Brighton & Hove
SAB
Safeguarding Adults Board

Annual Report
2024-25

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A Message from our Independent Chair

It is a privilege to introduce the Annual Report for Brighton and Hove Safeguarding Adults Board (BHSAB) 2024-25.

The report highlights the work that the Board has been engaged with over the year. I am grateful to all partners for their ongoing contributions to the Board, and their continuing support. As I stated in my last Annual Report it is important to lead the BHSAB in delivery of priorities as part of the continuous learning journey for all engaged in adult safeguarding and the well-being of residents in Brighton and Hove.

The Report highlights that all partners of the Board have continued to deliver services, provide care and support to people, and continue to respond to the changing safeguarding needs and risks that occur, alongside the ever-changing demands, and pressures upon organisations which is evidenced in the data section and other information provided. A new feature of the work undertaken by the SAB is to oversee and include rough sleeping within its assurance role. As a result of a Safeguarding Adults Review in the City, and one in East Sussex, our focus this year has been upon out of area homeless housing. The SAB recently learnt that this is reducing. Some excellent work has been undertaken in addressing this; however, demand remains high in the city. The SAB is continuing to focus our assurance upon the services to avert rough sleeping in the next year.

The SAB partners have increased the number of face-to-face learning events, and the value of learning together is not to be understated. The Multi-Agency Risk Management (MARM) framework has been introduced, ensuring professionals are coordinated with the individual at risk so they are supported appropriately. This is a preventative process that reduces the need for safeguarding interventions. Prevention is a key component to the work and included in our priorities next year. You will see that further work in this area features significantly.

It is important we continue to learn from Safeguarding Adult Reviews (SARs) locally, and you will note that we have published SAR Oliver, referred to later in this Report. Along with the second National Analysis of Safeguarding Adult Reviews (2019-23) the SAB has considered the evidence and impact of the learning to prevent abuse and neglect where at all possible. A further priority in 2025-26 will be actively hearing the voice of those involved in adult safeguarding, and implementing effective learning from this, which is critical to the Board's assurance function.

A further significant area of work this year has been progressing Board budget discussions so we can reach agreement in principle for annual uplifts in line with other partners' budgets. This is important for the continued development of the SAB and its ability to meet its statutory duties.

Outcomes of the work undertaken this year, in line with the current three-year Strategic Plan, have informed our future priorities and this will ensure support for the continuing work / learning and will direct us to further areas of intervention and assurance.

Finally, I would like to thank all the Chairs for the subgroups and Guy Jackson the Board Manager and his staff for effectively and efficiently managing the business of the Board and for their ongoing commitment to the Board. I would also like to acknowledge the work of the staff and managers across all the statutory, voluntary and community partners who are committed to working together to keep people safe in the City.

Seona Douglas
Independent Chair, Brighton and Hove Safeguarding Adults Board

A Message from Healthwatch

I am pleased to provide commentary on this year's Safeguarding Adults Board Annual Report 2024-25 on behalf of Healthwatch Brighton and Hove.

This year's report highlights the impact that good safeguarding practice can make to individuals and their families. The Safeguarding Adults Board (SAB) met this year to discuss forthcoming priorities for the next three years and it was heartening to hear all members recognise the need to collect and embed the voice of the service user in our work.

This year has seen some significant developments in safeguarding practice stemming from published Safeguarding Adult Reviews (SARs). Our Healthwatch representative, Brigid Day, has continued to act in the capacity of Chair of the SAR Subgroup which reports into the SAB. Recommendations from published SARs in 2024-5 have resulted in:

- a Multi-Agency Risk Management (MARM) framework being established in Brighton & Hove that meets on a regular basis and is led by the local authority. MARM will evidence better safeguarding practice once it is established.
- the importance of a clearly identified lead professional, or agency being incorporated across a range of pan-Sussex SAB policies and protocols that includes multi-agency working guidance in the Sussex Safeguarding Procedures.
- a significant development within the partnership through Sussex Partnership Foundation NHS Trust, Sussex Police, and South-East Coast Ambulance NHS Trust working together to design and implement the Blue Light Line. This is a new Rapid Response service which has been launched in Sussex to support the emergency services when they are responding to a person in mental distress to ensure they receive timely and appropriate help.

My thanks to Brigid for her continued dedication as Chair of the SAR subgroup.

Other notable developments this year include a necessary system-level focus on multi-agency transitions with a strategy in development to support people transitioning from Children to Adult services, and multi-agency guidance to support professionals working with adults who move out of area.

It is evident that the SAB is making good progress under the Chair of Seona Douglas and her team and Healthwatch looks forward to our continued collaboration with the Board.

Alan Boyd
Chief Executive Officer, Healthwatch Brighton and Hove

Our Board

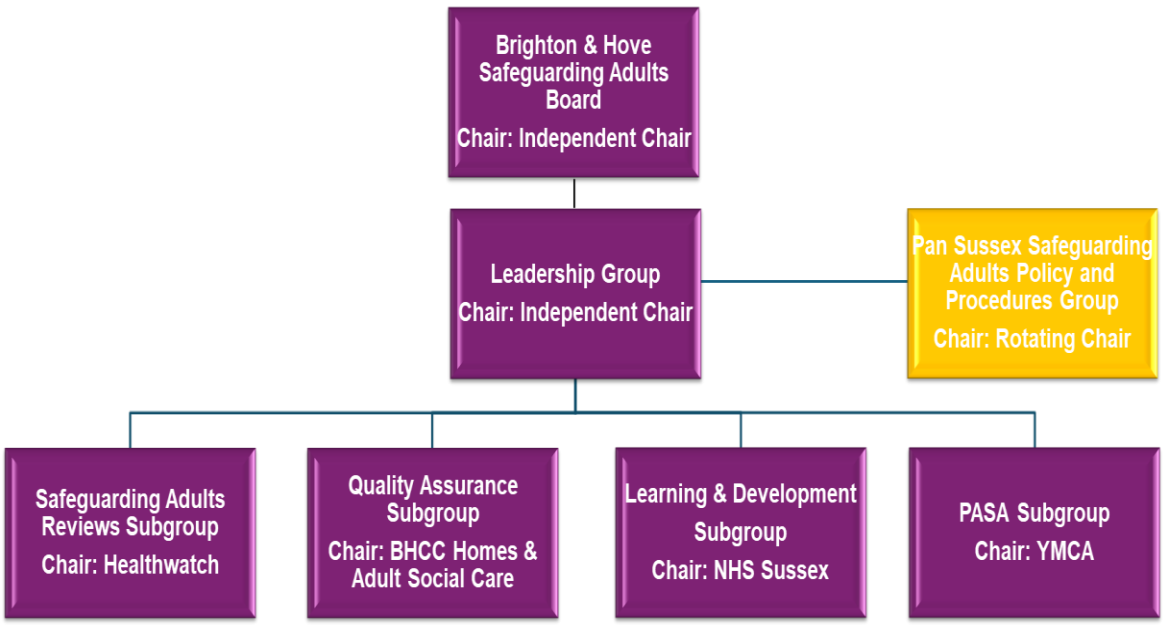
There is a requirement under the Care Act 2014 for each local authority area to establish a Safeguarding Adults Board (SAB). SABs are multi-agency partnerships that work together to oversee and lead adult safeguarding arrangements for people who have care and support needs and protect them from abuse and neglect.

Our Statutory Partners

- **Brighton & Hove City Council**
- **NHS Sussex**
- **Sussex Police**

The Brighton & Hove SAB recognises the importance of public, private and community organisations working in partnership through our full board and across our subgroups to ensure people are able to live together in safety, free from abuse, neglect and exploitation in a city that does not tolerate this. Working in partnership actively prevents abuse occurring and ensuring that when it does happen everyone knows how to report it.

Our Board Structure



What have we done this year?

This has been the last year of our current three-year Strategic Plan (2022-25) which contains four overarching strategic aims, with several objectives under each strategic aim. These four strategic aims are –

Accountability and Leadership

Performance and Quality

Promotion and Engagement

Integration and Workforce Development

Each year the SAB partners review the progress made in delivering the strategic priorities based on local information, learning from SAB activities, and individual issues identified by partners. Areas of focus are identified and work plans for the board and subgroups developed to take forward key areas for improvement. The key areas of focus for 2024-25 were –

- **Embedding learning from SAB activities**
- **Transitional Safeguarding**
- **Developing Effective Outcomes to Self-Neglect**
- **Embedding learning from trauma-informed and multiple compound needs**

The work undertaken by the SAB in relation to these four areas of focus is summarised below and the area indicated under the strategic priorities (in italics). Other work is also undertaken which relates to the role and responsibilities of the SAB.

A glossary is included at the end of this report to provide further detail on acronyms and terms used. An * is used to identify that further information can be found in the glossary.

Accountability and Leadership

An-person Strategic Development Event was held with partner organisations to review and update the SAB Constitution, governance arrangements, and overall progress over the last three years. This has been used to support the development of the new SAB Strategic Plan for 2025-28 and to identify agreed areas of focus for the partnership going forward.

- Embedding learning from SAB activities, Transitional Safeguarding, Development of effective outcomes in self-neglect, Embedding **trauma-informed and multiple and intersectional* needs into organisational practice**

As part of our bi-annual self-assessment and peer challenge process the SAB has worked with our colleagues from the East and West Sussex SABs to develop a pan-Sussex Self-Assessment tool for 2025. This is used to gain assurance from partner organisations as to their safeguarding arrangements and how they use learning from SAB activities.

- Embedding learning from SAB activities

Full board, leadership, subgroup, and affiliated meetings have taken place throughout the year to progress the strategic priorities and areas of focus. Membership of the full board and subgroups has continued to increase, with the Department of Work and Pensions, Rough Sleeper commissioning services, and several third sector organisations joining our groups.

- Embedding learning from SAB activities

Performance and Quality

In line with the identified priorities for 2024-25 the SAB has developed a multi-agency data dashboard, to increase oversight and assurance of adult safeguarding activity. Data from the local authority's Adult Social Care and Housing departments, as well as internal SAB processes, has started this process and directly led to a multi-agency audit on homelessness as well as an increasing focus on SAR protected characteristics data.

- Embedding learning from SAB activities

The SAB has published one mandatory SAR, Oliver, this year with three further SARs in progress. There are more details on SAR Oliver, including the key learning themes – transitions and transitional safeguarding, mental health and housing, as well as safeguarding processes, on page 18 of this report. Three in-person SAR learning events have been held this year with attendees from over 30 organisations.

- Transitional Safeguarding

A multi-agency audit undertaken jointly with the East Sussex SAB on adults who move across local authority areas has been completed, with multi-agency guidance to support work with adults who move out of area developed as an outcome. A further multi-agency audit on local homeless deaths is in progress to gain assurance around the use of the SAR pathway and other multi-agency processes in place.

- Development of effective outcomes in self-neglect

Promotion and Engagement

Case studies and presentations to the board have come from organisations that include Public Health, Families Children and Learning directorate, Housing services, and Mental Health services. These have focused on a range of topics including hoarding, multi-agency risk, and organisational abuse.

- Transitional Safeguarding, Development of effective outcomes in self-neglect

The SAB has delivered presentations and updates on our work at a range of settings including the Voluntary and Community Social Enterprise (VCSE) Mental Health network, YMCA Safeguarding Forum, Parents who have children removed from their care forum, Safeguarding Children Partnership Exploitation Workshop, Home Care forum, and Changing Futures Stakeholder forum.

- Embedding trauma-informed and multiple and intersectional needs into practice

The SAB has attended national SAB and Regional South-East SAB meetings, both regional and local Trauma-Informed Communities of Practice, Suicide Prevention Steering Group, and Safeguarding Children Partnership Exploitation subgroup. The SAB has also attended webinars on Discriminatory Abuse, Homelessness, as well as the second national SAR analysis with learning integrated into current SARs and subgroup processes.

- Embedding learning from SAB activities

Integration and Workforce Development

The SAB has worked with our colleagues in the East and West Sussex SABs and statutory partners to publish Version 5 of the Pan-Sussex Safeguarding Adult Policy and Procedures. These include new and updated chapters on topics such as multiple compound needs, trauma-informed approaches, multi-agency working, and Domestic Abuse. The multi-agency self-neglect procedures have been updated and standalone guidance published.

- Development of effective outcomes in self-neglect, Embedding trauma-informed and multiple and intersectional needs into organisational practice

The SAB has developed a range of learning and development resources during 2024-25 to support workforce development. These include transitional safeguarding and trauma-informed approaches, SAR learning briefings, and Multi-Agency Risk Management resources and guidance (to support the implementation of the new MARM pilot framework)

- Transitional Safeguarding, Embedding trauma-informed and multiple and intersectional needs into organisational practice

The SAB collaborated with our colleagues in the East and West Sussex SABs to produce a webinar on preventing self-neglect as part of the NHS Sussex 2024 Safeguarding fortnight. This was attended by over 100 representatives from organisations across Sussex and a video of the webinar produced that is available on the BHSAB website.

- Development of effective outcomes in self-neglect

What difference is this making?

The SAB is keen to focus on the difference being made as a result of work undertaken both collectively as well as individually by partners. Here are examples of feedback received during 2024-25 from both people using services and professionals.

Feedback provided by BHCC Homes and Adult Social Care from people who received a safeguarding enquiry.

A safeguarding enquiry into physical abuse by a paid carer

"V said she was happy with this outcome and just wanted to put everything to do with the incident behind her now and get on with her life."

A safeguarding enquiry undertaken into domestic abuse

"N does not want any support from Adult Social Care, saying she is 'ok' and 'fine at the moment' but agreed she will call GP, where she can talk more" confidentially, if she

A safeguarding enquiry where the person's outcomes were met

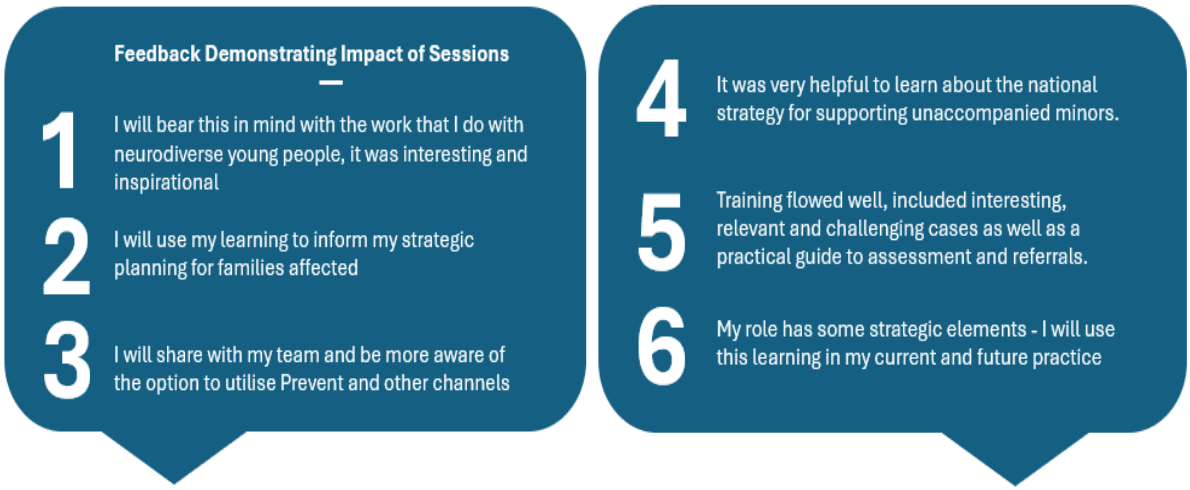
"P was asked what she would like to happen. She stated that she wants to remain in her flat with T caring for her but knows that the state of the flat needs to be managed to make it safe for them to continue to live in and to stop Z (housing providers) from taking action to evict them."

A safeguarding enquiry into self-neglect and hoarding behaviour

"W does not want a deep clean. W does not want to reduce hoarded items. W does not want to lose his tenancy, although does cite a desire to move from X. W wishes to move to a larger property so he can purchase more items."

Feedback provided by University Hospitals Sussex staff on their Level 3 Safeguarding training programme.

"*The blended learning was a good way of delivering this course. It presented at the right level, and it was informative, helpful and interesting. Well presented.*"



Feedback provided by BHCC Adult Social Care staff on being required to undertake safeguarding enquiries training.

"I have attended several safeguarding sessions in the past. I felt that it was interactive and the case studies used were relevant to our places of work. The course lead was approachable and inclusive of all attendees."

"Alison kept it moving at a good pace. There was a chance to split into groups and have discussions and contribution was encouraged."

"This was a fantastic course with a really good trainer, both interesting and informative. I have learnt a lot and enjoyed the experience of group learning with others from differing areas of social care."

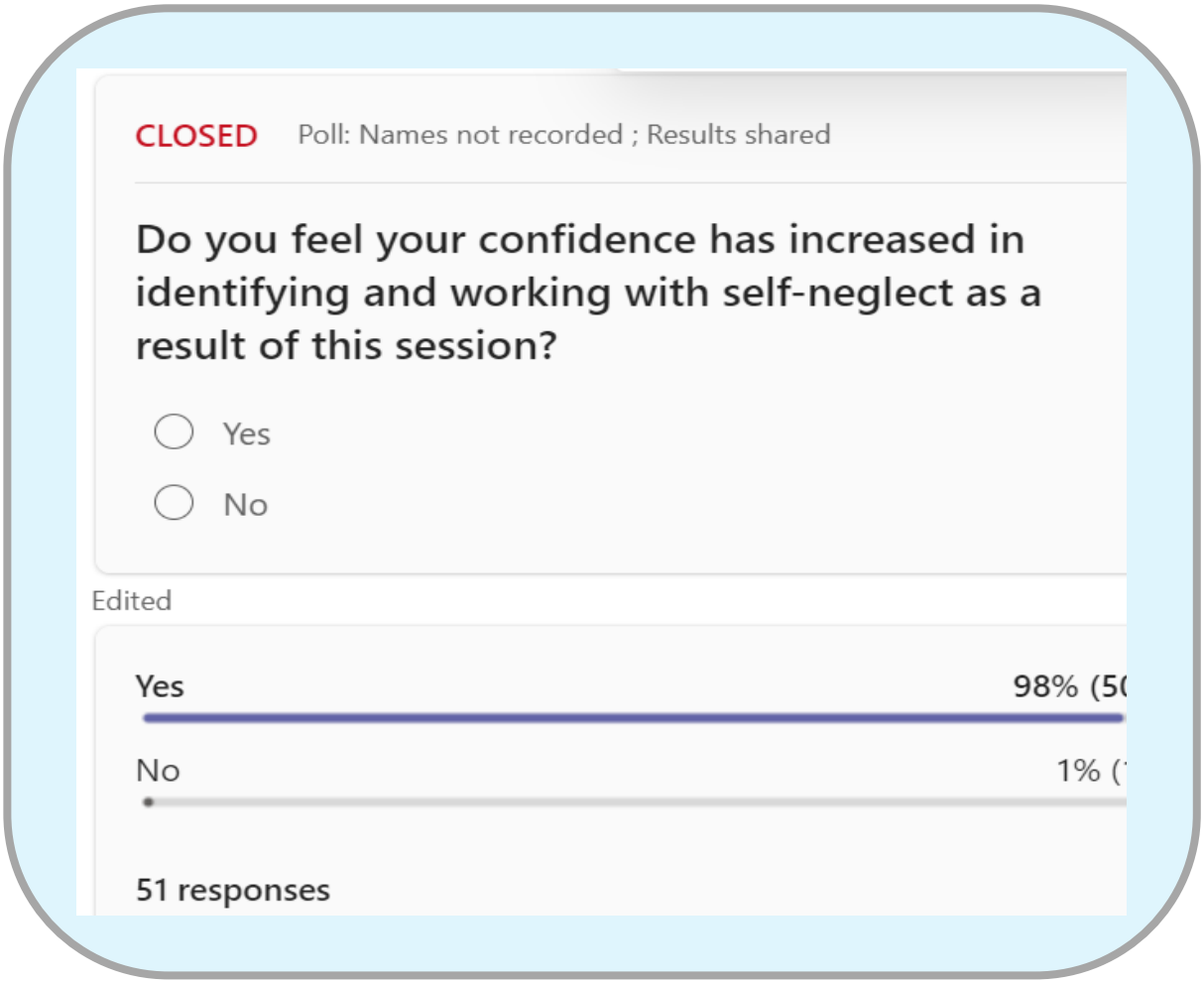
Feedback from a Pan-Sussex Safeguarding Adults Board webinar providing guidance on working with people who self-neglect.

This webinar was attended by a wide range of frontline professionals across both children and adult services that included GPs, Medical Consultants, Nurses, Occupational Therapists, Social Workers, Mental Health practitioners, Housing Education and Employment representatives, Social Prescribers, and colleagues from domestic violence agencies including Victim Support.

"Polished delivery - some of the best training I have attended in recent years. Thank you."

"Thank you that was very useful and

"Hoping the rest of the training this fortnight is as relevant and helpful as this, thank you."



Safeguarding Adults Reviews

Under section 44 of the Care Act 2014 Safeguarding Adults Boards (SABs) have a statutory duty to commission Safeguarding Adults Reviews (SARs).

Mandatory SARs must be undertaken when an adult with care and support in its area dies, or experiences serious harm, and it is suspected this was as a result of abuse or neglect, including self-neglect and there is concern organisations could have worked together more effectively to protect the adult from harm.

Discretionary SARs can be undertaken by SABs in situations where this duty is not met, but it is considered there would be benefit in a review being undertaken. This is usually where it is thought learning could reduce the likelihood of something similar occurring in the future or it is in the public interest.

The purpose of SARs is to identify effective multi-agency learning, which can be shared and applied in the future to prevent similar harm re-occurring. They are not about apportioning blame, or any one organisation being held accountable.

During 2024-25 the SAB received five SAR referrals, with one of these relating to four separate individuals. The categories of abuse and neglect identified in these referrals are:

- **Neglect**
- **Self-neglect**
- **Organisational Abuse**
- **Physical abuse**
- **Sexual Abuse**
- **Financial abuse**
- **Exploitation**

Further information is being gathered in relation to three of the referrals, with the most recent referral being processed.

There are two mandatory SARs currently in progress, which will be concluded during the next year. A discretionary SAR has recently concluded and will be published shortly. The SAB continues to utilise a diverse range of approaches and methodologies with this discretionary review taking the form of an appreciative enquiry, with a facilitated panel discussion and a concise systems report produced by one of our statutory partner organisations who were not involved.

The SAB published one mandatory SAR during 2024-25 and you can find a summary of this below, which has informed local strategy development for young people who need support in transitioning to adulthood.

We have continued to develop our SAR governance arrangements with learning from the second national analysis of SARs shared with the group. New data collection processes have been created to capture an increasing range of information going forward, which include protected characteristics, more detailed consideration of abuse and neglect categories, and timelines. Learning from the national analysis and internal data collection has been used to improve existing processes including increasing focus on protected characteristics in independent reviewer contracts.

The subgroup terms of reference have been reviewed and updated, and the accompanying members pack is also being reviewed and updated.

Oliver

Oliver was a 25-year-old white, British, male who had experienced abuse growing up and had been a looked after child. As he grew older he had mental health and substance misuse issues, and as an adult a history of offending behaviour with Oliver serving two custodial sentences. He received support from a range of both statutory and non-statutory organisations across children and adult services and lived in several different settings, including staying with family and in supported accommodation.

In mid-2022 Oliver started using alcohol heavily and safeguarding concerns were raised after he disclosed sexual abuse. A safeguarding enquiry was undertaken but organisations struggled to engage with Oliver. Further safeguarding concerns were raised in relation to his general wellbeing, mental health in particular, but these were not progressed as abuse or neglect was not identified.

Oliver agreed to a voluntary admission to a private residential mental health setting but was discharged due to drug and alcohol use and after presenting as homeless was placed in emergency accommodation in East Sussex due to a lack of availability locally.

Oliver and his family requested he be moved back to Brighton & Hove but there were no suitable options available. He continued to use alcohol and substances heavily and expressed suicidal ideation. He was discharged by mental health services shortly after this and found deceased in the emergency accommodation ten days later.

This SAR focused on several themes: transitions and transitional safeguarding, mental health and unstable housing / homelessness, as well as safeguarding processes and procedures.

10 recommendations were made, which include the implementation of formal transitions processes, a review of temporary accommodation processes, and the creation of stronger links between Leaving Care and Adult Social Care services.

You can find the full report **here** and a summarised learning briefing via our SAR website page **here**.

An Action Plan has been developed to take the recommendations forward.

Our Board Partners' Data

Brighton and Hove City Council Homes and Adult Social Care

Overview

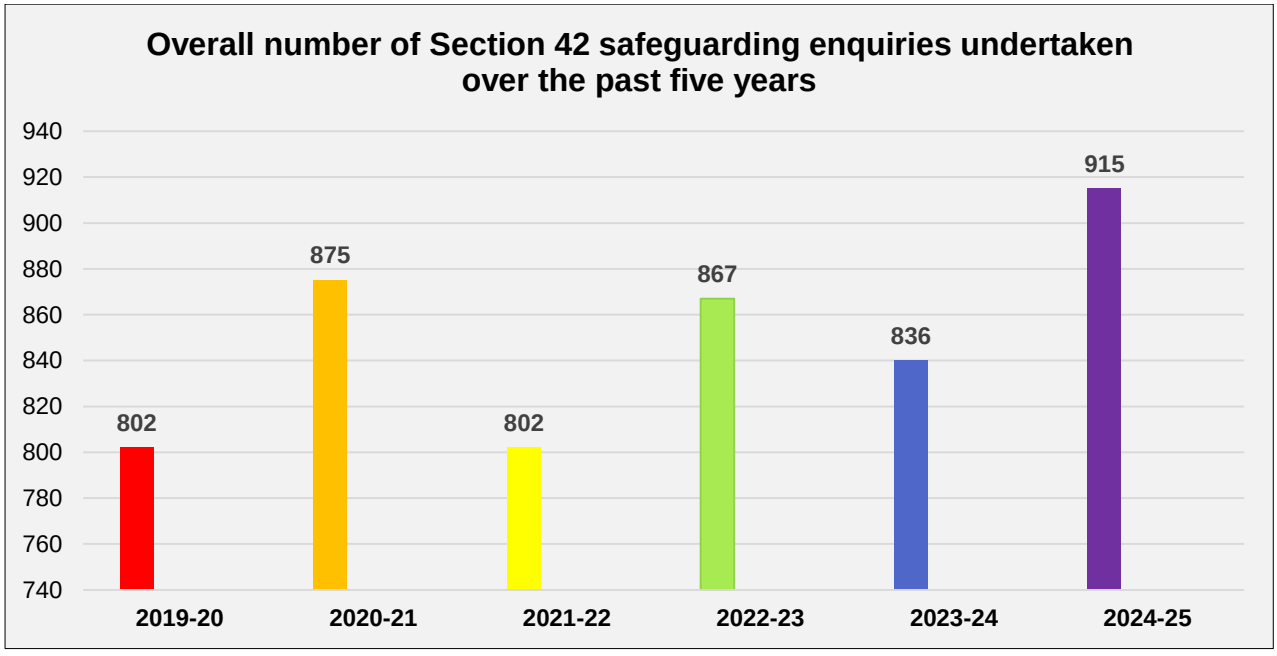
The Homes and Adult Social Care directorate, which was formerly known as Health Care and Wellbeing, continues to ensure robust oversight of safeguarding adults across all areas of our service. Through the implementation of Power BI (a data analytics reporting tool), we have significantly enhanced our oversight of safeguarding adults performance across adult social care. Power BI has enabled us to centralise, visualise, and analyse safeguarding data in real time, offering a comprehensive and accessible view for our practitioners and managers.

Additional oversight and governance is provided via a monthly performance oversight senior management board and led by a quarterly safeguarding steering group comprising adult social care senior leadership team members and chaired by Steve Hook, Director of Adult Social Care.

What our Performance Data tells us

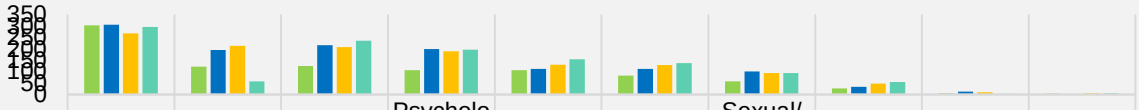
During this year we received 5485 safeguarding concerns, with a conversion rate overall across the year of 16.91%, predominantly in our front door Adult Safeguarding and Duty Service and within Mental Services where our social work teams are based (S.75 agreement). This is an increase from last year when 4601 concerns were received.

From those concerns we completed 915 safeguarding adults enquiries under section 42 of the Care Act, an increase from 836 last year.



Neglect and omission continue to represent our greatest proportion of safeguarding enquiries, almost 25% of all undertaken in the last year. Taking a closer look at this data we can see that these enquiries recorded 31% of these concerns taking place in the person's own home, 21% taking place in a care home with nursing and 15% in an acute hospital setting. Almost 40% of all enquiries were regarding people aged 65-84 years of age with 49% of these regarding people recorded as female gender and 48% for male gender, a slight decrease from the year prior of 56% female.

Overall number of safeguarding enquiries opened from 2021-25, by abuse and neglect category

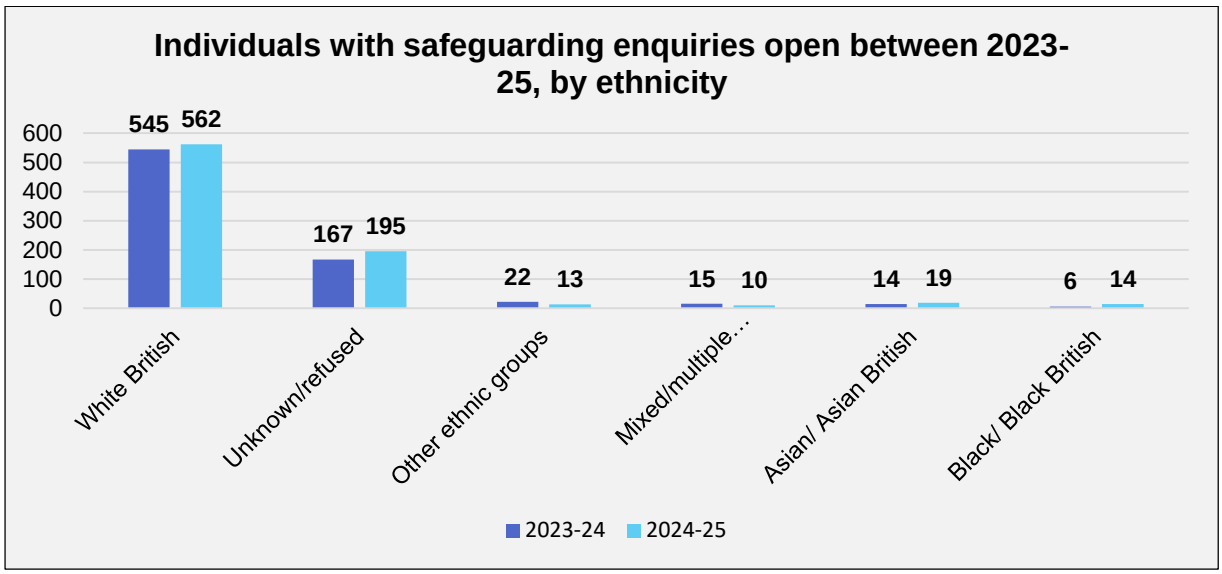


	Neglect & omission	Physical	Financial & material	Psychological and emotional	Self neglect	Domestic	Sexual/ Sexual exploitation	Organisational	Discriminatory	Modern Slavery
2021-22	303	122	125	106	107	83	58	27	5	4
2022-23	306	195	216	199	112	112	101	34	12	1
2023-24	268	213	207	189	130	129	94	48	10	6
2024-25	295	58	235	196	154	138	94	55	3	6

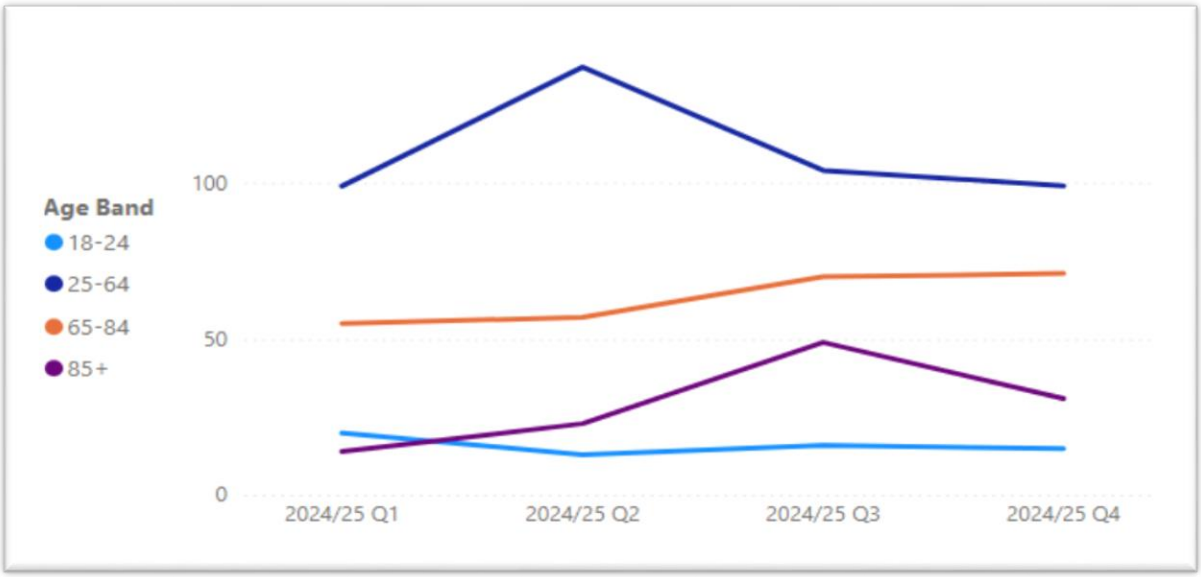
We have observed a static figure of 6 enquiries completed regarding modern slavery of people with care and support needs, however there is an increasing trend with regard to concerns being reported around care workers (care homes and care agencies in the communities). While these are not taken forward under our Care Act safeguarding duties if these individuals are not indicated to have care and support needs themselves, this information is shared with community safety and exploitation and quality monitoring partners across the Local Authority, and with our colleagues in Sussex Police. We understand this reflects an increasing trend regionally/nationally.

Type of Risk	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	Total
Neglect and acts of omission	18.31%	17.07%	23.81%	24.44%	**20.95%**
Financial or material abuse	20.42%	15.99%	15.61%	14.92%	**16.57%**
Physical abuse	13.73%	17.89%	15.08%	16.19%	**15.82%**
Psychological abuse	14.08%	16.80%	11.90%	12.06%	**13.74%**
Self-neglect	13.73%	10.30%	10.32%	12.70%	**11.59%**
Domestic abuse	9.15%	11.11%	10.32%	11.43%	**10.55%**
Sexual abuse	5.99%	4.88%	6.61%	5.71%	**5.79%**
Organisational abuse	2.11%	3.52%	4.76%	1.59%	**3.12%**
Sexual exploitation	2.46%	1.08%	0.79%	0.63%	**1.19%**
Modern slavery		1.08%	0.26%	0.32%	**0.45%**
Discriminatory abuse		0.27%	0.53%		**0.22%**
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Demographics

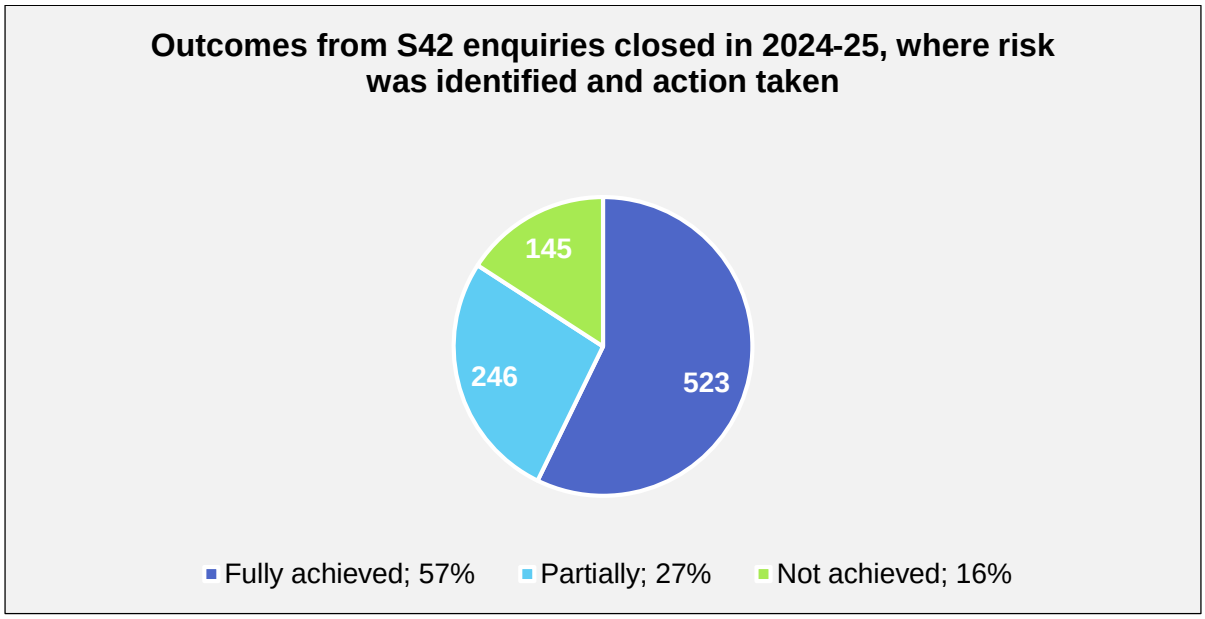


Location of Risk	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	Total
Own home	52.75%	41.89%	45.61%	39.60%	**44.83%**
In the community (excluding community services)	11.93%	13.51%	10.81%	12.00%	**11.97%**
Care home - nursing	10.09%	13.06%	8.45%	10.80%	**10.45%**
In a community service (including supported accommodation)	6.88%	12.61%	8.78%	7.60%	**8.92%**
Care home - residential	9.17%	3.60%	9.80%	6.80%	**7.51%**
Hospital - acute	3.21%	4.95%	8.11%	11.20%	**7.10%**
Hospital - mental health	3.21%	5.86%	3.72%	7.60%	**5.07%**
Other	1.38%	4.05%	4.05%	3.20%	**3.25%**
Hospital - community	1.38%	0.45%	0.68%	1.20%	**0.91%**
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**



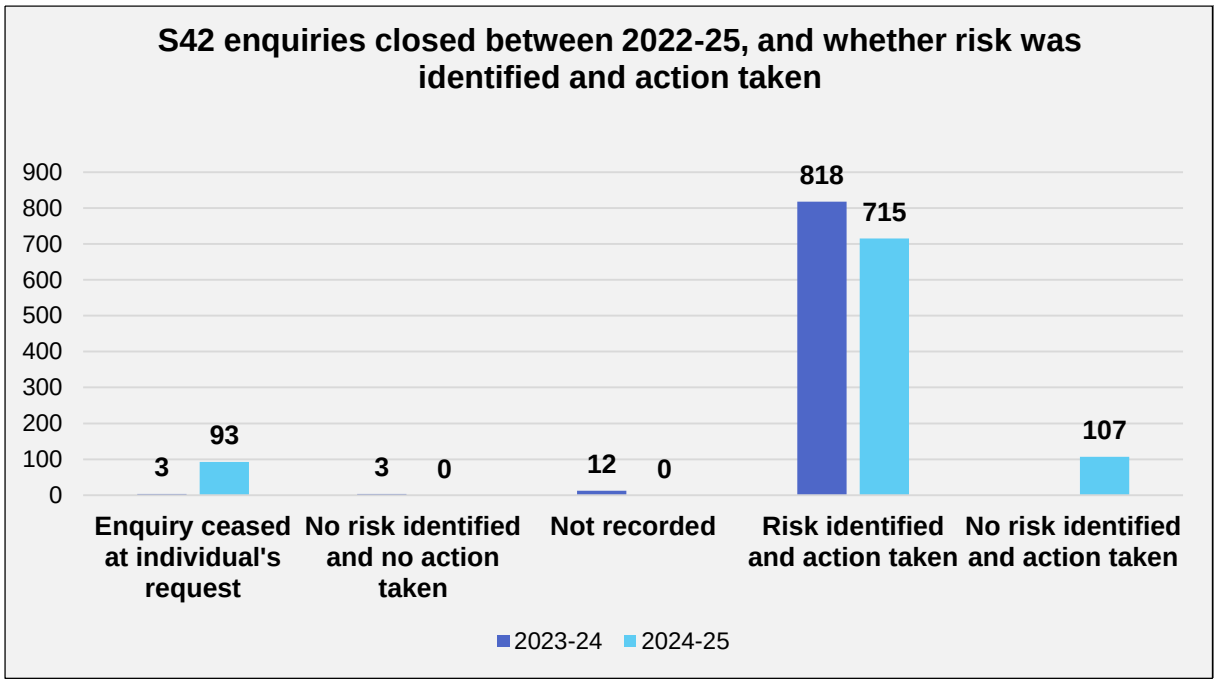
Over the year period 45% of all abuse and neglect was reported to take place in the person's own home, and predominantly for people between the ages of 25-64 years old (49.88%) with 29.36% of people 65-84 years old. We have observed increasing trends this year in safeguarding concerns with the location recorded as acute hospital (3.21% Quarter 1 to 11.16% Quarter 4) and in mental health hospitals (3.21% Quarter 1 to 7.57% Quarter 4).

Outcomes



People's outcomes were fully or partially met in 84.15% of enquiries this year, evidencing our ongoing commitment to Making Safeguarding Personal with consistent good performance and recording in this key area. Due to the introduction of a new post in adult social care of a Safeguarding Development Officer supporting the Head of Safeguarding Adults, we have been able to expand our quality assurance offer providing both quarterly data monitoring and an extended Making Safeguarding Personal Quality Assurance task in relation to safeguarding enquiries themselves and the person's feedback. Good practice around working with people to understand their aims and objectives and recording these within our enquiries is consistently evident.

This is fed back regularly to front line practitioners and managers, recognising their good practice and dedication, and reported quarterly to the SAB Quality Assurance Subgroup and the Professional Practice Team to support our safeguarding practice audit framework, which has a quarterly completion cycle and regular oversight.



Quality Assurance: **Data and Development**

On a quarterly basis, we report the number of safeguarding enquiries undertaken, the types of abuse and neglect which are prevalent, our conversion rates, and a sample of qualitative feedback from people receiving safeguarding responses to the Safeguarding Adults Board Quality Assurance Group. We have committed to developing a measure around referral data, if this is possible, and are currently exploring this. We acknowledge that, if this would bring further benefits for ourselves and for our partners in understanding more about where our referrals come from, particularly repeat referrals and those which do not indicate care and support or abuse or neglect.

Quality Assurance: Working Together

Through an extensive period of working jointly with East Sussex Fire and Rescue Service and information governance and performance colleagues we have been able to develop automated monthly reporting for people who wish to receive a fire safety check. This recently went live and will bring benefits to our front-line practitioners in reducing manual paperwork completion, strengthening our commitment to prevention and working together to find creative information sharing solutions with our partners.

Progress has been made on a focused area of causing others enquiries, with partners meeting regularly to review open enquiries and keep sight of these. Themes are also being addressed by the provider with oversight at strategic level, enabling further assurance and aims.

Challenges

The challenges noted in last year's annual report remain, with adult social care continuing to receive a very high level of information submissions from partners that

do not indicate a need for social care advice / information, a need for care and support assessment or review, or abuse and neglect safeguarding concerns.

These predominantly include information highlighting a need for a person to access community wellbeing mental health or GP / health services. Discussions are ongoing working with partners to ensure that people are signposted to relevant services at the right time to support their needs. This is key, both to ensure that we focus our resources on abuse and neglect of people with care and support needs, but also that people who are experiencing difficulties with their wellbeing and mental health are directed to appropriate community-based support services at the right time.

While we have achieved some progress within the Sussex-wide partnership with this in terms of opening the conversation, there is more work to do. We aim to design a local briefing for partner agencies this year outlining the remit of adult social care and continuing to encourage partners to signpost people to wellbeing support and, where needed, to share concerns regarding mental health and wellbeing with appropriate primary care services.

We have recently observed a substantial increase in the number of requests for information for DARDR – Domestic Abuse Related Death Review (formerly Domestic Homicide Review) following the expanded scope nationally. Reviews now cover cases where a victim has died by suicide, neglect, or in unexplained circumstances, as long as domestic abuse is a contributing factor.

NHS Sussex (Integrated Care Board)

NHS Sussex, the Integrated Care Board (ICB), remains committed to working alongside both statutory and the wider partners of the Safeguarding Adults Board (SAB) to safeguard the local population and continues to take an active role as a statutory partner of the SAB in driving safeguarding improvements.

NHS Sussex is represented on all SAB subgroups and the SAB's leadership group and supports all key decision-making functions of the SAB as one of three lead partner agencies alongside adult social care and the police. NHS Sussex also continues to chair the Learning and Development Subgroup.

We continue to support the enhancing of safeguarding practice across the health economy in Brighton and Hove, and wider across the Sussex footprint. The NHS: Safeguarding accountability and assurance framework was revised during 2024-25 and NHS Sussex reviewed arrangements to ensure that we continue to meet statutory obligations. Below are key highlights of our achievements in 2024-25.

Clinical Safeguarding Advice and support

NHS Sussex ICB provide an important clinical safeguarding advisory role across the health and social care system. Where safeguarding concerns of a clinical nature have been raised, the Local Authority will consider the need for a safeguarding response under Section 42 of the Care Act as indicated below.

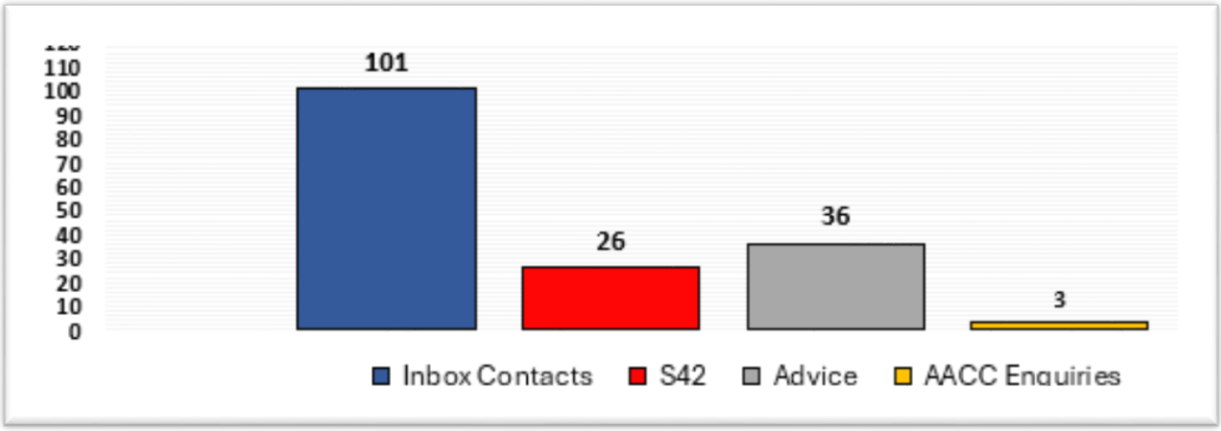
2.3. Receiving concerns and undertaking enquiries | Section 2 | Sussex Safeguarding Adults Policy and Procedures

Practical examples of the support and guidance from NHS Sussex include (not an exhaustive list):

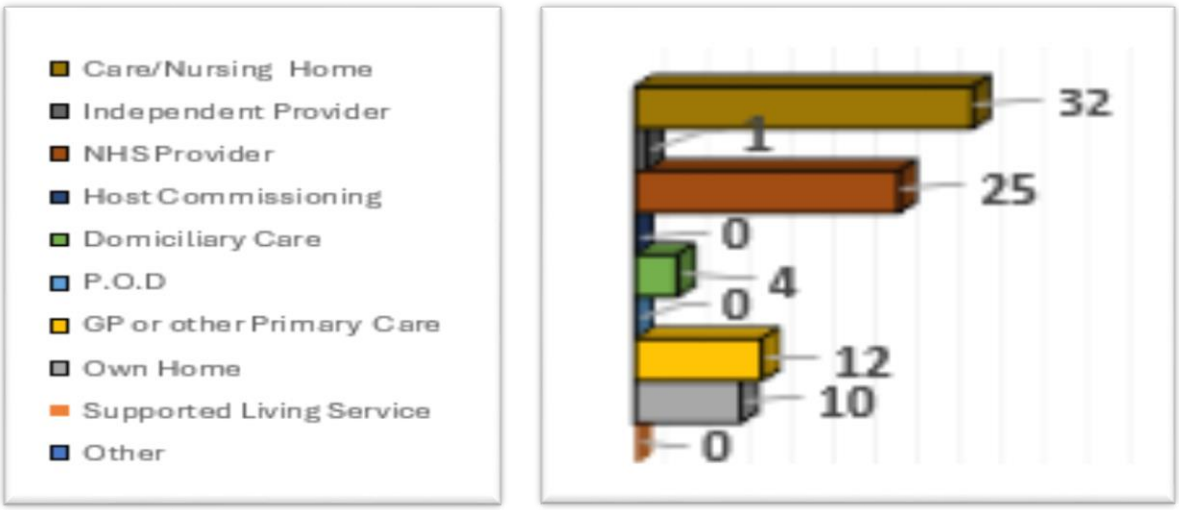
- Advice and support for cases involving multiple providers and / or multiple health professionals (when there is a clinical element); in this circumstance NHS Sussex MUST be involved / notified of the concerns.
- Offering advice to the lead enquiry officer at the local authority as to the appropriate questions to ask regarding the clinical aspects of an enquiry.
- Advice or scrutiny of a report received from a health provider, where significant concerns remain regarding the quality of a response and / or where an impartial view and oversight is required.
- Support for undertaking an enquiry where this is a clinical element in a service where the provider is a small independent service, and it is identified by the lead enquiry officer or the provider that there is no one else within the provider to support undertaking the enquiry.
- Advice and support for highly contentious clinical cases where there may be adverse publicity/high level challenge from family members.
- Where the Adult Death Protocol has been followed and leads to concerns about a provider's ability in regard to clinical care.
- Complex situations where applications to the Court of Protection may need to be considered.
- Poor engagement from a provider.
- Support for independently evaluating and triangulating information / evidence gained in an enquiry from a provider, regarding clinical care aspects, and presenting this within safeguarding meetings as deemed appropriate.
- This is to be determined on a case-by-case basis, and the NHS Sussex Safeguarding team will advise where external advice may be required, and where possible how this can be provided.
- Where the NHS Sussex Safeguarding Team are to be involved in a safeguarding enquiry, agreement will be sought by the local authority regarding attendance at any safeguarding planning, review and conclusion meetings and what information will be required for such meetings.

To this end, we have developed a duty rota to cover the ICB safeguarding inbox and offer a robust advice and signposting service to ensure multi agency colleagues across Brighton and Hove are supported with health-related safeguarding issues. Our Named GPs for safeguarding offer a separate advice line for GP practices, and this data is not currently included in this report. We aim to merge this data going forward from Q1, 2025/26.

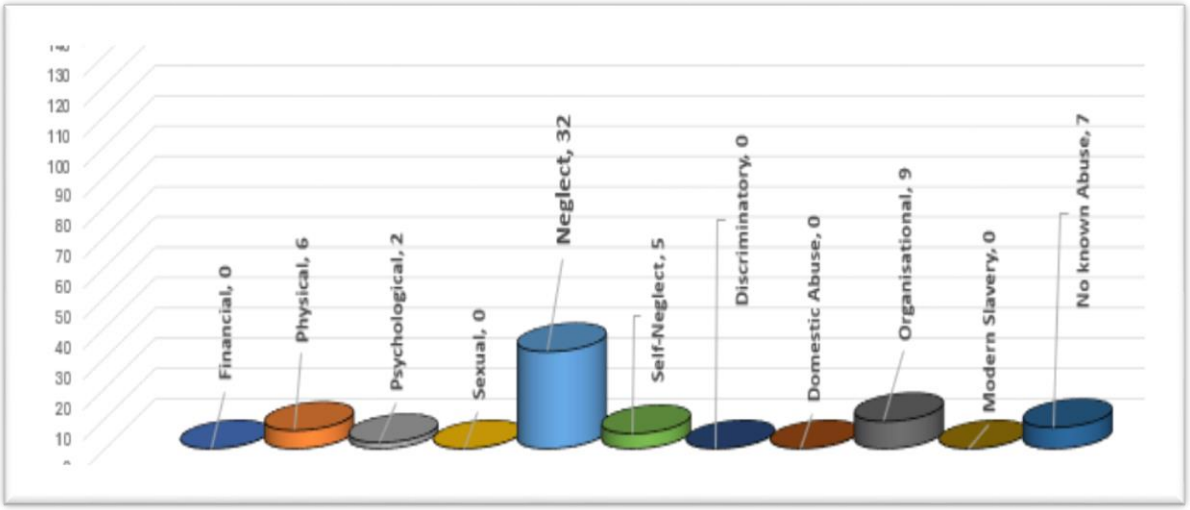
The first graph below represents the total number of Brighton and Hove related contacts received via the generic Safeguarding Inbox or via the designated safeguarding adults nurses directly during 2024-25. Out of this total, 26 related to Section 42s and 36 related to professionals asking for advice. A further three were specific to AACC (All Age Continuing Care) enquiries and the remaining not shown would have mostly been 'information only' emails.



The second graph below relates to the 'Provider / Service Type' in connection to the relevant contacts from the first graph showing the highest number of contacts came from Care / Nursing Homes and NHS Providers.

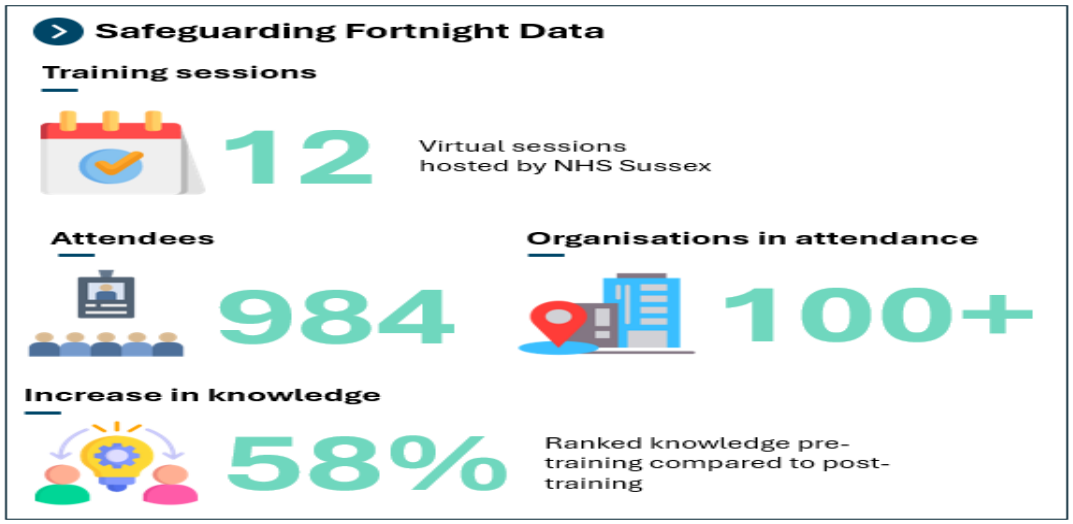


The third graph follows on from the previous two and shows as with the Homes and ASC date the most common form of abuse escalated to the inbox is neglect.



It should be noted that the total number of Inbox Contacts in the first graph does not equal the totals on the other graphs because the contact may not be relevant and NHS Sussex are not always provided with the relevant information to accurately record this.

NHS Sussex held the Safeguarding and Children in Care fortnight in November 2024 with the theme of 'Hidden Harm'. These training sessions gave frontline professionals and their managers across Sussex the opportunity for a learning and reflective space to improve understanding and awareness. This year marked the first year of collaboration with the three Safeguarding Children Partnerships and three Safeguarding Adults Boards to share resources and increase impact and awareness across the system.

- 

Provider assurance

NHS Sussex have gained assurance from health providers in Brighton and Hove through quarterly exception reporting, biannual safeguarding assurance self-assessment and through site visiting. The quarterly exception report was reviewed in 24/25 and has been amended to ensure we receive the data required to provide a picture of where gaps may be, or to highlight good practice. It has been agreed that relevant data collected can be shared with Brighton and Hove to inform the Board multi-agency data dashboard in 2025/26.

Working in Partnership to Provide Effective Safeguarding Arrangements

During 2024-25, following a joint SAR commissioned by East Sussex SAB, NHS Sussex led on a collaborative piece of work developing a Self-Neglect Management Flow Chart for use by primary care across Sussex to support and improve practice around identifying self-neglect, making referrals and undertaking carers assessment. The tool was promoted during Safeguarding Fortnight and initial feedback from providers was positive, further work is planned to gain feedback about the impact on practise from primary care in 2025-26.

Sexual Safety Charter

During 2024, NHS Sussex led and supported implementation and roll out of the NHSE Sexual Safety Charter that launched in September 2023 across both ICBs and the provider network. The aim of the Charter is to ensure a systematic, trauma-informed approach to sexual misconduct and violence throughout the workplace. A gap analysis and action plan were developed in the last year, to ensure improvements were in place and relevant safeguarding and HR policies were updated. A mandatory virtual training package 'understanding sexual misconduct in the workplace' was launched in Q3, which will enable staff to recognise and report sexual misconduct and to understand how to support colleagues (victims and witnesses).

Mental Capacity Act (MCA)

Following the identification of gaps in learning in recent SARs, specific MCA training has been delivered to 93 primary care staff across Sussex throughout 2024 to support the embedding of MCA in GP practice. The training was refreshed in January 2025 and is offered to ICB clinical staff on a bi-monthly basis and includes practical application of the MCA. 60 people attended the sessions in Q4 with practitioners feeling more competent in applying MCA to practice based on feedback. Focused development work and training has been undertaken with All Age Continuing Care (AACC) to ensure application of MCA for 16/17-year-olds and an MCA Competency Framework will be developed by end of 2025-26 to strengthen compliance.

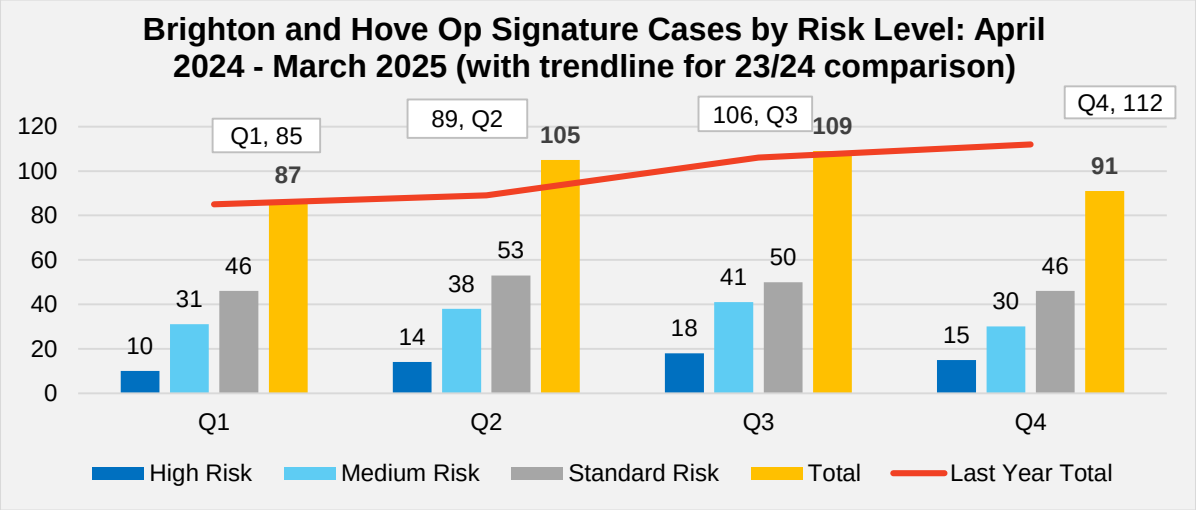
All Age Continuing Care

During Q2 of 2024, NHS Sussex introduced a dedicated safeguarding specialist nurse role to join the AACC team and provide daily safeguarding support to AACC staff and management of complex safeguarding cases. This role was developed following recognition of complexities of cases and an increase of safeguarding concerns relating to people with care needs funded by NHS Continuing Care. The nurse is supported by the safeguarding team through supervision.

Sussex Police

Operation Signature (known as Op Signature) ensures all vulnerable fraud victims receive a visit from a uniformed officer or Police Community Support Officer (PCSO), who provide reassurance and support, and makes referrals to or signposts to other agencies who can help. The data used in this report is taken from the Sussex Police Fraud Power BI dashboard. In order to focus on vulnerable victims, this report uses Op Signature data unless stated otherwise.

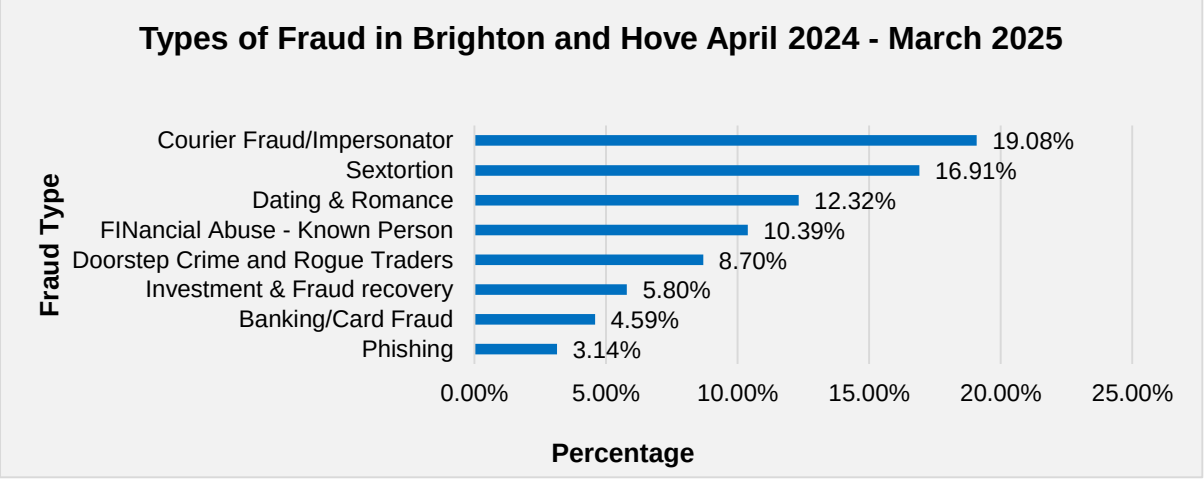
As Sextortion is a blackmail offence and not fraud, this has not been included within the Brighton and Hove overview demographic data. This is to give a more accurate vulnerable fraud victim profile so it would not be adversely affected due to the inclusion of non-fraud data. The data period in this report is inclusive of data between April 2024 – March 2025. There is also data from April 2023 – March 2024 included within this report, when comparing trends.



There was a continual increase in the number of Operation Signature cases between Q1 and Q3 in Brighton and Hove, before a decrease in Q4. Cases were at their lowest in in Q1 and peaked in Q3, compared to previous year where the number of cases grew every quarter. However, the total number of cases for the year was identical to 23/24 with a total of 392.

High risk reports were at their lowest in Q1(10 actual) and peaked in Q3(18 actual). Medium risk reports were at their lowest in Q4 (30 actual) and peaked in Q3 (41 actual). Standard risk reports were at their lowest in Q1 & Q4 (46 actual) and peaked in Q2 (53 actual).

There was a total of £4.16 million lost in Brighton and Hove between April 2023 – March 2024. Between April 2024 – March 2025 the total lost was £4.77 million. The equates to an average loss per victim of £11,628.



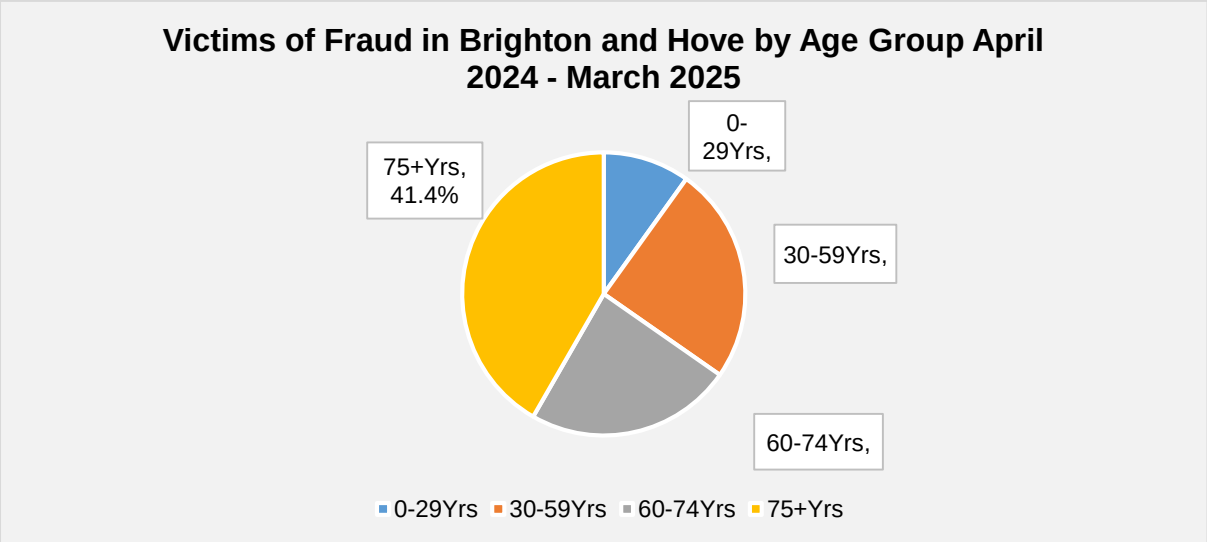
Between April 2024 and March 2025 in Brighton and Hove, the top three fraud types were Courier fraud / impersonator, Sextortion and Dating and romance. Compared to the previous year we have the same three fraud types. However, Courier fraud/impersonator has overtaken sextortion to be the most reported fraud type. This change could possibly be accounted for as victims of sextortion under the age of 18 are no longer coming into Operation Signature as they have in previous years.

Courier fraud / impersonator offences accounted for almost a fifth of all fraud reports in Brighton and Hove in the last year (19%) and compared to the previous year the number of reports increased by approximately 36% (increase of 21 actual). Victims of this type of fraud were most frequently female (72%), this differs considerably from the previous year where 52% of victims were male. Over two thirds of the victims were over the age of 75 (67.1%) and 55.7% of victims lived alone.

Sextortion is a form of blackmail where a perpetrator threatens to reveal intimate images of the victim online unless they give in to their demands – these demands are typically for money or further images. Criminals might befriend victims online by using a fake identify and then persuade them to perform sexual acts in front of their webcam. Criminals will then threaten to share the images with the victims' friends and family which can make the victims feel embarrassed and ashamed and prevent them from coming forward to report the incident.

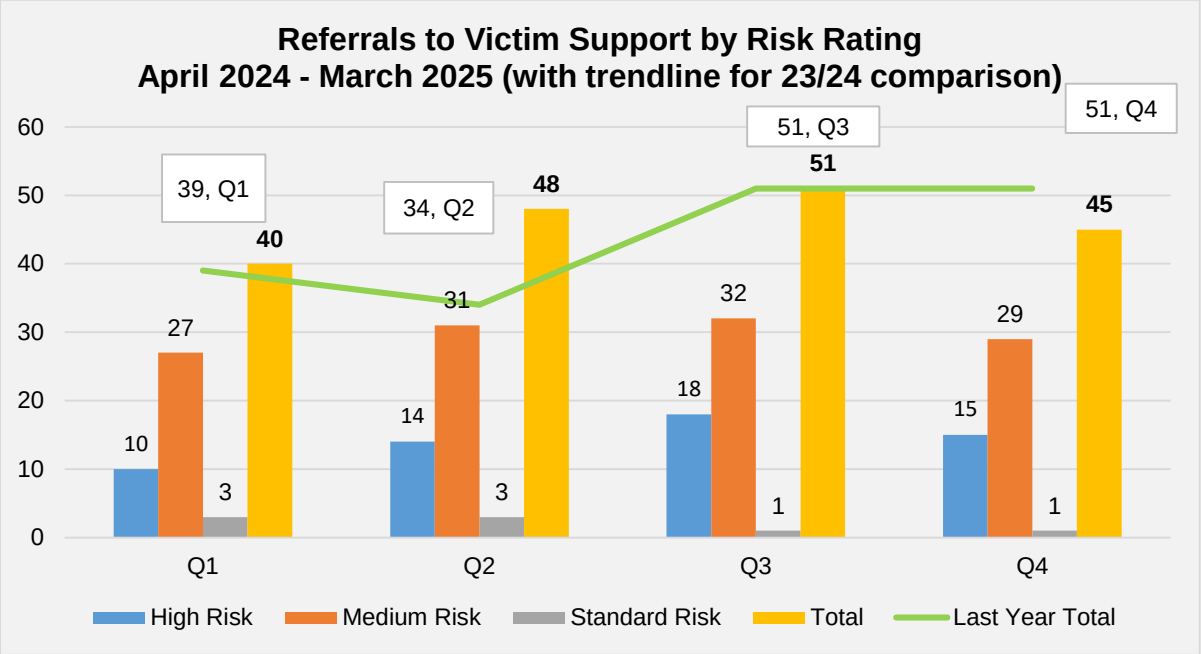
Sextortion offences was the second most frequent reported offence accounting for nearly 17% of fraud offences in Brighton and Hove in the last year. Compared to the previous year, the number of reports has decreased by 36.4% - an actual decrease of 40 cases. In the last year, 67% of victims were aged 0-29 years old. Males were the most frequent victims of sextortion offences accounting for 87% of victims; victims more frequently did not live alone (80%).

Dating and Romance fraud was the third most frequent type of fraud between April 2024 - March 2025. The number of reports is identical to the number reported the previous year (51 actual). There were slightly more male victims than female (a difference of 1 actual). Victims' age groups were most frequently aged 30-59 (33.3%). It was more frequent that victims of Dating and romance fraud lived alone (61%).

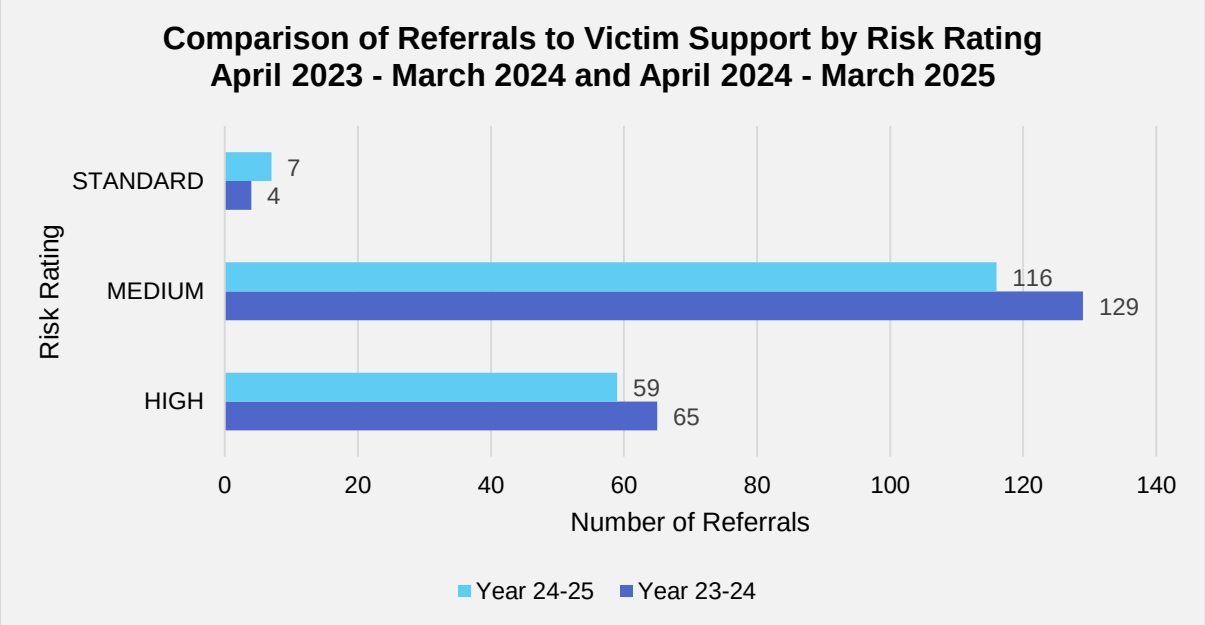


NOTE: As sextortion is blackmail and not fraud, this has not been included within the Brighton and Hove overview demographic data (above). This is to give a more accurate vulnerable fraud victim profile so it would not be adversely affected due to the inclusion of non-fraud data.

Between April 2024 - March 2025, just over 40% of victims in Brighton and Hove were aged 75 and over (144 actual). Compared to the previous year this is an increase of 23% of victims being over the age of 75.



Between April 2024 - March 2025, the number of referrals to Victim Support increased from Q1 to Q3. Q4 saw a decrease. Q1 had the lowest number of referrals. However, referrals peaked in Q3, a difference of 11 to Q1.



Medium and High-Risk referrals to Victim Support in April 2024 – March 2025 decreased compared to the previous year. The number of standard risk case referrals increased. Overall, the number of referrals to Victim Support decreased by 8% compared to the previous year. Medium risk referrals were the most frequent risk referral risk rating.

Sussex Partnership NHS Foundation Trust (SPFT)

Brighton and Hove adult mental health services are provided jointly by the Local Authority and Sussex Partnership NHS Foundation Trust (SPFT) under a Section 75 (NHS Act 2000) agreement, which allows for the integration of health and social care services.

SPFT has a dedicated Safeguarding Service that supports the Trust to carry out its work in line with safeguarding legislation and best practice. The service delivers safeguarding training across the Trust, provides safeguarding consultations for clinical staff, contributes to quality reviews of its services and is involved in specific safeguarding issues as they arise. The service represents the Trust in multi-agency safeguarding forums, such as the Brighton and Hove Safeguarding Adults Board.

Safeguarding Incidents

Table 1 shows the number of safeguarding adult incidents that were raised by SPFT teams working in Brighton and Hove in 2024-25; numbers in brackets are the previous year's figures. The overall numbers increased compared to the previous year. Part of this increase is likely due to greater understanding of safeguarding concerns and the requirement to record and raise them with the local authority.

Table 1 - Adult Safeguarding Concern Incident Numbers 2024-25

Categories of Abuse	2024/25
Physical	**79** (91)
Sexual	**32** (19)
Financial	**34** (34)
Discriminatory	**2** (2)
Domestic	**34** (45)
Psychological/emotional	**52** (29)
Neglect & acts of omission	**53** (36)
Self-neglect	**26** (32)
Organisational	**22** (10
Modern slavery	**0** (0)
Total	**334** (298)

Section 42 Enquiries

SPFT safeguarding enquiry information records 24 enquiries within Brighton and Hove where the Trust was named as the cause of risk. This was an increase of 10 on the previous year. Most of these enquiries were linked to inpatient mental health settings

and were classified as neglect and acts of omission. The integrated working of SPFT and Brighton & Hove City Council Adult Social Care Mental Health Teams enables close working to manage these safeguarding enquiries in line with the desired outcomes of the adult at risk. The enquiries are undertaken by social care staff who are seconded within SPFT mental health services.

Safeguarding Adult Reviews

SPFT participates in the Safeguarding Adults Review (SAR) work of the SAB. In September, the SAB published SAR Oliver. This was a significant review for SPFT because Oliver was a mental health service user who had been open to its services shortly before he died. SPFT, alongside partner agencies, is addressing the recommendations arising from the review. For SPFT, the recommendations focus on maintaining contact and service provision with patients who move between different geographical areas. The review highlights the challenges of multi-agency working and service provision for people with multiple compound needs.

Safeguarding Initiatives and Projects

Prevent - The Trust reviewed and updated its Prevent Policy to reflect changes to terminology and definitions arising from the national review of Prevent in 2023. The Trust also began a project to analyse 130 cases referred by SPFT to the Prevent Channel Panel process. The work will conclude in 2025, and its results will be shared to inform all services of the characteristics of people being referred to Prevent who are linked to mental health services. It is hoped that the report will lead to publication of an academic paper in this area of work.

Responding to Trust to staff experiencing or perpetrating domestic abuse - The Trust reviewed its staff domestic abuse policy to ensure that support of its own staff who experience domestic abuse is in line with best practice.

Changing the language: a guide to language for mental health - The Trust's safeguarding service contributed to the development of a new language guide for mental health. Learning from SARs about the power of language to engage or exclude was shared with the project and is reflected in the guide. The guide can be found at Changing the Language Guide and is for use by all agencies.

Self-harm within inpatient settings - The safeguarding service has developed guidance on when inpatient self-harm incidents should be raised as safeguarding concerns with local authorities. Self-harm, and suicide, is not a category of abuse under the Care Act 2014, however, when it occurs in an inpatient setting it can lead to concerns that it might have been preventable and that the harm resulted from neglect of care. This guidance will aid decision making about how to apply safeguarding criteria to self-harm.

Sussex Community NHS Foundation Trust

Sussex Community NHS Foundation Trust (SCFT) serves a wide geographical area which includes; West Sussex, Brighton and Hove, High Weald, Lewes and Havens, and provides health services in the community to both adults and children.

Safeguarding is a fundamental part of our recruitment process, ensuring appropriate checks are in place to ensure all staff are employed within SCFT services to contribute to the delivery of excellent care within the community. All staff have access to mandatory and statutory safeguarding training for adults and children appropriate to their role and position within the Trust, including higher-level training for those in specialist roles.

SCFT has a safeguarding team which provides specialist advice for both adults and children across all services and supports staff to recognise signs of abuse and how to report it. The Trust works effectively with all safeguarding partnerships to ensure a multi-disciplinary and cross-agency approach.

The safeguarding team works closely with new service developments to ensure we provide high quality and effective health services. The team is part of a Quality and Safety Department, which enables close working both with specialist safety teams and clinical staff. This ensures that we focus on learning for improvement and strengthens our personalised approach to safeguarding. In 2025-26 there will a Trust-wide focus on developing good practice around the Mental Capacity Act and Mental Capacity Act assessments.

We continue to work in line with our safeguarding strategy, which underpins our commitment to providing excellent care at the heart of the community. The aim of the strategy is to ensure that everything we do, wherever it takes place, ensures the safety, security, and well-being of children and adults who are involved with our services. This will be achieved through achieving the following goals, which reflect the priorities of the Trust's Strategy:

Our People - We will provide effective safeguarding advice and guidance to our staff, volunteers, and carers to enable them to support people with safeguarding concerns.

Inclusive - We will recognise and respect diversity to meet the safeguarding needs of marginalised and seldom-heard groups, reducing inequalities and deprivation within our communities.

Learning - We will continue to promote a culture of continuous safeguarding improvement and learning in the face of economic uncertainty.

Partnerships - We will build on internal and external partnerships to strengthen our safeguarding practice. Developed with the help of SAB partners, the strategy sets out how we will deliver our commitment to safeguarding and our strategic priorities for the next three years.

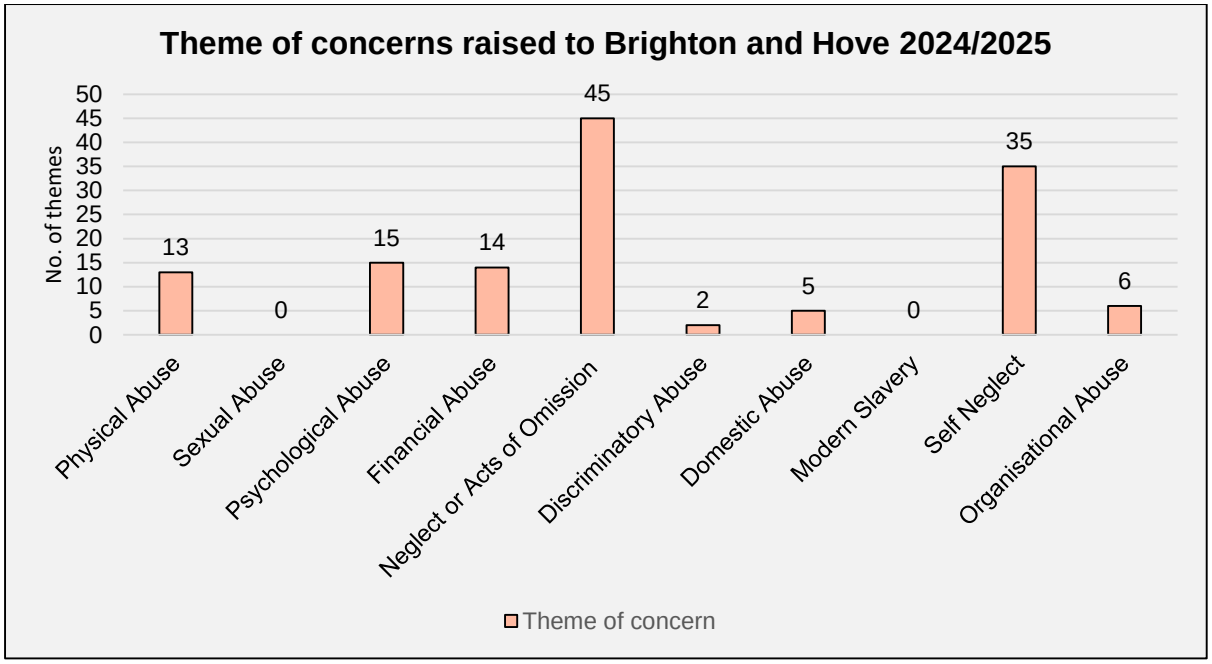
Safeguarding Adults Training

Level	Target Cohort	Target Compliance	2024-25 Data	Analysis of Variance
L2	Mandatory for all staff	85%	98%	Compliance remained above SCFT compliance target of 95%.
L3	Mandatory for all Adult and Specialist Services registered nursing and AHP staff Band 5-8a	85%	90.5%	In line with the NHS Intercollegiate Guidance the annual target is 85%.
L3 WRAP	Mandatory for Adult and Specialist Services staff that require Adult Safeguarding L3, and Childrens Services.	85%	97.5%	Compliance evidences that the final stretched third year target of 85% by Q4 2023-24 has been met.
L3 MCA	Mandatory training for all new starters (in L3 cohort) and is also accessible to all staff should they chose to complete it.		New starter compliance: 96.4%	ESR Module MCA: Assessing Mental Capacity. Completion will fluctuate depending on new staff flow into SCFT, and substantive staff choice to complete.

Raising safeguarding concerns

SCFT staff demonstrate an awareness of risk and escalate adult safeguarding concerns to ensure support is provided to the adults involved. Safeguarding concerns raised to Brighton and Hove City Council are as follows:

Adult safeguarding concerns raised by SCFT to BHCC 2024-25	
BHCC	**102**



The table above shows the various safeguarding themes captured within the concerns raised to BHCC, and the key theme of neglect / acts of omission is as expected given the broad scope of issues encompassed within this category across health and social care services. These concerns may relate to care provided by SCFT, care delivered by other health or social care providers of care given by unpaid carers, such as family members and friends.

SCFT Internal Safeguarding Adults Advice Line

SCFT staff have access to specialist advice via the SCFT safeguarding advice line. This support enables SCFT staff to improve their practice, knowledge and confidence in safeguarding and supports better outcomes for adults who need care and support. This also reinforces a culture of developing improved outcomes in the promotion of safeguarding adults from harm and abuse in line with the values expected from all healthcare professionals.

SCFT: Safeguarding Adults Advice Line	2024-25
Contacts (Trust-wide)	**552**

Advice line contact demonstrates that staff discuss concerns directly with patients (when appropriate to do so and in line with consideration of mental capacity), provide risk mitigation where possible, provide safety netting information and case management, and contact Adult Social Care directly when urgency is required. The SCFT Safeguarding Adults team also escalates potential quality issues within other provider services to the NHS Sussex Integrated Care Board (ICB) Safeguarding Team for wider consideration.

East Sussex Fire and Rescue Service (ESFRS)

Table 1 below shows the number of Home Safety Visits (HSV) conducted by East Sussex Fire and Rescue Service in 2024-25 and includes the number of HSV referrals received from Brighton and Hove Homes and ASC, and Brighton and Hove Carelink. There is a slight increase from the overall number of visits undertaken last year of 2,412 with a more consistent number taking place throughout this year.

The work BHCC Homes and Adult Social Care have been undertaking with the Fire service to automate referral processes should support continued consistency in this area going forward.

Table 1: **Home Safety Visits and Referrals in Brighton and Hove** **2024-25**	Q1 Total	Q2 Total	Q3 Total	Q4 Total	**Total**
Home Safety Visits Completed	625	662	608	607	**2502**
Home Safety visit Referrals from B&H Adult Social Care/Access	30	14	21	19	**84**
Home Safety visit Referrals from B&H Carelink	21	24	25	2	**72**

Table 2 below shows the number of CTN (Coming to Notice) Safeguarding Concerns raised by ESFRS in Brighton and Hove over the past year. The total number of visits this year (121) has reduced from last year with a reduction in the number of CTN concerns raised in relation to hoarding, which has reduced from 59 in 2023-24 to 39 this year.

The work being undertaken to increase understanding and awareness of self-neglect, and hoarding behaviour, through the Responding to Hoarding Behaviour framework, updated Pan-Sussex Self-Neglect procedures and accompanying webinars should help in improving earlier multi-agency responses to these issues.

Table 2: **Safeguarding Coming to Notice forms raised to Adult Social Care** **2024-25**	**Total: 121**
Additional Support	37

Hoarding	39
Living Conditions	16
Mental Health	6
Self-Neglect	4
Unsuitable Living accommodation	4
Alcohol	3
Suicidal/Self Harm	3
Smoking	2
Unattended Cooking	2
Cuckooing	1
Domestic Abuse	1
Financial Abuse	1
Possible Abuse	1
Welfare Concerns	1
Arson (inc threats)	0
ASB	0
Bariatric	0
Building Concerns	0
County lines	0
Falls	0
Firewise - Firesetting	0
Hate Crime	0
Modern Slavery	0
Repeats Incidents	0
Substance Misuse	0
Threats of Harm	0

University Hospitals Sussex NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust (UH Sussex) is one of the largest organisations in the NHS. It employs approximately 20,000 staff and serves a population of 1.8 million people. The Trust delivers services from seven hospitals across Brighton and Hove, West and Mid Sussex and part of East Sussex.

The Safeguarding Adults Team at UH Sussex offers specialist support across all hospital sites and outlying services. The team faced some challenges towards the latter half of the year due to staff vacancies and changes to the senior leadership team. However, all vacant posts have been successfully recruited into, and a new safeguarding senior leadership team have been appointed to ensure UH Sussex continues to embed the principles of safeguarding practice throughout the organisation.

Figure 1 below pertains to the number of safeguarding concerns raised by UH Sussex staff, across all categories of harm or abuse, on behalf of people attending our hospitals who are residents of Brighton and Hove. It also provides a comparator with the number of safeguarding concerns raised the previous year.

Fig 1: Safeguarding Concerns raised by UH Sussex

This shows that in common with other partners the highest number of safeguarding concerns were raised in relation to neglect and omission, and that there was a significant increase in this area from the previous year. There were also increases in relation to psychological abuse, self-neglect and domestic violence. Figures 2 and 3 show the number of safeguarding concerns raised by gender and age, with just under 50% in relation to individuals aged over 65.

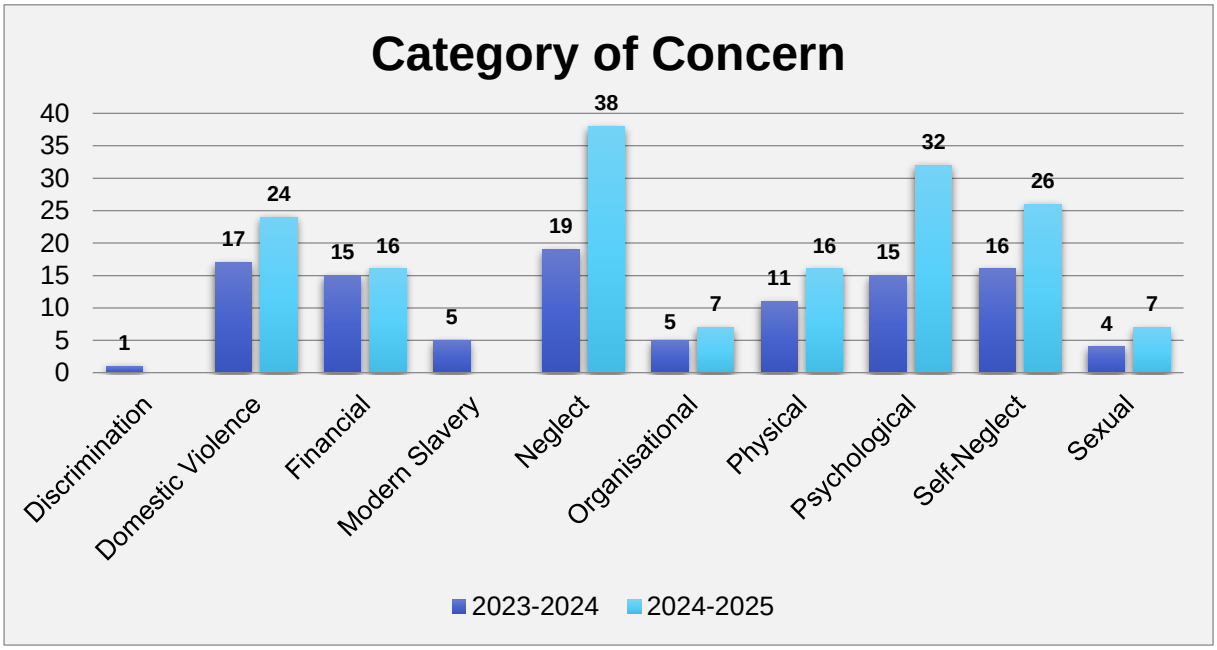


Fig 2: Safeguarding Concerns Raised by Gender 2024 – 2025

Figures 2 and 3 provide additional data pertaining to safeguarding concerns raised by UH Sussex staff during 2024-25 in relation to gender and age categories.

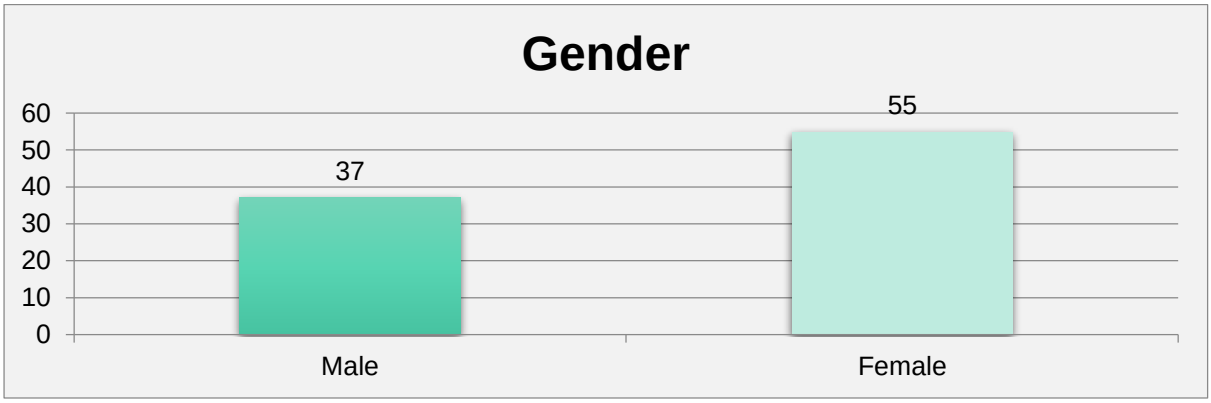
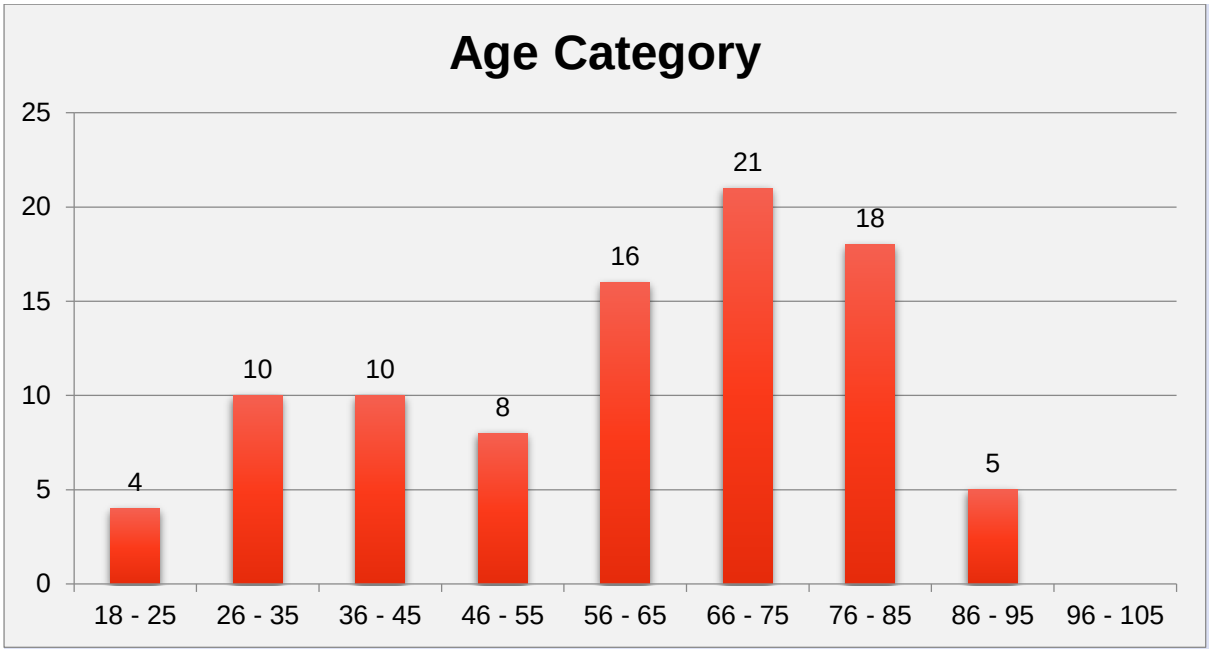


Fig 3: Safeguarding Concerns Raised by Age 2024-25



Domestic Abuse

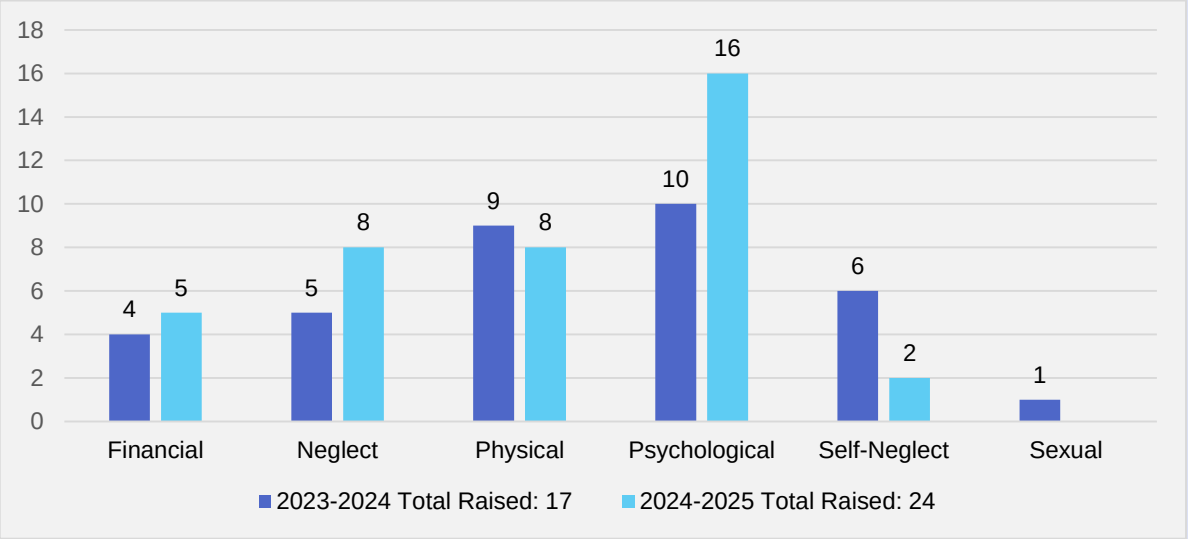
Figure 4 below pertains to adult safeguarding concerns raised by UH Sussex staff specifically relating to domestic abuse. It is worth noting that one safeguarding concern may relate to multiple categories of harm and abuse that constitute domestic abuse.

Victim Support provide specialist domestic services across Brighton and Hove. They employ a Health Independent Domestic Violence Advisor (HIDVA) who provides onsite specialist support to the Royal Sussex County Hospital in Brighton. The HIDVA works closely with the UH Sussex safeguarding teams, supporting people accessing hospital services across paediatric, maternity and adult healthcare services. Moving forward in 2025-26, UH Sussex is working with Victim Support to facilitate the provision of male HIDVA onsite support to the hospital. As well as raising safeguarding concerns relating to domestic abuse, UH Sussex staff can refer direct to the onsite HIDVA or Victim Support.

Awareness of domestic abuse is included in mandatory safeguarding adults training. The HIDVA supported the safeguarding adults team in the delivery of additional bespoke training to clinical staff and, in particular, has delivered multiple training sessions for staff working within the Emergency Department at the Royal Sussex County Hospital in Brighton.

The revised UH Sussex Domestic Abuse policy was ratified in December 2024 and is in place across the organisation to support staff with the recognition and response to domestic abuse.

Fig 4: Safeguarding Concerns Raised Relating to Domestic Abuse



Training

Safeguarding adults training has continued to be an area of focus and, in particular, the Safeguarding Adults team have undertaken significant work to improve compliance amongst frontline clinical staff with Level 3 safeguarding adults. The team implemented a blended learning programme consisting of e-learning modules as well as face to face training which includes discussion of case studies and learning from SARs. The Safeguarding Adults training also includes Prevent, Mental Capacity Act and Deprivation of Liberty Safeguards. Completing all elements of the blended learning programme is mandatory for clinical staff. Since implementing the programme at the start of Q3, compliance with Level 3 safeguarding adults training has improved significantly from 55% to 88% at the end of Quarter 4.

Level 1 safeguarding adults training is included as part of induction the UH Sussex for all staff. Level 2 training is provided via an e-learning module developed for staff during COVID -19. Reviewing and updating level 2 training is one of the team objectives for 2025-26.

Partnership working

The safeguarding adults team continues to work in partnership with the SAB throughout 2024-25, contributing to an increasing number of Safeguarding Adults Reviews and Domestic Abuse Related Death Reviews, many of which are ongoing or awaiting publication. These include SAR Frank and Paul, SAR Henry, and SAR Hassan.

As part of ongoing actions from the previous SAR Craig, UH Sussex continues to improve MCA processes across the organisation. A revised template document for completion of Mental Capacity Assessments is mandated for use by clinicians across all UH Sussex hospitals. Moving forward into 2025-26, a new Mental Capacity Act and DoLS Operational Group is to be implemented. The Terms of Reference have been

agreed by the UH Sussex Safeguarding Strategy Committee and membership includes senior nursing leadership, medical staff, allied health professionals, local authority DoLS leads, the LeDeR* senior reviewer and the programme lead at NHS Sussex. The first meeting of the Operational Group is expected to take place in Q1 and, moving forward, will be chaired by the newly appointed Head of Nursing for Safeguarding Adults and Learning Disability.

The Sussex SAB protocols are highlighted during staff training to include raising awareness of, for example, the SAR protocol and the Adult Death Protocol. The Sussex Safeguarding Threshold Document is accessible to all staff via the Safeguarding Adults Team Infonet page and an electronic copy is sent to all staff attending the Level 3 training.

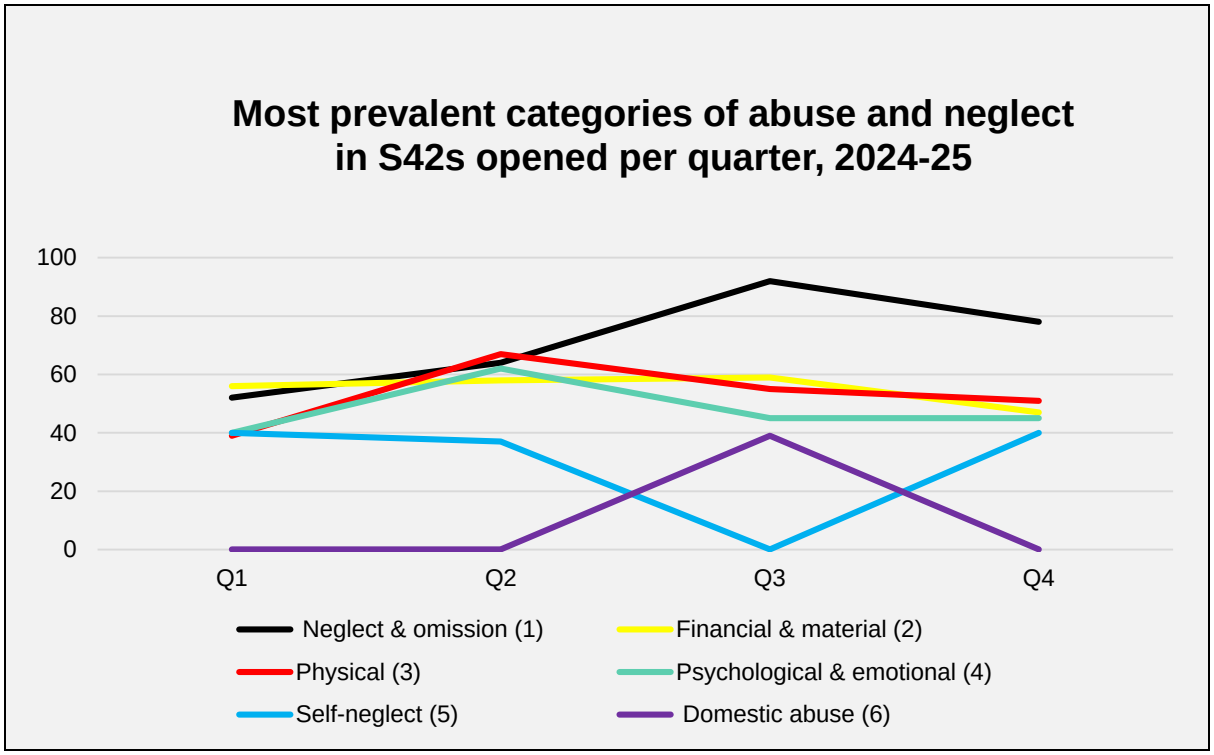
The Lead Nurse for Safeguarding Adults continues to act as vice-chair of the SAB Learning and Development subgroup and represents UH Sussex at the SAR subgroup and Quality Assurance subgroup.

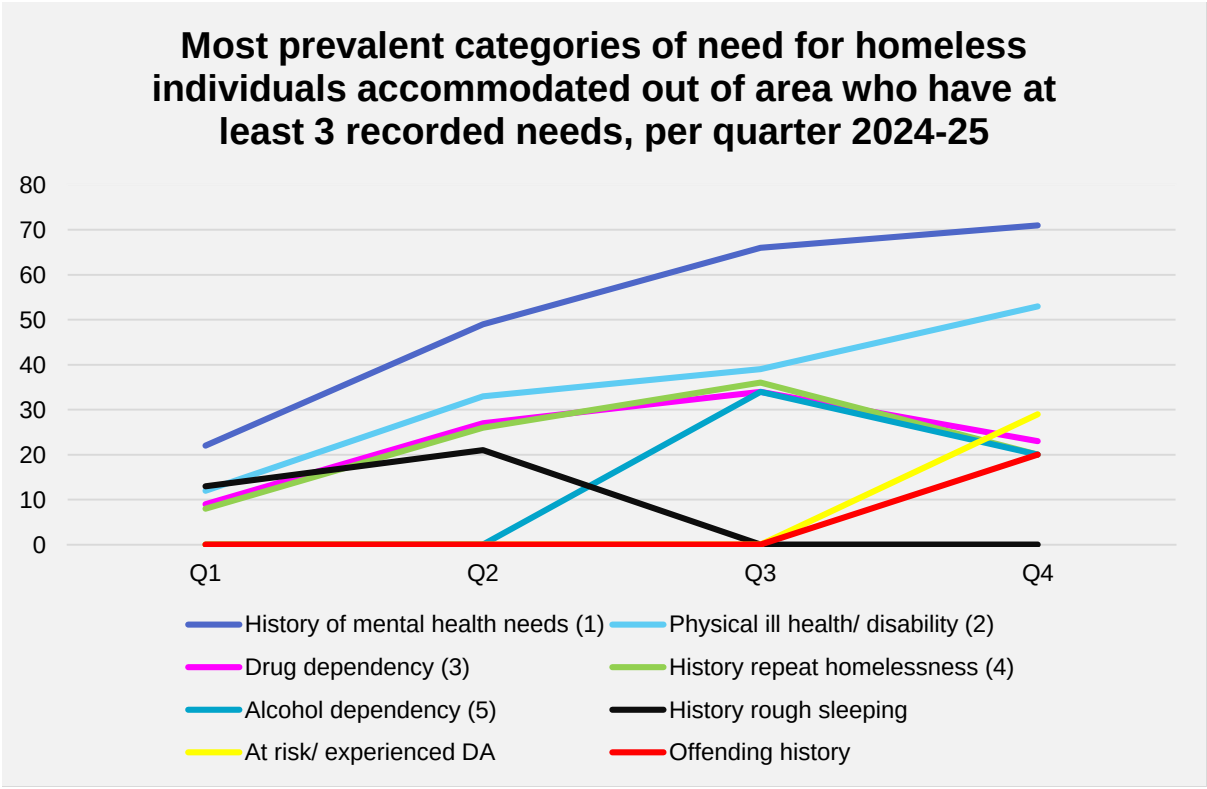
2024-25 BHSAB data dashboard end of year summary data

The following charts provide oversight of select data sets included on the BHSAB's data dashboard from the council's Homes and Adult Social Care directorate.

These provide an overview of the categories of abuse and neglect identified in section 42 enquiries throughout the year in the first table and in the second table the most prevalent categories of need for homeless individuals accommodated out of area. This shows that a history of mental health needs is the most common category and reflects the increase seen in recent years in individuals who experience multiple compound needs.

N.B. '0' on these charts represents that the applicable category did not appear within the top five for that quarter.





Future Priorities

The previous BHSAB three-year Strategic Plan has now concluded. An in-person learning event has been held with our partners to review progress over this period and to identify and agree future priorities to inform the next three-year BHSAB Strategic Plan. These reflect priorities identified from recently published and ongoing SARs, other SAB activities, individual partner priorities, as well as the previous self-assessment and peer challenge process.

Partners consider that whilst some updates are required, the four previous strategic priorities – Leadership and Accountability, Performance and Quality, Communication and Engagement, and Workforce Development all remain key. A further fifth strategic priority has been identified, the need to understand the informed voice of those involved in adult safeguarding processes and for this to be used to inform future improvement actions. This will be taken forward through a targeted piece of work over the next year.

A key focus for the partnership is the board becoming more evidence-based through the increased use of data as well as quality assurance mechanisms and continuing to develop our relationships with other boards and partnerships. These will be woven through the new Strategic Plan for 2025-28 and are crucial elements of the three specific areas of focus. These are framed as questions that will be posed to the partnership

The new areas of focus that will be taken forward are -

- **How do we know we are learning?**
- **How does Transitional Safeguarding support people?**
- **How do we deliver prevention in safeguarding?**

Safeguarding Adult Reviews (SARs)

The SAB will continue to progress the SARs already underway and those in the process of being commissioned to ensure these are completed in a timely manner and learning is effectively shared across the partnership.

We will continue to progress SAR action plans already underway, including the implementation of new transitional safeguarding arrangements locally, and working in partnership with independent reviewers and partners to translate recommendations made into effective improvement actions.

We will continue to incorporate learning from a range of forces, including the second national SAR analysis, into our internal processes and publish recently updated guidance to support partner organisations in providing accurate and timely information to support SAR processes.

Quality Assurance

Quality assurance is a key part in the board becoming more evidence-based and data driven. Following the recruitment of a Board Support Officer last year a multi-agency

data dashboard has been developed. Detailed information from the local authority Housing and Adult Social Care directorates is being regularly gathered and analysed, before being presented to the Quality Assurance subgroup and full board. This provides assurance on statutory adult safeguarding activity across the city, including themes and emerging issues, and as part of a preventative approach to adult safeguarding. This has already led to a multi-agency audit exploring multi-agency working arrangements in relation to the death of homeless individuals. The next phase of the data dashboard will be incorporating information from other statutory partners, Sussex Police and NHS Sussex, that includes community safety data.

We will continue our SAB multi-agency quality assurance audit programme, firstly concluding the audit currently underway on homeless deaths and multi-agency working arrangements, before expanding the programme to incorporate reviews of previous audits undertaken. This will help the board understand developments introduced since the audits were undertaken and current arrangements.

The introduction of a new partner quality assurance spotlight at subgroup meetings will enable the board to understand internal quality assurance processes being undertaken and where there are learning opportunities that can be shared.

A further quality assurance activity that will be undertaken during 2025-26 will be the bi-annual Pan-Sussex Self-Assessment and Peer Challenge. The BHSAB has collaborated with the East Sussex and West Sussex Safeguarding Adults Boards to develop a self-assessment tool that will be circulated to all board partners for completion ahead of a peer challenge event taking place.

Learning and Development

The learning and development priorities for 2024-25 aligned to the BHSAB areas of focus. The progress made will be reviewed and new learning and development priorities agreed for 2025-26 and activities identified and undertaken. These will be based on the BHSAB priorities and areas of focus, learning from Safeguarding Adult Reviews, quality assurance processes, and adult safeguarding themes and issues identified as priorities by individual partner members.

Embedding learning at all layers has been identified as a continuing area of focus for the BHSAB during 2025-26. As part of an evidence-based approach we will look to evaluate the effectiveness of how learning from previous SARs, and other SAB activities including previous areas of focus, is being embedded across the partnership and where there are areas for further development.

We will continue developing our relationships with other boards and partnerships, identifying shared themes and opportunities for joint learning and development activities such as system networking events. As transitional safeguarding arrangements develop locally the BHSAB will undertake learning and development activities to support with raising knowledge and awareness of this.

We will use the learning and development subgroup to continue to request updates from partner agencies in relation to internal learning and development activities being undertaken to gain assurance as well as seeking to share learning opportunities where relevant.

Communication and Engagement

Communication and engagement with communities is a priority for the BHSAB during 2025-26 and we will develop new approaches that reach adults, communities, and professionals across organisations with involvement in adult safeguarding.

This will include reviewing the membership of the board and subgroups, developing a communication and engagement strategy to increase knowledge and understanding of the work of the BHSAB, as well as commissioning a piece of work to understand the experiences of those with an informed voice who have had lived experience in adult safeguarding and to use this to inform future improvement actions.

The Practitioners Alliance for Safeguarding Adults (PASA) became a formal subgroup of the SAB during 2024-25 and during the year ahead we will continue to increase the membership so that professionals across the system in safeguarding roles, whether in the statutory or independent sectors, can use this to increase their knowledge and understanding of adult safeguarding. We will also involve PASA members in contributing to the development of policies and procedures appropriate and seek to understand how they are involving individuals with lived experience in their processes and where there are examples of good practice we can learn from.

The Brighton and Hove SAB will continue to work with our colleagues at the East Sussex and West Sussex SABs, and our statutory partners, in relation to the pan-Sussex safeguarding procedures and shared resources that support a consistent approach to adult safeguarding across Sussex wherever possible. This includes a new website to host the pan-Sussex Safeguarding Policy and Procedures that will improve accessibility and contains several new and updated chapters reflecting learning from recently published SARs.

Appendix

Glossary of Terms

Changing Futures

Changing Futures Sussex is one of 15 programmes set up across the country to improve the way local systems and services work for adults experiencing multiple disadvantage. The aim is to create an environment where individuals experiencing multiple disadvantage can receive flexible, trauma informed, person-centred support when they need it, leading to increased periods of stability and more opportunities to make positive changes in their lives.

Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty safeguards (DoLS) ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person's best interests. Representation and the right to challenge a deprivation are other safeguards that are part of DoLS.

Intersectional (Multiple and Intersectional Needs)

In this context intersectional needs is used to describe the ways that multiple needs (for example homelessness, mental health issues, substance use, domestic abuse and current or historical offending behaviour) interact or compound and exacerbate each other, so that a combination of increasing health and social care needs are experienced simultaneously.

LeDeR (Learning Disabilities Mortality Review Programme)

LeDeR is a service improvement programme, funded by the NHS, established to improve healthcare for people with a learning disability and autistic people. It aims to

improve care for people with a learning disability and autistic people, reduce health inequalities for people with a learning disability and autistic people, and prevent people with a learning disability and autistic people from early deaths.

Practitioners Alliance for Safeguarding Adults (PASA)

This is a group that enables frontline professionals from organisations involved in adult safeguarding, including those working in the independent and voluntary sector, to come together to identify and discuss current or emerging adult safeguarding themes and issues. It provides an opportunity for these themes or issues to be communicated to the SAB and for the group to provide direct feedback on work undertaken by the board, and by individual partner organisations, and for members of PASA to contribute to the development of this work.

Prevent

Prevent is a government-led, multi-agency counter-terrorism programme that aims to stop individuals felt to be vulnerable to potential radicalisation becoming involved in or supporting terrorism. A range of partners participate in the Prevent programme, including Police, the local authority, and community organisations.

Our Partners

In addition to the three statutory partners the further partners of the Brighton and Hove SAB are:

- University Hospitals Sussex NHS Trust
- East Sussex Fire and Rescue Service
- Healthwatch Brighton and Hove
- National Probation Service
- South-East Coast Ambulance Service NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- Department of Work and Pensions
- Bridging Change
- Voluntary and Community Sector representation (represented by the Practitioners' Alliance for Safeguarding Adults)
- Brighton and Hove Safeguarding Children Partnership

In addition, the SAB Board maintains links with the following:

- East Sussex SAB
- West Sussex SAB
- The National Network of Chairs of SABs
- The Safeguarding Adults Board Manager Network
- Brighton and Hove Community Safety Partnership
- South-East Regional SAB Network

Partner Attendance at BHSAB Board Meetings during 2024-25

Organisation	June 2024	Sept 2024	Dec 2024	March 2025

BHCC Cabinet Members for Adult Social Care and Health and Wellbeing Board	✓	✓	✓	✓
BHCC Adult Social Care	✓	✓	✓	✓
BHCC Housing People Services	✓	✓	✓	✓
Bridging Change	✓		✓	✓
Brighton & Hove and East Sussex Probation Services	✓	✓	✓	✓
Change Grow Live	✓		✓	✓
Department of Work and Pensions	✓	✓	✓	✓
East Sussex Fire and Rescue Service	✓	✓	✓	✓
Healthwatch	✓	✓	✓	✓
Money Advice Plus	✓		✓	✓
NHS Sussex	✓	✓	✓	✓
NHS Sussex Named GP for Safeguarding	✓		✓	✓
Public Health	✓	✓		✓
South-East Coast Ambulance Service				
Sussex Police	✓	✓	✓	✓
Sussex CFT	✓	✓	✓	✓
Sussex SPFT	✓	✓	✓	
University Hospitals Sussex	✓	✓		✓
YMCA	✓	✓	✓	✓

Our Budget

The Brighton and Hove SAB has a pooled budget; Partner agencies contribute to the running of the board financially, and by chairing and facilitating meetings, providing use of their buildings and facilities, and contributing time and expertise to learning events.

Income for 2024-25

Brighton and Hove City Council	£110,040
Sussex Police	£22,610
NHS Sussex	£26,600
Total	**£159,250**

With a full staffing complement expenditure was higher during 204-25 than during the previous year. Review costs were less than anticipated with one review previously anticipated as being completed during this year now concluding in 2025-26.

Expenditure in 2024-25

Item	Subtotal	Total
Staffing		£150,254

Business Manager	*£71,758*	
Administrator	*£23,089*	
Board Support Officer	*£43,112*	
Independent Chair	*£11,359*	
Other	*£936*	
Safeguarding Adult Reviews		£5,400
Website costs		£1,066
BHSAB Events		£1,062
Other costs		£1,170
Sundry costs	£539	
Apprenticeship levy	£581	
Learning and Development	£50	
Total		**£158,952**