Brighton & Hove
SAB
Safeguarding Adults Board

Annual Report

2025/26

Contents

Contents 1
A Message from our Independent Chair 2
A Message from Healthwatch 3
Our City 4
What have we done this year to make a difference? 7
How do we know we are making a difference? 10
Our Budget 13
Safeguarding Adults Reviews 14
SAB Partner Reports 16
Brighton and Hove City Council Homes and Adult Social Care 16
Sussex Police 21
NHS Sussex (Integrated Care Board) 25
Sussex Partnership NHS Foundation Trust (SPFT) 29
Sussex Community NHS Foundation Trust 32
University Hospitals Sussex NHS Foundation Trust 35
East Sussex Fire and Rescue Services (ESFRS) 38
What will we do next year? 39
Appendix 42

A Message from our Independent Chair

It is a privilege and pleasure to introduce the Annual Report for the Brighton and Hove Safeguarding Adults Board (BHSAB) 2025/26

A key feature of the BHSAB has been to lead the SAB in developing the priorities as part of the continuous learning journey for all engaged in adult safeguarding, and the wellbeing of residents in Brighton and Hove.

The Report details the work that has been undertaken, and outcomes that have been achieved. A major emphasis for the SAB is identifying the impact of the work undertaken for the people living in Brighton and Hove, and how we can ensure that we hear the voice of those who are requiring protection from risk and harm, and how partners work together with people to ensure they are safe to live a fulfilling life.

A key feature this year has been the commencement of the project that is being led by Healthwatch Brighton and Hove, to understand people's experiences of safeguarding, to inform future practice and provide support behind this for professionals. This work has started so the BHSAB look forward to hearing the voice of the people in relation to their views

As the Report highlights all partners of the Board have continued to deliver services, provide support to people, and are responding to the changing safeguarding needs and risks that occur, in what I have highlighted as challenging times for public services. The sub-groups, and in particular the Chairs, are owed much gratitude for their continued dedication and commitment to ensuring that the BHSAB's priorities are delivered.

The statutory partner organisations have provided details about how they are contributing to identifying and supporting people at risk, and those who may require care and support so they can live safely in our community

I am grateful to all partners for their contributions and ongoing support as there continue to be challenges across many partners with structural and staffing changes both in the last year and which will continue, the commitment to Brighton and Hove Safeguarding Board, and focus upon serving the people of the city to ensure prevention of abuse and neglect has been solid.

Finally, I would like to thank the Business Manager for efficiently and effectively managing the business of the Board despite the staffing challenges. I would also again this year wish to acknowledge the work of staff and managers across all statutory, voluntary and community partners who are committed to working together to safeguard those at risk across 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 2025-26 on behalf of Healthwatch Brighton and Hove Community Interest Company. We are the independent patient champion for people in the city.

The Safeguarding Adults Board (SAB) has continued to perform strongly under the SAB Leadership. Highlights include:

- updated key protocols and guidance that support professionals to be effective and timely in their approaches to safeguarding
- an enhanced data dashboard to increase awareness of performance and quality
- an audit on homelessness
- an online conference on transitions and transitional safeguarding to learn from reviews and to highlight developments being undertaken.

The SAB published two Safeguarding Adult Reviews (SAR) this year. The individual stories make for difficult reading and we must never forget the lives of those affected, including the impacts on family, friends and professionals. The reviews have identified valuable learning opportunities and recommendations which the SAB are actively progressing:

- a review of prescription arrangements, internal mental health processes and of exploitation processes, and the embedding of trauma-informed approaches and self-neglect.
- significant actions include the creation of a local Multi-Agency Risk Management (MARM) framework, a multi-disciplinary team to support those with multiple compound needs, a review of cuckooing arrangements, and the range of pan-Sussex SAB protocols and guidance available.

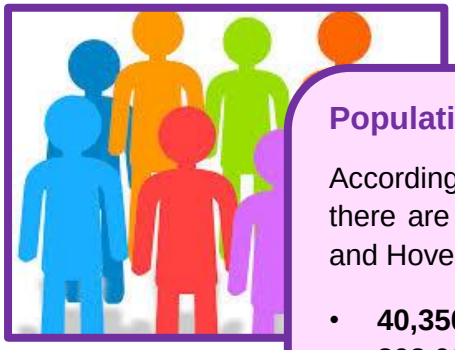
My thanks to Brigid, who in her role as a Healthwatch volunteer, continues to independently Chair the SAR subgroup displaying empathy, professionalism and dedication.

Looking forward, the multi-agency refresh of the SAB's 3-year strategy contains a welcome addition to hear more from people who have experienced the council's safeguarding processes, and to learn from these. I am pleased that Healthwatch was appointed to independently lead this work, supported through engagement with lived experience advisory groups. Outcomes from this work will be included next year's annual report. This may be the last contribution I make if government plans to close Healthwatch go ahead, but I am confident that the SAB partnership is committed to putting people's voices at the heart of adult safeguarding, so that their views are considered in the development of future processes and procedures.

Alan Boyd

Chief Executive Officer, Healthwatch Brighton and Hove

Our City



Population

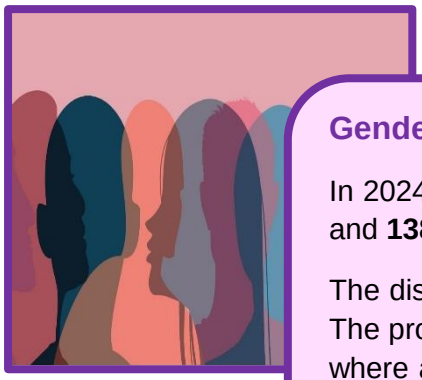
According to the most recent Office of National Statistics (ONS) there are an estimated **283,870** people who reside in Brighton and Hove. This includes -

- **40,350** children aged 0 to 15 years (14%)
- **203,000** working-age adults aged 16 to 66 (72%)
- **40,520** older people aged over 66 (14%)

Ethnicity

72,272 of the residents in Brighton and Hove (26 per cent) of the city's population) are from a Black or minoritised ethnic background.

Whilst slightly higher compared with the South-East (21 per cent) much more in line with England as a whole (27 per cent).



Gender

In 2024 there were an estimated **145,400** females (51 per cent) and **138,470** males (49 per cent) residents in the city.

The distribution of male and female residents is relatively even. The proportion of female residents increases after the age of 75 where an estimated 57 per cent of residents are female and 43 per cent male.

Sexual orientation and gender reassignment

One in ten residents identify as LGBTQIA+.

At least **25,247** residents aged 16+ identify as gay, lesbian, bisexual or another sexual orientation. This is just over three times higher than the South-East overall and 3.5 times higher than in England as a whole. It is the highest proportion seen in any upper tier authority in England.

Health

There are over **50,900** adults with long-term health conditions.

Over 22 pr cent of adults aged over 20+ in the city have two or more long-term physical or mental health conditions – with a strong link to deprivation (54 per cent). **19,060** residents in the city (8 per cent) have physical **and** mental health conditions.

Carers

A total of 20,804 people in the city (8 per cent) provide some amount of unpaid care each week.

Approximately 11,334 residents (4 per cent) provide 19 hours care or less per week, 4,040 (2 per cent) provide 20 to 49 hours care and 5,430 (2 per cent) provide 50 hours care or more. This is similar to both the South-East (9 per cent) and England as a whole (8 per cent).

Information on our city is taken from the Brighton and Hove Joint Strategic Needs Assessment (JSNA) Executive Summary March 2026 and the 2021 Census.

JSNA Health and Wellbeing in Brighton and Hove Executive Summary

Who are we?

The Brighton and Hove Safeguarding Adults Board (SAB) is a multi-agency statutory partnership that provides leadership and strategic oversight of adult safeguarding work across Brighton and Hove aiming to prevent abuse and neglect and protect adults at risk of significant harm. There are three statutory partner organisations, a wide range of partner organisations (see Appendix 1), other boards and partnerships.

Our statutory partners

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

We focus on working in partnership, both locally and across Sussex where possible, to develop consistency across adult safeguarding arrangements.

Under the Care Act 2014 Safeguarding Adults Boards have three statutory duties:

- **To develop and publish a strategic plan setting out how we will meet our objectives and how our partner agencies will contribute to this.**

- **To publish an Annual Report detailing how effective our work has been.**

- **To arrange for Safeguarding Adults Reviews (SARs) to be undertaken when the criteria under Section 44 of the Care Act are considered to have been met.**

Our Board Structure

What have we done this year to make a difference?

The SAB published a three-year Strategic Plan for 2025-28 (See Appendix 3). This contains five overarching strategic priorities which will make a difference for people in the city. Within the strategic plan specific areas of focus are identified that sit under the priorities which are reviewed annually and updated as necessary.

The three areas of focus for 2025-26 were framed as questions for the partnership to consider in how the work of the board and partners will make a difference for people using services in Brighton and Hove. The three areas of focus were –

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

Unfortunately, the SAB Business Unit had reduced resource for much of 2025/26, which impacted progressing work in some priority areas.

Below are details of key work delivered in 2025/26 against the five overarching strategic priorities and how we are meeting this year's areas of focus for 2025/26.

Accountability and Leadership

The biannual partnership self-assessment and peer challenge took place this year. This identified the key issues and priorities for the board and partners that need to be progressed in order to make a difference for people using services. As an outcome these informed the updated BHSAB Strategic Plan and subgroup work plans relating to how to ensure people in our community are protected from abuse.

How do we know we are learning, and how do we deliver prevention in safeguarding

Full board, leadership, subgroup, and affiliated meetings have taken place during the year. A range of agencies have provided assurance on safeguarding related activities and difference this is making including Changing Futures, LeDeR (See Appendix 1 for glossary of terms) programme, Department of Work and Pensions, Right Care Right Person, and local authority provider commissioning arrangements e.g. safeguarding those on welfare benefits, with multiple compound needs, and with mental health needs.

How do we know we are learning, and how do we deliver prevention in safeguarding

Sussex SABs and statutory partners reviewed and updated key protocols and guidance that support professionals to be effective and timely in their approaches to safeguarding. These include the Pan-Sussex Safeguarding Adults Procedures, Adult Death Protocol, Self-neglect Procedures, and the development of standalone guidance that all support a preventative approach to safeguarding.

How do we deliver prevention in safeguarding

Performance and Quality

The BHSAB's quarterly multi-agency data dashboard has continued to develop with information provided by health and police colleagues. This has increased the board's awareness of performance and quality in safeguarding arrangements across the system, as well as identifying local issues for further follow-up to support where improvements need to be made. Examples include multi-agency review processes for those who die whilst homeless and the identification of domestic abuse.

How do we deliver prevention in safeguarding

The board's multi-agency quality assurance programme has continued with an audit on homelessness and review processes arising from the data dashboard expanding this year, as well as a further online audit on the application of the Mental Capacity Act in practice. This will assess how learning from previous reviews is being embedded to increase understanding of statutory safeguarding processes amongst professionals which will improve the support offered to people using services.

How do we know we are learning

The board has published two Safeguarding Adult Reviews this year, 'Henry', and a thematic review on three individuals titled 'Frank Paul and William'. These have identified valuable learning opportunities and further information on these reviews, including key themes, (on page 18 of this report). The SAB is working with partners to support effective improvements being made to the findings from these reviews.

How do we know we are learning

Communication and Engagement with Communities

The BHSAB has communicated and engaged with colleagues and communities that includes those working in housing and mental health, acquired brain injury, learning disabilities, hospitals, carers, and minoritised ethnic communities. This supports improved working relationships across the system. Examples include increasing knowledge of statutory safeguarding processes and procedures, SAB protocols and resources to support improved information-sharing, escalation, and identification of abuse.

How do we deliver prevention in safeguarding

As part of the work being undertaken on hearing the informed voice of those involved in safeguarding engagement was undertaken with lived experience advisory groups. This is to ensure communications are accessible and appropriate and that a wide range of people are able to participate in this work to inform the partnership of their experiences. This will be analysed to increase understanding of current pathways and contribute to future improvements.

How do we know we are learning

The reduced resource in the SAB Business Unit team has meant it has not been possible to fully progress this priority. Once there is additional resource in place this will be taken forward more fully in exploring how the SAB can communicate and engage with communities across the city in ensuring that safeguarding processes and pathways are available and accessible to all.

Inclusion and Workforce fit for the Future

The BHSAB and Safeguarding Children Partnership hosted an online conference on transitions and transitional safeguarding. This was in response to learning from reviews and to highlight developments being undertaken. It was attended by a wide range of professionals across Children and Adult services with a majority of respondents stating their learning in this area increased due to the conference.

How do we know we are learning, and how does transitional safeguarding support people

The board has developed and published a varied range of resources to support workforce development and increase knowledge, skills and experience of those working directly with people. These include a SAR video, 7-minute learning briefings on hate and anti-social behaviour and cuckooing, transitional safeguarding resources, and joint guidance developed with the BHSCP on review processes. These examples enable a consistent and supportive approach by professionals.

How do we know we are learning, and how does transitional safeguarding support people

As part of an increasing focus on data and assurance to capture learning from SARs and other SAB activities a tool has been developed to start regularly gathering information on learning activities being undertaken by partners. This includes asking for details of specific events, how these relate to SAB learning, and what difference these have had for people using services in the city. For example, specific learning or service improvements made as a result of this activity.

How do we know we are learning

Informed Voice of the Person

Healthwatch Brighton and Hove have been commissioned to work with the board, undertaking qualitative research to understand the experiences of people who have had direct involvement in statutory safeguarding processes including how agencies worked together and how people's views and wishes were considered. This is in the early stage of development and will be progressed over the next eighteen months with the final report and recommendations to be used to support future improvements for those using services.

How do we deliver prevention in safeguarding

A survey has been distributed to people involved in safeguarding processes within a set time period. A trauma-informed approach was used to identify those appropriate to contact and the feedback from the responses received will be analysed. Healthwatch will arrange to interview those willing to provide further detailed feedback to enhance understanding of their experiences for the board to target areas that matter to people.

How do we know we are learning

This work will continue during 2026-27 and consideration will be given as to whether further data needs to be obtained and surveys undertaken to ensure a sufficient range of views and experiences are gathered. Once completed the outcomes will be presented to the SAB with recommendations as to how the safeguarding engagement can be improved.

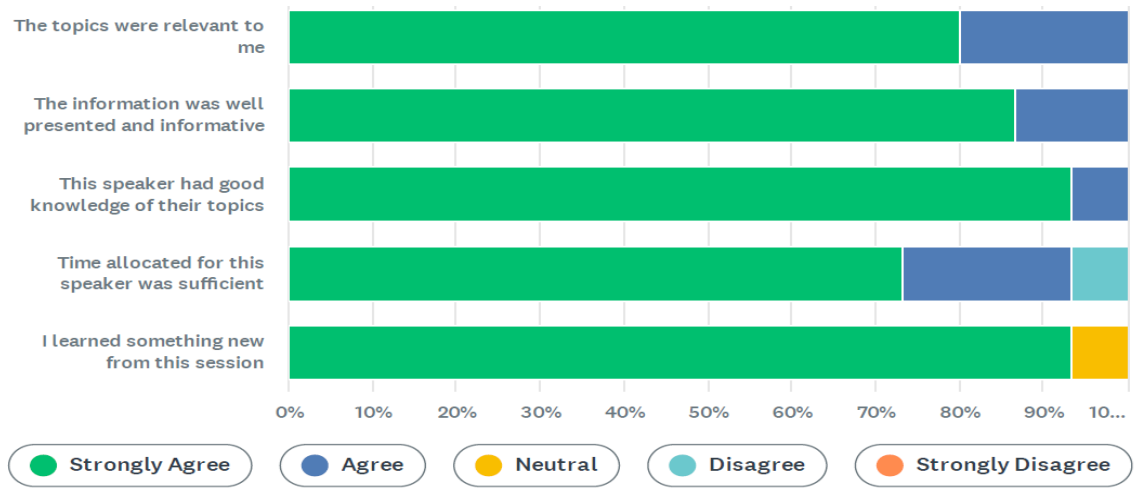
How do we know we are learning, and how do we deliver prevention in safeguarding

How do we know we are making a difference?

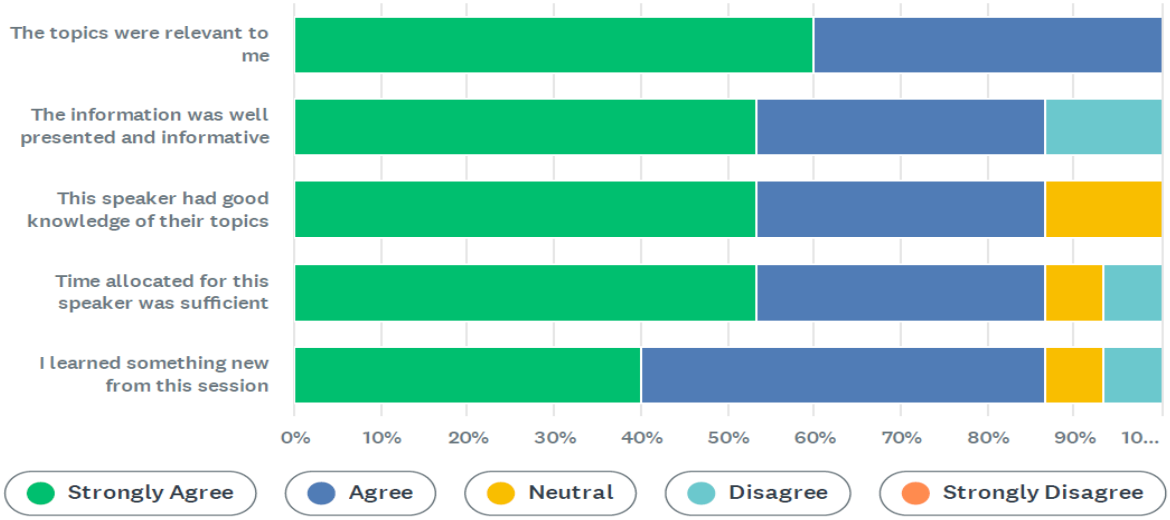
Activities undertaken by the BHSAB during 20256/26 endeavour to reduce harm, grow learning and grow the preventative agenda for people in Brighton and Hove. A measure of success for the board and its partners agencies can be reflected in the feedback received through the activities run. (Note: further feedback is included later in the report in relevant data sections.)

A key activity for the BHSAB was the conference held jointly with colleagues in the Brighton and Hove Safeguarding Children Partnership and statutory partners on transitions and transitional safeguarding. This was in response to learning from previous reviews identifying this as a key area of development locally. The conference included several sessions with guest speakers, case studies, the voice of lived experience, and highlighting new policies and procedures to support professionals working in this area. Approximately 100 delegates attended from across the children and adult partnerships and below is some of the feedback received.

Session on Transitional Safeguarding and Systems Leadership



Session on Transitional Safeguarding and how we can work differently



Here is some of the individual feedback shared following the conference.

What learning will be useful?

"Viewing transitional safeguarding from a systems leadership point of view. Don't simplify complexity, clarify complexity"

"The concept of an early help offer for younger adults"

"Share with team about the SARs referenced, the MARM and the existing transitions panels and considering who would benefit from being referred"

"It was good to hear about transitional safeguarding work going on in other services…especially the Police and health"

"I felt very inspired"

What changes are you going to make?

"Adapt our training for staff based on models shared today"

"Be braver in multi-agency case reviews about the need for professional curiosity"

"Encourage creative responses to those of transitional age and gently challenge push back"

In overall terms all respondents either strongly agreed or agreed that every session was relevant and over 70% either strongly agreed or agreed that they learned something new from all of the sessions.

Below is further feedback received by the BHSAB from activities undertaken during 2025-26.

SAR Frank, Paul and William Family Feedback

"My brother was let down extremely badly by Brighton and Hove"

"Many thanks for looking into this and including (Paul) in your case"

Presentation to the Sussex Acquired Brain Injury Forum on work undertaken in this area

"Thank-you, it's so good to hear that this happening"

SAR Learning Event feedback

"I'd also like to recognise the way you led the event that created a psychologically safe space for open discussion without judgement. I learned a great deal from the way you facilitated the session."

Feedback provided by BHCC Homes and Adult Social Care from staff who undertook safeguarding training.

Safeguarding Adults Basic Awareness Training

"I learnt about the different types of abuse at workplaces, and what measures can be taken by members of staff to avoid it happening again as it is my duty of care in my workplace to keep service users safe."

Safeguarding Adults Basic Awareness Training

"Many of the reasons that people are placed in vulnerable situations that cause safeguarding concerns to arise is due to lack of funding or support until people reach absolute crisis point. Feel like this needs to be acknowledged in the training more explicitly so that we can learn how best practice and theory actually works in the reality of an under-resourced and over-stretched sector, especially with the prospect of further cuts to funding. Without this, felt a bit like ignoring the elephant in the room."

Safeguarding Adults Training to carry out Enquiries

"In my head safeguarding was super scary but actually I have learnt that you follow the steps, you have help you have support and there is a process."

Safeguarding Adults Training to carry out Enquiries

"Something new I learnt was that I am leaving work in Safeguarding Enquiry for too long when I should perhaps be moving to Safeguarding Plan."

I did a similar course to this about 2 years ago, it was helpful then, but now that I am more experienced at carrying out Safeguarding Enquiries I feel that I got even more from the course this time.

Our Budget

The Brighton and Hove SAB have 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.

There are currently discussions between the partners about securing the budget allocations for the future, as it is reasonable for partners to minimally meet annual salary and inflationary increases. It has been disappointing that there has not been recruitment to the vacant posts as this has impacted upon delivery of this year's priorities and it must be noted that the budget decisions are for the SAB and therefore it is not an individual organisation's role to control the spend of this allocated funding.

This year the BHSAB's expenditure has exceeded our income, which is due to in particular to the increase in commissioning of Safeguarding Adult Reviews and the qualitative research project to hear the voice of adults involved in adult safeguarding. It should be noted that the overspend is covered by an overall budget surplus carried forward from previous years of approximately £100,000.

Income for 2025-26

Brighton and Hove City Council	£114,540
Sussex Police	£22,610
NHS Sussex	£26,600
Total	**£163,750**

Expenditure in 2025-26

Item	**Total**
Staffing	£141,124.73
Safeguarding Adult Reviews	£18,345.87
Website costs	£1,207.33
BHSAB Lived Experience Project	£4,575
Learning and Development	£275.00
Other Costs	£1125.48
Total	**£166,653.41**

Safeguarding Adults Reviews

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

Safeguarding Adult Reviews (known as 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.

Under section 44(4) of the Care Act a discretionary review can be undertaken by SABs in situations where this duty is not met, but it is considered there are learning opportunities that will 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. SARs are not about apportioning blame or identifying any one organisation being held accountable. During 2025-26 the SAB received seven SAR referrals, with the primary issues in these referrals identified as:

- **Acquired Brain Injury**
- **Mental health**
- **Neglect**
- **Self-neglect**
- **Domestic Abuse**
- **Organisational Abuse**

These referrals have been considered by the multi-agency SAR subgroup. Consideration takes place through a range of processes that includes referrers attending meeting, further information being requested from organisations involved to support decision-making, and assurance sought from organisations concerned regarding single-agency issues identified.

The BHSAB published two SARs during 2025/26 and summaries of these are below. These include the background to the review, details of the individuals concerned, key learning themes and recommendations made. There are links to the review reports and learning resources that are available on the Brighton and Hove Safeguarding Adults Board website.

Of the two published reviews one is a Safeguarding Adult Review and the other is a discretionary review where valuable learning opportunities were identified. In supporting a proportionate and flexible approach to undertaking Safeguarding Adult Reviews locally the discretionary review was undertaken by one of our statutory partners, Brighton and Hove City Council's Adult Social Care.

SAR Henry

Henry was a 61-year-old man of white, British ethnicity who lived alone in a privately rented flat. He had experienced abuse and mental health issues since childhood, previous drug and alcohol use, and had received support from mental health services.

A local authority tenant moved into the flat below Henry's with issues beginning to occur between them shortly after this. Agencies were responsive and took supportive actions, but issues continued with Henry repeatedly contacting organisations to report these and the impact they were having on his wellbeing. They were investigated and no evidence of anti-social behaviour on the part of the neighbour was found with it noted Henry had instigated some of the issues.

As the situation continued Henry began exhibiting self-harm and suicidal ideation, including taking overdoses. He initially accepted treatment and support but following a third overdose he declined to attend hospital. Henry was considered to be able to make a capacitated decision about this with professionals feeling they had no choice but to respect his wishes. He was sadly found deceased over a week later**.**

It was recognised Henry received a high level of support with numerous examples of good practice. However, learning opportunities were identified and a discretionary review commissioned to explore these. The review identified four key themes: multi-agency working, mental capacity, mental health and suicidal ideation, and medication prescription. Six recommendations are being taken forward that include mental capacity training, a review of prescription arrangements, and internal mental health processes. The full report and a learning briefing can be found **here**.

SAR Frank Paul and William

Frank, Paul and William were middle-aged white, British men and whilst their care and support needs differed and the events took place during different time periods there were a number of similarities in their situations. In addition to their ethnicity and age they all lived alone with limited support networks, experienced exploitation (and cuckooing in particular), self-neglect, had a history of previous substance use, and there had been delays in formal support and safeguarding processes.

There were also various themes relating to two of the three individuals that included contact with criminal justice, hospital discharge processes, previous trauma, and mental capacity. They were considered to have multiple compound needs and a thematic review arranged.

The independent reviewer identified six learning themes: multi-agency working and use of policies and procedures, cuckooing and exploitation, self-neglect and safeguarding, professional curiosity and trauma-informed approaches, mental capacity and resources, and discharge processes.

They recognised that significant actions have been undertaken since the events occurred that include the creation of a local Multi-Agency Risk Management (MARM) framework, a multi-disciplinary team to support those with multiple compound needs, the review of cuckooing arrangements, and the range of pan-Sussex SAB protocols and guidance available. However, they made five recommendations to support further improvements that includes a review of exploitation processes, the embedding of trauma-informed approaches and self-neglect. The full report and a learning briefing in the form of a video narrated by the reviewer can be found **here**.

SAB Partner Reports

Brighton and Hove City Council Homes and Adult Social Care

BHCC Adult Social Care

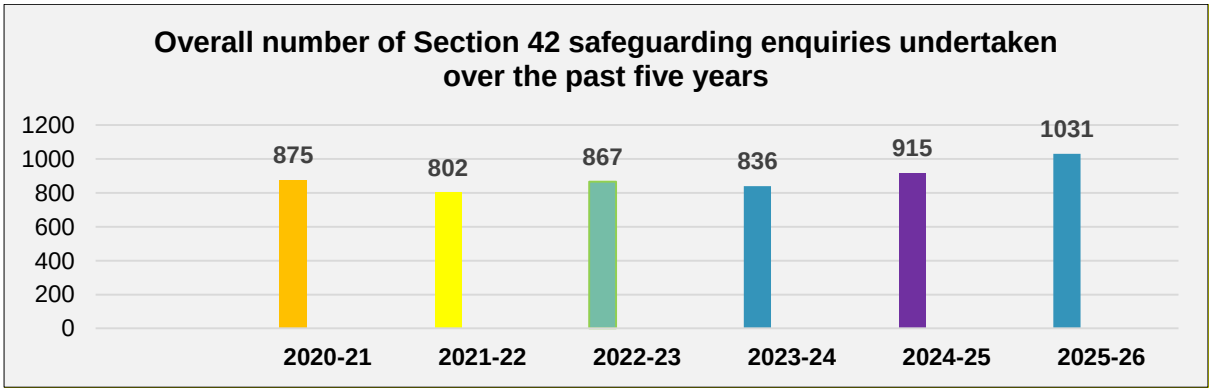
The Homes and Adult Social Care directorate continues to ensure robust oversight of safeguarding adults across all areas of our service. Over the past two years we have prepared extensively for our CQC inspection, which has now been completed. We have responded to our inspection preparation and its outcome through the development of a dedicated reviewing team, which we believe will support prevention in safeguarding, through the implementation of a waiting safely framework. The framework aims to support people from our community who are awaiting an adult social care response whether that be for assessment, review, or a safeguarding response under the Care Act.

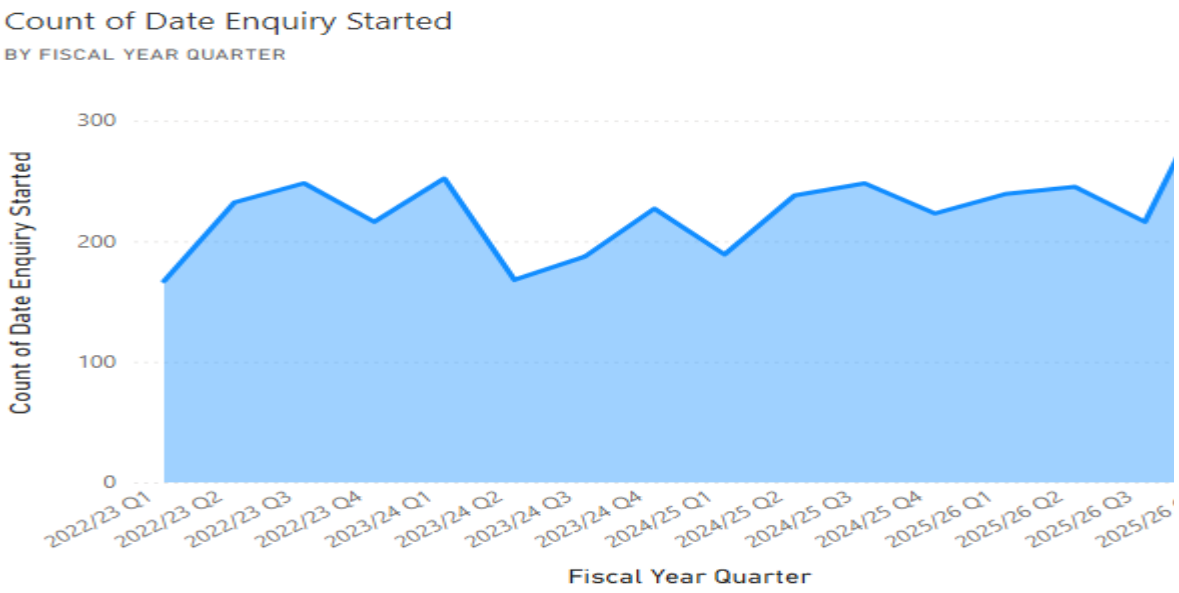
The Waiting Safely Framework sets out a consistent and safe approach to our response for people on Adult Social Care (ASC) waiting lists, ensuring that individuals awaiting allocation are prioritised, monitored, contacted, and kept safe throughout their wait. The framework will be launched in April 2026 and introduces new performance measures to monitor compliance and support consistent practice across all teams, this has the oversight and governance of our Performance Improvement Board. Shaped by practitioner and manager feedback, it aligns with the principles of safe, person-centred care and is designed to improve the experience of people who draw on care and support.

We continue to utilise the functionality and analysis capabilities of Power BI and have significantly enhanced our governance of our performance through this Board and also via our Safeguarding Steering Group for Adult Social Care.

What our performance data tells us

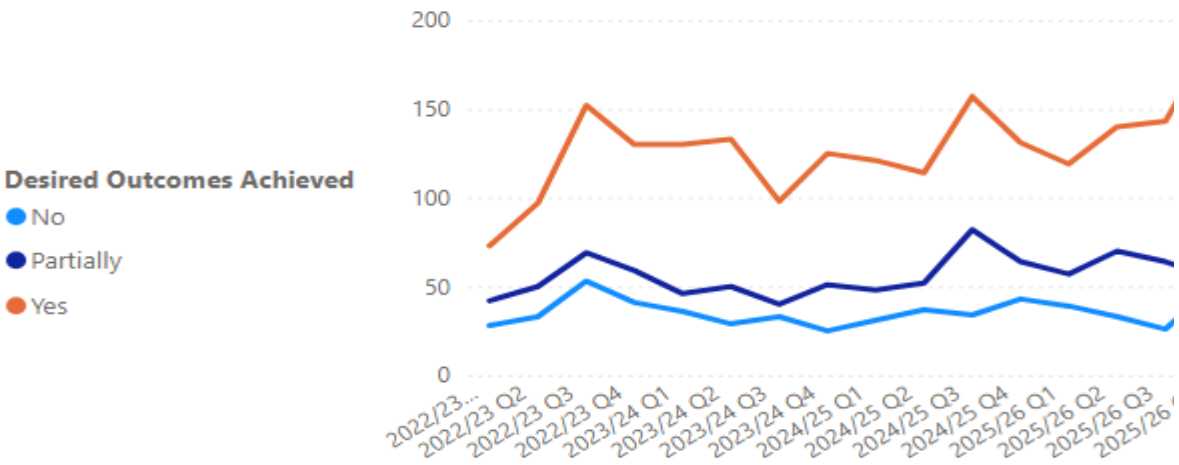
During this year we received 6027 safeguarding concerns, an increase of 542 concerns on the previous year, with a conversion rate overall across the year of 17.84%, an increase of 1% from the previous year, predominantly in our front door Adult Safeguarding and Duty Service and within Mental Services where our social work teams are based (S.75 agreement). Year on year the number of concerns has continued to increase. From those concerns we completed 1075 safeguarding adults enquiries under Section 42 of the Care Act, an increase of 160 from last year. We have continued to observe this year on year increase in the number of safeguarding concerns received and also enquiries completed.





Our safeguarding enquiries are primarily provided for people whose gender is recorded as female (55.27%) with 43.88% provided for people whose gender is recorded as male, and 0.42% recorded as indeterminate.

People's outcomes were fully or partially met in 84.97% of enquiries this year, which evidences our ongoing commitment to Making Safeguarding Personal and providing quality assurance of this through regular checks to support learning and development. This is comparable with last year (84.15%) and a corporate key performance indicator of Brighton and Hove City Council. This continues to be fed back regularly to front facing practitioners and managers, recognising their good practice and dedication, and reported quarterly to the SAB Quality Assurance Subgroup and our steering group to support our safeguarding practice, which has a quarterly completion cycle and regular oversight.



Brighton and Hove Multi Agency Risk Management Framework (MARM)

During this year we have brought permanence to our two stage MARM framework, with referrals (stage 1) continuing, predominantly these require information and advice/increased working together and a smaller number (8) of the most complex risk laden referrals where all operational multi agency responses have been provided and very high risk remains being brought into stage 2 formal multi agency meetings.

Since the introduction of the MARM within a pilot (October 2024) to date we have supported 20 people through the framework, all referrals have identified people with multiple and compound needs, 7 of these for young people aged between 16-25 (transitional safeguarding), 12 of these for adults aged 25-64 years old and 1 person over 65. Predominantly referrals indicate people who identify as male and are of White British ethnic heritage.

We are continuing with the development of our MARM recording tool, which will increase our data and analysis capability enabling us our increased understanding of themes trends and intersectionality in our referrals and joint work in this area.

We are delighted to feedback that this framework and these outcomes are evidencing strengthened multi agency working, good quality safeguarding practice particularly for people experiencing disadvantage who may be harder to reach in the city. It has been well received and supported by a wide range of partners including those in East Sussex on a recent MARM meeting case.

Impact and outcomes for our community

Outcomes primarily include increased access to support service provision for disadvantaged groups who we know can find navigating and accessing services more challenging, or find it more difficult to engage with support regularly. This more flexible preventative approach, which brings colleagues with expertise together to promote more innovative solutions while supporting one another as partners with high levels of risk. is beneficial for our community particularly those people with multiple compound needs (MCN) but also supports the ongoing work around development of a longer term model in the city.

It is a positive step forwards in terms of supporting our community and in utilising a preventative approach to safeguarding that although the Sussex Changing Future Programme formally ends in June 26 each of the three Place partnerships have agreed local legacy arrangements plus the ambition to develop a longer-term Sussex MCN strategy.

As a recent presentation to the BHSAB highlighted, Brighton and Hove Health and Care Partnership have agreed a funding model across Local Authority and NHS Sussex that will retain the current level of resources within the Changing Futures multi disciplinary team (MDT).

The MDT will continue to be led by Adult Social Care, include Change Grow Live Rough Sleeper Navigator Service, Domestic Violence role, specialist social workers and housing options roles and aligned support from health partners. The service have also retained the peer support workers and one of the key aims of the MDT is to increase capacity to support up to 200 people a year.

Challenges

The challenges noted in last year's annual report remain, with adult social care continuing to receive a 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.

We continue to work with our partners to ensure that people are signposted or referred to relevant services at the right time to support their needs. We acknowledge the progress that our police partners have made through refreshed policy and training on this area and are reviewing our RAG rating guidance for SIGNS (police assessment of risk form) In addition the extensive proactive work in the partnership led by Right Care Right Person which has created additional resource support services in this area namely Blue Light Line and response service, supporting this need which is greatly appreciated bringing improved response to people in mental health crisis and importantly supporting first responders (Sussex Police and South-East Coast Ambulance service colleagues).

We have now completed our design of a local briefing for partner agencies for roll out 2026/2027. This outlines the remit of adult social care and adult safeguarding and will be continuing to encourage partners to signpost people to wellbeing support and, where needed, to share concerns regarding which are solely around mental health and wellbeing rather than highlighting the need for care and support assessment/safeguarding (abuse or neglect) with appropriate community based care services.

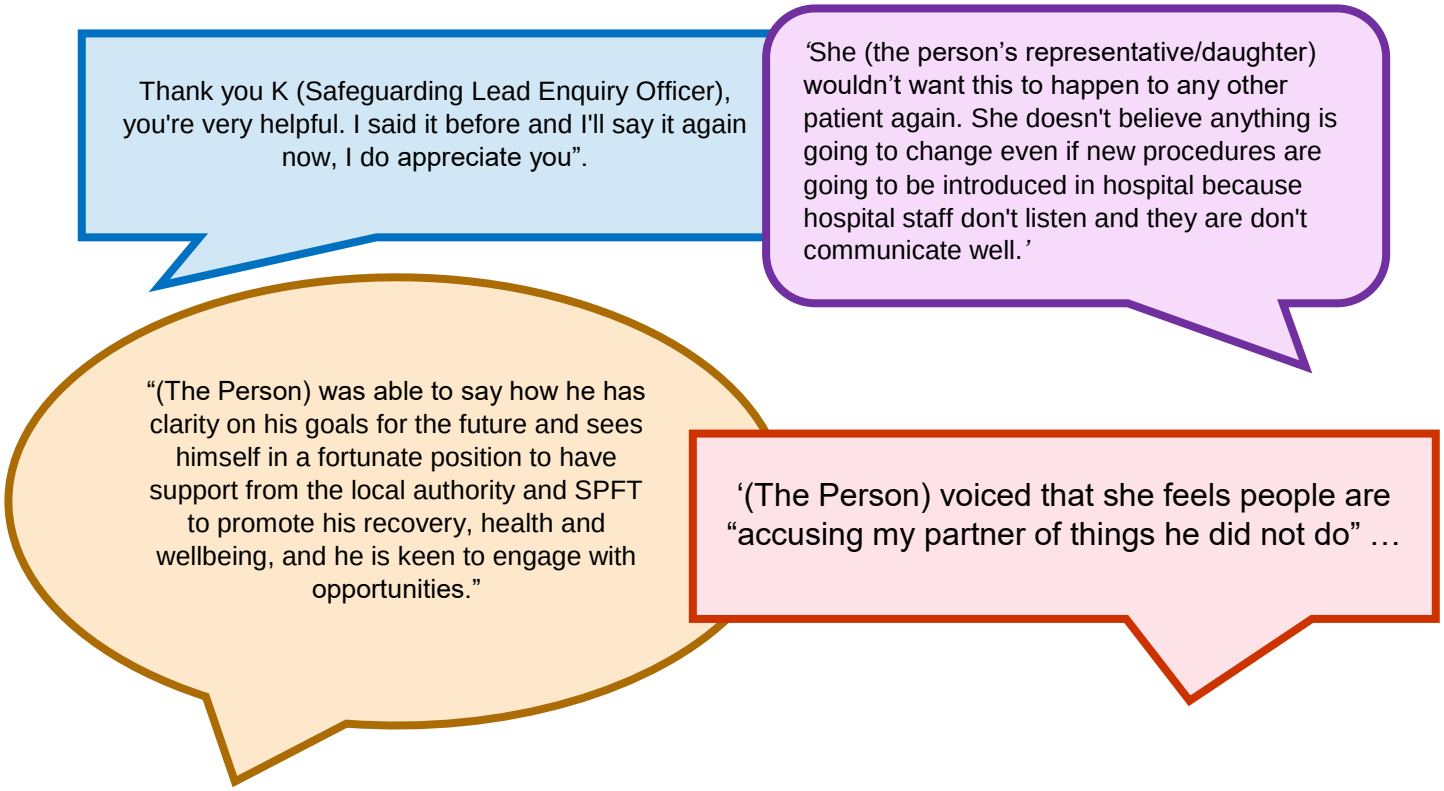
We continue to work on increasing our data functionality; we have developed data around referrals from partners and are committed to improved data performance on the areas of ethnicity and repeat referrals and this will remain on our workplan as we work to review our safeguarding enquiry tool this year. This is supported by learning from our proportionate safeguarding responses pilot, with initial feedback indicating an increase in enquiries and also in timely completion. All positives that we want to progress further to support our responses to those who are experiencing abuse or neglect and need our support.

We have observed a very significant increase this year in the number of Domestic Abuse Related Death Reviews (formerly Domestic Homicide Review) following the expanded scope nationally around death completed by suicide.

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

"I feel like the whole situation has been taken seriously, and the right changes have been made. I can see C****** are trying to learn from what happened. It's reassuring to know someone has listened and acted. I feel safer now, and I hope this helps prevent it happening to someone else."

"I like having S (son and alleged perpetrator of financial abuse) around - he can do things for me".



BHCC Housing People Services

Housing People Services have undertaken a range of activities over the last year as part of a multi-agency approach to supporting people with care and support needs, and that aligns to learning from Safeguarding Adult Reviews and the work of the Safeguarding Adults Board.

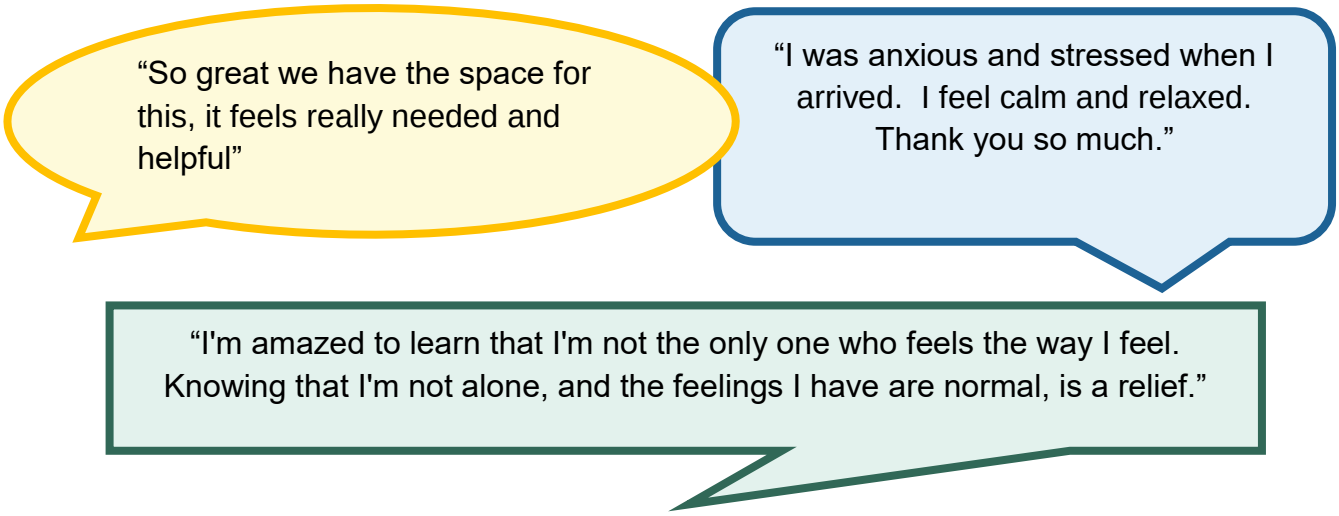
Working in partnership with Adult Social Care, Sussex Partnership Foundation Trust, and East Sussex Fire and Rescue Service they have created a new Hoarding Panel that will commence in April 2026. The Panel will focus on secure tenants and leaseholders / tenants in high rise blocks where addressing hoarding behaviour is proving particularly challenging for tenants and professionals. Following the principles of the BHSAB and ESSAB 'Responding to Hoarding Behaviour Framework' it will aim to ensure a multi-agency, trauma-informed and preventative approach is taken in working with people where hoarding issues are identified as well as ensuring statutory duties around adult safeguarding, and self-neglect in particular, are followed.

As part of their work in this area Housing People Services and Adult Social Care have also jointly commissioned a cleaning / decluttering service to carry out practical tasks associated with hoarding behaviour and self-neglect. A key driver behind this was to develop a trauma informed and efficient service as part of a joined-up approach to responding to hoarding behaviour. This service is also due to start in Apil.

In recognising the impact of trauma on staff, as well as those using services, the Tenancy Services team have launched a Reflective Practice (RP) programme to improve psychological safety and peer support for those working in Housing Services and to better understand interactions with people using services.

Internal RP facilitators have been trained and three staff groups and a managers group was established with regular sessions being held. Fifty-seven members of the service have signed up for sessions so far and feedback evidences the positive impact it is already having in improving care and support for each other and achieving better outcomes for tenants and those at risk of homelessness.

Feedback from professionals who attended the BHCC Housing Services Reflective Practice Groups



Sussex Police

Overview

Number of Adult Safeguarding enquiries (Section 42 per local authority)

This data is taken from the annual reports of each local authority. At the time of writing, the reports for financial year 2025-2026 were not available for any of the required local authorities. Therefore, the below data has been taken from the previous annual reports, covering financial year 2024-2025.

Section 42 enquiries undertaken by local authority in financial year 2024-2025

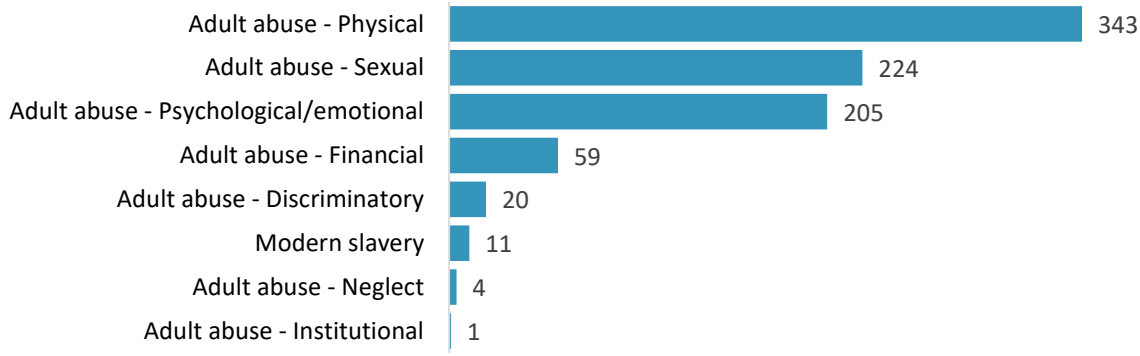
Local Authority	Section S42s
Brighton and Hove	915
East Sussex	3082
West Sussex	1654
Grand Total	**5651**

Crimes per category of adult abuse risk

Sussex Police's Microsoft Power BI Demand dashboard (an interactive data visualisation software product) suggests that **737** adult abuse markers were added to occurrences with an adult victim in Brighton and Hove during the financial year 2025-2026. This is the Police identification system where adult abuse may be occurring.

The most used adult abuse marker was Adult Abuse – Physical, accounting for **48.0%** of all adult abuse markers. Sexual abuse was the second most used marker at **30.4%**, and psychological/emotional abuse was the third most common marker, at **27.8%**. This aligns with the rest of the force, with these three markers being the most used across the whole Sussex Force area, in the same order, over the same period.

Breakdown of Occurrences with Adult Abuse Occurrence Markers

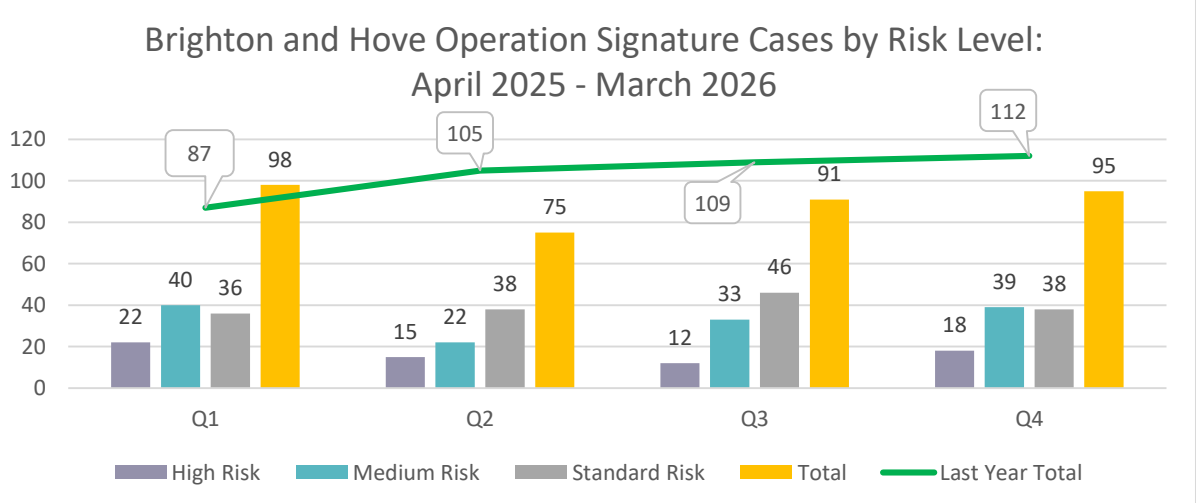


Operation Signature

Operation Signature ensures that all people who have experienced fraud and have been identified by police as requiring local (or additional) safeguarding receive a visit from a uniformed officer or community support officer (PCSO), who provides 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.

SCARFs (single combined assessment of risk forms), now SIGNS, is part of Op Signature. In order to focus on adult safeguarding this report uses Op Signature data unless stated otherwise. The data period in this report is inclusive of data between April 2025 – March 2026. There is also data from April 2024 – March 2025 included within this report, when comparing trends.

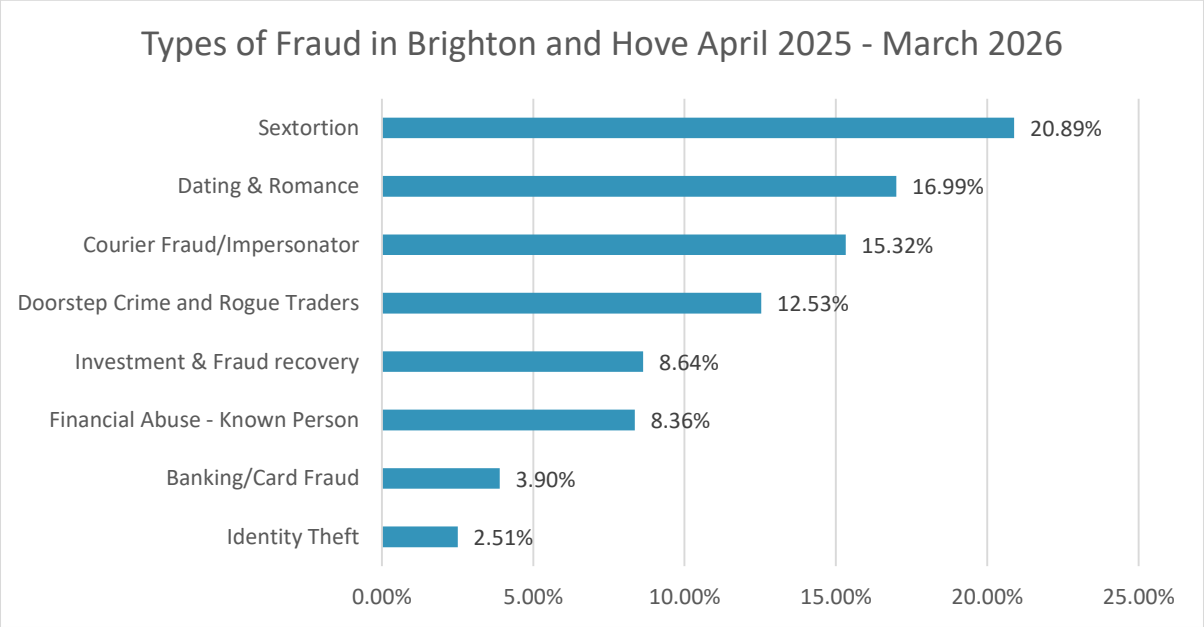
Brighton and Hove Operation Signature Cases by Risk Level: April 2025 – March 2026 with a Line of Comparison for April 2024 – March 2025.



Fraud reports across Brighton and Hove were consistent across the year, with the number of reports between 91 and 98 for Q1, Q3 and Q4, with a dip in the number of reports in Q2, which coincides with the summer holidays when we expect to see a dip in the number of reports. High risk reports were at their highest in Q1(22 actual) and lowest in Q3(12 actual). Medium risk reports were at their highest in Q1 (40 actual) and lowest in Q2 (22 actual). Standard risk reports were at their highest in Q3 (46 actual) and lowest in Q1 (36 actual).

There was a total of £4.77 million lost in Brighton and Hove between April 2024 – March 2025. Between April 2025 – March 2026 the total lost was £2.26 million. This equates to an average loss per victim of £6297. This reduction of losses is 52% lower compared to the previous year.

Types of Fraud in Brighton and Hove – April 2025 – March 2026.



Between April 2025 and March 2026 in Brighton and Hove, the top 3 fraud types were financially motivated sexual abuse(sextortion), dating and romance fraud and courier/impersonator fraud. Compared to the previous year we have the same 3 fraud types; however financially motivated sexual abuse(sextortion) and dating and romance fraud reports have overtaken courier/impersonator fraud to be the most reported fraud types. This change could possibly be accounted for because of a significant increase in reports from the LGBTQ+ community making sextortion reports originating from the Grindr dating app.

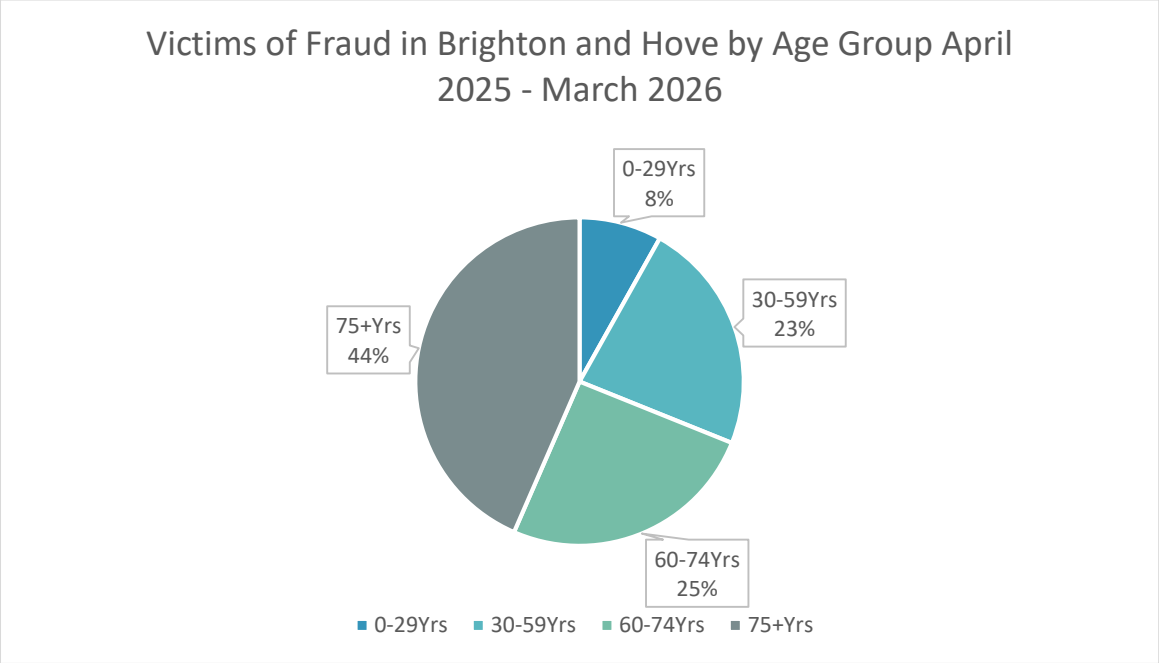
Financially motivated sexual abuse(sextortion) offences accounted for almost a fifth of all fraud reports in Brighton and Hove in the last year (21 per cent) and compared to the previous year the number of reports increased by approximately 7 per cent (increase of 5 actual). People who experienced this type of fraud were most frequently male (90 per cent). Financially motivated sexual abuse (sextortion) is a form of blackmail where a perpetrator threatens to reveal intimate images of the person 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 identity 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.

Dating and romance offences was the second most frequent reported offence accounting for nearly 17 per cent of fraud offences in Brighton and Hove last year. Compared to the previous year the number of reports has increased 15 per cent, which is an actual increase of 8 cases. Last year 41 per cent of victims were aged between 30-59 years old. Males were marginally more frequent victims of dating and romance offences accounting for 52 per cent of victims; victims more frequently did live alone (67 per cent).

Courier/impersonator fraud was the third most frequent type of fraud between April 2025 - March 2026. The number of reports is 30 per cent lower than last year with 55 actual reports compared to 79 last year. 67 per cent of reports were made by females, compared to 33 males per cent. The average age of victims is 78 years old with 70 per cent of reports coming from victims over 75 years old.

Victims of Fraud in Brighton and Hove by Age Group – April 2025 – March 2026



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 profile of those who have experienced fraud and have been identified by Police as requiring local (or additional) safeguarding so it would not be adversely affected due to the inclusion of non-fraud data.

Between April 2025 - March 2026, 44 per cent of victims in Brighton and Hove were aged 75 and over (126 actual). Compared to the previous year while the proportion of over 75 has increased, however the actual number of fraud reports from this age group has decrease by 18 reports actual.

Feedback from Invisible Harms: Understanding the Hidden Health Impact of Fraud

The view of victims

"I am thinking about it most days and move between angry with myself and the people that carried it out. I don't have much energy to do much at the moment and "feel lost"

"I've been told my skin condition could be due to stress - this is the only thing that I've been stressed about."

The view of professionals

"And not trusting anyone anymore. You know the impact, it can be huge, and sometimes they don't recover from this. They're so fearful of the world that they become more and more isolated."

"We do find with older people the harm is greater because there is the inability to earn it back. They haven't got time to, they don't, there's no physical time to recover and earn that money back, especially if you've been scammed out of your pension or your savings. What are you supposed to do then? And you're 70. What do you do? You're not going to go back to work at that particular stage, are you? That's not what happens."

Feedback on Support Provided

"One of the most important and healing things for me that happened in the aftermath of the fraud, was the kindness with which I was treated by all officials I dealt with at my bank, and at Action Fraud, at a time when I felt stupid and undeserving of it. That kindness went a long way to preventing the adverse mental and emotional effects escalating. I am convinced also that it helped me to restore my self-esteem and get through the post-fraud healing process much quicker than I might have done."

NHS Sussex (Integrated Care Board)

Introduction

NHS Sussex (the Integrated Care Board) 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. As a strategic commissioner of health services, NHS Sussex promotes safeguarding standards through procurement, contract monitoring and provider assurance processes, helping to embed robust safeguarding policies, procedures and governance arrangements across commissioned health services.

The impact of NHS Sussex's safeguarding work is reflected in improved system assurance, stronger multi-agency partnership working and the effective embedding of learning across health services. Through health leadership of safeguarding reviews, delivery of training and supervision, oversight and assurance of NHS providers and other health organisations, and active participation in Safeguarding Adults Board activities. NHS Sussex has also

strengthened professional practice, strengthened responses to complex safeguarding concerns and promoted a culture of continuous learning.

NHS Sussex is represented on all SAB subgroups, 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.

As with the previous year, 2025/26 saw high levels of safeguarding activity including a high number of statutory safeguarding adult, combined adults/children review recommendations and an increase in domestic abuse related death reviews, which reflects the regional and national picture.

As an organisation, NHS Sussex has met its safeguarding priorities and safely discharged its statutory safeguarding functions during 2025/26.

Delivery of Statutory Safeguarding Functions

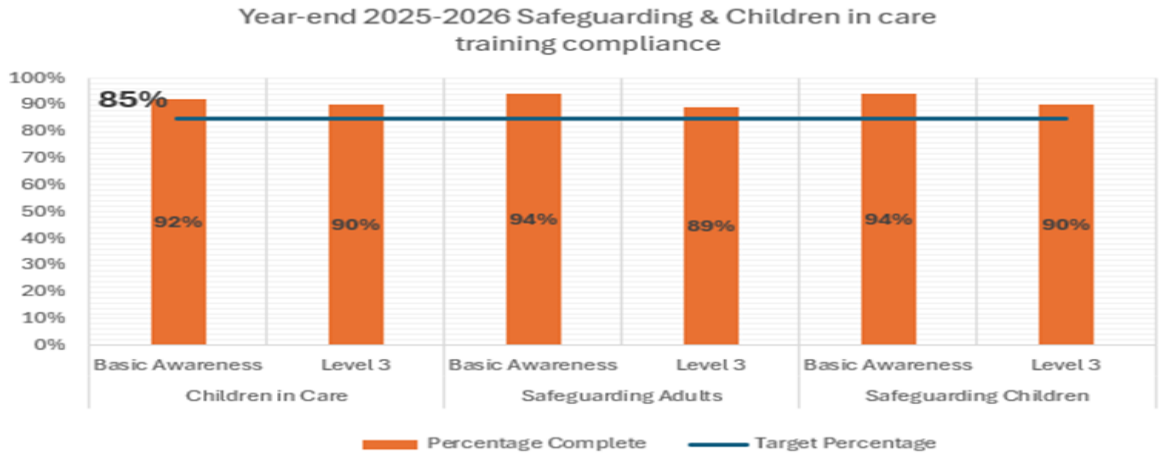
Key Statutory Duties
Safeguarding and Children in Care training: • Statutory safeguarding and children in care training for NHS Sussex staff was above the 85 per cent compliance target for all levels of required safeguarding and children in care training as of March 2026 (see training section). • Safeguarding Fortnight took place between the 10th -21st of November 2025 and delivered system-wide learning, including key themes from recent reviews regarding knife crime, adultification with the main conference focusing on 'Violence affecting young people' (see section on Safeguarding Fortnight) • Benchmarking against the new 2025 Intercollegiate Document Guidance was completed to ensure that the right training is included in safeguarding and children in care led sessions for the Integrated Care Board.
Specialist safeguarding staffing – All statutory duties were met by the team through alignment of workstreams with all the necessary specialist roles in place.
Safeguarding Adult Board (SAB) self-assessment – NHS Sussex completed the biannual self-assessment in June 2025. All areas were rated green except one area rated amber, in relation to emerging challenges, these were:
• The increasing number of statutory reviews across Sussex. The safeguarding team continue to monitor and work with providers to ensure actions from reviews are completed and embedded in learning. • Potential reduced capacity of workforce in NHS Sussex due to nationally mandated changes to the form and function of Integrated Care Boards (ICBs) and associated efficiencies. • Increasing mental health presentations, often linked with multiple compound needs and self-neglect. • Increased numbers of people presenting in asylum hotels reporting exploitation and risk of onward trafficking

• Peer challenge events were held, amber areas were reviewed, and assurance provided of work undertaken.
Statutory Reviews – NHS Sussex continue to be involved in all reviews with full participation and oversight of provider actions; dissemination of learning from the reviews is embedded in training programmes.
Safeguarding supervision - Supervision has been provided to all Named professionals across the system, supporting complex case management and ensuring health providers have support and guidance from NHS Sussex.
Mental Capacity Act - Targeted project with All Age Continuing Care (AACC) team to develop knowledge, skills and resources to assess mental capacity and decision making. Intranet pages updated. In addition, training in relation to MCA policy and guidance was delivered to All Age Continuing Care for those working with 16/17 year old children.
Prevent Duty – NHS Sussex is compliant with the Prevent Duty and maintains oversight of Prevent training compliance across Sussex health providers. Mandatory training ensures ICB staff can recognise and respond to risks of radicalisation, with clear referral pathways in place to Channel panel. NHS Sussex understands local risk and works closely with police and local authorities to ensure effective information sharing and coordinated safeguarding responses (see section on PREVENT duty).
Standards: The biannual safeguarding self-assessment was completed by the main health providers in Sussex in Q3 2025/26. Action plans were developed for any areas not rated green and monitored by NHS Sussex for improvement.

Training to improve safeguarding practice

All NHS Sussex staff receive safeguarding and children in care training, at a level suitable to their role, as defined in the national Intercollegiate Document guidance. The safeguarding team provide a rolling programme of Level 1, 2 and Level 3 training. A full day training, which includes safeguarding adults, children and children in care enables NHS Sussex to discharge their statutory duty to ensure all staff are aware of learning from local child safeguarding practice reviews, safeguarding adult reviews and domestic abuse related domestic homicides.

Training compliance rates exceeded targets throughout the year, see data below:



Safeguarding Fortnight

During November 2025, the team delivered Safeguarding and Children in Care Fortnight. Across the fortnight NHS Sussex provided three virtual events focussing on the role of the Health Independent Domestic Violence Advisor, Safeguarding against Harmful Online Narratives and Exploitation. Organisations across Sussex attended the sessions contributing to continued professional development around safeguarding.

Feedback Demonstrating Impact of Sessions

1. Informative, engaging and well-delivered sessions that were clear, concise and directly relevant to practice.
2. High-quality delivery from knowledgeable presenters, with valuable local context and practical resources to support learning.
3. Training has positively influenced practice, with attendees using new knowledge, resources and insights to inform their work.

Assurance across commissioned services

During 2025/26 NHS Sussex have gained assurance from health providers through quarterly exception reporting and the biannual Safeguarding Assurance Self-Assessment benchmarked against the Sussex Safeguarding Standards. Sussex main health providers have provided assurance that their statutory safeguarding processes are in place providing NHS Sussex with necessary data to demonstrate good practice or highlight any gaps or areas for improvement. These are discussed with safeguarding leads and fed back to safeguarding committees and Quality Review Meetings where necessary.

Sussex-wide safeguarding assurance site visits took place in 2025 across independent mental health units with NHS commissioned beds in support of the Provider Collaborative.

Training in partnership with Safeguarding Adult Boards

To support the focus on transitional safeguarding as a key priority for BHSAB, a joint online conference was held in partnership the BHSCP in December 2025 supported by NHS Sussex and with a range of presenters from across the partnership and expert external guest speaker. This was attended by approximately 100 people. Subsequently, several resources were developed and added to the BHSAB website to support professionals.

NHS Sussex facilitated four Trauma Informed Care (TIC) training sessions for Sussex Police which enabled officers to have a better understanding and approach to TIC within their organisation.

In partnership with SPFT, NHS Sussex facilitated four Mental Capacity Act (MCA) training sessions on behalf of the West Sussex Safeguarding Adults Board (WSSAB). The programme was delivered across four separate sessions: two tailored for practitioners and two for managers. The training received excellent feedback, and the practitioner session has since been recorded and adopted as a SAB learning resource, which will be made available online in 2026/27.

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 integration of health and social care services.

SPFT provides a Safeguarding Service that delivers safeguarding training and support to its staff. The Safeguarding Service contributes to the Trust's programme of quality reviews of its services and participates in the multi-agency work of the Sussex Safeguarding Adults Boards and Safer Community Partnerships. The Service leads on the Trust's Prevent work and contributes to Multi Agency Risk Assessment Conference (MARAC) duties. It monitors and analyses safeguarding activity across the Trust.

Safeguarding Concerns

Table 1 shows the number of safeguarding adult concerns (239) that were raised by SPFT teams working in Brighton and Hove in 2025/26. The SPFT Adult Safeguarding Team has oversight of these and can check the details as they are raised. SPFT uses this ability to assure itself that safeguarding concerns are being raised by teams and that actions are taken to reduce risk. We report quarterly through our own safeguarding governance processes on the number and type of safeguarding concerns being raised across the Trust; the information helps SPFT understand trends, patterns and themes linked to safeguarding concerns.

We are aware from this data of the high number of concerns that do not lead to Section 42 enquiries. The Trust continues to promote the use of the Sussex *Safeguarding Adults Thresholds: Guidance for Professionals.* Use of this document helps staff to understand statutory safeguarding criteria, improves the quality of concerns being raised and leads to fewer inappropriate safeguarding referrals.

Table 1 - Adult Safeguarding Concern Incident Numbers 2025/26

Categories of Abuse	2025/26 *
Physical	45
Sexual	20
Financial	20
Discriminatory	1
Domestic	25
Psychological/emotional	40
Neglect and acts of omission	37
Self-neglect	31
Organisational	20
Modern slavery	0
Total	**239**

(* Figures for 2025/26 were based on reports from nine months of the year pro-rated for twelve months; this was due to changes in SPFT reporting systems that led to a gap in data.)

Section 42 Enquiries

SPFT safeguarding enquiry information recorded thirty-three enquiries within Brighton and Hove where the Trust was named as the cause of risk in 2025/26. Most of these enquiries were linked to inpatient mental health settings and were classified as neglect and acts of omission. Each team linked to Section 42 enquiries will take individual learning from the outcome of the enquiries connected to their service. The SPFT safeguarding service contributes to quality reviews of services and discusses with services the safeguarding enquires that have occurred in their team and how this has informed practice. Safeguarding enquiries alongside other work identified the need for bespoke training around sexual safety for patients and staff on Trust wards; this informed sexual safety training undertaken in 2025/26.

The integrated working of SPFT and Brighton and 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 Policy Review - SPFT reviewed and updated its safeguarding adult policy in 2025/26. The policy now includes a section about the links between the application of the Mental Capacity Act and safeguarding. This recognises learning from Safeguarding Adult Reviews that have shown how poor understanding of mental capacity can lead to safeguarding risks. This is especially relevant to people who self-neglect. The revised policy makes reference to the Sussex Self-Neglect Practice Guidance for Staff and the importance of understanding concepts of fluctuating, decisional and executive capacity. In conjunction with the ICB, SPFT has participated in a series of mental capacity briefings linked to safeguarding and self-neglect.

Co-occurring Substance Use and Mental Health Conditions (Dual Diagnosis) Policy - Triggered in part by Safeguarding Adult Review recommendations, the Trust has developed a new policy covering work with people with co-occurring substance use and mental health conditions. The policy covers integrated assessment and support planning, with the aim of improving outcomes and preventing harm. It demonstrates the commitment of the Trust to providing mental health care for people with co-occurring conditions and clarifies responsibilities and expectations of services working with this group of people.

Domestic abuse - The Trust's clinical audit team undertook an audit of domestic abuse practice in its clinical teams. Initial results indicate that the Trust will need to improve its practice in relation to routine enquiry of domestic abuse as part of its assessment processes. Early identification of domestic abuse increases opportunities for intervention to prevent further abuse. The results from the audit will also inform the scheduled review of its domestic abuse and sexual violence policy.

Integrated Housing Specialist Service - SPFT's housing team is now a Trust-wide service offering consistent, trauma informed housing advice. Since its launch the service has supported more than 800 people facing homelessness or housing crises to navigate housing and health systems.

A 2025 evaluation of the service found a 60% reduction in urgent care use after receiving housing interventions. The evaluation won the national Ben Pattison prize for its originality, rigour, and contribution to advancing housing scholarship in October 2025. Co-located with 13 local housing authorities, the specialists ensure early identification of housing risk, improved cross-sector collaboration, and fairer access to support through a central referral and triage system. An infographic attached provides a summary of the service's evaluation.

Housing-Infographic.pdf

Prevent - The Trust has completed an internal study that analysed 137 cases referred by SPFT to the Sussex Prevent Channel Panel process. The report identified an emerging Prevent trend in which SPFT is supporting a cohort of predominately young white males with complex vulnerabilities, such as mental health needs, neurodiversity, isolation, and trauma, who present with significant risks of radicalisation through online activities. Extremist ideologies, for some of these individuals, appear to help make sense of their internal distress. The Trust is seeking ways of sharing its findings through publication of the study in an academic journal.

Feedback provided by SPFT from safeguarding enquiries undertaken and the impact of these

Category of Abuse/Neglect:	Physical Abuse
Circumstances:	The person was severely assaulted by a peer and was rushed to Accident and Emergency with injuries to their face and mouth. They were told their damaged tooth would need extracting, and an appointment has been made for the next working day. They had to pay for this appointment (which they did without protestation) and interacted politely and appropriately with the dentist throughout the appointment.
Impact of Safeguarding Activity:	The person told staff afterwards they wanted to sue the hospital for the damage that has been inflicted on him. The perpetrator of the physical abuse was transferred for safety to a different ward and the person was satisfied that the peer who assaulted them was prevented from coming into contact with them again.
Category of Abuse/Neglect	Neglect and acts of omission
Circumstances:	Concerns were raised regarding care on a mental health setting ward as the person had not been changed after urinary incontinence and some belongings had gone missing. The person was assessed as lacking mental capacity to engage with the safeguarding enquiry intervention, so their sibling was appointed as the appropriate person to advocate for them. The sibling noted that the family and the

	patient did not like the hospital where this had occurred and it was, “the worst time ever”.
Impact of Safeguarding Activity:	The person had been moved to an alternative mental health setting and their family felt this has improved their mental health but expressed concerns that they would be moved again without warning.
Category of Abuse/Neglect	Neglect and acts of omission
Circumstances:	Concerns were raised as the person in a mental health setting had not received their evening medication for five consecutive days as they had been granted leave. It did not appear planning had taken place to offer/administer medication following leave and this had a significant impact on their mental health. The person had substantial difficulty engaging with the enquiry due to their poor mental health.
Impact of Safeguarding Activity:	The professional leading the safeguarding enquiry liaised with the person’s adult relation. The relation said the family were happy with the overall level of care that had been provided and understood that errors can happen. They felt that the staff are "really lovely people" and could not think of anything to add to the enquiry in terms of outcomes and wishes.

Sussex Community NHS Foundation Trust

Sussex Community NHS Foundation Trust (SCFT) provides community health services across Brighton and Hove and wider Sussex, supporting adults with a wide range of health and care needs. During 2025-2026 the Trust has continued to strengthen its safeguarding approach with a greater focus on outcomes for people and learning across the system.

How do we know we are learning?

SCFT has strengthened the use of specialist safeguarding advice and workforce development to improve practice. The Trust safeguarding adult’s advice line received 675 contacts from SCFT staff during 2025-26, providing real-time guidance to staff managing complex situations. This has supported:

- Earlier detection of risk
- Increased staff confidence and
- More consistent safeguarding decision making across services

As a result, people are more likely to have safeguarding concerns recognised and acted on promptly.

SCFT has also maintained high training compliance with:

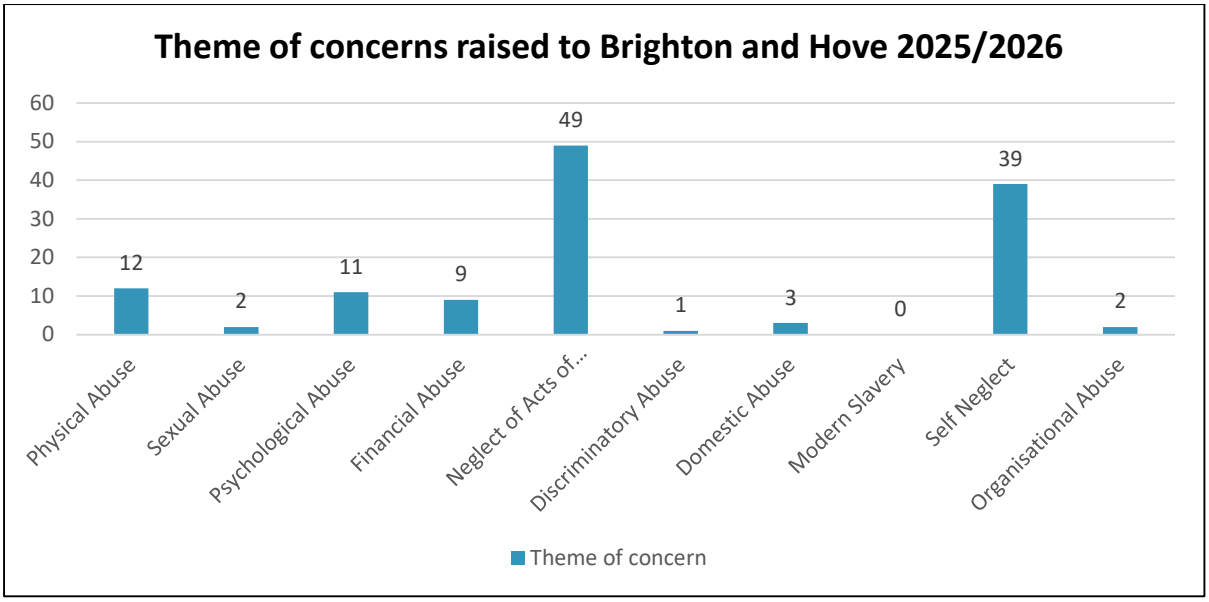
- 98.2% compliance for Level 2 training
- 94.3% compliance for Level 3 training

A well-trained workforce improves the quality of safeguarding conversations, supports Making Safeguarding Personal approaches, and increases the likelihood that people's wishes and outcomes are understood and acted on. Further detail about training compliance can be found in the table below.

Level	Target Cohort	Target Compliance	2025-2026 Data	Analysis of Variance
L2	Mandatory for all staff	85%	98.2%	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%	94.3%	In line with the NHS Intercollegiate Guidance the annual target is 85%
L3 Prevent	Mandatory for Adult and Specialist Services staff that require Adult Safeguarding L3, and Children's Services.	85%	99.3%	Compliance evidence that the final stretched third year target of 85% by Q4 23-24 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: 93.4%	ESR Module MCA: Assessing Mental Capacity. Completion will fluctuate depending on new staff flow into SCFT, and substantive staff choice to complete.

How do we deliver prevention in safeguarding?

SCFT has focused on early recognition and escalation of safeguarding concerns. 98 safeguarding concerns were raised to Brighton and Hove City Council by SCFT in 2025-26. The pattern of concerns, particularly neglect and self-neglect, reflects proactive identification of risk and awareness of complexity. The table below 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's internal safeguarding advice line supports staff to seek specialist guidance before escalating concerns externally. This enables staff to discuss situations with specialist safeguarding nurses and consider proportionate responses. Many concerns are appropriately managed within services following this advice, reducing the need for referrals to the local authority where this is not necessary. This means that people receive timely support within the service they are already known to without unnecessary escalation into formal safeguarding processes. Where referrals are made, they are more appropriate, supporting effective multi-agency responses. This reduces duplication and helps ensure local authority safeguarding resources are focused on those at greatest risk.

SCFT's safeguarding team also works closely with service developments and clinical teams within the Trust, ensuring safeguarding is considered at the design stage of services. This means that safeguarding is built into care pathways from the outset.

How does partnership working support people?

SCFT continues to work closely with SAB partners and operations services. The trust is embedded within multi-agency safeguarding systems, including the MARM and SAB subgroups, contributing to coordinated responses. This means that people experience a more joined up response, with clearer shared understanding across agencies.

Developing practice in key areas

During 2025-26 SCFT has prioritised strengthening practice around the Mental Capacity Act (MCA). A Trust-wide focus has supported improved understanding of capacity, decision making and safeguarding risk. This aims to improve quality of capacity assessments and better support of people who may be at risk of self-neglect.

Supporting an inclusive and responsive safeguarding approach

SCFT's safeguarding strategy focuses on:

- Supporting staff, volunteers and carers
- Addressing inequalities and reaching marginalised groups
- Promoting continuous learning and improvement, and
- Strengthening partnerships

This supports a more inclusive safeguarding approach where people from seldom-heard groups receive appropriate support and practice is more responsive to individual needs and context.

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 provide specialist support across all hospital sites and outlying services managed by UH Sussex. There has been a change in senior leadership which has further strengthened the governance and strategic direction of safeguarding across the organisation.

Fig 1 below shows the number of safeguarding concerns raised by UH Sussex staff regarding Brighton and Hove residents who have attended our hospitals, and in relation to the 10 categories or harm identified within the Care Act 2014. It also provides a comparator with the previous year.

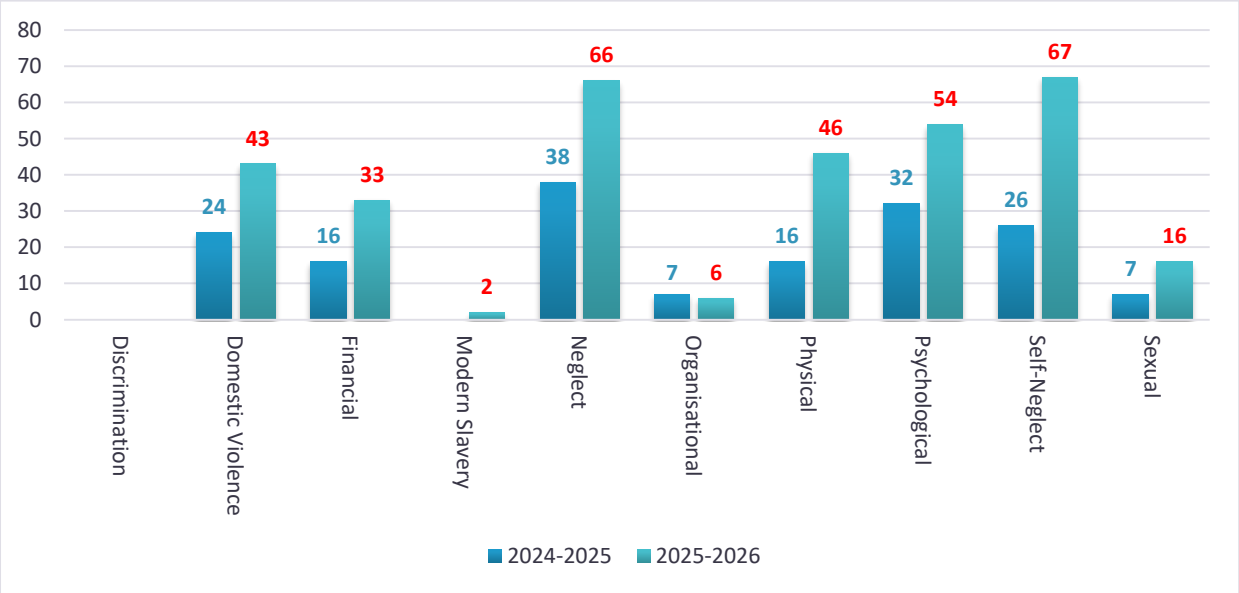


Fig 2: Safeguarding Concerns Raised by Gender 2025-2026

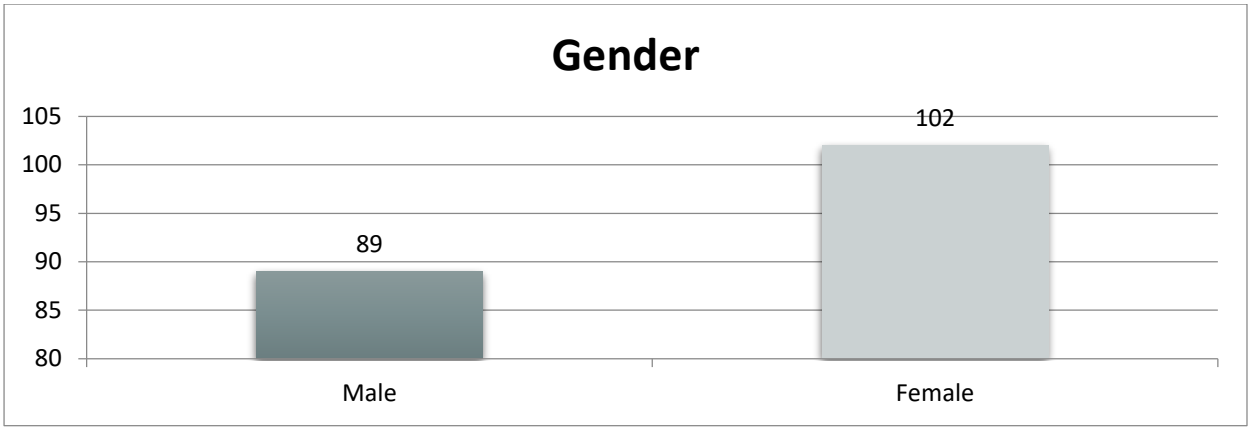
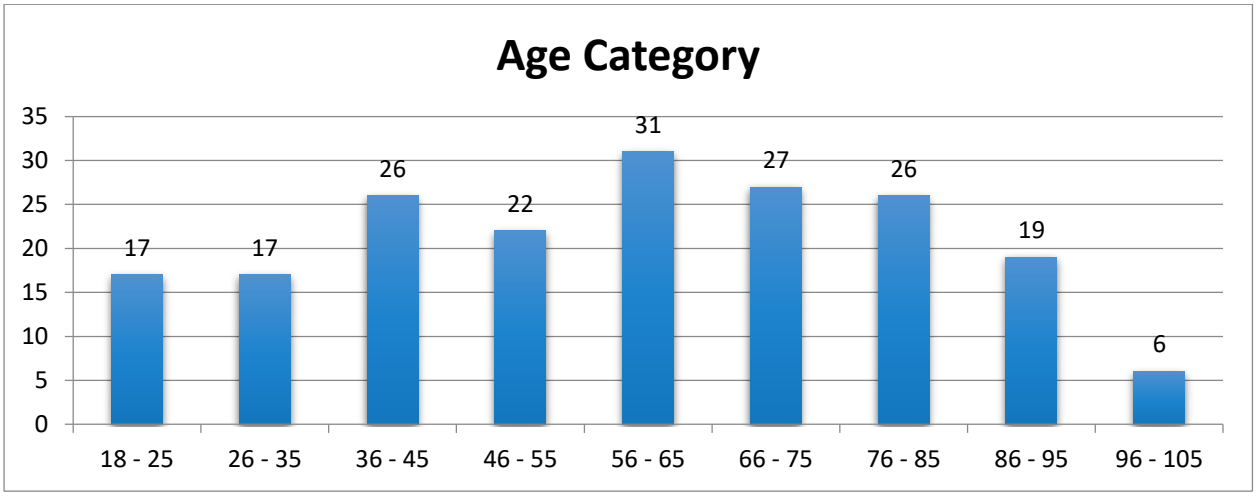


Fig 3: Safeguarding Concerns Raised by Age Categories 2025 – 2026



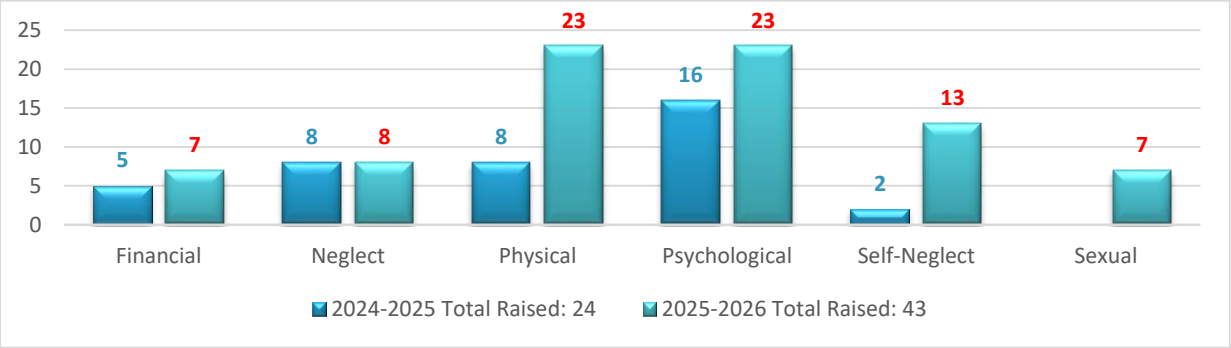
There has been a significant increase in the number of safeguarding concerns raised by UHSussex staff (140 in 2024-25) with the category of self-neglect being one of the highest areas of concern.

Figures 2 and 3 provide additional data pertaining to concerns raised by age and gender categories. There has been an increase in the number of safeguarding concerns raised across all age categories with 59 per cent in relation to 18 – 65 and 41 per cent in relation to individuals aged 65 and over.

Domestic Abuse

Figure 4 below pertains to adult safeguarding concerns raised by UHSussex staff particularly relating to domestic abuse. Whilst this has almost doubled, domestic abuse continues to remain a specific area of focus within safeguarding adults training to better improve UH Sussex staff recognition and response to domestic abuse. Victim Support continue to provide specialist support across Brighton and Hove and on-site Health Independent Domestic Violence Advisor (HIDVA) support to the Royal Sussex County Hospital. Victim Support have also recruited a male HIDVA who provides additional on-site support to further break down barriers regarding domestic abuse. The HIDVA role is integral to providing timely risk assessment and safety planning for both patients and staff who are experiencing domestic abuse.

Fig 4: Safeguarding Concerns Raised Relating to Domestic Abuse



Training

A new training needs analysis (TNA) has been developed by the Head of Nursing for safeguarding adults and approved by the UH Sussex Safeguarding Strategic Committee. The TNA has identified a significant increase in the number of staff in clinical roles requiring level 3 Safeguarding Adults training. Currently this is delivered via a blended learning approach with a series of e-learning modules to be completed prior to attending a face-to-face workshop delivered by the Safeguarding Adults Team. As at the end of quarter 4, training compliance stands at 81.6 per cent.

It is expected that NHS England will be implementing a national e-learning for Safeguarding Adults Level 3 in 2026/27. Alongside this, the safeguarding adults team will be implementing a yearly face to face update which will be delivered in collaboration with the HIDVAs, to provide more in-depth training regarding domestic abuse and to share learning from statutory reviews such as Safeguarding Adult Reviews (SARs) and Domestic Abuse Related Death Reviews (DARDRs)

The provision of safeguarding supervision has been identified as a priority for 2026/2027. This will supplement statutory training and provide a framework for staff to further embed safeguarding into clinical practice.

Partnership Working

UH Sussex continues to have a strong partnership with the Brighton and Hove Safeguarding Adults Board. UH Sussex is represented by the safeguarding senior leadership team at both the Safeguarding Adults Board and associated subgroups and also the Brighton and Hove Prevent Board.

The UHSx safeguarding adults' team work in collaboration with partners, contributing as subgroup and statutory review panel members. As part of embedding the learning from SAR activity, UH Sussex continues to promote the Sussex self-neglect guidance for professionals and raise awareness of Brighton and Hove MARM. The High Intensity User Group has been re-established with an Emergency Department Consultant lead and multi-agency collaboration integral to safeguarding those identified of being at significant risk of harm due to self-neglect and experiencing multiple and compound needs.

The safeguarding adults team supports frontline staff when there is a need to convene a multi-agency meeting under the Pan Sussex guidance. Further embedding learning from DARDRs and improving recognition and response to domestic abuse, in particular understanding

domestic abuse in the context of substance use and mental health has been identified as a workstream for 2026 -2027.

East Sussex Fire and Rescue Services (ESFRS)

Table 1 below shows the number of Home Safety Visits (HSV) conducted by East Sussex Fire and Rescue Service in Brighton and Hove for 2025/26 and includes the number of HSV referrals received from Brighton and Hove Adult Social Care, Brighton and Hove City Council, and Brighton and Hove Carelink.

The automated referral processes ESFRS receive monthly from Brighton and Hove Adult Social Care have increased the number of referrals from 84 in 2024/25 to 312 in 2025/26.

Table 1: Home Safety Visits & Referrals in Brighton & Hove	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Home Safety Visits Completed in B&H	570	606	586	603	2365
Home Safety visit Referrals from B&H Adult Social Care/Access	61	99	109	43	312
Home Safety visit Referrals from B&H Carelink	3	8	2	13	26
Home Safety visit Referrals from BHCC	19	35	33	26	113

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 CTN's this year (104) has reduced from last year with an increase in the number of CTN concerns raised in relation to hoarding and mental health concerns.

Table 2: Safeguarding Coming to notice forms raised to Adult Social Care/Childrens services/Housing or other partner agencies	Qtr 1 Total	Qtr 2 Total	Qtr 3 Total	Qtr 4 Total	Total
Additional Support	10	9	5	0	24
Alcohol	0	2	4	0	6
Arson (inc threats)	0	0	0	0	0
ASB	0	0	0	0	0
Bariatric	0	0	1	0	1
Building Concerns	0	0	0	0	0
Cuckooing	0	0	0	0	0
County lines	0	0	0	0	0
Domestic Abuse	0	0	0	0	0
Falls	0	0	0	0	0
Firewise - Firesetting	0	0	0	0	0
Financial Abuse	0	0	0	0	0
Hate Crime	0	0	0	0	0
Hoarding	13	14	14	0	41
Living Conditions	4	2	3	0	9
Mental Health	7	0	4	0	11
Modern Slavery	0	0	0	0	0
Possible Abuse	0	0	1	0	1
Repeats Incidents	0	0	0	0	0
Self Neglect	2	0	0	0	2
Smoking	0	0	0	0	0
Substance Misuse	0	2	0	0	2
Suicidal/Self Harm	0	2	0	0	2
Threats of Harm	0	0	0	0	0
Unattended Cooking	2	0	0	0	2
Unsuitable Living accomodation	2	0	1	0	3
Welfare Concerns	0	0	0	0	0
Total	40	31	33	0	104

What will we do next year?

Overview

The work undertaken over the course of this year, both directly by the SAB and by our partners, through processes such as the Pan-Sussex SAB Self-Assessment and Peer Challenge will lead to the Strategic Plan being updated for 2026-27, as we enter the second year of the current three-year plan.

The three current areas of focus will remain unchanged.

- How do we know we are learning
- How does transitional safeguarding support people
- How do we deliver prevention' in safeguarding

However, in recognising progress made against these over the previous year and new emerging themes and issues being identified new specific pieces of work will be undertaken which focus strategically and seek assurance from people in the community that they recognise the change or impact. These specific pieces of work will include –

- The development of multi-agency reflective sessions to support embedding learning in response to the increasing complexity being seen,
- Continuing to develop a pan-Sussex approach to learning and development and increasing our understanding of how learning from SARs and other SAB activities is being embedded by our partners.
- We will continue to develop our SAR processes, seeking to increase the timeliness of learning opportunities and that where possible issues and themes are identified and responded to at a regional and national level.
- The board will continue to support partners in the development and implementation of transitional safeguarding arrangements in response to learning from previous SARs.

In continuing to deliver prevention in safeguarding there will be a focus on ensuring that the review of current resources and development of new resources, supports a preventative approach to adult safeguarding and professionals across the system are aware of and utilising these resources.

The board will also work with partners, as well as other boards and partnerships in this area to explore the development of specific prevention guidance for professionals working directly with people.

Safeguarding Adult Reviews (SARs)

We will continue to develop our use of data in our SAR processes, improving the range of data gathered and ensuring there is regular oversight of this within our multi-agency SAR subgroup to identify where gaps and delays occur in review processes and actions to reduce these.

We will take forward existing SAR action plans, completing the outstanding actions including the development of formal transitions and transitional safeguarding arrangements.

Quality assurance

The board will seek to maintain the significant progress made with the multi-agency data dashboard over the past year, considering the current range of data being received and where if there are further developments that can be made to this in understanding key themes and issues locally.

The current multi-agency audits underway will be concluded and once the SAB Business Unit has additional resource the multi-agency audit programme will fully resume, incorporating learning from SARs as well as reviewing previous audits to understand the differences made through these and how learning has been embedded.

The qualitative research project being undertaken with Healthwatch Brighton and Hove to understand the experiences of people who have had direct involvement in statutory safeguarding processes including how agencies worked together will continue.

Learning and development

The Learning and Development subgroup will continue to progress the areas of focus and specific actions identified by the BHSAB in the updated Strategic Plan for 2026-27. This will include exploring the development of prevention guidance.

In continuing to focus on data and assurance as to how learning from SARs and other SAB activities is being embedded and the difference this is making the tool developed to gather

information on learning activities being undertaken by partners will start to be regularly distributed for completion.

As part of working with other boards and partnerships and responding to themes and issues identified at a regional and national level the BHSAB will work with our colleagues in the other Sussex SABs and statutory partners to explore the creation of a pan-Sussex Learning and Development subgroup in the year ahead.

Communication and engagement

The board's ability to undertake communication and engagement activities during 2025-26 has been restricted due to limited resource in the BHSAB business unit. This will continue to be the case in the first part of 2026-27, whilst recruitment processes are underway, but it is hoped this will improve in the second part of the year.

We will continue to share our learning, including published SARs, across a range of formats – attending in-person and virtual multi-agency and single agency events and meetings as well as through the SAB newsletter, website, and targeted emails that seeks to improve how learning is disseminated within partner agencies at all levels.

We will also 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.

Appendix

Appendix 1 - 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.

Intersectional (Multiple and Intersectional Needs)

In this context intersectional needs are used to describe the ways that multiple needs (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.

Mult-agency Risk Assessment Conference (MARAC)

MARAC is a domestic abuse Multi-Agency Risk Assessment Conference held on a regular basis in each area. The conferences bring together representatives from a range of agencies to discuss the safety, health and well-being of people experiencing domestic abuse (and their children).

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 at risk of 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.

SCARF

The Single Combined Assessment of Risk Form (SCARF) is a document used by the Police in situations where they believe they have identified an adult at risk. In these situations, SCARFs are shared with statutory partners to facilitate early and effective identification of risk, joint decision making, and coordinated action.

Appendix 2

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

Appendix 3 – Strategic Plan 2025-28

About Us

The Brighton and Hove Safeguarding Adults Board (BHSAB) is a multi-agency strategic partnership that has a unique statutory role in co-ordinating the strategic development of adult safeguarding across Brighton and Hove and ensures the effectiveness of the work undertaken by partner agencies in this area. It comprises senior officers within adult social care, criminal justice, health, housing, community safety, voluntary organisations and service user representative groups.

The BHSAB has three statutory duties under the Care Act 2014:

- **To publish a strategic plan for each financial year that sets out how it will meet its main objective and what the members will do to achieve this. The plan will be developed in partnership and make use of all available evidence and intelligence.**
- **To publish an Annual Report detailing what it has done during the year to achieve its main objectives and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews and subsequent action.**
- **To conduct any Safeguarding Adults Review in accordance with Section 44 of the Care Act.**

Our Vision

The **vision** of the BHSAB is that people are able to live together in safety, in a city that does not tolerate abuse, neglect and exploitation and that works in partnership to actively prevent abuse occurring and ensuring that when it does happen everyone knows how to report it and that it is effectively responded to.

Our **mission statement** is that we, as the BHSAB, will work effectively, supporting and constructively challenging ourselves and each other and actively learning from our communities with involvement in adult safeguarding to identify where we can make best use of our time and efforts in achieving improved outcomes that benefit those who use services and those who care for them.

We will do this by –

- Using evidence to gain assurance that effective safeguarding arrangements are in place as defined by the Care Act 2014 and accompanying statutory guidance.
- Ensuring that the principles of Making Safeguarding Personal and the informed voice of the person are central to safeguarding arrangements.
- Working collaboratively with our partner agencies to prevent abuse and neglect where possible.
- Ensuring individuals and agencies provide timely and proportionate responses when abuse, neglect or exploitation has occurred.
- Striving for continuous improvement in safeguarding practice and supporting partner agencies to embed learning from local and national Safeguarding Adults Reviews, other learning reviews and quality assurance processes.

- Understanding the experiences of adults and communities with involvement in adult safeguarding processes and integrating learning from this in future arrangements.

Our Strategic Plan

This is the BHSAB's fourth Strategic Plan and covers the period from 2025-28 whist also being updated as required to ensure the specific areas of focus reflect emerging themes, issues and challenges. The first BHSAB Strategic Plan, from 2016-2019, embedded and tested compliance against the Care Act 2014. The second Strategic Plan, from 2019- 2022, built on these foundations and broadened the focus of the SAB with six wide-ranging priority areas. The third Strategic Plan streamlined these to four key priorities and introduced specific areas of focus that were reviewed and updated during the three-year-period.

The strategic priorities and areas of focus for the Safeguarding Adults Board are identified by the multi-agency partnership through several processes; these include SAB Development Events, bi-annual Self-Assessment and Peer Challenges, learning from SARs and multi-agency audit processes as well as the individual priorities of partners.

The BHSAB previous Strategic Plans, with previous priorities and objectives can be found here.

BHSAB-Strategic-Plan-2022-25.pdf

BHSAB-Strategic-Plan-2019-2022-Final.pdf

1) **Strategic Priority: Accountability and Leadership**

Aim: For the SAB to continue to provide strategic leadership locally and work in partnership across Sussex in embedding the principles of safeguarding and contributing to a consistent and coherent approach to adult safeguarding arrangements and the prevention of abuse, neglect, and exploitation.

Objectives -

- Continue to develop, and review relevant policies, procedures, and processes, including pan-Sussex policies and procedures, to support consistent and current safeguarding practice.
- Strengthen arrangements with other Boards and Partnerships *(e.g. Safeguarding Children Partnership, Community Safety Partnership and Domestic Abuse Oversight Board)* to share information and effectively respond to safeguarding themes, issues and emerging trends.
- Ensure clear and transparent annual budget plans are in place for all SAB activities to enable the work of the Board to be undertaken.

2) **Strategic Priority: Performance and Quality**

Aim: To use an evidence-based approach that focuses on data and quality assurance mechanisms in continuing to develop a multi-agency focus on adult safeguarding performance and to understand the impact of the activities being undertaken by the SAB and partner organisations.

Objectives -

- A range of multi-agency safeguarding data being routinely gathered and analysed to provide evidence-based assurance of adult safeguarding performance and to identify issues or emerging themes, which can be used to influence future priorities and effect change.
- Ensure that effective internal and multi-agency quality assurance mechanisms are in place and being undertaken that hold partners to account for safeguarding practice and measure the impact of activities undertaken.
- Ensure effective and up-to-date arrangements are in place for the undertaking of SARs to ensure these are proportionate, focused and timely, and follow national guidance so as to shape learning and continuous improvement.

3) **Strategic Priority: Communication and Engagement with Communities**

Aim: To review existing communication and engagement strategies across the SAB and partners and develop new approaches that reach adults, communities, and professionals across organisations with involvement in adult safeguarding.

Objectives -

- Review the membership of the SAB and subgroups to ensure these include appropriate representation from professionals and organisations with involvement in adult safeguarding to enable effective engagement.
- Establish a SAB communication and engagement programme to increase knowledge and understanding of the work of the board and adult safeguarding arrangements.
- Ensure that the communication and engagement strategies developed are easily accessible and reflect the diversity of local communities and changing demographics.

4) **Strategic Priority: Inclusion and Workforce fit for the Future**

Aim: Ensure the workforce is equipped to support adults appropriately where abuse, neglect and exploitation has taken place.

Objectives -

- To undertake a range of learning and development activities from SAB activities such as SARs, referrals, and quality assurance processes to ensure these are effectively communicated and embedded into practice to facilitate organisational change and achieve best practice.
- Promote awareness of adult safeguarding, including the role and responsibilities of the SAB and SARs, offering professionals across organisations the opportunity to be involved in the work of the SAB wherever possible.
- Ensure that effective internal and multi-agency mechanisms are in place to review the effectiveness and impact of adult safeguarding training.

5) **Strategic Priority: Informed Voice of the Person**

Aim: To develop effective strategies that seek to understand the experiences of adults and communities with involvement in adult safeguarding processes and ensure informed voices 'are heard' in future arrangements to prevent abuse, neglect and exploitation.

Objectives -

- To work with partners and use existing networks to understand current arrangements and commission a piece of work focusing on those who have been in contact with adult safeguarding to enable meaningful feedback on existing pathways and processes, engagement strategies and safeguarding outcomes.
- To analyse the results of this and work in partnership to identify where SMART improvements can be made to multi-agency adult safeguarding arrangements.
- To monitor and review the outcomes of improvement activities undertaken as part of an evidence-based approach in understanding the impact of the work of the SAB.

Areas of Focus

As part of our Strategic Plan 2025-28 the Safeguarding Adults Board has identified specific areas of focus that link to our broader strategic priorities. These have been established though a development event held with partners and will be reviewed and updated as required over the course of the three-year strategic plan.

1. **How do we know we are learning?**

- **Use evidence-based, quality assurance mechanisms as a means of understanding how learning from previous SARs, and other SAB activities, is being embedded across organisations.**
- **Evaluate the effectiveness of how learning from previous SARs, and other SAB activities including previous areas of focus is being embedded, identifying successful learning and development processes across the partnership and where there are areas for further development.**
- **Using learning from this to expand the range of learning and development approaches in effectively embedding learning at all layers across organisations.**

2. **How does transitional safeguarding support people?**

- **To ensure formal local transitions and transitional safeguarding arrangements are established in line with the recommendations from published SARs that support an improved multi-agency understanding of, and inclusive response to, young people approaching adulthood.**
- **To support the implementation of formal local transitions arrangements through a range of SAB learning and development activities, including briefings and resources, to ensure these are effectively communicated and embedded into practice to facilitate organisational change.**
- **Ensure quality assurance mechanisms are used in taking an evidence-based approach to measure the effectiveness of formal transitions arrangements and the impact these have for those using services.**

3. **How do we deliver prevention in safeguarding?**

- **To work with statutory partners to receive a range of multi-agency adult safeguarding data to gain assurance around performance and to identify key themes, including root causes, to inform future priorities as part of a preventative approach.**
- **To work with other boards and partnerships across Sussex, including the Sussex SABs, the Brighton and Hove Safeguarding Children Partnership and Community Safety to explore the development of a joint early help and intervention approach.**
- **Review the Pan-Sussex SAB Safeguarding Thresholds Guidance to include increased clarity on referral pathways with the aim of improving communication processes in situations where the eligibility criteria for statutory intervention is not met.**