Kent and Medway Safeguarding Adults Board

Annual Report – Summary

April 2023 – March 2024

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Section 1. Role of the Kent and Medway Safeguarding Adults Board (KMSAB) – at a glance

Purpose	The Boar[1]d 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.
3 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 are 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.
Board Members	**Independent Chair** – Andrew Rabey **Statutory Partners** – Kent County Council, Medway Council, Kent and Medway NHS Integrated Care Board, Kent Police **Other Partner agencies** - Advocacy People, Department of Work and Pensions, East Kent Hospitals University NHS Foundation Trust, HM Prison Service, Kent and Medway NHS and Social Care Partnership Trust, Kent Fire & Rescue Service, Maidstone and Tunbridge Wells NHS Trust, Medway NHS Foundation Trust, Public Health (Kent and Medway) Dartford and Gravesham NHS Trust, 12 District and Borough Councils across Kent, HCRG Care Group, Kent and Medway Healthwatch, Kent Community Health NHS Foundation Trust, Kent Integrated Care Alliance Medway Community Healthcare, Probation Service, South East Coast Ambulance Service NHS Foundation Trust
Vision	"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".
Strategic Plan Priorities	The KMSAB Strategic Plan 2022 – 2025 is available here. The priorities are 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.

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

Board structure

Executive Group

Delivers the responsibilities as set out in the Care Act 2014 and the supporting statutory guidance

Business Group

- 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 partnerships 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.

Working Groups (WG) – terms of reference available on this link.					
Communications and Engagement (CEWG)	**Joint Exploitation (JEG)**	**Learning and Development (LDWG)**	**Practice, Policy and Procedures (PPPWG)**	**Quality Assurance (QAWG)**	**Safeguarding Adults Review (SARWG)**
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 improve practice and prevent abuse.	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.	Co-ordinates the commissioning, delivery and evaluation of the Board's multi-agency safeguarding adults training programme.	Develops, reviews, and updates the Board's policies and procedures, in line with changes in legislation, guidance and good practice - identified through Safeguarding Adults Reviews, research, audit, practice, performance monitoring and feedback from practitioners or those with lived experience.	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.	Delivers the Board's statutory responsibility to conduct Safeguarding Adults Reviews and holds agencies to account for improvement in practice.

Section 2. Priorities and Achievements

This section details how we delivered against our strategic priorities during 2023 – 2024. It is recognised that activity can cut across more than one priority.

Priority - Promote Person Centred Safeguarding - Putting adults at the centre of our work.

Objectives:

- Raise awareness of adult safeguarding to ensure that people understand what abuse is, how to recognise the signs and how to seek help.
- Enable residents of Kent and Medway to voice their opinions on the work of the Board.
- 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.
- 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.

What we achieved:

National Safeguarding Adults Awareness Week	• Members supported National Safeguarding Adults' Awareness Week, raising awareness of adults safeguarding within their organisations and with public. More information on the week is available here. • To support agencies, the Communication and Engagement Working Group updated the Board's social media package and the toolkit of awareness raising materials. • KMSAB partner agencies participated in the week by sharing the social media messaging and hosting events within their agencies. • Acknowledging that some people do not access digital content, public facing events also took place during the week, such as information stands is shopping centres, hospitals and talks at community events. • There were 6214 visits to the KMSAB webpages during the week, with 282 clicks to the "worried about and adult?' pages for the public.
'Who cares for the carers?' event	• The Board and the Community Safety Partnership hosted a half-day joint seminar to share the learning from Kent and Medway's recently completed Safeguarding Adults Reviews and Domestic Homicide Reviews. • Over 90 practitioners attended the event, which received positive feedback. • The event, and the distribution of the resource pack beforehand, saw 953 visits to the 'information for carers' pages on the

	KMSAB website in one week.
Engagement with local communities	• During 2023/2024, a brief article, titled "Are you concerned about an adult?", continued to be included in every edition of Medway Matters and December issues of Community Ad magazine. • Members of KMSAB and the Business Unit hosted a stand at the Kent Police Open Day on 2 July, where 7000 members of the public were in attendance. • As part of their work, the Independent Chair of the Board, Board Manager and the Board's Business Development and Engagement Officer, continued to meet with charities, voluntary sector and other community leads. • To support partner agencies and others to facilitate conversations about adult safeguarding the communication and engagement group developed a 'key messages and conversations starters guide'. The document also provides links to key resources and contacts.
Support for relevant targeted awareness campaigns	• Support for carers and carer stress have been identified as themes in Safeguarding Adults Reviews and Domestic Homicide Reviews. Another prevalent theme is alcohol and substance dependency and co-occurring conditions. In response to this, the Communication and Engagement Working Group produced materials to support the 'national carers week' and 'alcohol awareness week' campaigns. These were shared by KMSAB partner agencies. Following the campaigns, there was an increase in visits to the KMSAB webpages.
Professional Curiosity	• To support practitioners, the KMSAB developed professional curiosity webpages, providing a central repository for guidance, resources, videos and useful links. • Between 27 July 2023 (the date the website was published) and 31 March 2024 the content was accessed 4994 times. • The Quality Assurance Working Group asked each agency how they embed 'professional curiosity' and what processes are in place to allow them to reflect on their practice and receive appropriate supervision, as part of their Annual Agency Report update.
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 to determine what support may be required to enable them to contribute.
Accessible communication	• The KMSAB leaflet which explains how to recognise and respond to abuse is available in 26 different languages. These are promoted widely at in person events and through social media. • The leaflet is also available in easy read and British Sign Language (BSL) friendly formats. • Appreciating different learning styles and accessibility preferences, the KMSAB also makes videos available, such as the

	'tricky friends' animation and Hampshire's adult safeguarding animation. • The Board's website and materials are regularly audited to ensure that they meet the accessibility requirements for public sector bodies.
Meetings with Healthwatch Kent and Healthwatch Medway	• Healthwatch leads met with the Independent Chair of the Board and the Board Manager during the year. The meetings provided the opportunity for Healthwatch to share insights into information that they have received on key areas of safeguarding. • This information is triangulated with other information received by the Board to support existing work or to identify new areas of focus.
Awareness of Advocacy Services	• During 2023-2024 the Board continued to promote advocacy services. In addition to features in the newsletter and advocacy representation at Board meetings: ○ The Advocacy People hosted a Board open session to raise awareness of the statutory advocacy services available across Kent and Medway. ○ The Board's self-assessment framework included a standard relating to advocacy.
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 must enhance their involvement, choice and control as well as improving quality of life, wellbeing and safety. • The Board continued to update and promote their dedicated MSP webpages. The pages were accessed 7215 times between 1 April 2023 and 31 March 2024 • To measure how agencies embed MSP in practice, relevant standards were added to the self-assessment framework 2023.
Consent to a safeguarding referral.	• It is best practice that wherever possible, and safe to do so, consent should be sought from the individual the safeguarding concern relates to, before a referral to the local authority is submitted. • As qualitative data received by the Board indicated that this was an area for development, improvement activity took place, including: ○ Medway Council and Kent County Council amended their online referral forms, to make the views and wishes of the adult a mandatory reporting field. ○ The Board reinforced the message through policy and awareness raising activity. ○ The impact of this was measured though quality assurance activity.
Provide stakeholders	• In addition to supporting safeguarding adults awareness week, agencies are encouraged to share messages about adult safeguarding throughout the year.

with tools to help them raise awareness of the board and local safeguarding arrangements	• To support agencies with this, the Communication and Engagement working group continued to update and promote their toolkit of awareness raising materials. The toolkit includes posters, social media graphics, signature banners and video files (short graphics used on social media to catch attention). • The Board's newsletters, training, open sessions and one to one meetings, are also used to promote the toolkit. • The Kent Integrated Care Alliance, an independent body who support Local Care Providers in Kent, shared messages within their network on carers' responsibilities, how people are identified as carers, carers' stress and the impact of this.

Priority - Strengthen System Assurance – Checking that organisations are working well together to support adults

Objectives:

- Establish a mechanism to identify system issues and risks to provide assurance to Kent and Medway residents that effective safeguarding arrangements are in place.
- Improving public understanding of the roles and responsibilities of partners.
- Improving interagency understanding of the roles and responsibilities of other partner organisations.
- Agencies discharging their respective responsibilities to safeguard people.
- Ensure effective Board to Board/Partnership arrangements.
- Ensure an effective functioning Board with appropriate support structures.

What we achieved:

Quality assurance framework	• During 2023-2024, Quality Assurance Working Group (QAWG) members reviewed and continued to implement the quality assurance framework, which sets out the methods and tools used to measure the effectiveness of partners' safeguarding activity. • The Chair of the Quality Assurance Working Group is Lee-Anne Farach, Director of People & Deputy Chief Executive, Medway Council.
Self-Assessment Framework	• One of the most comprehensive quality assurance tools utilised by the Board 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. • 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. • A total of 35 agencies were required to complete the SAF.
2022 Self-Assessment Framework	• In addition to the 2023 SAF, members of the Quality Assurance Working Group continued to measure compliance against the 2022 standards, detailed in the last annual report. These standards were based upon learning from Safeguarding Adults Reviews. • At the time of writing, of the 30 agencies who completed the SAF, 13 agencies had amber standards outstanding (33 standards in total). Agencies have until October 2024 to reach the standard required, following this, the Independent Chair will write to the agencies concerned to advise of the actions outstanding and associated risk.
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.
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 31 responses were submitted. Appendix 2 provides some good practice highlights from the responses received.
Use of Qualitative and Quantitative data	• The Board is cognisant that work to develop a data dashboard has not progressed at the pace expected and this work will be a priority for 2024/5 to ensure it is delivered within the timeframe allocated in the strategic plan. • Regular data is received from Medway Council and annual data is received from KCC adult social care. • To mitigate, the Board does seek and utilise qualitative data, to identify good practice, system issues and risks, and to provide assurance. Many of these data sources have been referenced throughout this annual report.
Continuous improvement cycle	• The Board utilises the principles of continuous improvement and this is reflected in the way working groups are configured. **Intelligence** is used to identify where action is required, **action is taken** (such as amending policy, training delivery, awareness raising and escalation). **Assurance is then sought** from agencies, through mechanisms such as the SAF. Following this, **change is measured** (for example through data, feedback from staff and good practice examples). If there is insufficient change more information is sought on the barriers to change so that the cycle can start again.

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 ○ Multi Agency Risk Assessment Conference (MARAC) • 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. • Kent and Medway Public Health representatives attend and contribute to Board meetings. • 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.
Right Care, Right Person	• The 'right care, right person' approach was launched in Kent on 2 April 2024. The initiative between police forces nationally and the NHS is designed to ensure that when there are concerns for a person's welfare linked to mental health, medical or social care issues, the right person with the right skills, training and experience will respond instead of the police being the default first responder. • The KMSAB worked with multi-agency partners during the implementation phase, this included the Independent Chair of the Board facilitating 3 multi-agency practitioner workshops.
KMSAB Executive Meetings	• The Board Executive Membership met on 4 occasions in 2023-2024.
District Safeguarding Leads Meeting	• To improve the sharing of information, intelligence and best practice between the Board and 12 districts councils across Kent, a quarterly Adult Safeguarding District Safeguarding Leads meeting was established. The meeting is Chaired by the Chief Executive of Maidstone Borough Council.
No surprises principle and Escalation Policy	• As detailed in the strategic plan, the Board follows the 'No Surprises' principle whereby safeguarding partners, as part of collaborative working, keep each other informed of significant or relevant matters, especially those that may arise in public, in relation to their safeguarding responsibilities. • The Board continued to raise awareness and promote the use of the revised escalation policy for resolving practitioner differences.
Quarterly Contextual Safeguarding Report	• A contextual safeguarding report is shared and discussed with relevant partner agencies at the quarterly Joint Exploitation Group meetings. • These reports provide district level intelligence on areas of concern in each locality, which may impact on children and adults at risk, and what actions are in place to mitigate the risk, for example increased police presence or targeted work.

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. • In Kent and Medway 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 the area. Their work is focused on promoting person centred safeguarding, ensuring appropriate and timely support is provided to those at risk of radicalisation. • In February 2024, a hybrid conference on tackling Hateful Extremism across Kent and Medway was held and over 250 in person or online delegates attended.

Priority - Embed Improvement and Shape Future Practice -Helping the organisations we work with to keep getting better.

Objectives:

- The voice of the person is listened to and there is evidence that their wishes are respected.
- Learn from experience and have a workforce that is knowledgeable and confident in the application of their safeguarding adults roles and responsibilities.
- Develop the right balance between support and challenge aimed at system improvement.
- Partners will be able to contribute to safeguarding at regional and national level.

What we achieved:

Kent and Medway Safeguarding Adults Board Policy and Procedures	• The Board's main policy, "Multi-Agency Safeguarding Adults Policy, Protocols and Practitioner Guidance for Kent and Medway", is supplemented by a number of additional policies, which are updated in accordance with a policy update schedule.
	• During 2023/2024, Practice, Policy and Procedures Working Group members completed their review and revision of the following documents:
	  ○ Kent and Medway Safeguarding Adults Board Protocol: When Adults at Risk Abuse Each Other
	  ○ Kent and Medway Safeguarding Adults Board A Quick Guide to Identifying and Responding to Self-Neglect and Hoarding

	○ Protocols for Kent and Medway to Safeguard Adult who are at Risk of Exploitation, Modern Slavery and Human Trafficking. • 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. • Additionally, as homelessness had been identified as an emerging theme within Safeguarding Adults Reviews and referrals, a task and finish group was established to develop a practitioner resource.
Monitoring of Safeguarding Adult Reviews (SAR) Action Plans	• As detailed in section 3, learning is identified and responded to at all stages of the SAR process. • **Single agency recommendations identified by the SAR author** - At the conclusion of each SAR, an action plan is completed to address the recommendations for improvement set by the independent author. The actions are quality assured by the SAR working group to make sure that they are specific, measurable, achievable, realistic and have clear timescales (SMART). Updates are submitted to the SARWG for approval and sign off. They must have the appropriate evidence to support. • **Thematic Recommendations -** Where a review identifies recommendations and learning that is more systemic or thematic, this is added to the Board's thematic action plan. Each theme has a list of the SARs where the theme was a feature and a summary of the actions taken by the Board and others system partners (such as public health) to address the recommendation/theme. • The themes are shared when a SAR is commissioned, so that we can build on learning rather than replicate it. 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. They also provide the opportunity to highlight and disseminate good practice. An example of this is SAR Akram, as this SAR progressed and more information was received, positive learning was established. In addition to publishing the report and sharing the reflective practice briefing, an open session took place. To enhance reach, this session was recorded and is available here. • Many of the quality assurance tools designed by the Board ask agencies to highlight good practice examples so that these can be shared, as they can be an impactful method of learning. Examples of good practice are regularly included in the Board's newsletter and training.
National SAB Managers 'We see you – we hear you' Excellence	• The 2023 National Safeguarding Adults Excellence Awards were led by Bexley SAB, on behalf of the national network of SAB managers. • Kent and Medway nominees won in 2 categories. A social worker won the Empowerment Champion (individual winner) category and the KCC Community Warden Service, Tonbridge, Maidstone and Malling won the Empowerment and Protection Champion (Team Winner) • Additionally 10 other individuals/teams were nominated.

Awards	
Learning from SAR referrals that do not meet the criteria	• As detailed in section 3, when a SAR referral is received, the Board business unit will establish which KMSAB partner agencies have been involved with the individual and will send them a summary of agency involvement form to complete, with relevant and proportionate information relating to their involvement with the adult. • The referral and summary of agency involvement forms are considered by the SAR working group's decision making panel. • This process is very robust and is similar to a 'rapid review' for each referral. Where a SAR is not commissioned, the group will still highlight any good practice and identify any single agency learning. There may also be occasions where learning is identified that whilst not meeting the SAR criteria, would benefit from awareness raising. • Any single agency actions are monitored by the group until they are complete.
Recruitment of KMSAB Learning and Development Manager	• During 2023/2024 the KMSAB made the decision to move from commissioning a training provider, to deliver the Board's training offer, to recruiting a full time learning and development manager. • Following a successful recruitment campaign, two part time managers commenced their job share in November 2023. • They worked closely with Learning and Development Working Group members to develop a training and development proposal, designing course content and materials to commence training in April 2024.
SAR Video and Reflective Learning Briefings	• To support the sharing of SAR learning, and in acknowledgement of individuals' different learning styles and preferences, published SAR reports are now accompanied by a short video summary. The videos are available on the following link: Kent and Medway SAB - Safeguarding Adult Reviews (kmsab.org.uk) • 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.
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 410 people/agencies subscribe to the KMSAB newsletter (a 19% increase from 2022/2023), with many cascading it further within their organisations.
Regional and National Forums	• The Independent Safeguarding Adults Board (SAB) Chair attends the national SAB Independent Chair Network and chairs the regional meeting of Independent SAB Chairs and SAB Managers.

	• The Board Manager attends the regional meeting and also attends the national SAB Manager's network, attended by 170 SAB managers.
	• These network meetings are extremely beneficial and provide the opportunity to share information, resources, best practice, learning and collaborate on joint projects. They also provide the Boards with a stronger national voice, should they wish to escalate concerns to relevant government departments.
	• The KMSAB used the national SAR escalation protocol to escalate the following:
	  ○ SARs where out of area placements were a feature
	  ○ Risks associated with the non-availability of specialist autism placements.

Self Neglect and Hoarding Learning Events	• The KMSAB learning and development managers hosted two half-day self-neglect and hoarding Safeguarding Adults Review workshops in March 2024, with over 140 delegates in attendance. • Feedback received indicated that the sessions were valuable, both in terms of content and in providing multi-agency networking opportunities.
Multi-agency risk management framework (MARM)	• In response to SAR findings and recommendations, Board members agreed in principle to a multi-agency risk management process (MARM). Members of the Practice, Policies and Procedures Working Group developed a MARM framework, which was circulated consultation. • The MARM framework is designed to support anyone working with an adult where there is a high level of risk of harm and the circumstances sit outside the statutory adult safeguarding framework, but where a multi-agency approach would be beneficial. It enables a proactive approach which helps to identify and respond to risks before crisis point is reached. It can be initiated by either statutory or non-statutory organisations.
Embedding new SAR policy	• During 2023-2024 members worked to the revised SAR policy, which was designed to ensure greater clarity, consistency, and a focus on establishing the lessons in a timely and rigorous way, without compromising on quality. Of the 12 SARs commissioned, 6 utilised the day and/or practitioner methodology and one will be included in a thematic SAR.

Section 3. Safeguarding Adults Reviews

3.1. 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)[2]

More information on the SAR process is available here.

3.2. Purpose of a Safeguarding Adults Review

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

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

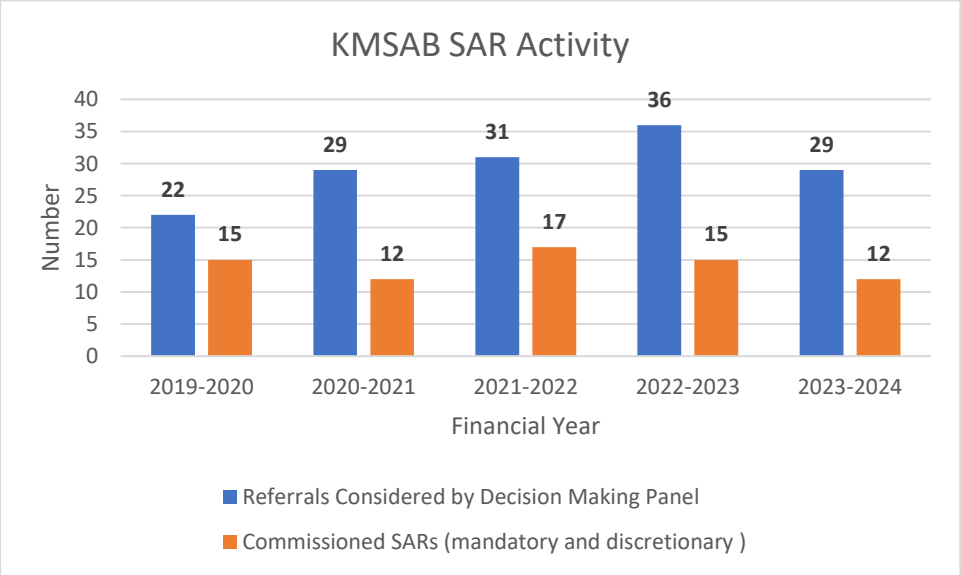
3.3. Safeguarding Adults Review Activity

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.

2023/2024 saw a reduction in the number of SAR referrals received and commissioned.



The KMSAB received 29 new SAR referrals between April 2023 and March 2024, of these:

- 11 mandatory SARs were commissioned.
- 1 discretionary SAR was commissioned.
- 17 did not meet the criteria and no further action for the Board was required.

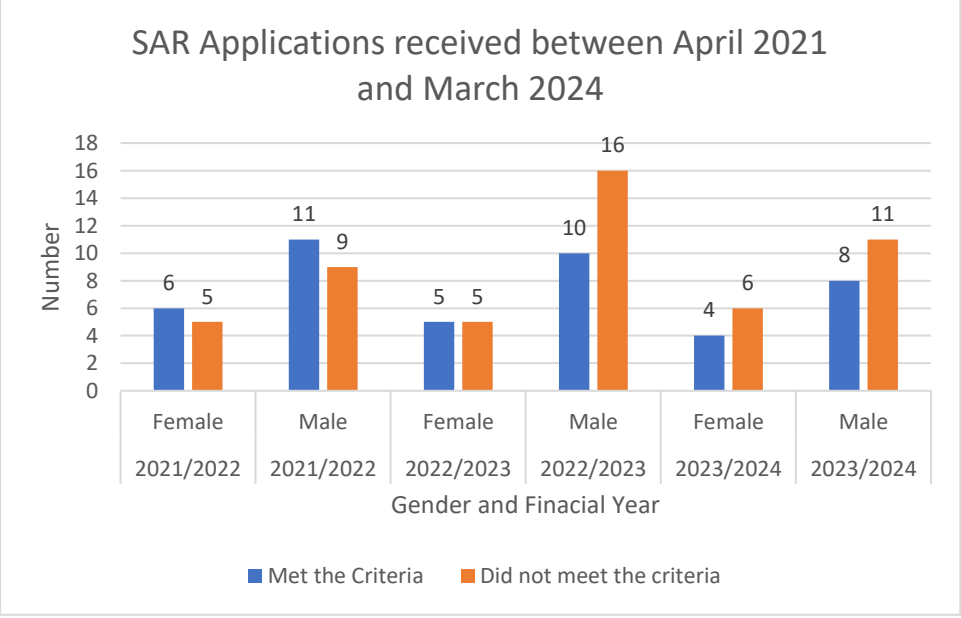
The summary of agency involvement returns allow members to consider information that may not have been available to the person who made the SAR referral, and, in many cases, the additional information evidenced that agencies did work together, so the criteria was not met.

Gender - SAR applications received between April 2021 and March 2024[3]

There continues to be more SAR referrals for males, including people who identified as male. Of the 29 SAR referrals received between April 2023 and March 2024, 66% were for males and 34% for females. In 2021/2022 the proportion was 35% female to 65% male. In 2022/2023 the proportion was 28% female to 72% male.

The gender breakdown of SARs commissioned reflects the referral rate, with 67% of SARs commissioned relating to males and 33% females.

	Referrals (Number)	Referrals (Percentage)	SARs commissioned (Number)	SARs Commissioned (Percentage)
2023/2024				
Male	19	66%	8	67%
Female	10	34%	4	33%
2022/23				
Male	26	72%	10	67%
Female	10	28%	5	33%
2021/2022				
Male	20	65%	11	65%
Female	11	35%	6	35%



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

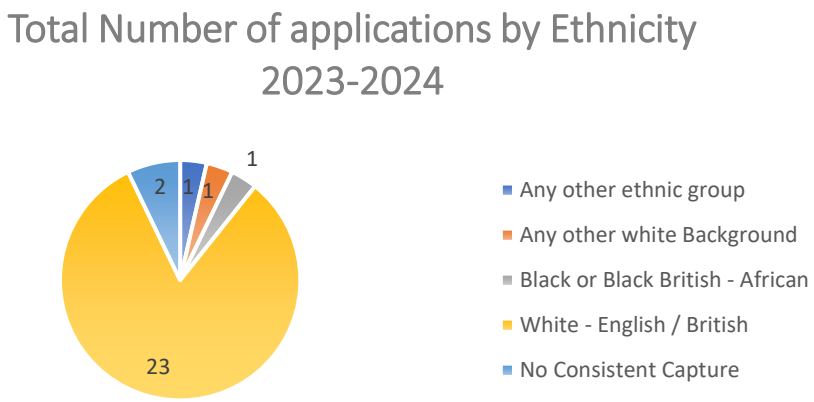
The conversion rate of application to commissioned SARs for female and males is consistent this financial year, with 42% conversion rate for males and 40% for females. In 2022-2023 the rate was 50% for males and 38% for females.

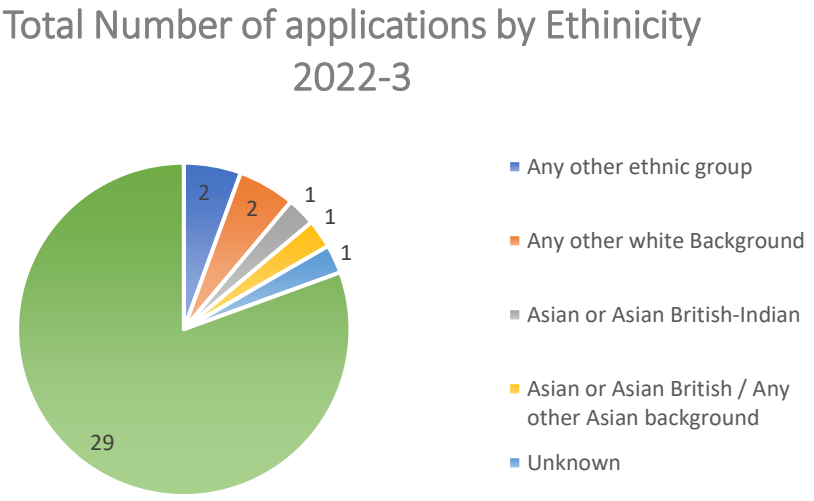
Ethnicity - applications received between April 2023 and March 2024

Of the 28 referrals received, 82% of the individuals were 'White British-English'. 4% any other ethnic group, 4% any other white background and 4% Black or Black British – African. 67% 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	1	1	100%
Any other white background	1	1	100%
Black or Black British – African	1	1	100%
No consistent data capture[4]	2	1	50%
White British/English	23	8	35%

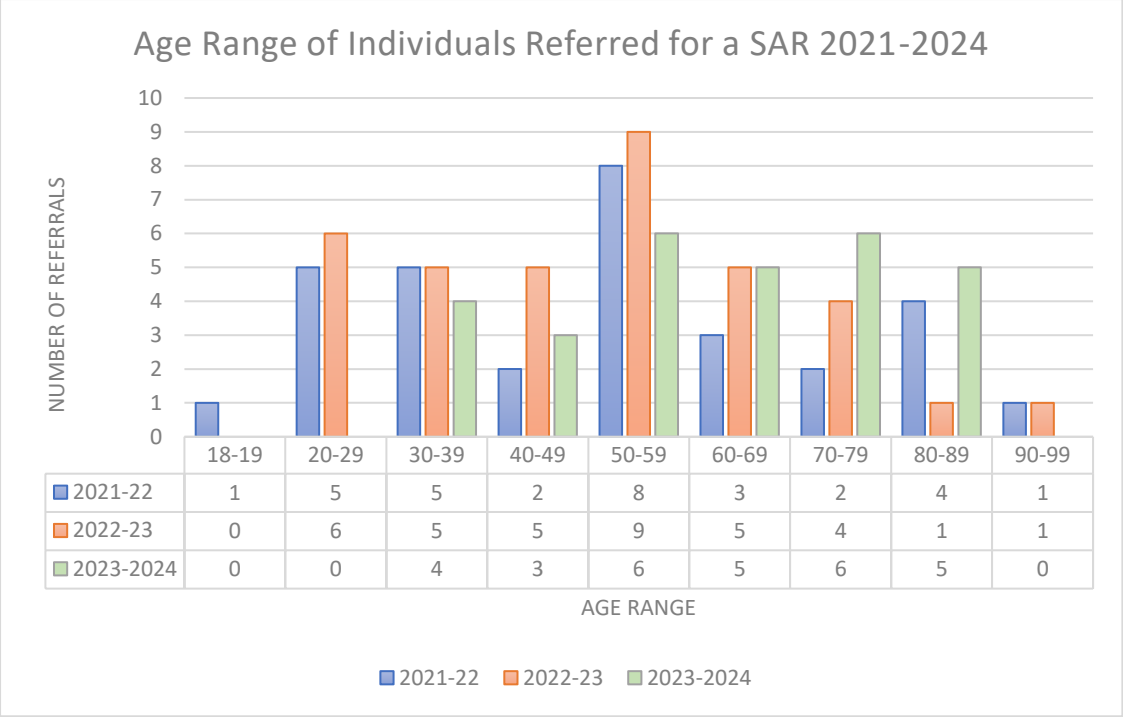
[4] The ethnicity data captured by agencies differed, with no consensus.



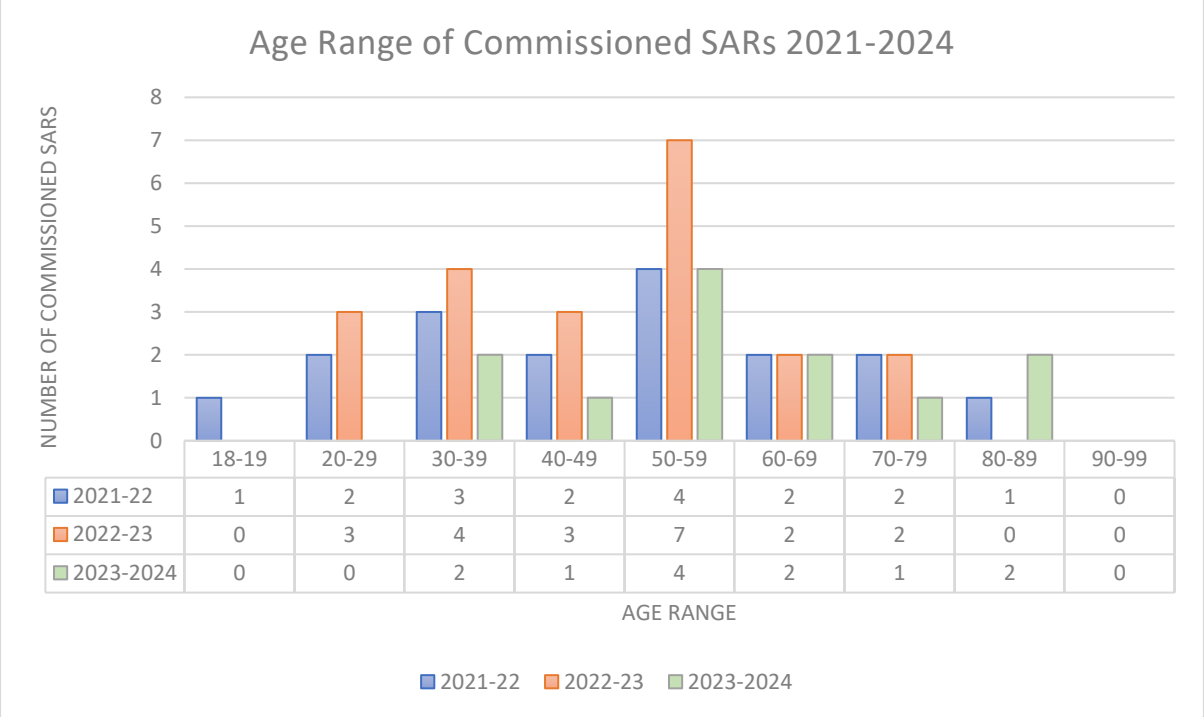


Age – SAR applications received between April 2023 and March 2024

Of the SAR referrals received, the most frequent categories were the 50-59 age range (as previous years) and the 70-79 range. As expected, due to the numbers received, most SARs were commissioned relating to individuals aged between 50-59. It is noted that within the 70-79 age range, only one of the 6 SAR referrals met the criteria. The Board manager has reviewed the SAR decisions in respect of this category to ensure that there is no unconscious or other bias, this was found not to be the case and the decisions are appropriate, given the additional information available to the decision making panel.



	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
2023-2024	0	0	4	3	6	5	6	5	0



	18-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99
2021-22	1	2	3	2	4	2	2	1	0
2022-23	0	3	4	3	7	2	2	0	0
2023-2024	0	0	2	1	4	2	1	2	0

3.4. Completed Safeguarding Adults Reviews

Completed reviews are available on the KMSAB website. Since the last annual report, the following SARs have been published: **All names are pseudonyms to protect the identity of those concerned.**

Rivers - Full report	Summary
Published: 11 September 2024	**Methodology**: Day Review
Recommendations related to: - • Safe-discharge from hospital • Safe handover of care, information sharing • Single agency action: effective training • Involving Individuals and their families in decision making	

Glen - Full report	Summary Video
Published: 4 September 2024	**Methodology**: **Traditional review**
Recommendations related to: - • Self-neglect • Legal literacy and Making Safeguarding Personal • Advanced decision making, including involvement of families	

Stuart - Full report	Summary
Published: 4 September 2024	**Methodology**: Day Review
Recommendations related to: - • Legal literacy and strengths based practice • Safe-discharge • Whole family approach, carers assessments and wellbeing principle • Domestic abuse • Advocacy • Awareness of policies and procedures	

Linda - Full Report	Summary Video
Published: 3 June 2024	**Methodology**: Traditional review
Recommendations related to: - • Safety and risk assessments • Professionals/multi-agency meetings • Capacity/legal literacy • Self-neglect	

Nik - Full report	Summary Video
Published: 21 August 2024	**Methodology**: Traditional review
Recommendations related to: - • Legal literacy • Making Safeguarding Personal, trauma informed practice and safe discharge • Suicide prevention and mental capacity • Deprivation of Liberty Safeguards (DoLs).	

Charlie - Full Report	Summary
Published: Published 10 October 2023	**Methodology**: Traditional review
Recommendations related to: - • Suitability of informal carers • Self-neglect and hoarding	

Adam - Full Report	Summary Video
Published: Published 24 May 2024	**Methodology**: Traditional review
Recommendations related to: - • Professional curiosity/think family • Self-neglect and hoarding	

Olivia - Full Report	Summary
Published: Published 15 February 2024	**Methodology**: Traditional review
Recommendations related to: - • Awareness of Learning Disability Review Guidance provided by NHS England • Workplace Violence	

Derek- Full Report	Summary Video
Published: Published 24 May 2024	**Methodology**: Traditional review
Recommendations related to: - • Safe discharge • Police welfare visits • Deprivation of liberty safeguards • Self-neglect and records of decision making	

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Akram - Full Report	Summary Video
Published: Published 27 October 2023	**Methodology**: Traditional review
Recommendations related to: - • **Sharing good practice from this review** • **Multi-agency working - contact information** • **Commissioning of semi-independent living**	

Ethan - Full report	Summary
Published: Published 29 September 2023	**Methodology**: Traditional review
Recommendations related to: - • Community Treatment Orders • Mental Health Act and Section 117 • Co-occurring conditions • Commissioning and information sharing	

Terry - Full Report	Summary Video
Published: Published 10 October 2023	**Methodology**: Day review
Recommendations related to: - • Self-Neglect and Legal Literacy (application of the Mental Capacity Act) • Co-occurring conditions, multi-agency working and evidenced decision making	

Norman - Full report	Summary
Published: Published 16 July 2024	**Methodology**: Traditional review
Recommendations related to: - • Self-neglect • Legal literacy, mental capacity • Involving family members, carers assessments • Co-occurring conditions and safe discharge • Specific Learning for the Department of Work and Pensions (DWP)	

Nora - Full report	Summary
Published: Published 7 August 2024	**Methodology**: Traditional review
Recommendations related to: - • Specific learning for hospitals in relation to Multiple Sclerosis pathways and business continuity • Specific learning for Adult Social Care in relation to reviews of care plans • Carers assessments • Multi-agency working • Specific learning for GP in relation to safeguarding thresholds and training	

Stephen - Full Report	Summary
Published: Published 24 May 2024	**Methodology**: Traditional review
Recommendations related to: - • Trauma informed practice • Commissioning and legal literacy • Autism training • Transition planning • Dynamic Risk Register and evidenced decision making • Placement availability • Long term management of complex cases	

The Board is reliant on partner agencies to share the learning from reviews and incorporate these into practice. The effectiveness of this is measured through the Board's self-assessment framework.

As previously highlighted, 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 learning to be raised from SAR decision making stage onwards. Themes 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 additional actions taken during 2023/2024. These are in addition to activity that individual agencies undertake and the information provided in section 2.

Recommendation/Theme	Actions taken by the Board

Legal literacy
 	
This theme was a feature in (9) 60% of the SARs published during this period.
	• The 2023 self-assessment framework included 8 standards relating to legal literacy.
	• The KMSAB continued to promote legal literacy though information shared in the newsletter.
	• The learning and development managers designed the course content for the following multi-agency learning modules, which commenced in April 2024.
	  ○ Adult legal literacy
	  ○ Domestic abuse
	  ○ Collaborative working including multi-agency section 42 enquiries
	  ○ Self-neglect and hoarding workshop
	  ○ Self-neglect and hoarding workshop for non-statutory partners
	• The Board continued to promote the KMSAB Legal Framework and Interventions guidance document, which provides a summary of the different enforcement powers that can be used, as appropriate.
	• A executive functioning grab sheet was shared widely and added to the KMSAB website.

Identifying and responding to self-neglect and hoarding This theme was a feature in (7) 47% of the SARs published during this period.	• The Practice, Policies and Procedures Working Group (PPPWG) reviewed the Kent and Medway multi-agency policies and procedure to support people that self-neglect or demonstrate hoarding behaviour and the accompanying practitioner guide to ensure that it fully supports frontline practitioners to be able to work with adults at risk who appear to be self-neglecting and/or hoarding. As part of this review, PPPWG members sought feedback from frontline practitioners through a questionnaire, which assisted with understanding how the policy is used in practice, what works well and any barriers that practitioners experience when using the policy. • Articles promoting the KMSAB self-neglect and hoarding policy, and sharing best practice in relation working with people who self-neglect and/or hoard, were included in the newsletter throughout the year. This included a community care article on "Ten top tips when working with adults who hoard" . • The KMSAB Learning and Development Managers hosted two free half day SAR learning events in March 2024, focusing on how to support people experiencing self-neglect and hoarding.
Multi-agency working and	• Activity to address this theme has been summarised in section 2 – "Strengthening system assurance,

Recommendation/Theme	Actions taken by the Board
information sharing This theme was a feature in (5) 33% of the SARs published during this period.	checking that organisations are working well together to support adults". • Additionally, the development of the multi-agency risk management framework, detailed in priority 3, was in response to SAR findings and learning from best practice nationally.
Safe-discharge from hospitals This theme was a feature in (5) 33% 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 at Board and related meetings. In addition, safe discharge falls under 'shared outcome 5' of the Kent and Medway Integrated Care Strategy**.** • The 2023 self-assessment framework included the following standard, 'the organisation has processes in place to determine additional vulnerabilities and act where appropriate in relation to planning/discharge planning'. As of June 2024, 53% of the 35 agencies that completed the SAF had achieved a green rating for this standard. • The KMSAB Independent Chair, Board Manager and designated nurses attended the ICB Systems Quality Group to share learning from SARs where safe discharge was a theme and to discuss improvement activity. • SARWG members commissioned a discharge audit. This will identify areas of development, strength and good practice for each provider, which can be collated, considered and shared to support improvement work. • The Board's newsletter promoted relevant guidance and best practice. • KMPT, KCC and Medway Council are working on a 'clinically ready for discharge multi-agency policy and practice guidance.'
Carers, including raising awareness of a carers right to a formal carer's assessment. This theme was a feature in (4) 27% of the SARs published during this period	• Activity to address this theme has been summarised in section 2 – "Promote Person Centred Safeguarding - Putting adults at the centre of our work." Additionally, • The self-assessment framework included the following measure*: "The agency meets its legal obligations under the Care Act so that carers are referred for a Carer's Assessment, or the need for a Carer's Assessments is highlighted to the Local Authority"*. As of May 2024 53% of the 35 agencies that completed

Recommendation/Theme	Actions taken by the Board
	the SAF had achieved a green rating. • SAR working group members developed a Domestic Abuse - Sibling on Sibling Awareness Briefing which was shared and added to the Board's website. • KMSAB hosted an open session in March on carers: an anti-racist perspective • Board members were required to produce a statement of assurance to the SARWG detailing measures in place to address the findings relating to this theme.
Working with individuals who are dependent on alcohol or substances. Including co-occurring conditions This theme was a feature in (4) 27% of the SARs published during this period.	• 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", continued to be promoted by the Board and are available on KMSAB webpages, to reach a wider audience. • The SARWG commissioned a thematic review of SARs where alcohol dependency was a factor. This is due for publication by December 2024. • The following measure was included in the 2023 SAF "*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."* As of June 2024 53% of the 35 agencies that completed the SAF, had achieved a green rating for this standard.
Think Family and Person Centred – Strength based practice. This theme was a feature in (4) 27% of the SARs published during this period	• Each of the Board's working groups has continued to incorporate think family, making safeguarding personal and strength based practice in their annual delivery plan actions. • The Communication and Engagement Working Group has promoted advocacy, making safeguarding personal materials and trauma informed practice through newsletters, events, the website and open sessions. For example, KMSAB hosted an open session on SAR 'Akram' to highlight working with an asylum-seeking young person. • The Quality Assurance Working Group asked member agencies, through their self-assessment framework return, to evidence the following: o *The Making Safeguarding Personal (MSP) approach is embedded into the organisation's*

Recommendation/Theme	Actions taken by the Board
	safeguarding practices. The individual or their advocate/representative is involved throughout, If this has not been possible, the reasons are clearly documented. ○ *The organisation gathers and takes into consideration the views and experiences of those at risk of abuse and neglect and uses this to improve safeguarding* ○ *Relevant staff are aware of the range of Advocacy Services in their local area and how to make appropriate referrals* ○ *The organisation promotes equality and diversity and culturally competent practice.* ○ *The organisation seeks feedback from adults with care and support needs (or their advocate/representative) and this informs safeguarding practices and/or the work of the KMSAB* ○ *The organisation has a "did not attend/was not brought policy" which takes into account how to work with individuals where engagement is challenging* • The KMSAB newsletter raised awareness of The Care Act and Whole-Family Approaches document which aims to provide practical guidance for practitioners working in adult social care in relation to carrying out assessments and developing plans which consider the needs of the whole family. • The Policies, Procedures and Practice Working Group ensures that all policy reviews and updates include consideration of making safeguarding personal, think family and the strength based approach.

As many of the themes identified in SARs extend beyond safeguarding, the Independent Chair of the Board wrote to Kent and Medway Public Health to share the learning and to request an update on the work being undertaken, to promote a system response, to reduce duplication and to incorporate into assurance reports. Public Health representatives attended a SARWG meeting to present their updates.

Acronyms

ADSS	Alzheimer's and Dementia Support Services
ASC	Adult Social Care
CEWG	Communication and Engagement Working Group
DHR	Domestic Homicide Reviews
DWP	Department of Work and Pensions
ICB	Integrated Care Board
JEG	Joint Exploitation Group
KCC	Kent County Council
KMPT	Kent and Medway NHS and Social Care Partnership Trust
KMSAB	Kent and Medway Safeguarding Adults Board
LDWG	Learning and Development Working Group
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NHS	National Health Service
PPPWG	Practice, Policy and Procedures Working Group
QAWG	Quality Assurance Working Group
SAF	Self Assessment Framework
SAR	Safeguarding Adults Review
SARWG	Safeguarding Adults Review Working Group
SECAmb	South East Coast Ambulance Service

Glossary of terms

Care Needs Assessment	If an individual thinks that they have any care and support needs, they are entitled to a free care needs assessment. A care needs assessment provides the opportunity for an individual to share information, with adult social care, about their situation and what changes they would like to make in their life. A care needs assessment looks at how needs impact on wellbeing and the outcomes the individual would like to achieve in their daily life. Adult Social Care will assess care and support needs with the individual and decide if they are at the level where they need support. Needs could be eligible if the individual is not able to do a combination of certain things that significantly affect their wellbeing. These may include: • washing themselves • getting dressed • going to work, college or volunteering • keeping the home safe to live in. More information is available here: Medway Kent

Carers Assessment	A carer's assessment is free and anyone over 18 can ask for one. A person can have a carers assessment even if the person they care for does not get any help from the council, and they will not need to be assessed. The assessment might recommend things like: • someone to take over caring so the carer can take a break • gym membership and exercise classes to relieve stress • help with taxi fares, if the carer does not drive • help with gardening and housework • training how to lift safely • putting the carer in touch with local support groups • advice about benefits for carers A carer does not need the permission of the person they are caring for to request a carers assessment. 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.
Cerebral Palsy	Cerebral palsy is the name for a group of lifelong conditions that affect movement and co-ordination. It's caused by a problem with the brain that develops before, during or soon after birth. 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.
Community Treatment Order (CTO)	"The purpose of a CTO is to allow suitable patients to be treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others - that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. The principles, in particular, treating patients using the least restrictive option and maximising their independence; and purpose and effectiveness should always be considered when considering CTOs" (Mental Health Act Code of Practice, paragraph 29.5) More information is available here and 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.
Deprivation of Liberty Safeguards	Deprivation of Liberty Safeguards (DOLS) exists to safeguard individuals when a deprivation of liberty is an unavoidable part of a best interests care plan. Individuals who are identified as potentially deprived of their liberty must be considered on a case-by-case basis and all appropriate steps taken to remove the risk of a deprivation

	of liberty where possible. DOLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 of the European Convention on the Human Rights (ECHR) in a hospital or care home, whether placed under public or private arrangements. The safeguards exist to provide a legal framework and protection in circumstances where deprivation of liberty appears to be unavoidable in a person's best interest. More information is available here
Diabetic ketoacidosis (DKA)	Diabetic ketoacidosis (DKA) is a serious condition that can happen in people with diabetes. It's where a lack of insulin causes harmful substances called ketones to build up in the blood. It can be life threatening and needs urgent treatment in hospital. 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.
Hepatitis C	Hepatitis C is a virus that can infect the liver. If left untreated, it can sometimes cause serious and potentially life-threatening damage to the liver over many years. But with modern treatments, it's usually possible to cure the infection, and most people with it will have a normal life expectancy. More information is available here.
Independent Mental Capacity Advocate (IMCA)	IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. More information is available here: Independent Mental Capacity Advocate (IMCA) - SCIE
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 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
Making Safeguarding	Making Safeguarding Personal (MSP) is about professionals working with adults at risk to ensure that they are making a difference to

Personal	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.
Multiple sclerosis (MS)	Multiple sclerosis (MS) is a condition that affects the brain and spinal cord. It cannot currently be cured, but treatment can often help manage it. More information is available here.
Neuropathic pain	Neuropathic pain is a type of persistent (or chronic) pain caused by problems with the nervous system. This is the part of the body that helps people feel touch, pressure, pain, temperature, position, movement, and vibration. This can be in muscles, joints, skin, and the layers of tissue just beneath the skin (fascia). More information is available here.
Oesophagitis	Oesophagitis means inflammation of the lining of the oesophagus. Most cases of oesophagitis are due to the reflux of stomach acid which irritates the inside lining of the oesophagus causing the inflammation. More information is available here.
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.
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.
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.
Tracheostomy tube	A tracheostomy (also called a tracheotomy) is a procedure where a hole is made at the front of the neck. A tube is inserted through the opening and into the windpipe (trachea) to help the person breathe. More information is available **here**.