is available here
Schizophrenia	Schizophrenia is a severe long-term mental health condition. It causes a range of different psychological symptoms. Doctors often describe schizophrenia as a type of psychosis. This means the person may not always be able to distinguish their own thoughts and ideas from reality. More information is available here.

Section 117 "Aftercare"	s117 of the Mental Health Act 1983 (Amended 2007) imposes a joint duty on the Local Social Services and the Integrated Care Board (ICB) to plan and provide after-care services, free of charge, to those who have been detained under applicable sections of Mental Health Act (MHA) The ultimate aim of s117 is to enable the individual to remain in the community, with as few restrictions as are necessary, wherever possible. More information is available here.
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.
Sepsis	Sepsis is a life-threatening reaction to an infection. It happens when the immune system overreacts to an infection and starts to damage the body's own tissues and organs. More information is available here.
South East Coast Ambulance Service NHS Foundation Trust (SECAmb)	Respond to 999 calls from the public, urgent calls from healthcare professionals and provide NHS 111 services across the region. More information is available here.
Spinal stenosis.	Spinal stenosis is a term used to describe the narrowing of the spinal canal, which may progress to cause compression of the spinal nerves and can cause back pain and/or leg pain.