Report to:	**People Scrutiny Committee**
Date of meeting:	**22 September 2025**
By:	**Seona Douglas, Independent Chair, East Sussex Safeguarding Adults Board**
Title:	**East Sussex Safeguarding Adults Board Annual Report 2024–25**
Purpose:	**To present the annual report detailing how effective the work of the Safeguarding Adults Board (SAB) has been against the Strategic Priorities, as required by the Care Act 2014.**

RECOMMENDATIONS:

People Scrutiny Committee is recommended to consider and comment on the report.

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1. Background

1.1 The Care Act 2014 requires each Safeguarding Adults Board (SAB) to:

- **Develop and publish a Strategic Plan** (Appendix 1) setting out how they will meet their objectives and how their member and partner agencies will contribute.
- **Publish an Annual Report** (Appendix 2) detailing how effective their work has been.
- **Commission Safeguarding Adults Reviews** (SARs) for any cases which meet the criteria for these.

2. Supporting Information

2.1 The 2024–25 Annual Report (Appendix 2) is structured around the SAB priorities as outlined in the East Sussex SAB strategic plan (Appendix 1). Partner agencies have contributed performance and activity updates, and a detailed data appendix within the report evidences the effectiveness of multi-agency safeguarding arrangements.

2.2 The SAB team has been strengthened with a permanent Board Support Coordinator and Administrator, jointly funded by Adult Social Care and Health (ASCH). Membership of the Board can be found in Appendix 4 of the Annual Report.

2.3 In 2024/25 there were fewer Safeguarding Adults Reviews (SAR) referrals than the previous year. However, recommendations from SARs published in the last two years continue to shape the Board's strategic workstreams, including transitional safeguarding, multiple compound needs, and alcohol-related self-neglect.

<u>Safeguarding Data (2024/25)</u>

2.4 Key data from ASCH for 2024/25 can be found in Appendix 1 of the Annual Report. This includes:

- 15,385 safeguarding concerns were recorded
- 3,082 enquiries were initiated
- 53% of outcomes were fully achieved, and 42% partially achieved
- Neglect and Acts of Omission remained the most common risk type.
- Most risks occurred in the adult's own home.

- Financial abuse, neglect, and self-neglect increased, while domestic abuse decreased

*Note regarding statistics: the way data was recorded underwent a change regarding 'episodes' which makes it difficult to compare with previous years

Safeguarding Adult Reviews (SARs)

2.5 SAR referral activity during 2024/25 remained low, with only one SAR concluding within the reporting period (01/04/2024 – 31/03/2025). This represents a significant decrease compared to the five SARs published in 2023/2. The single concluded SAR in 2024/25 was SAR Jack, which involved one adult who suffered serious harm and subsequently died.

2.6 A total of 8 recommendations and associated actions from SAR Jack were incorporated into the SAR Action Plan in 2024/25. These were developed in partnership with SAB agencies to support system learning and drive improvement.

2.7 In addition to the concluded SAR, other SARs remained ongoing during 2024/25 and are expected to conclude in the 2025/26 reporting year. This reflects the nature of SARs, which are often complex and may span multiple years from commissioning to completion.

Strategic Themes and Progress 2024–25

2.8 **Theme 1: Accountability and Leadership**

- A pan-Sussex self-assessment was undertaken in early 2024, with agencies rating their safeguarding activity against Making Safeguarding Personal, leadership, and governance criteria. Results inform areas for targeted development.
- Sussex Police, NHS Sussex, and East Sussex Fire and Rescue Service (ESFRS) continued to chair and contribute to SAB subgroups. Data dashboards and referral data from Multi-Agency Risk Management Meetings now feed into performance reporting.

2.9 **Theme 2: Safeguarding Policies and Procedures**

- The SAB launched a new Sussex Safeguarding Adults Policy and Procedures website to promote consistency, access, and joint learning.
- Updated guidance was published on Trauma-Informed Safeguarding and Complex Needs. Learning briefings were issued for all published SARs.

2.10 **Theme 3: Performance, Quality and Organisational Learning**

- A new SAB Data Dashboard was launched, improving the use of partner data to inform decision-making.
- The Board developed a shared audit tool to review safeguarding casework across borders with Brighton & Hove and undertook a focused audit on housing moves, identifying barriers and areas for improvement.

2.11 **Theme 4: Prevention, Engagement and Making Safeguarding Personal**

- Over 6,400 home safety visits were conducted by ESFRS, identifying at-risk adults and referring for safeguarding where appropriate.
- Healthwatch East Sussex engaged over 3,500 people and produced 35 reports on care quality and user voice. Their work supports improved person-centred safeguarding.
- An Easy Read safeguarding leaflet was co-produced with adults with learning disabilities to improve public understanding of safeguarding and how to get help.

2.12 **Theme 5: Integration, Training and Workforce Development**

- SAB training covered key issues such as coercion, self-neglect, and modern slavery. Workshops on dependent drinking were held in response to SAR recommendations.
- NHS Sussex led safeguarding training on neurodiversity and trauma, improving frontline confidence and competence.

Progress on 2024–25 SAB Strategic Priorities

2.13 **Self-Neglect**

- Guidance for a multi-agency framework to support adults who self-neglect was completed in late 2024 by the Sussex Safeguarding Policy and Procedures Review Group. This guidance focuses on preventing harm by empowering individuals to understand risks and fostering a shared understanding across agencies, to ensure effective response.
- The Sussex Safeguarding Policy and Procedures Review Group also launched the Sussex Self-Neglect Practice Guidance which outlines a collaborative five step process: identification; lead agency assignment; information sharing; multi-agency meetings; and risk assessments.
- A podcast series, "Conversations in Self-Neglect,", developed in partnership with Changing Futures and Care for the Carers East Sussex, was launched featuring practitioners sharing examples of positive safeguarding practice. The series is aimed at informal carers, family members and practitioners and offers practical and easy to understand definitions and examples of how self-neglect is identified and the steps to take to protect an adult at risk of self-neglect. This is supporting awareness and skill development in frontline services.
- Best practice guidance on safeguarding adults experiencing homelessness has been published and shared with agencies across the county.
- Carers' consultation work was completed in partnership with the voluntary sector, helping inform the Board's approach to safeguarding awareness for unpaid carers.
- The multi-agency audit on self-neglect has been scoped and is now scheduled for delivery in 2025/26, with tools and criteria agreed by the Performance, Quality and Audit subgroup. This audit focuses on self-neglect referrals, following recommendations from the SAR Gwen and Ian published in January 2024, and aligns with the Board's commitment to improving safeguarding practices, embedding revised pan-Sussex Self-Neglect Procedures and addressing systemic gaps to improve the identification and prevention of self-neglect where possible.
- *Responding to Hoarding Behaviour Framework* was updated in 2025. This is a multi-agency guide to reduce risks of abuse/neglect linked to hoarding, prioritising autonomy, safety and collaborative solutions.

2.14 **Prevention and Early Intervention**

- SAB Multi-Agency Safeguarding Learning Event to review a complex situation involving an individual with serious health needs and a history of domestic abuse. Changes developed following this event include follow-up protocols for missed appointments, improved record keeping and more accessible training, peer support and supervisor support.
- Self-Neglect animation awareness piece has been developed by Bexhill College sixth form media department and is currently being reviewed by the Training and Workforce Development subgroup.

- A dedicated Task and Finish Group was established under the Training Workforce Development Subgroup to revitalize the SAB's multi-agency safeguarding training offer. The focus of this review has been on innovation, inclusivity and evidence-based improvement with a comprehensive review of key training topics including Self-Neglect; Modern Slavery Awareness; Coercion and Control, Domestic Abuse – covering the Domestic Abuse, Stalking and Honour Based (DASH) Risk Identification Checklist and Multi Agency Risk Assessment Conference (MARAC), and Safety Planning; An Introduction to the Mental Capacity Act; and Safeguarding Introduction and Refresher sessions.

2.15 **Safeguarding and Homelessness**

- Multi-Agency Audit focused on adults facing risks linked to housing instability, mental health, and safeguarding concerns during moves across local authority boundaries. This has led to the development of Pan-Sussex Safeguarding Guidance for Adults Moving out of Area.
- Strengthening Safeguarding for Adults Rough Sleeping through a permanent housing representative attending the SAR subgroup, ensuring housing expertise informs safeguarding decisions and systemic improvements
- Direct Notification Protocol enabling immediate notification to the subgroup in the event of a rough sleeper's death. This triggers an assessment to determine whether a SAR referral should be made.

3. Conclusion and Recommendations

3.1 The SAB has delivered strongly against its new Strategic Plan and Year 1 objectives. New partnerships, tools, and training are embedding across the system. Themes such as self-neglect, trauma-informed care, and safeguarding transitions remain at the forefront of strategic learning and service improvement.

3.2 The SAB will continue to progress work on any new SARs in 2025/26, seek assurances of evidence-based implementation of recommendations and actions and showcasing improved practice and impact, and enhance the data dashboard to support qualitative and quantitative analysis of strategic themes, ensuring insights directly inform actions that drive improved practices.

3.4 The Board remains committed to working across health, social care, housing, and community partners to prevent abuse and improve outcomes for adults with care and support needs.

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Appendices:

Appendix 1 - SAB Strategic Plan 2024-27

Appendix 2 – SAB Annual Report 2024-25