SAB East Sussex Safeguarding Adults Board

Annual Report 2024 - 2025

Contents

You can get all our publications in a format to suit you.

If you would prefer this report in an alternative format or language, please contact us: ESSAB.Contact@eastsussex.gov.uk

Photographs courtesy of Aging Better Resource Space

Foreword by the East Sussex Safeguarding Adults Board Chair

It is my privilege to present the Annual Report for East Sussex Adults Safeguarding Board (SAB) for 2024/25. This year marks the launch of our refreshed Strategic Plan 2024-2027, focusing on collaboration, prevention, and trauma-informed practice.

This Annual Report highlights the work that the Board has been engaged with over the year 2024-2025. I am grateful to all partners for their ongoing support. This year has seen many changes in personnel, and I want to welcome all the new partner representative's and thank them for being extensively engaged in its work.

All partners of the Board have continued to deliver services and provide care and support to people, and respond to safeguarding within the continually changing environment, which is evidenced in the Annual Report, alongside the data and additional information provided, through the Partners submissions.

Self-Neglect has been a significant issue this year and addressing the issues this raises for people and communities. Linked with prevention and homelessness it can feature through these themes, and you will note the activities to address knowledge and understanding not only for front line practitioners, but for people who live in our communities and their carers.

We have published one Safeguarding Adult Review this year; however, work has continued learning from Reviews published in previous years to enhance and improve practice through learning opportunities, using various media with the support of local organisations, in particular students from Bexhill College.

Our 2024–27 priorities remain anchored in collaboration, prevention, and amplifying the voices of adults at risk. We will expand trauma-informed training, strengthen data-sharing infrastructure, and deepen partnerships with housing and health sectors to address emerging risks.

Finally, I would like to thank all the Chairs of the subgroups and Board Office for supporting managing the business of the SAB. I would also like to acknowledge the work of the staff and managers across all the statutory, voluntary and community partners who are committed to working together to keep people safe in East Sussex.

Seona Douglas

Seona Douglas - Independent Safeguarding Board Chair

Our role and purpose

The East Sussex Safeguarding Adults Board (SAB) is a multi-agency statutory partnership which provides leadership and strategic oversight of adult safeguarding work across East Sussex.

The work of the SAB is underpinned by the Care Act 2014, which sets out we must do:

Develop and publish a Strategic Plan setting out how we will meet our objectives and how our partner agencies will contribute to these objectives.

Publish an annual report detailing how effective our work has been over the past 12 months.

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.

The East Sussex SAB is led by our Independent Chair, and supported by a SAB Development Manager, a Board Support Coordinator and a part-time Administrator. The Board **(see Appendix 4)** meets at least four times a year and is supported by a range of subgroups which are crucial in ensuring that the priorities set out in the Strategic Plan are delivered – these include: the Safeguarding Adult Review subgroup, Operational Practice subgroup, Performance, Quality and Audit subgroup, Training and Workforce Development subgroup, Safeguarding Community Network and the Sussex Safeguarding Policy and Procedures Review Group **(see Appendix 5**). These subgroups ensure that the work of the Board really makes a difference to local safeguarding practice, and to the outcomes that adults, and their carers, wish to achieve.

Our Vision

Our vision is for all agencies to work together and effectively build resilience and empower communities in responding to abuse, neglect, and exploitation, and to widely promote the message that safeguarding is everybody's business in that:

- Abuse is not tolerated.
- People know what to do if abuse happens.
- People and organisations are proactive in working together to respond effectively to abuse.

Our Purpose

Our overarching purpose is to ensure strategically that agencies work in partnership to deliver joined-up support that safeguards adults, with care and support needs, from abuse, neglect, and exploitation. We do this by:

- Gaining assurance that local safeguarding arrangements are in place as defined by the Care Act 2014, and its statutory guidance.
- Working collaboratively to prevent abuse and neglect, where possible.
- Ensuring partner agencies are effective when abuse and neglect has occurred and give timely and proportionate responses.
- Gaining assurance that the principles of Making Safeguarding Personal (MSP) are central to safeguarding, and practice is person-centred, and outcome focused.
- Striving for continuous improvement in safeguarding practice and supporting partner agencies to embed learning from local and national SARs, other learning reviews, and multi-agency audits.

Partnership Working

The SAB has formal links with other strategic partnerships in East Sussex, including the East Sussex Safeguarding Children Partnership (ESSCP), Safer Communities Partnership (SCP), Children and Young People's Trust (CYPT) and the Health and Wellbeing Board. In addition, the Board currently maintains links with Sussex-wide and national networks and forums including:

- The National Network for Chairs of SABs.
- The National SAB Managers Network.
- The South-East Regional SAB Network.
- The Sussex Domestic Abuse Partnership Board
- The **Changing Futures Programme Sussex**

Collaboration with the Multiple Compound Needs (MCN) Board enables a coordinated multi-sector approach to the transformation and improvement of services for individuals experiencing Multiple Disadvantage. The Board works closely with the neighbouring Brighton & Hove and West Sussex SABs, and our Safeguarding Policy and Procedures are adopted on a Sussex wide basis, as well as many protocols and guidance documents.

Our Strategic Priorities 2024-2027

Self-Neglect

Improve and develop effective multi-agency working and practice with adults who self-neglect.

Develop a shared understanding, and early recognition of the issues involved in working with adults who self-neglect with a focus on substance misuse, mental capacity, exploitation, and multiple compound needs.

Prevention and Early Intervention

Ensure informal carers who take on adult caring responsibilities have an understanding and awareness of adult safeguarding and what support they can access for the person they are caring for as well as for themselves.

Promote and raise awareness of the important role informal carers have in preventing neglect, abuse, or harm and ensuring informal carers know how to raise and report safeguarding concerns.

Safeguarding and Homelessness

Promote positive practice with professionals working at the interface of homelessness and adult safeguarding.

Ensure professionals use trauma informed approaches and consider local multi-agency risk management pathways and legal frameworks to identify what action is needed to reduce or remove potential risk.

Multi-Agency Working

A key area of learning identified in many Safeguarding Adult Reviews (SARs) commissioned in Sussex is the need for more effective partnership working to protect the adult.

Multi-agency working will be promoted and embedded within these priority areas of work.

The Strategic Plan has two main purposes:

To specify the actions required by the SAB and its member agencies to implement the strategy
To inform the local community and all interested parties about the work undertaken annually

The strategic plan can be viewed here:

ESSAB Strategic Plan 2024-2027

Partner Agency Contributions to the SAB Strategic Plan

The agencies listed below each play a vital role in delivering the priorities set out in the East Sussex Safeguarding Adults Board (SAB) Strategic Plan. Their ongoing work supports key areas such as prevention, multi-agency collaboration, safeguarding practice, and improving outcomes for adults at risk. In addition to their operational contributions, several partners also lead SAB subgroups.

A key responsibility of the statutory partners (Local Authority, Police and ICB) is the funding of the Safeguarding Adults Boards duties, and activities to meet its legal duties. Non statutory partners in East Sussex, Fire and Rescue service and the Hospital contribute to the work of the SAB and therefore showing a real commitment to safeguarding and its importance strategically and operationally. For a breakdown of the funding, please see **Appendix 1.**

A brief overview of each agency's contribution is outlined below. For more detailed information on specific activity and impact, please see **Appendix 2** for agencies detailed safeguarding reports.

Adult Social Care and Health (ASCH) ASCH plays a central role in delivering the SAB's strategic priorities, particularly around Making Safeguarding Personal, multi-agency working, and self-neglect. Their data-led approach supports the board's focus on performance, quality, and audit, while their work on mental capacity, advocacy, and outcome tracking reflects a strong commitment to person-centred safeguarding. ASCH also chairs the Operational Practice Subgroup (OPS).

Sussex Police: Sussex Police's safeguarding work contributes to SAB goals around prevention, risk management, and trauma-informed practice. Their work related to fraud prevention initiatives like Operation Signature, and cross-agency risk assessments and links with ASCH, highlight their active role in protecting vulnerable adults. Their efforts also support the SAB's priorities on multi-agency coordination and responding to exploitation. Sussex Police chairs the Performance and Quality Audit (PQA) Subgroup.

Sussex Partnership NHS Foundation Trust (SPFT) SPFT's safeguarding service aligns closely with SAB themes of organisational learning, workforce development, and mental health-informed safeguarding. Their use of the Sussex Thresholds Guidance, SAR engagement (e.g., SAR Jack), internal learning initiatives strengthen multi-agency working. Their collaborative work with ASCH on information-sharing is a strong example of effective partnership.

East Sussex Fire and Rescue Service (ESFRS): Through home safety visits, hoarding-related referrals, and safeguarding alerts, ESFRS contributes directly to the SAB's goals on prevention and early intervention. Their close ties with vulnerable adults at home position them well to identify risk. ESFRS also chairs the Safeguarding Adults Review (SAR) Subgroup, helping embed learning from reviews into practice.

Probation Service: While no update was provided in this cycle, the Probation Service remains a core partner, supporting SAB goals around risk management, multi-agency safeguarding, and supporting individuals with complex needs in contact with the criminal justice system.

East Sussex Healthcare NHS Trust (ESHT) ESHT contributes to SAB strategic aims through its work on domestic abuse, trauma-informed care, and complex case management. Their Mental Capacity Act (MCA) improvements, Think Family model, and involvement in transitional safeguarding (e.g., long-stay patients) address multiple SAB priorities. Their daily safeguarding huddles support real-time, person-centred responses.

NHS Sussex Integrated Care Board (ICB) As a lead SAB partner, NHS Sussex ICB supports all core strategic objectives. They chair the Multi-Agency Risk Management Meetings, (MARM), and the Training and Workforce Development (TWD) subgroup, lead SAR-related actions, and deliver innovative training (e.g., on neurodiversity and trauma). Their role in developing tools such as the Self-Neglect Management Flow Chart supports Year 1 SAB priorities on self-neglect, multi-agency learning, and carer support.

Sussex Community NHS Foundation Trust (SCFT) SCFT aligns with SAB priorities through its safeguarding strategy, focus on Mental Capacity Act (MCA) implementation, and strong training compliance. Their safeguarding advice line and concern-raising to ASCH demonstrate a commitment to person-centred, responsive practice, and they contribute to system-wide improvement through partnership with the ICB and quality escalation pathways.

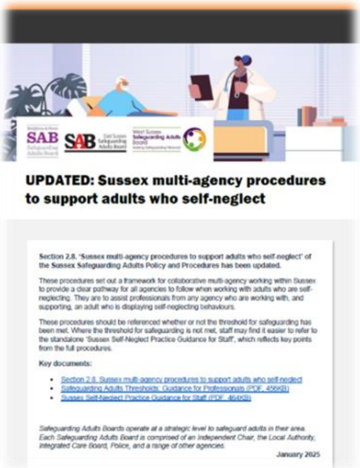
Southeast Coast Ambulance Service (SECAmb) SECAmb supports the SAB's strategic priorities through its significant safeguarding activity across both NHS 111 and 999 services. In 2024/25, the service managed a substantial volume of adult referrals, contributing to early identification and timely escalation of risk. Their collaborative work with social care and police, robust audit processes, and commitment to continuous improvement align strongly with SAB goals on prevention, multi-agency working, and embedding safeguarding into frontline practice.

Healthwatch East Sussex Healthwatch supports SAB priorities by capturing lived experience and promoting person-centred safeguarding. In 2024/25, they published 35 reports and engaged with thousands of residents, highlighting feedback from people who use services, and helping to improve care. As chair of the Safeguarding Community Network (SCN), they play a key role in promoting engagement and accountability.

Key Achievements 2024 – 25

Strategic Priority 1: Self Neglect

Following the West Sussex Safeguarding Adults Board Thematic SAR (self-neglect) a review of The Sussex Multi-agency Procedures to Support Adults who Self-neglect was completed in late 2024 by the Sussex Safeguarding Policy and Procedures Review Group. These provided guidance for a multi-agency framework to support adults who self-neglect, with the focus upon preventing harm by empowering individuals to understand risks, and fostering a shared understanding across agencies, to ensure effective responses. They outline flexible leadership (local authority or other agencies, depending on safeguarding needs) and guide professionals in convening multi-agency meetings. The purpose is to support practitioners working with self-neglecting adults and uphold a duty of care, whether interventions fall under formal safeguarding enquiries or proactive support.


UPDATED: Sussex multi-agency procedures to support adults who self-neglect

Section 2.8. 'Sussex multi-agency procedures to support adults who self-neglect' of the Sussex Safeguarding Adults Policy and Procedures has been updated.

These procedures set out a framework for collaborative multi-agency working within Sussex to provide a clear pathway for all agencies to follow when working with adults who are self-neglecting. They are to assist professionals from any agency who are working with, and supporting, an adult who is displaying self-neglecting behaviours.

These procedures should be referenced whether or not the threshold for safeguarding has been met. Where the threshold for safeguarding is not met, staff may find it easier to refer to the standalone 'Sussex Self-Neglect Practice Guidance for Staff', which reflects key points from the full procedures.

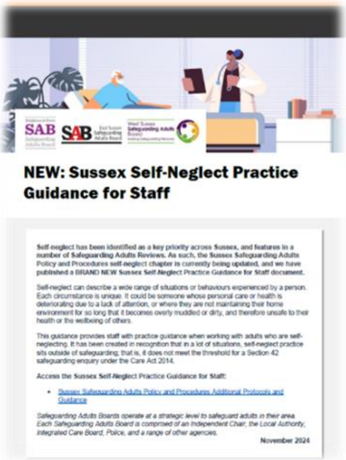
Key documents:

- Section 2.8. Sussex multi-agency procedures to support adults who self-neglect
- Safeguarding Adults Thresholds: Guidance for Professionals (PDF, 456KB)
- Sussex Self-Neglect Practice Guidance for Staff (PDF, 464KB)

Safeguarding Adults Boards operate at a strategic level to safeguard adults in their area. Each Safeguarding Adults Board is comprised of an Independent Chair, the Local Authority, Integrated Care Board, Police, and a range of other agencies.

January 2025

Also launched in late 2024 by the Sussex Safeguarding Policy and Procedures Review Group was the Sussex Self-Neglect Practice Guidance. This supports a structured, person-centred framework for professionals to address self-neglect, whether cases meet formal safeguarding thresholds (under the Care Act's Section 42) or not. It outlines a collaborative five-step process—identification, lead agency assignment, information-sharing, multi-agency meetings, and risk assessments—emphasising proactive engagement and trauma-informed approaches to build trust. Key considerations include rigorous mental capacity assessments (accounting for fluctuating or executive capacity), balancing autonomy with duty of care, and


NEW: Sussex Self-Neglect Practice Guidance for Staff

Self-neglect has been identified as a key priority across Sussex, and features in a number of Safeguarding Adults Reviews. As such, the Sussex Safeguarding Adults Policy and Procedures self-neglect chapter is currently being updated, and we have published a BRAND NEW Sussex Self-Neglect Practice Guidance for Staff document.

Self-neglect can describe a wide range of situations or behaviours experienced by a person. Each circumstance is unique. It could be someone whose personal care or health is deteriorating due to a lack of attention, or where they are not maintaining their home environment for so long that it becomes overly muddled or dirty, and therefore unsafe to their health or the wellbeing of others.

This guidance provides staff with practice guidance when working with adults who are self-neglecting. It has been created in recognition that in a lot of situations, self-neglect practice sits outside of safeguarding; that is, it does not meet the threshold for a Section 42 safeguarding enquiry under the Care Act 2014.

Access the Sussex Self-Neglect Practice Guidance for Staff:

- Sussex Safeguarding Adults Policy and Procedures Additional Protocols and Guidance

Safeguarding Adults Boards operate at a strategic level to safeguard adults in their area. Each Safeguarding Adults Board is comprised of an Independent Chair, the Local Authority, Integrated Care Board, Police, and a range of other agencies.

November 2024

prioritising professional curiosity to uncover hidden risks to ensure people and others are safe within their living environment.

This work is rooted in lessons from Safeguarding Adult Reviews (SARs), and includes early collaboration, and adherence to ethical-legal principles to safeguard vulnerable adults while respecting their rights. The guidance advocates for gradual, practical interventions tailored to individual needs while mandating multi-agency coordination. For extreme cases, where action may be required, it highlights legal pathways such as High Court interventions or Court of Protection referrals.

Conversations in Self-Neglect

Conversations in self-neglect - the role of carers. Produced by the ESSAB & CFTC East Sussex.

The East Sussex SAB has ensured learning from the second national SAR analysis, published in July 2023. 652 reviews completed between April 2019 and March 2023 were analysed. Both the first and second national SAR analysis it showed the most common type of abuse/neglect overall within SARs was ‘self-neglect’.

The national picture of an increase in self-neglect is also mirrored locally with self-neglect which has been a significant and consistent theme of a SAR published this year by the SAB:

- SAR Gwen & Ian

All our published SARs can be found online, here: Published safeguarding adult reviews (SARs) | East Sussex Safeguarding Adults Board

In response to the continuing identification of self-neglect, during 2024/2025 the East Sussex SAB launched three-podcasts in a series entitled: ‘**Conversations in Self-Neglect,’** developed in partnership with Changing Futures Sussex and Care for the Carers East Sussex. These podcasts are aimed at both informal carers/ family members and practitioners. They offer 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.

1. Mental capacity developed in partnership with East Sussex Changing Futures.
2. Am I a carer? developed in partnership with East Sussex Care for the Carers.
3. The role of carers in identifying self-neglect developed in partnership with East Sussex Care for the Carers.

NHS Safeguarding Fortnight 2024

The Sussex NHS Integrated Care Board delivered a fortnight of multi-agency learning events in November 2024, the theme of the fortnight was 'hidden harm'. Pan Sussex SAB managers and the named GP for safeguarding delivered a 'Guidance on working with people who self-neglect' session.

Feedback from attendees confirmed that they were taking forward the related learning to embed into practice and discussing the issues more with colleagues and people they are in contact with. The feedback however also highlighted a continuing need for ongoing support, case-based learning, and possibly supervised practice or peer reflection, especially in complex areas like self-neglect.

Enhancing Support for Carers and Self-Neglect Management in Primary Care

In response to the learning from SAR Gwen and Ian, East Sussex SAB and NHS Sussex ICB have worked collaboratively to strengthen primary care responses to self-neglect, carer support, and safeguarding best practice. A key output was the co-development of a Self-Neglect Management Flow Chart—a practical, trauma-informed tool approved by the NHS ICB Head of Safeguarding. Now integrated into Mental Capacity Act (MCA) refresher training, it supports practitioners in identifying and responding to self-neglect and has been positively received by frontline staff. This will also hopefully act as an early indicator as part of preventing situations deteriorate, so that people can be supported as early as possible.

Additionally, a renewed partnership with Care for the Carers has enhanced visibility and access to support for informal carers. All NHS organisations in Sussex now host dedicated carer support webpages, while GP practices provide clear carer registration pathways, visible noticeboard materials, and easy-read resources—helping to ensure that carers can access tailored advice and are recognised within safeguarding processes. Outcomes of this work has been:

- Carers are now proactively identified and supported through streamlined registration processes, with their status logged in patient records to trigger timely interventions.
- Primary care teams are better equipped to address self-neglect risks with earlier intervention and collaborative safeguarding

Please see **Appendix 3** for the Self Assessment and Management of Self Neglect flow chart.

Multi-Agency Audit in relation to people suffering from Self-Neglect

The ESSAB Performance and Quality Audit (PQA) subgroup has coordinated a multi-agency audit focused on self-neglect referrals, following recommendations from the Safeguarding Adult Review (SAR) Gwen and Ian (published January 2024). This audit aligns with the Board's commitment to improving safeguarding practices, embedding revised pan-Sussex Self-Neglect Procedures (released late 2024), and addressing systemic gaps identified in SAR findings to improve the identification and prevention of self-neglect where possible.

The SAR highlighted critical learning points, including:

Missed opportunities to escalate self-neglect concerns and initiate multi-agency risk management meetings.

Inconsistent application of Self-Neglect Procedures across agencies, particularly in triggering assessments and safeguarding actions.

Gaps in identifying carers' needs and proactive risk management.

The multi-agency audit group considered a sample of six people. As a result of the findings, action is being taken to include improving referral quality, ensuring consistent MCA assessments, enhancing multi-agency collaboration, strengthening carer support, and embedding person-centred planning.
Targeted training, regarding MCA application (particularly around executive functioning), and refresh guidance to promote information-sharing and the need to explain information clearly or in the appropriate language will be necessary. Good practice will drive real-world learning, and ongoing improvement.

Responding to Hoarding Behaviour Framework

Hoarding behaviour was recognised in the Care Act 2014 as one of the manifestations of self-neglect. It is an increasingly prevalent issue and is a complex condition which can involve risk to life, is subject to more than one area of legislation, and involves the health and wellbeing of the person at risk, as well as any others that may be in the household or surrounding properties. It is key therefore that a collaborative, multi-agency approach is taken in identifying and responding to hoarding behaviour.
Building on the success of the Hoarding framework published in 2023 by East Sussex & Brighton & Hove Safeguarding Adults Boards, the guidance was updated in 2025. The Hoarding framework is a multi-agency guide to reduce risks of abuse/neglect linked to hoarding, prioritising autonomy, safety, and collaborative solutions such as:

Enhanced Trauma-Informed Focus: Strengthened guidance on selecting a trauma-informed Lead Professional to build trust and ensure consistent support in high-risk cases.

Fire Safety: Expanded partnership with Fire & Rescue, emphasising early home safety visits and tailored escape plans for mobility-impaired individuals.

Child Safeguarding Clarity: Explicit links to Sussex Child Protection Procedures, stressing "think family" principles when children are exposed to hoarding environments.

Legislative Alignment: Updated references to the Data Protection Act 2018 and streamlined links to the pan-Sussex Safeguarding Adults Threshold Guidance.

Resource Expansion: Added tools for assessing digital/data hoarding risks and revised clutter rating guidance to improve risk stratification.

Core Principles and multi-agency coordination

A person-centred, trauma-informed approach should guide practice—using respectful language (e.g. "losing control of your home" vs. "hoarding") and recognising emotional attachments. Interventions should be sequenced, starting with mental health support and addressing root causes like trauma or isolation. All actions must align with Care Act 2014, MCA, and Environmental Health duties.
Effective response requires clear roles across housing, health, fire, and voluntary sectors, with Hoarding Panels/MARM processes supporting complex cases. The framework—adopted both locally and nationally—will be reviewed again in 2028.
Link to website: Responding to Hoarding Behaviour Framework

Strategic Priority 2: Prevention and Early Intervention

SAB Multi-Agency Safeguarding Learning Event

In early 2025, the East Sussex Safeguarding Adults Board held a closed learning event to review a complex situation involving an individual with serious health needs and a history of domestic abuse. Professionals from health, social care, and police came together to reflect on what went wrong, and how to improve joint safeguarding work.

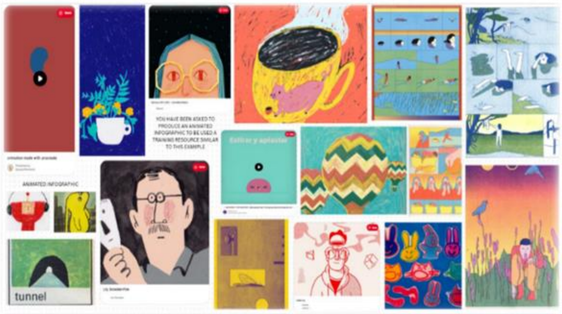
Outcomes & Next Steps

The event showed how reflective practice can lead to real opportunities for improvements. Changes already in place include:

- Follow-up protocols for missed appointments
- Improved record keeping
- More accessible training, peer support and supervisor support

Looking ahead, one key focus will be on making sure individual's voices remain central to all safeguarding decisions. This event demonstrated how strong partnerships can lead to safer, more coordinated support, however all partners needed to be aware of the voice of the individual in all their interactions.

Self-Neglect Animation Awareness Piece



A key area for the Training and Workforce Development (TWD) Subgroup is to ensure learning from multi-agency audits, data, work of the SAB and SARs are effectively embedded into practice and facilitate organisational change.

Through the TWD during 2024/2025 we collaborated with the local Bexhill College sixth form media department to create a bespoke self-neglect awareness animation. The self-neglect animation has been created by Bexhill College and is currently being reviewed by the TWD Subgroup.

SAB Training Review: Embedding Learning

The Training and Workforce Development (TWD) subgroup continues to play a key role in strengthening safeguarding practice across the partnership by ensuring learning insights is actively embedded into training and frontline delivery.

To support this, a dedicated Task and Finish Group was established under the TWD Subgroup to revitalise the SAB's multi-agency safeguarding training offer. The focus 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 Honor Based (DASH) Risk Identification Checklist and Multi Agency Risk Assessment Conference - MARAC, and safety planning (which is under separate review), an introduction to the Mental Capacity Act (MCA), and general safeguarding introduction and refresher sessions.

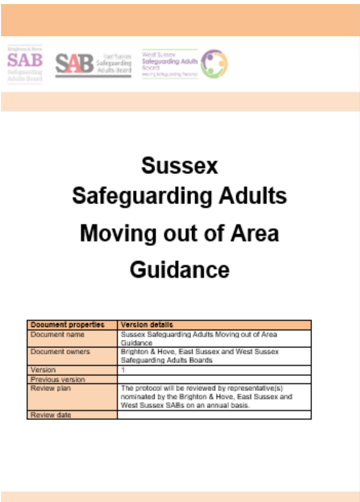
Progress

- **Content Updates**: All revised courses now align with the *Talking About Adult Social Care* guidance and reflect learning, ensuring that materials are both up to date and practically relevant.
- **Lived Experience Integration**: The group is actively exploring how to include survivor and carer voices in future training sessions, to bring learning to life and enhance real-world understanding.

- **Modern Slavery Training:** This workshop has undergone a targeted review, aligning with both emerging best practice and recent legislative changes. Delivery is now supported by specialist police officers whose core role is tackling modern slavery, providing valuable front-line expertise and real-case insight to learners.
- **Mental Capacity Act (MCA):** The TWD subgroup is currently exploring how to strengthen MCA content across the training offer e.g. bite-sized learning sessions, particularly focused on executive function and safeguarding.
- **Domestic Abuse (DA):** A review of the Domestic Abuse training offer is ongoing, particularly identification in older people.

Strategic Priority 3: Safeguarding and Homelessness

Multi Agency Audit and Development of Pan-Sussex Safeguarding Guidance


Sussex
Safeguarding Adults
Moving out of Area
Guidance

Document properties	Version details
Document name	Sussex Safeguarding Adults Moving out of Area Guidance
Document owners	Brighton & Hove, East Sussex and West Sussex Safeguarding Adults Boards
Version	1
Previous version	
Review plan	The protocol will be reviewed by representative(s) nominated by the Brighton & Hove, East Sussex and West Sussex SABs on an annual basis.
Review date	

In response to key learning from SAR Charlie published in May 2023, gaps were identified in supporting adults with complex needs during transitions between local authority areas, East Sussex SAB and Brighton & Hove SAB carried out a joint audit. The audit focused on adults facing risks linked to housing instability, mental health, and safeguarding concerns during moves across local authority boundaries. Findings from the audit highlighted the need for more timely mental capacity assessments, better information-sharing, and trauma-informed risk management. Agencies also acknowledged challenges in meeting urgent housing needs while fulfilling safeguarding responsibilities.

To address these issues, the Pan-Sussex Safeguarding Adults Boards co-developed the *Sussex Safeguarding Adults Moving Out of Area Guidance*. This was launched in Spring 2025. This new guidance supports professionals by:

- Clarifying local authority roles during transitions, in line with the Care Act 2014
- Embedding Multi-Agency Risk Management (MARM) approaches for high-risk cases
- Promoting trauma-informed engagement using tools like the Compassionate Curiosity Toolkit
- Improving communication and escalation pathways across agencies

This work reflects a strong, shared commitment to turning the lessons learnt into real-world improvements—ensuring that adults remain safeguarded, supported, and central to decisions during periods of transition.

Strengthening Safeguarding for Adults Rough Sleeping

The ESSAB Safeguarding Adult Review (SAR) subgroup has proactively strengthened its safeguarding processes for individuals experiencing rough sleeping, in direct response to national recommendations. Recognising the critical intersection of rough sleeping, self-neglect, and compounded health and social care needs, the subgroup has implemented the following measures:

Permanent Housing Representative A dedicated housing representative has been formally welcomed to the SAR subgroup, ensuring housing expertise informs safeguarding decisions and systemic improvements.

Direct Notification Protocol A robust link has been established with the Rough Sleeping Initiative (RSI), 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 is warranted under Section 44 of the Care Act 2014 and more generally learning to prevent further deaths where possible.

By bringing in housing expertise and improving how agencies communicate, the subgroup is tackling the complex risks rough sleepers face—such as mental ill-health, addiction, and self-neglect —which can make them more vulnerable to abuse and harm.

Safeguarding Adults Reviews (SARs)

The SAR Subgroup acts with delegated responsibility from the East Sussex SAB. Its' main purpose is to monitor the delivery of its statutory duties with regards to SARs and other reviews of cases where there are lessons to be learnt.

SABs have a statutory duty under the Care Act 2014 to undertake Safeguarding Adults Reviews (SARs). This is when:

An adult dies because of abuse or neglect (including death by suicide), whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

Or

An adult is still alive but has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult

Published Safeguarding Adult Reviews 2024/25

SAR Jack was published on the SAB website in 2024/25 and can be viewed here: Published safeguarding adult reviews (SARs) | East Sussex Safeguarding Adults Board

Jack was 27 years old when he took his own life in July 2022.
Jack experienced a lot of trauma, in his life, including the loss of loved ones.
He was vulnerable to abuse and often struggled with challenging behaviour.
He didn't have a stable home and spent a lot of time on the streets.
Due to these challenges, Jack had to deal with many different organisations and services. These started before he was born and continued until his death. He was often in and out of prisons, homeless shelters and hospitals.
The review showed that people who worked with Jack understood his problems with alcohol, homelessness, and getting into trouble with the law.
They recognised that his past experiences had a big impact on him and made him vulnerable.
Because of this, the review focussed on what is working well and what could be strengthened.

Current status of recommendations:

The East Sussex Safeguarding Adults Board (SAB) and its partners have made significant strides in strengthening safeguarding practices through the implementation of the 8 Recommendation in Jack's Review.
The recommendations have been actioned during 2024/25 where possible, with several still in progress due to their ongoing nature. The recommendations from Jack's review and those from previous years, are being addressed through the priorities and subgroups as detailed above in this Annual Report.

Next 12 months

There is a renewed emphasis on enhancing the governance and structure of the Board to optimise functionality. This strategic shift aims to facilitate improvements, establish a clearer monitoring framework, drive change effectively, and yield more favourable outcomes.

The East Sussex Safeguarding Adults Board (SAB) has enhanced alignment with Strategic Priorities set forth until 2027.

ESSAB Strategic Plan 2024-2027

The following will be directed towards the following key areas:

- Reviewing of Terms of Reference for each of the SAR subgroups.
- Enhancing governance practices concerning Safeguarding Adults Reviews (SARs) and evidence-based implementation of recommendations and actions and showcasing improved practice and impact.
- Emphasis will be placed on offering more precise recommendations with a focus on multi-agency collaboration.
- In the area of Homelessness and Substance Misuse, enhancing practitioners' comprehension and application of the Self-Neglect Toolkit with particular attention to Mental Capacity and the Hoarding Framework.
- Enhance the data dashboard to support qualitative and quantitative analysis of strategic themes, ensuring insights directly inform actions that drive improved practices.

Glossary

Abuse: A violation of an individual's human and civil rights by any other person or persons. Can include physical, emotional, sexual, or financial abuse, as well as neglect, self-neglect, and discriminatory abuse.

Adult at Risk: An adult who has care and support needs (whether or not the local authority is meeting any of those needs) and is experiencing, or at risk of, abuse or neglect.

Care Act 2014: Legislation that outlines the responsibilities of local authorities and other agencies in safeguarding adults with care and support needs. It introduced the statutory requirement for Safeguarding Adults Boards.

Carer: A person who provides unpaid care and support to an adult who needs help due to illness, disability, a mental health condition, or an addiction.

Changing Futures The Changing Futures programme is a £77 million joint initiative by the Department for Levelling Up, Housing and Communities (DLUHC) and The National Lottery Community Fund, the largest community funder in the UK.

DASH/DARA Forms: Risk assessment tools used primarily in domestic abuse cases to identify risk levels and guide intervention.

Executive Functioning: Mental skills that include working memory, flexible thinking, and self-control. Impairments can affect an individual's capacity to make decisions.

Hoarding: A pattern of behavior characterised by excessive acquisition and inability or unwillingness to discard possessions, resulting in clutter that disrupts living spaces and can cause health and safety risks.

Independent Chair: An individual appointed to lead the SAB independently from partner agencies, ensuring impartiality in governance and decision-making.

Making Safeguarding Personal (MSP): A person-centred approach to safeguarding that focuses on achieving the outcomes that matter to the individual.

Mental Capacity Act (MCA): Law that provides a framework to empower and protect people who may lack capacity to make some decisions for themselves.

Multi-Agency Risk Management (MARM): A coordinated approach involving different organisations working together to manage high-risk safeguarding concerns.

Multiple Compound Needs (MCN): Multiple disadvantage or multiple complex/compound needs (MCN) is defined by the national Changing Futures programme as people who experience three or more of: homelessness, current or historical offending, substance misuse, domestic abuse, and mental ill health

Operation Signature: A Sussex Police initiative aimed at identifying and safeguarding vulnerable victims of fraud.

Pan-Sussex Procedures: Safeguarding policies and procedures that are agreed and adopted jointly by the three Sussex Safeguarding Adults Boards (East Sussex, West Sussex, and Brighton & Hove).

Professional Curiosity: An approach that encourages practitioners to explore concerns in more depth and not take information at face value.

Safeguarding Adults Board (SAB): A multi-agency partnership responsible for ensuring that safeguarding arrangements work effectively to protect adults with care and support needs.

Safeguarding Adults Review (SAR): A statutory review conducted when an adult dies or experiences serious harm due to abuse or neglect, and there is concern about how agencies worked together.

Self-Neglect: A person's failure to attend to their basic needs, such as personal hygiene, health, or surroundings, which can result in a risk to their well-being.

Strategic Plan: A document published by the SAB that outlines its objectives, priorities, and how partners will work together to improve safeguarding outcomes.

Subgroups: Specialist working groups under the SAB that focus on areas such as Safeguarding Adult Reviews, Operational Practice, Quality and Audit, and Workforce Development.

Sussex Safeguarding Policy and Procedures Review Group: A multi-agency group that reviews and updates safeguarding policies and procedures across Sussex.

Threshold Guidance: Criteria used by practitioners to assess the level of risk or need and determine the appropriate safeguarding response.

Transition is the term used within the 2014 Care Act (and also the Children and Families Act 2014) to describe the range of processes that local authorities should use to support a child with care needs or young carer (and their informal networks of support) to move successfully from childhood into adulthood. The 3 groups of people that transition applies to are: Young people with Care and Support needs who are approaching adulthood; Adult carers of young people with Care and Support needs who are approaching adulthood; and Young carers who are themselves approaching adulthood

Trauma-Informed Practice: Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development. A working definition of trauma-informed practice is detailed on the Gov.uk website.

Workforce Development Subgroup (TWD): A subgroup of the SAB responsible for training and ensuring that learning from reviews and audits is embedded into professional practice.

Appendix 1 SAB Budget

Adult Social Care and Health (ASCH), NHS Sussex Integrated Care Board (ICB), Sussex Police, East Sussex Healthcare Trust (ESHT) and East Sussex Fire and Rescue (ESFRS) contribute annually to the SAB budget. SAB Partners support with the running of the Board, for example by offering to chair meetings and co-delivering training. The budget contributions are reviewed annually to ensure that the SAB is delivering its statutory duties.

Income 2024 – 2025

Partner Contributions	**£135,985**
Carryover from 23/24	£5,512
Total	£141,497

Expenditure 2024 – 2025

SAB Staffing	£112,944
Independent Chair	£16,859
Safeguarding Adult Reviews	£3,150
Website (SAB & Procedures) and training costs	£1,030
Total	£134,626
Carry Forward 2025/26	**£7,192**

Appendix 2 Partnership information and data

Adult Social Care and Health (ASCH)

The Care Act 2014 sets out statutory duties and responsibilities for safeguarding adults including the requirement to undertake enquiries under section 42 of the Act. Below is a summary of key safeguarding activity during 2023/24 for both concerns raised, and enquiries undertaken by Adult Social Care and Health (ASCH) in East Sussex Council.

The number of safeguarding concerns received in 2024/25 is 15,385

For 2024/25 ASCH have enhanced their way of recording referrals coming into Health and Social Care Connect - the 'front door' with a new way of recording contacts to enable a smoother transition from a safeguarding concern to a safeguarding enquiry.

Comparisons with previous years are challenging, as the HSCC safeguarding pilot has significantly increased the number of safeguarding concerns recorded as reportable contacts rather than as free-text case notes, which are not easily quantifiable.
The number of enquiries (S42 and Other) that commenced in 2024/25 was 3,082

Table of concerns received/ how many concerns did not progress/enquiries started

Year	Total Concerns	Concerns not progressed to enquiry	Enquiries started (S42 and Other
2024/25	**15,385**	**12,256**	**3,082**

Note**:** Counting the concerns that raise an enquiry. Concerns (contacts) linked to an existing enquiry are not being counted. The concerns not progressed plus enquiries started will not equal the total concerns, as some enquiries started within the year from a concern received before the year, and some concerns progress to enquiries which started after the year end (but the difference is very small).

Type and location of risk reported nationally in 2023/24 in completed section 42 enquiries.
The most common type of risk in Section 42 enquiries which concluded in the year was Neglect and Acts of Omission, which accounted for 36% of risks (32% nationally in 2023/24) and the most common location of the risk was the person's own home at 40% (compared to 46% nationally in 2023/24)

The risk figures that the NHS uses in their national report are figures from the Safeguarding Adults Return (SAC) return. The ASCH figures have therefore compared the number on their 24/25 SAC return to the 23/24 national figure.
The location of risk figures that NHS use in their national report are figures from the SAC return. ASCH have therefore taken the 24/25 SAC return SG2b figure and compared to the national figure for 23/24.

The link to the 23/24 NHS SAC return report is: Safeguarding Adults, England, 2023-24 - NHS England Digital

Outcomes for completed Enquiries (S42 and Other)

Year	Fully achieved	Partially achieved	Not achieved
2024/25	53%	42%	5%

- The total outcomes fully or partially achieved for enquiries (S42 and Other) has remained the same as in 23/24 at 95%

Note: These figures are the same as the 23/24 figures.

Making Safeguarding Personal – outcomes for completed S42 enquiries

- Of the 2378 Section 42 enquiries completed, 80% (1906) were asked and outcomes were expressed.
- 53% of outcomes were fully achieved, 42% were partially achieved, 4% were not achieved (all cases had outcomes achieved recorded)

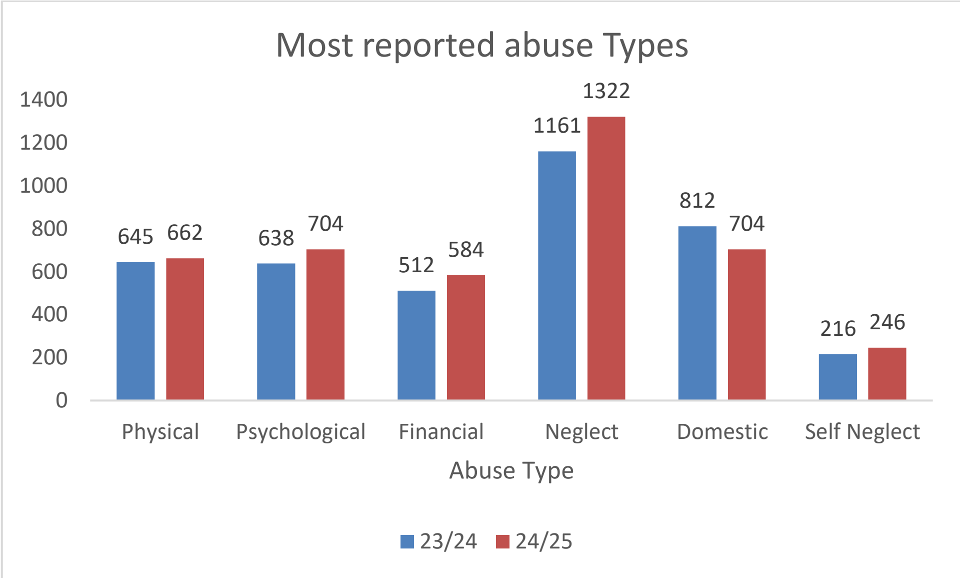
Mental capacity for completed Safeguarding Enquiries (S42 and Other)

Year	Has capacity	Lacks capacity	Not Known
2024/25	68%	30%	2%

Of Adults who lacked capacity, 98% were supported by an advocate in both 2023/24 and 2024/25.

Most reported abuse types for completed enquiries (S42 and Other)

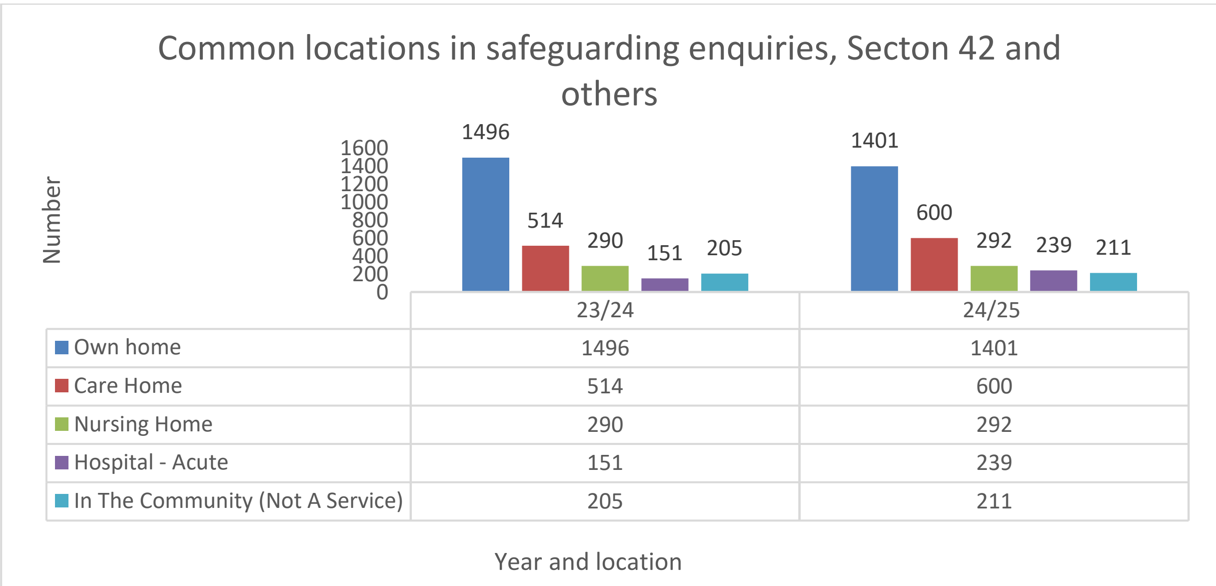
Below are graphs for completed enquiries. These are in the same order as last year. There can be more than one abuse type per enquiry.



- The most reported abuse types in 2024/25 remain the same as in 2023/24.
- Physical, Psychological, Financial, Neglect and Self Neglect all increased this year. Domestic abuse decreased this year
- The most significant changes in these abuse types are financial abuse, neglect, and self-neglect which have all increased by 14% this year. Domestic abuse has decreased by 13% this year.

Most common locations of abuse in completed safeguarding enquiries (S42 and Other)

This data shows enquiries, not episodes. There can be more than one location per enquiry.

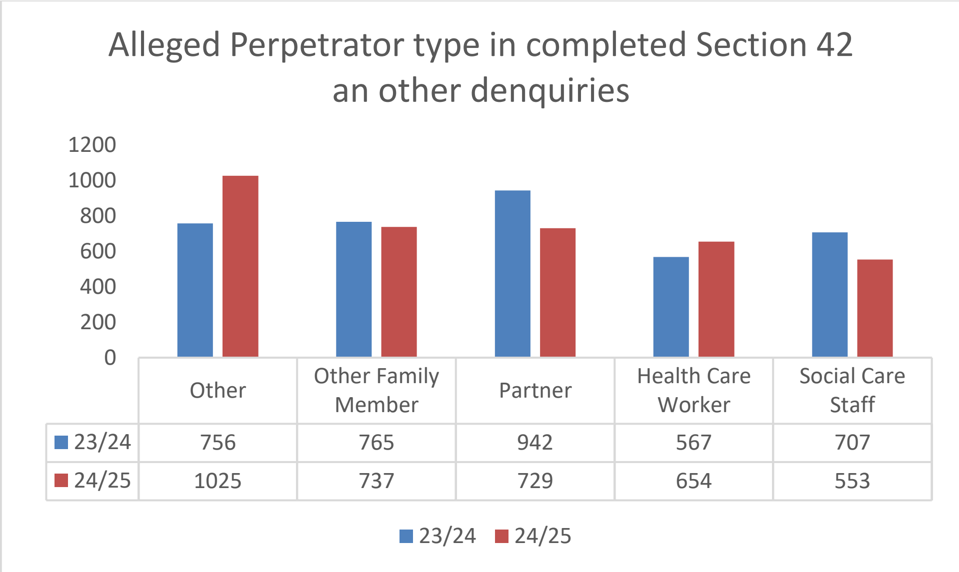


	23/24	24/25
Own home	1496	1401
Care Home	514	600
Nursing Home	290	292
Hospital - Acute	151	239
In The Community (Not A Service)	205	211

- The most common reported location of abuse in completed safeguarding enquiries is in the adult at risk's own home (1401). This has decreased by 6% in 24/25 compared to 23/24 (1496).
- The second most common location continues to be Care Homes. This has increased by 17%, from 514 in 23/24 to 600 in 24/25.

Alleged Perpetrator/PTCOR type in completed safeguarding enquiries (S42 and Other)

Below are graphs for completed enquiries and not for completed episodes. There can be more than one alleged perpetrator or person with Pretrial Conditions of Release (PTCOR) per enquiry.



Most common age and gender of victims in completed safeguarding enquiries (S42 and Other)

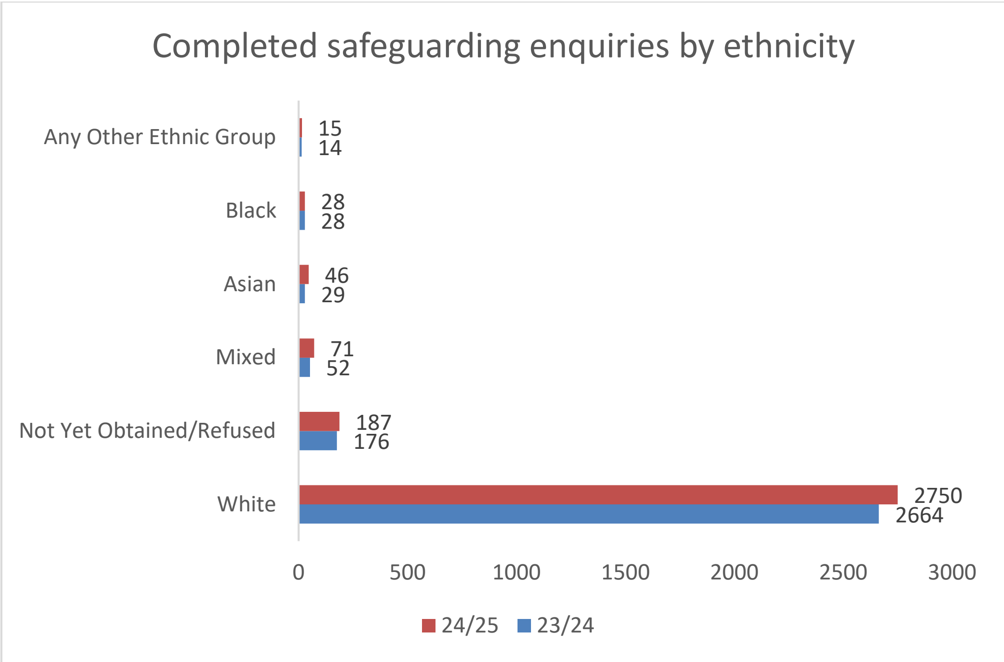
This data below shows enquiries, not episodes by counting once per enquiry (where an individual has multiple enquiries, they are counted once per enquiry)

All age/gender group combinations for ASCH are shown for 23/24 and 24/25, in decreasing order.

Age Group	Gender	23/24	24/25
18-64	Female	932	857
18-64	Male	385	474
85-94	Female	402	392
75-84	Female	395	384
75-84	Male	213	272
85-94	Male	202	219
65-74	Female	177	208
65-74	Male	142	177
95+	Female	90	79
95+	Male	24	28
18-64	Other	0	6
18-64	Unknown	1	1

Completed Safeguarding Enquiries by ethnicity

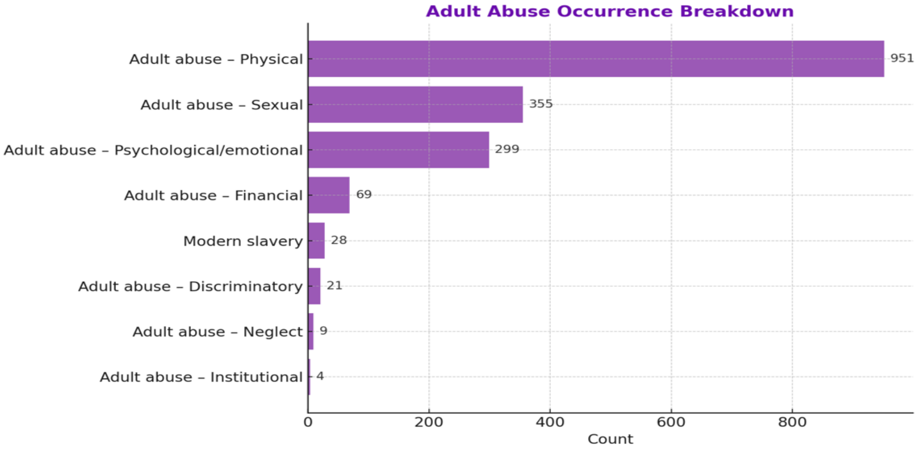
Below are graphs for completed enquiries and not for completed episodes. Counting once per enquiry (where an individual has multiple enquiries, they are counted once per enquiry)



- Adults of white origin continue to be the largest group, accounting for 89% of completed enquiries in 24/25, a slight decrease from 90% in 23/24
- The second largest group (excluding Not Yet Obtained/Refused) is once again Mixed, which has increased from 52 in 2023/24 to 71 in 2024/25.

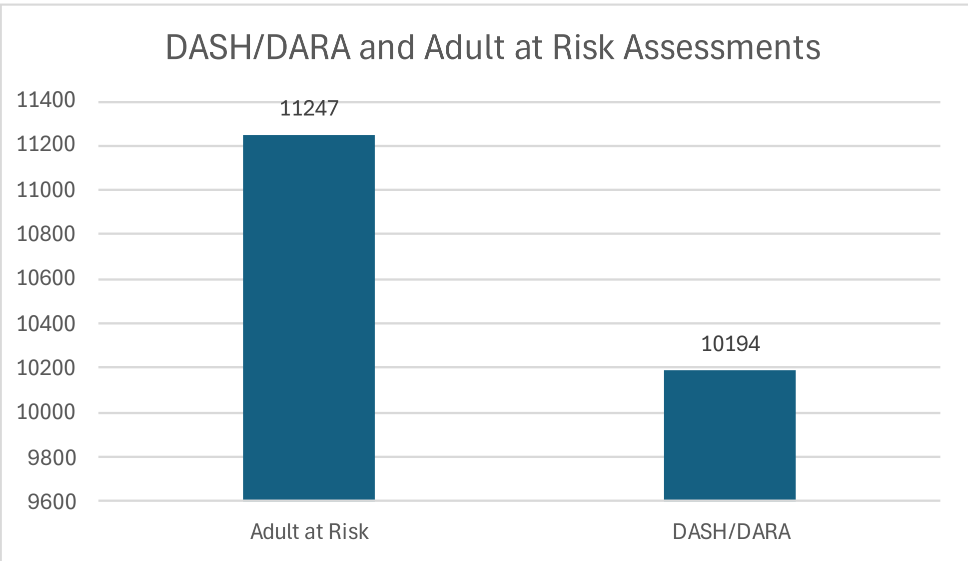
Sussex Police

The graph below shows the number of Crimes per Category of Abuse Risk reported between1st January 2024 to 1sJanuary 2025).



Domestic Abuse, Stalking and Harassment and ''Honour-based' violence (DASH) **Risk forms** (DASH) are for use by specialist domestic abuse and other nonpolice agencies for identification of risks when domestic abuse, 'honour-based' violence and/or stalking are disclosed.

The Vulnerable Adult at Risk (VAAR) section of the Single Combined Assessment of Risk Form (SCARF) is completed by the police for every safeguarding concern. Submissions for both the VAAR and DASH (now Domestic Abuse Risk Assessment - DARA) have decreased over the past 12 months. In 2023/24 VAARs totalled 12893 and DASH/DARAs 10362 **(see graph 2024/25 below).**



Operation Signature is the police service campaign to identify and support vulnerable victims of fraud. The campaign aims to combat fraud and scams with a particular focus on protecting the more vulnerable and elderly.

- In 2024/25 Operation Signature supported 1004 vulnerable victims of fraud in East Sussex. 496 of these victims were offered additional support from fraud caseworkers working for Victim Support.
- The 3 most common fraud types reported in that period were Courier Fraud, Doorstep crime/Rogue traders and Dating and Romance.
- 52% of the victims were aged over 75 years old.
- The 3 most common ways victims were contacted by fraudsters was by Phone, In person and via social media.
- During the 24/25 financial year, vulnerable residents of East Sussex lost a combined £14.66 million.

How Sussex Police tackle fraud

Sussex Police prevented £1.7 Million in fraud losses through banking protocol

This year, Sussex Police have successfully prevented £1.7 million from falling into the hands of criminals through the Banking Protocol initiative.

As part of this effort, Sussex Police implemented a reverse mechanism that allows them to proactively notify banks about vulnerable customers. Over the past 12 months, officers have submitted 195 Bank Notification Forms, enabling financial institutions to take safeguarding measures to protect victims' accounts. In many cases, this process has also led to banks refunding stolen funds to vulnerable victims of fraud. In addition, Sussex Police fraud prevention volunteers have provided tailored advice to 6,856 victims of fraud who are not classified as vulnerable. This allows police resources to be focused on directly supporting those most at risk.

Following the success of a pilot scheme in East Surrey, they are now expanding the Volunteer Fraud Prevention Programme to Sussex. The programme involves trained volunteers delivering in-person presentations and talks to raise awareness about common frauds and how to avoid them. Nine volunteers have already been recruited across Sussex, with the first now active in Hastings and working alongside the local Neighbourhood Policing Team (NPT).

Community partners, charities, and local organisations can request fraud awareness talks by contacting the Sussex and Surrey Fraud Prevention Engagement Team at: **SussexandSurreyFraudPreventionEngagements@surrey.police.uk**

The *Op Signature* team also produces a monthly newsletter that highlights emerging fraud trends and offers safeguarding advice. This publication currently reaches over 40,000 residents across Sussex and Surrey. You can sign up to receive it via the Sussex Alerts homepage: **Sussex Alerts Home Page - Sussex Alerts**

Sussex Partnership NHS Foundation Trust (SPFT)

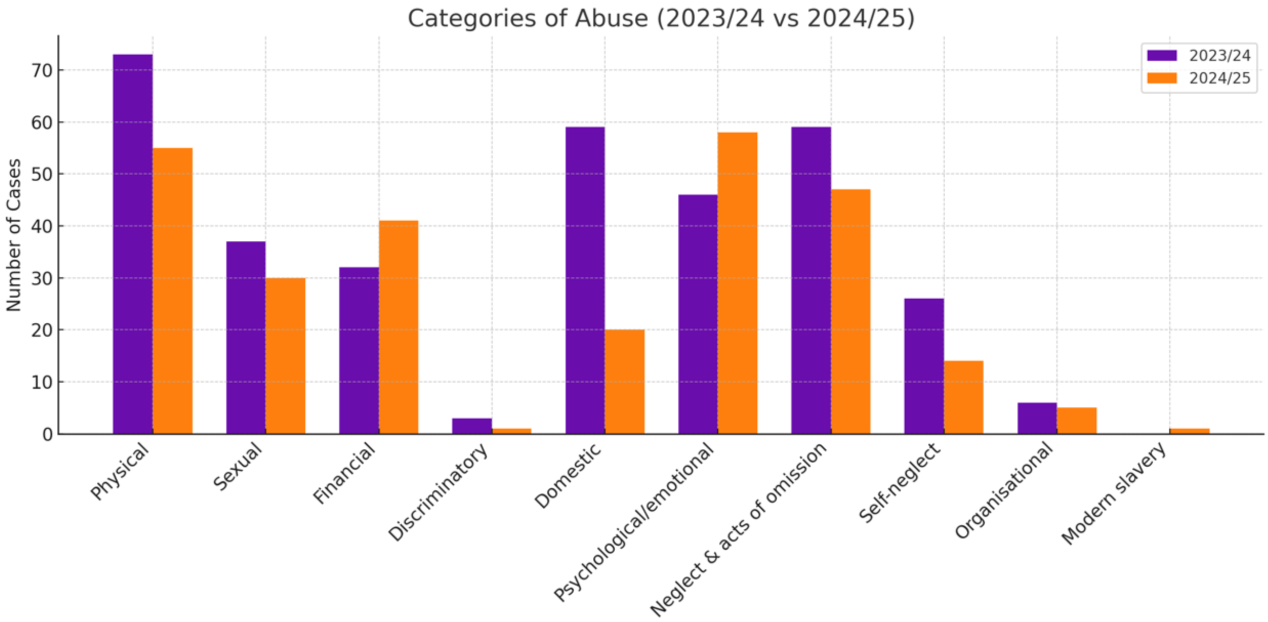
Safeguarding work within SPFT is led by its Safeguarding Service. The service provides safeguarding training and safeguarding consultations to its staff. It contributes to the Trust's programme of quality reviews of its services and participates in the multi-agency work of the Sussex Safeguarding Adults 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 Incidents - SPFT records safeguarding incidents within its incident recording system. This provides a central database for the storage and analysis of the Trust's safeguarding data. Table 1 shows the number of safeguarding adult incidents that were raised by SPFT teams working in East Sussex in 2024/25; numbers from the previous year are provided for comparison. The overall number of safeguarding incidents recorded reduced by 69. The Trust is promoting use of the Sussex *Safeguarding Adults Thresholds: Guidance for Professionals*. Use of this document helps staff to understand statutory safeguarding criteria and leads to fewer inappropriate safeguarding concerns being raised.

Table 1 - Adult Safeguarding Concern Incident Numbers 2023/24

Categories of Abuse	2023/24	2024/25
Physical	73	55
Sexual	37	30
Financial	32	41
Discriminatory	3	1
Domestic	59	20
Psychological/emotional	46	58
Neglect & acts of omission	59	47
Self-neglect	26	14
Organisational	6	5
Modern slavery	0	1
Total	**341**	**272**

Graph 1 – As per table, year comparison



Section 42 Enquiries - SPFT safeguarding enquiry information recorded thirty-four Section 42 enquiries within East Sussex where the Trust was named as the cause of risk. Most of the enquiries were linked to inpatient mental health settings where patients at risk of harm to themselves or others are accommodated together. A Section 42 enquiry and an SPFT internal quality review at the Department of Psychiatry in Eastbourne led to a programme of bespoke safeguarding training during 2024/25 to aid staff learning at this unit.

The total number of Section 42 enquiries was down from forty-seven in the previous year. Part of this reduction is attributed to the cessation of safeguarding enquiries being triggered automatically for every incident of a delay in hospital admission following a Mental Health Act assessment.

Safeguarding Adult Review (Jack) - SPFT contributed to SAR Jack that was published in September 2024. SPFT has shared learning from the review across its services. It has promoted use of the Sussex Multi-agency Procedures to Support Adults who Self-Neglect which were revised in line with a recommendation from the Safeguarding Adult review.

Information Sharing - The SPFT Safeguarding Service worked with East Sussex County Council to obtain read only access to the ESCC Adult Social Care client database. This improves safeguarding information sharing between the two organisations and is in line with best practice. SPFT now has this arrangement with each of the Sussex local authorities.

Prevent - The Trust reviewed and updated its Prevent Policy to reflect changes to terminology and definitions arising from the national review of Prevent in 2023. The Trust also began a project to analyse 130 cases referred by SPFT to the Prevent

Channel Panel process. The work will conclude in 2025. Its results will be shared to inform services of the characteristics of people being referred to Prevent who are linked to mental health services. It is hoped that the report will lead to publication of an academic paper.

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

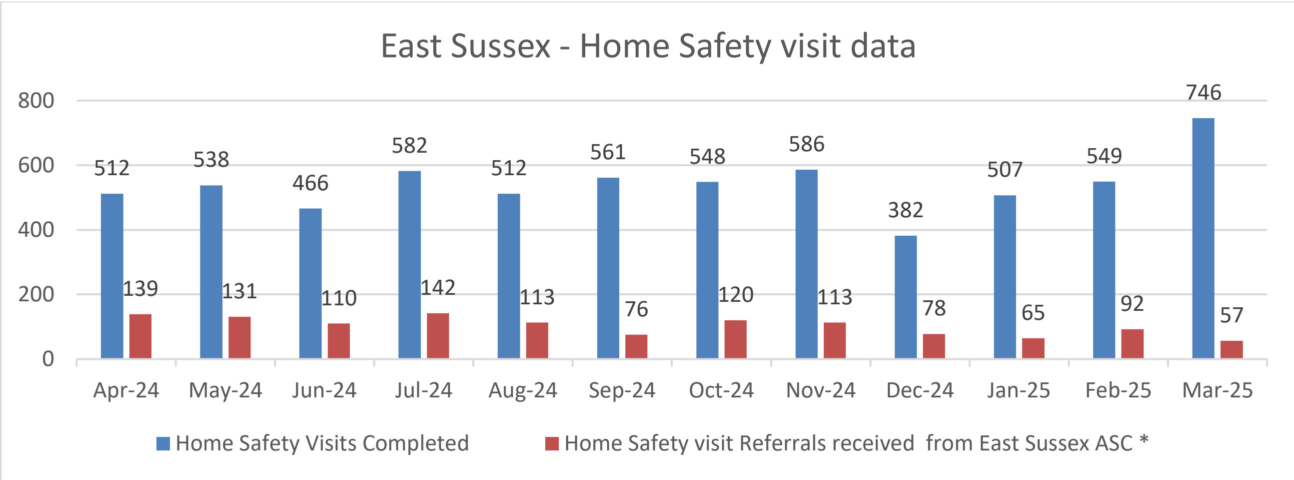
Changing the language: a guide to language for mental health - The Trust's safeguarding service contributed to the development of a new language guide for mental health. Learning from SARs about the power of language to engage or exclude was shared with the project and is reflected in the guide. The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

East Sussex Fire and Rescue Service

Home Safety Visits

East Sussex Fire and Rescue Service (ESFRS) provide Home Safety Visits (HSV's) to members of the community with essential information on safety in their home, escape plans and what to do in the case of a fire.

ESFRS also works with GP surgeries to deliver home safety visits to those most at risk from accidental dwelling fires.



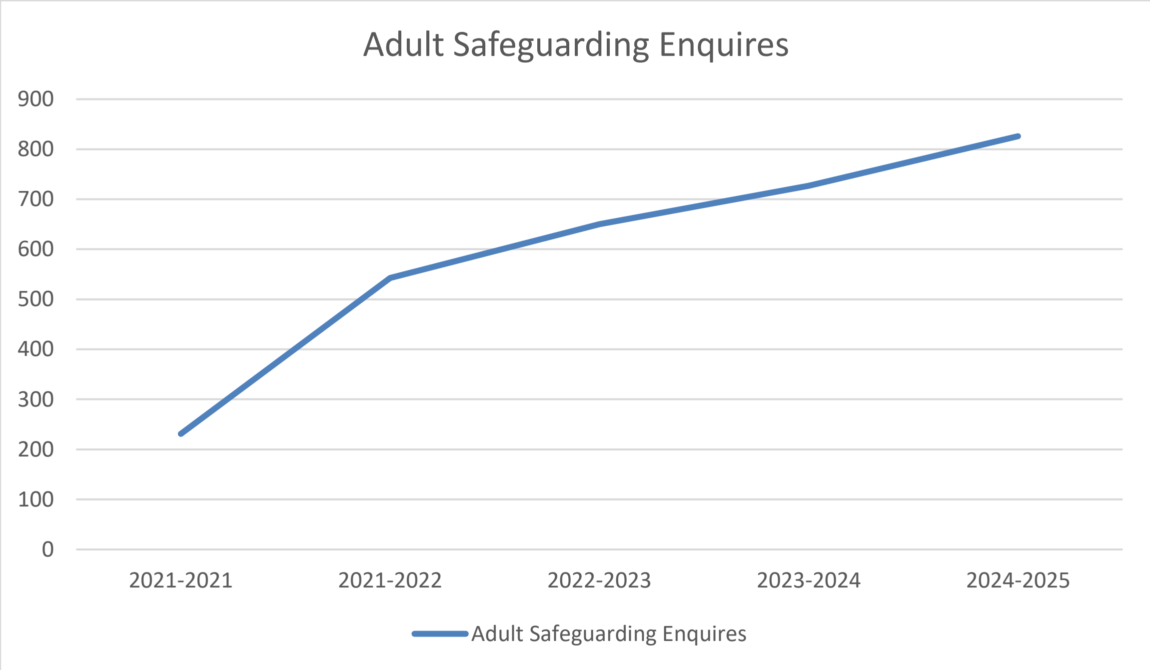
- In 2024/25 over 6,400 home safety visits were completed in East Sussex

Coming to Notice (CTN) forms

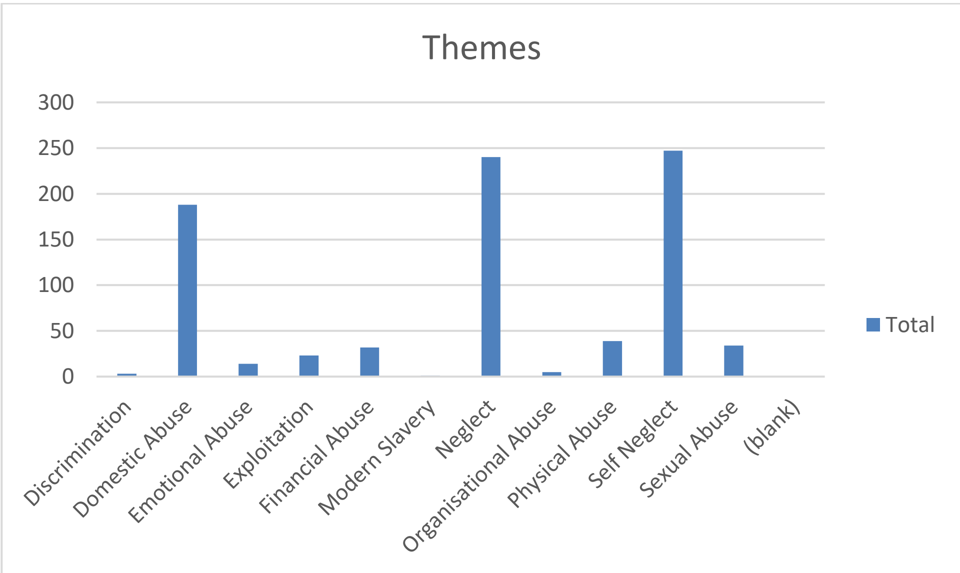
- 387 Coming to Notice (CTN) forms were submitted in 2024/25 in relation to safeguarding concerns.
- Hoarding represented 18% of all concerns.
- Additional support represented 11% of all concerns.

East Sussex Healthcase NHS Trust

East Sussex Healthcare NHS Trust (ESHT) safeguarding recorded a total of 826 adult social care enquiries; this continues to represent a year-on year increase.

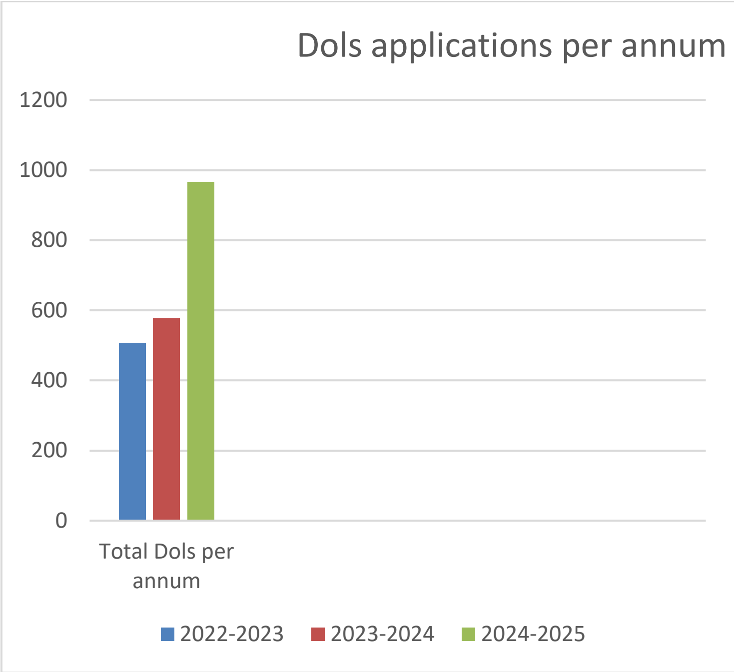


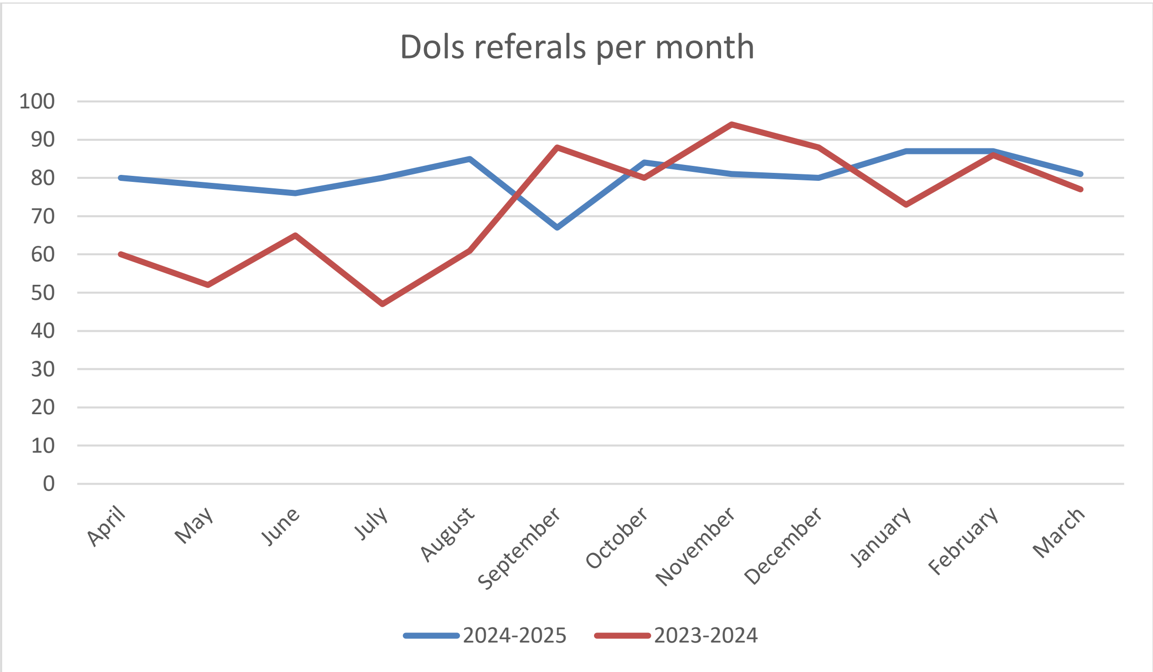
Neglect, self-neglect, and domestic abuse have featured as the prevalent themes for the last few years and this has continued.



- A screening tool for domestic abuse was embedded within the Emergency Department systems to support staff to undertake the routine enquiry of domestic abuse in March 2024, work to expand the tool and enable accessibility across the organisation is ongoing. This has resulted in an increase in domestic abuse referrals from these departments.

- A trauma informed training package has been developed and piloted within gateway areas. Trauma Informed Care has been presented to the Trust Board, and we continue to work alongside Changing Futures Pan Sussex Trauma Informed Community of Practice.
- The Trust signed up to the NHS Sexual safety charter in 2023 and completed work to implement the charter in 2024.
- A task and finish group was established to consider how to support staff to manage cases of self-neglect with plans to take forward a bi-weekly 'drop-in' for staff to access guidance and support, with the expertise of safeguarding and adult social care teams.
- The Trust has participated in broader work with partner agencies about Right Care Right person and in response to this established a Missing person meeting to consider any potential learning.
- Pilot of new digital assessment document for mental capacity assessments and Best Interest Decisions.
- The safeguarding team participated in learning events across the emergency Departments and Surgical teams to name a couple. Ad-hoc and team days across the trust are attended by the safeguarding team on request.
- There has been an additional and significant challenge with the very high numbers of patient with a very extended length of stay many of whom are frail, complex and at high risk of harm e.g., falls, pressure damage and psychological distress.
- The presentation of some cases is increasingly complex. An area where this is continued to be a feature is within Maternity Safeguarding, for example domestic abuse considerations have also to encompass any risks to new-borns and other families.
- ESHT continue to facilitate level 3 training as a Think Family Safeguarding model. The training was formally updated in 2023-2024 and continues to be reviewed on an ongoing basis to ensure it links to current themes. Staff access an assessed e-learning package prior to joining a facilitated session which is r via virtual training platform.
- The Health Independent Domestic Violence Advocate (HIDVA) facilitates Domestic Abuse training within the trust. In 2024 the HIDVA also facilitated a third cohort of training for Domestic Abuse champions within the trust training a further 22 members of staff.
- The Trust employs two Mental Capacity specialists who have developed workshops and training within the organisation. The impact of the work is demonstrated through the increase in Deprivation of Liberty applications.





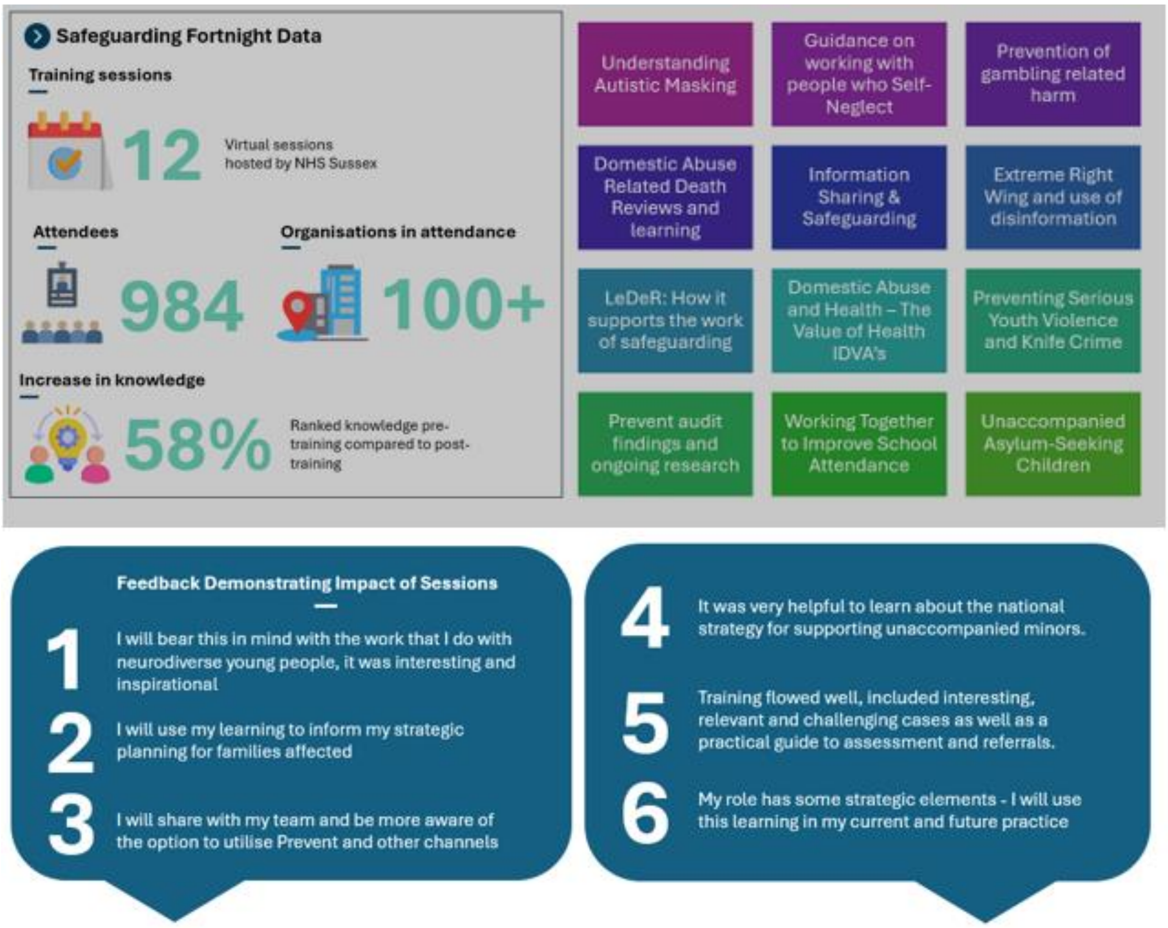
- The safeguarding team facilitate daily safeguarding huddles within the Emergency Departments to enable a process to support staff to recognise and manage safeguarding concerns in real time.

NHS Sussex Integrated Care Board

NHS Sussex have worked alongside both statutory and the wider partners of the Safeguarding Adults Board to safeguard the local population and is represented on all SAB subgroups and leadership groups. As one of the three lead partners, NHS Sussex supports all key decision-making functions of the SAB NHS Sussex chair the Training and Workforce Development (TWD) Sub-group, the Domestic Abuse Related Death Review (DARDR) Oversight Group and the Multi-Agency Risk Management Forum (MARM).

Training

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



NHS Sussex have led on two Level 4 training sessions for health professionals across the system:

'Improving care for women whose babies have been removed from their care'

Feedback post training included:

- *This was an excellent training session. I work in a psychiatric mother and baby unit and sometimes babies are separated from mothers, and I have never heard about Hope Boxes and have never heard about the charity Pause. The delivery of the sessions was very good.*
- *Excellent speakers. Particularly enjoyed hearing from the care leavers and the work being done around referrals to children's services for women who have been care experienced and currently well supported, and HOPE boxes work.*
- *Very thought-provoking session and I'm so glad to see the issues raised and considered for this group of women who go on suffering from the loss of their child*

By rating attendees' knowledge pre and post training, NHS Sussex identified a 25% increase in knowledge post training.

'Understanding Neurodiversity in Safeguarding'

Feedback post training included:

- *Brilliant training: I have always only thought about neuro divergent children and never really thought about neuro divergent parents, parenting neurotypical/divergent children (and other generations).*
- *It was good, I learnt about the different types of neurodiversity and to be more aware and attentive when around everyone*

By rating attendees' knowledge pre and post training, NHS Sussex identified a **20%** increase in knowledge post training.

Provider assurance

NHS Sussex currently has a role in oversight and assurance of health providers through quarterly exception reporting, biannual safeguarding assurance self-assessment and through undertaking site visits. The quarterly exception report was reviewed in 24/25 and has been amended to ensure we get the data required from providers that provides a picture of where gaps may be or to highlight good practice. It has been agreed that relevant data collected can be shared with the Safeguarding Adults Board to inform the dashboard.

During 24/25 a safeguarding benchmarking toolkit was developed and shared with all pharmacy, ophthalmology and dentistry practices in Sussex as a self-assessment.

Working in Partnership to Provide Effective Safeguarding Arrangements

In response to the joint SAR (Gwen & Ian) commissioned by the SAB, NHS Sussex led on a collaborative piece of work developing a Self-Neglect Management Flow Chart for use by primary care to support and improve practise around identifying self-neglect, making referrals and undertaking carers assessment. The tool was promoted during Safeguarding Fortnight and initial feedback from providers was positive. In 25/26 the tool will be reviewed, and an audit undertaken to evaluate the impact on practice

NHS Sussex Safeguarding Team continue as source of expertise across the health and social care system, providing leadership via regular supervision with colleagues in NHS Providers, leading local and regional safeguarding forums and providing advice to system partners on complex safeguarding cases involving health.

Sexual Safety Charter

During 2024/25 NHS Sussex led and supported implementation and roll out of the NHSE Sexual Safety Charter across both the ICB and the provider network. The aim of the Charter is to ensure a systematic, trauma-informed approach to sexual misconduct and violence towards staff throughout the workplace. A gap analysis and action plan were developed to ensure improvements were in place and relevant safeguarding and HR policies were updated. A mandatory virtual training package 'understanding sexual misconduct in the workplace' was launched in Q3, which enable staff to recognise and report sexual misconduct and to understand how to support colleagues (victims and witnesses).

Mental Capacity Act (MCA)

Following the identification of gaps in learning in recent SARs, specific MCA training has been delivered to 93 primary care staff throughout the year to support embedding of MCA in GP practice. The training was reviewed and updated in Jan 25 and is offered to clinical staff on a bimonthly basis 60 people attended the sessions in Q4 with practitioners feeling more competent in applying MCA to practice based on feedback. Focused development work and training has been undertaken with All Age Continuing Care (AACC) to ensure application of MCA for 16/17-year-olds and an MCA Competency Framework will be developed by end of Q2 25/26 and will strengthen compliance.

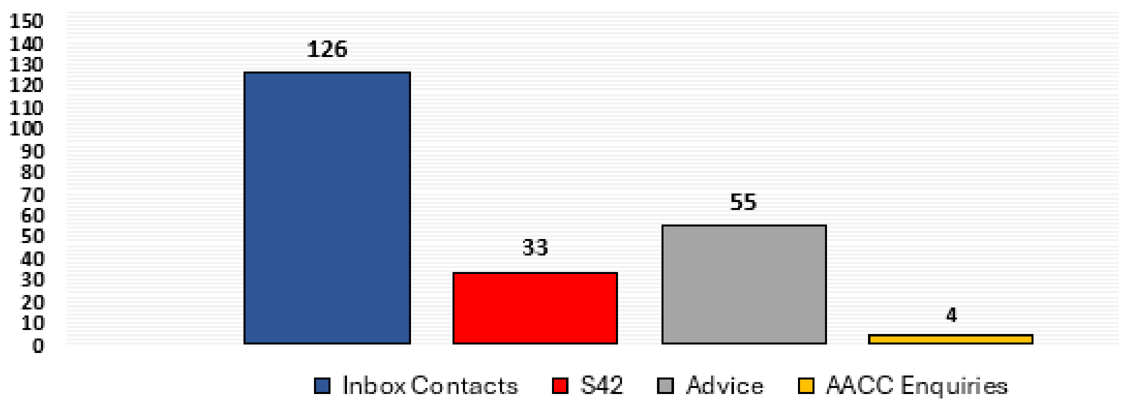
Clinical Safeguarding Advice and support

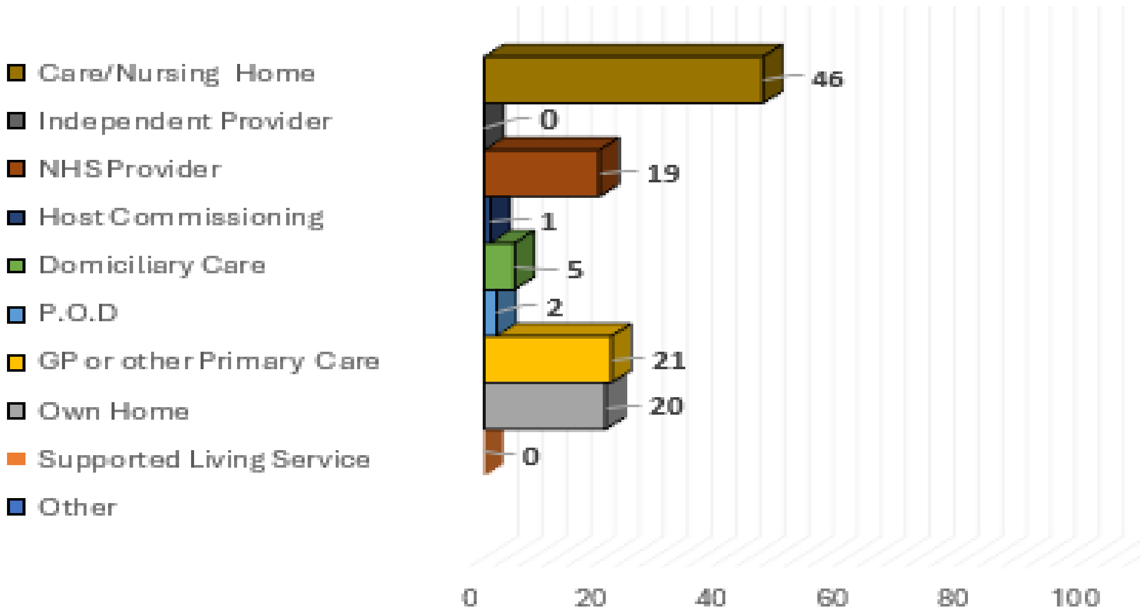
NHS Sussex provide an important clinical safeguarding advisory role across the health and social care system. Where safeguarding concerns of a clinical nature have been raised, the Local Authority will consider the need for a safeguarding response under Section 42 of the Care Act. 2.3. Receiving concerns and undertaking enquiries | Section 2 | Sussex Safeguarding Adults Policy and Procedures

NHS Sussex continue to offer a robust advice and signposting service to ensure multi agency colleagues are supported with health-related safeguarding issues. Our Named GPs for safeguarding offer a separate advice line for GP practices.

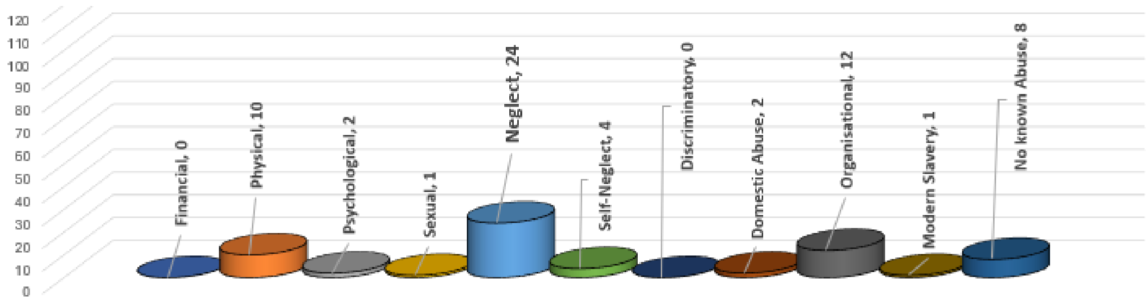
East Sussex Inbox contacts; April 1st 2024 – March 31st 2025

The graph below represents the number of contacts received by NHS Sussex in the last year. Of these 126 contacts, 33 were specific to section 42 enquiries, 55 were professionals asking for advice and 4 related to AACC enquiries. The second graph relates to the Provider/Service Type in relation to the contacts. These figures highlight the level of support given to partner agencies and providers and the collaborative working undertaken to address the needs of our population.





The graph below relates to the Type of Abuse in relation to the Inbox Contacts in the first graph.



Sussex Community NHS Foundation Trust (SCFT)

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

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

SCFT has a safeguarding team which provides specialist advice for both adults and children across all services and supports staff to recognise signs of abuse and how to report it. The Trust works effectively with all safeguarding partnerships to ensure a multi-disciplinary and cross-agency approach.
The safeguarding team works closely with new service developments to ensure we provide high quality and effective health services. The team is part of a Quality and Safety Department, which enables close working both with specialist safety teams and clinical staff. This ensures that SCFT focuses on learning for improvement and strengthens their personalised approach to safeguarding. In 2025/2026 there be will a trust-wide focus on developing good practice around the Mental Capacity Act and Mental Capacity Act assessments.

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

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

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

Learning – SCFT| will continue to promote a culture of continuous safeguarding improvement and learning in the face of economic uncertainty.

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

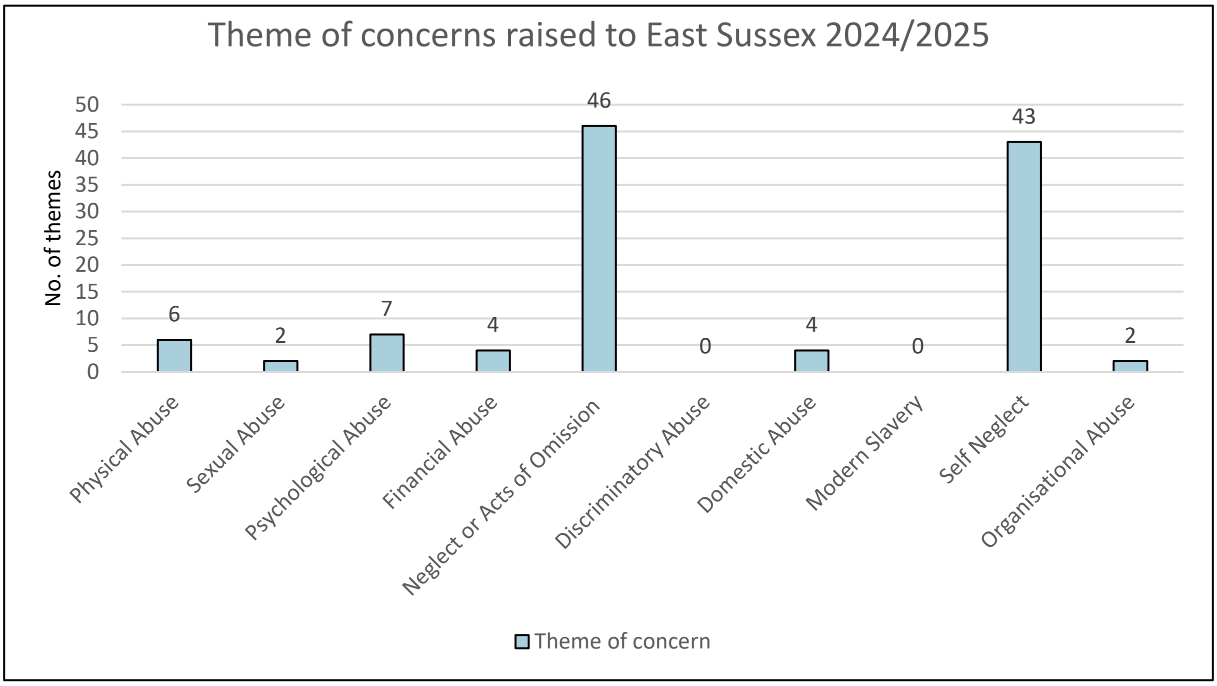
Safeguarding adults training

Level	Target Cohort	Target Compliance	2024-2025 Data	Analysis of Variance
L2	Mandatory for all staff	85%	98%	Compliance remained above SCFT compliance target of 95%
L3	Mandatory for all Adult and Specialist Services registered nursing and AHP staff Band 5-8a	85%	90.5%	In line with the NHS Intercollegiate Guidance the annual target is 85%
L3 WRAP	Mandatory for Adult and Specialist Services staff that require Adult Safeguarding L3, and Children's Services.	85%	97.5%	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: 96.4%	ESR Module MCA: Assessing Mental Capacity. Completion will fluctuate depending on new staff flow into SCFT, and substantive staff choice to complete.

Raising safeguarding concerns

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

Adult safeguarding concerns raised by SCFT to ESCC 2024-2025	
ESCC	**103**



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

SCFT Internal Safeguarding Adults Advice line

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

SCFT: Safeguarding Adults Advice Line	2024-2025
Contacts (Trust-wide)	552

East Sussex Healthwatch

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

Healthwatch is the independent consumer champion created to gather and represent the views of the public on issues related to health and social care. They have legal functions, including a statutory power to 'enter and view' health and care services, established under the Health and Social Care Act 2012.
Healthwatch published 35 reports in 2024/25. The reports include findings and recommendations in relation to health and social care concerns and experiences of East Sussex residents.

- 3,586 people shared their experiences of health and social care services with Healthwatch helping to raise awareness of issues and improve care.
- Healthwatch directly supported 566 people with enquiries through their Information and Signposting service, including users of food banks, migrants and residents in Lewes Prison
- Healthwatch conducted 'enter and view' visits to 20 care homes settings across East Sussex to ask people about their experiences of dentistry and oral health care and their experience of hospital discharge.
- Healthwatch conducted face-to-face engagement with 197 people during the Listening Tour 2024/25, which focused on Wealden District, Lewes and the Havens, and Hastings Borough.
- Healthwatch staff and volunteers carried out a 'mystery shopping' exercise of Modern General Practice, reviewing the website and in-hours phone messages of 55 GP practices from across East Sussex.
- During two phases of engagement Healthwatch staff and volunteers spoke to 358 people in the waiting rooms of Emergency Departments (ED) or Urgent Treatment Centres (UTC) at East Sussex hospitals about the journey they had taken before attending.
- Recommendations from Healthwatch reports are shared with statutory and VCSE partners. The Annual Report is presented to the East Sussex Health and Wellbeing Board.

You can view further information on all the reports Healthwatch have published here.

South East Coast Ambulance Service

South East Coast Ambulance Service (SECAmb) responds to 999 calls from the public, urgent calls from healthcare professionals and provide NHS 111 services across Brighton & Hove, East Sussex, West Sussex, Kent, Surrey, and North East Hampshire (a geographical area of 3,600 square miles). SECAmb employs over 4,000 staff with almost 90% of the workforce being operational staff - those caring for patients either face to face, or over the phone at our emergency dispatch centre where we receive 999 calls.

Safeguarding SECAmb reinforces the principle that safeguarding is everybody's responsibility and develops a culture of continuous learning and improvement to promote the safety and welfare of adults at risk, children and young people and looked after children.

In 2024/25, a total of approximately 41,000 referrals were received across the NHS111 and 999 services: 33,000 for adults and 8,000 for children. This equates to an increase of 23 per cent compared to the previous year. All referrals continue to be triaged by members of the Safeguarding team before forwarding to the relevant local authority or other lead agency.
Despite the continued increase in referral number and subsequent pressure on the team's capacity there is assurance that SECAmb are escalating concerns appropriately and in a timely way. There are regular touchpoint meetings with heads of service across the SECAmb footprint in both adult and children's social teams where discussions take place regarding the quality and appropriateness of referrals.
A randomised audit was conducted throughout February 2025, spanning a month, to ensure timely processing of referrals. The audit concluded

- 57.5% of referrals on average processed in 24 hours
- 22% of referrals on average processed in 48 hours
- 11.1% of referrals on average processed in 72 hours
- 9% of referrals on average processed between 72 and 120 hours

SECAmb's Safeguarding team have built good relationships with partners across social care and with the Designated Safeguarding Teams within the ICBs. This enables queries to be answered quickly where necessary to ensure there is no delay to patient care, it also raises the profile of the ambulance service within the wider safeguarding network.
Working in partnership with local police services has seen improvements in joint working when sharing referrals. The Trust has established a clear pathway to share concerns in a timely way particularly if there are concerns regarding potential areas of neglect.

An example of good safeguarding practice demonstrated by SECAmb clinicians were demonstrated when paramedics responded to an incident involving an elderly gentleman who had reportedly fallen. Upon arrival, the patient was assessed and deemed suitable for home treatment. However, when this outcome was communicated to his wife, she became highly distressed. She then revealed to the staff that her husband had been physically and emotionally abusing her for the past 20 years. Her intention was to leave the home while he was in the hospital. A call was made to the on-call safeguarding practitioner, and a safety plan was discussed for the wife.

The Probation Service

As of the 10th July 2025, there are 2928 cases which are managed by the Brighton and East Sussex Probation Delivery Unit.

In 2024/25, there have been increases in safeguarding enquiry requests and responses, as well as an increase in the number of police intelligence requests and responses.

- The percentage of cases with a safeguarding enquiry requested is 77.70%, which is an increase of 1.26% on 2024/25
- The percentage of cases with a safeguarding enquiry response is 75.47%, which is an increase of 3.73% on 2024/25
- The percentage of cases with a police enquiry requested is 83.85%, which is an increase of 2.67% on 2024/25
- The percentage of cases with a police enquiry response is 69.64%, which is an increase of 12.87% on 2024/25

Safeguarding and Police Requests & Referrals Within the Last 12 Months by Gender

	Type of Safeguarding Check / Referral						
Gender	Safeguarding Referral (Adult)	Safeguarding Referral (Child)	Safeguarding Enquiries Requested	Safeguarding Enquiries - Response Received	Police Intelligence Enquiries - Requested	Police Intelligence Enquiries - Response Received	Total
Female	1	1	191	160	257	184	794
Male	0	1	2054	1771	2551	1894	8271
Total	**1**	**2**	**2245**	**1931**	**2808**	**2078**	**9065**

- 91.24% of requests and responses are for males on the Brighton & East Sussex caseload
- The strategic plan can be viewed in:

Safeguarding and Police Requests & Referrals Within the Last 12 Months by Age

	Type of Safeguarding Check / Referral						
Age Group	Safeguarding Referral (Adult)	Safeguarding Referral (Child)	Safeguarding Enquiries Requested	Safeguarding Enquiries - Response Received	Police Intelligence Enquiries - Requested	Police Intelligence Enquiries - Response Received	Total
18-20	0	0	95	72	121	88	376
21-24	0	0	210	161	246	188	805
25-30	0	1	367	326	445	323	1462
31-40	0	1	783	696	975	693	3148
41-50	1	0	458	393	564	431	1847
51-60	0	0	238	198	327	247	1010
61-70	0	0	71	67	98	79	315
71-80	0	0	21	16	29	24	90
81-90	0	0	2	2	3	5	12
Total	**1**	**2**	**2245**	**1931**	**2808**	**2078**	**9065**

- 34.72% of requests and responses are for the 31-40 age group of the Brighton and East Sussex caseload

Appendix 3 Self-Neglect Assessment and Management

NHS Sussex

Self-Neglect Assessment and Management
(Digital Format with links)

The term self-neglect can be used to describe a wide range of situations or behaviours. It could be someone not looking after their own health or personal care or not maintaining their home environment for so long that it becomes cluttered, dirty and/or unsafe. The Care Act recognises self-neglect as a category of abuse and emphasises the importance of working together and the need to take preventative actions to minimise risk (Care Act 2014 (legislation.gov.uk))

GP ROLE	Manage a long-term condition by combining Knowing, Being and Doing	KNOWING	Understanding the person, their history, and the context of their behaviours	BEING	Developing an effective relationship based on honesty, reliability & respect.	DOING	Facilitating incremental negotiated changes aimed at reducing risk of harm. Refer to the MCA and your non-attendance policy and guidance.

Recognise Behaviours → **Make a diagnosis**

Diagnostic Triad of Behaviors
1. Neglect of personal needs
2. Neglect of environment
3. Declines interventions

± Hoarding
± Neglected pets

Consider Causes & Chronology

Mental	Social	Physical
Mental health disorders	Personal values	Functional disability
Learning disability	Traumatic life history	Sensory impairment
Autism	Alcohol misuse	Nutritional deficiency
Anxiety& depression	Drug misuse	Chronic pain
Organic brain disorder	Isolation	Sleep deprivation

Consider the temporal course of self-neglect, for example, is it recent or longstanding, has it varied in severity or simply progressed gradually over time. Does the chronology support the hypothesised causes?
Use your professional curiosity
ESSAB Professional-Curiosity-Learning-Briefing-final

May the person benefit from a **local authority Needs Assessment?**
- WSCC - West Sussex Adult social care assessment
- BHCC - Brighton & Hove adult-social-care-assessment
- ESCC - East Sussex Care needs assessment information

Look for any impairment of mind

Look for evidence of mental impairment which could affect the person's capacity to avoid harmful choices. What is its course (duration, progression & fluctuation) and does this correlate with the condition's history or could there be another factor at play which might require a different approach?

ACUTE	RECENT	VARIABLE	GRADUAL
Acute confusional state	Tumour / Medications	Acquired Brain Injury / Mental illness	Dementia

Protective or coercive others

How do family, friends, visitors and neighbours interact with the person:
- Supportive
- Indifferent
- Neglectful**
- Coercive**

Do they lack a support network?

Support for carers – Signpost for assistance.
Are you speaking with an unpaid carer? A carer is anyone who looks after a relative, friend or neighbour who couldn't manage without their help. This could be due to a disability, mental or physical ill health, addiction or frailty. The care they give is unpaid. Young Carers are children and young people who have a caring role. Caring often has a negative impact on peoples' own health and well-being and is recognised as a health inequality in Sussex.
- Support for carers - Sussex Health & Care (ics.nhs.uk)
- East Sussex How GP surgeries can help unpaid carers | Care For The Carers (cftc.org.uk)
- West Sussex Carers and Primary Care (carerssupport.org.uk)
- Brighton & Hove Primary Care Link Work - The Carers Centre

3 essential steps for GPs; Identify, Refer, Inform (more info below)

Assess capacity to avoid harm

The clinician should not default to the assumption that the person is choosing to make unwise choices in this situation. Sometimes the person may understand individual elements of what needs to be done to protect themselves but cannot complete the actions to keep themselves safe in an integrated and sustained manner and therefore lacks capacity
Sussex Self-Neglect Practice Guidance for Staff
This is lack of executive capacity as they can't execute the decision.
Situation escalating? Lacks capacity?
- Consider a local authority safeguarding referral**

Interventions by local services

Risk of harm may be reduced, and quality of life improved, by the cumulative benefit arising from separate interventions.
Also see your Non Attendance Policy

MENTAL	WELL-BEING	PHYSICAL	OTHER
Analgesia Psychotropics	Social interventions	Appliances. Support with ADL	Housing. RSPCA etc.

Multi-agency Approach

Consider a multi-agency approach when:
1. Information sharing is needed.
2. Universal services are struggling to manage risk.
3. Person lacks capacity or their capacity fluctuates, and decisions must be made in their best interests. **Follow the MCA.**

If you have held multi-agency meetings yet still feel that the person is at high and imminent risk from harm and appears to have capacity, then consult the Sussex multi-agency procedures to support adults who self-neglect and local Safeguarding Adults Board Multi-Agency Risk Management (MARM) protocols
- East Sussex SAB/multi-agency-risk-management-marm/
  West Sussex SAB MARM-protocol
- Brighton & Hove Multi-Agency Risk Management (MARM) Framework

Safeguarding Referral

****Raise a Safeguarding concern when:**
1. The person is at risk of abuse from others and cannot protect themselves.
2. A child or another adult at risk is living in the household
3. Legal action may be required because of public interest e.g. risk of fire
4. The person is at risk of harm from their self-neglect

Further information on signs and indicators of abuse and neglect and what should be reported as a safeguarding concern is available for professionals via;

Sussex Safeguarding Adults Thresholds Guidance for professionals (eastsussexsab.org.uk)
Self-neglect guidance page 9.

Quick References

Make a referral: Adult

West Sussex County Council
Raise a safeguarding concern using the online form
Contact the Adults Care Point: 01273 642121
Email: adults.carepoint@westsussex.gov.uk
For out of hours contact 0300222 7007

East Sussex County Council
Raise a concern using the online form
Contact Health & Social Care Connect: 0345 60 80 191
For out of hours contact 0345 60 80 191 & select option 2

Brighton & Hove City Council
Raise a concern using the online form
Email Health and Adult social care's safeguarding hub:
hascsafeguardinghub@brighton-hove.gov.uk
If you have concerns that someone may have care and support needs email:
accesspoint@brighton-hove.gov.uk

Make a referral: Child

West Sussex County Council
Raise a concern using the online form
Contact the Multi-Agency Safeguarding Hub (MASH) on 01403 229 900
For out of hours contact 0330 222 6664 or 07711 769657

East Sussex County Council
Contact the Single Point of Advice (SPoA) on 01323 464 222 or by the online form
For out of hours contact Emergency Duty Service on 01273 335 905 or 01273 335 906

Brighton and Hove City Council
Contact the Front Door for Families on 01273 290 400
Email: FrontDoorForFamilies@brighton-hove.gov.uk
For out of hours contact 01273 335 905 or 01273 335 906

Support from local fire officers – Home safety visits

West Sussex
https://www.westsussex.gov.uk/fire-emergencies-and-crime/west-sussex-fire-and-rescue-service/home-fire-safety/safe-and-well-visit/

East Sussex (including Brighton)
https://www.esfrs.org/hsvs

Support for Carers – Additional Information- Provided by Care for Carers

Identify - Many people do not identify as 'carers' initially. Ask patient if they are "looking after someone" who could not manage without their help. Add carer to the practice's Carer's Register & flag their record. **Record** SNOMED code: 224484003 (Patient themselves providing care) or 302767002 (Cares for a relative).
Inform - Tell carer that free support is available through their local carers organisation and suggest they register as a carer. If carer's wellbeing is affected by the caring role, refer on their behalf. **Record.**
Refer - At next interaction, ask about their caring role. If they have not self-referred, remind that support is available. If carer's wellbeing is affected by the caring role, refer on their behalf. Record.
East Sussex: Professional referrals | Care For The Carers (cftc.org.uk)
West Sussex: Referring Unpaid Carers: How to Spot the Signs - Carers Support
Brighton & Hove: Services for Professionals – Carers Hub Brighton

Relevant SAR learning- SAR Ian and Gwen

SAR-Gwen-Ian-Learning-Briefing-2024-.pd

NHS Sussex ICB 2024 00.6 (adapted from NHS Manchester/NHS Northamptonshire Flowcharts)

Appendix 4 SAB Membership

- East Sussex Adult Social Care & Health (ASCH)
- NHS Sussex Integrated Care Board (ICB)
- Sussex Police
- Care for the Carers
- Care Quality Commission (CQC)
- Change, Grow, Live (CGL)
- District and borough council representation
- East Sussex Fire and Rescue Service (ESFRS)
- East Sussex Healthcare NHS Trust (ESHT)
- East Sussex Safeguarding Children Partnership (ESSCP)
- Healthwatch
- HMP Lewes
- Independent Homecare representatives
- Kent, Surrey, Sussex Community Rehabilitation Company (KSS CRC)
- Lay members
- National Probation Service (NPS)
- NHS England
- Registered Care Association (RCA)
- South-East Coast Ambulance Service NHS Foundation Trust (SECamb)
- Sussex Community NHS Foundation Trust (SCFT)
- Sussex Partnership NHS Foundation Trust (SPFT)
- Trading Standards, East Sussex County Council
- Voluntary and community sector representation

Appendix 5 SAB Structure