



Annual report

2025/26

West Sussex
Safeguarding Adults
Board
Making Safeguarding Personal



**from the West Sussex
Safeguarding Adults Board**

Foreword

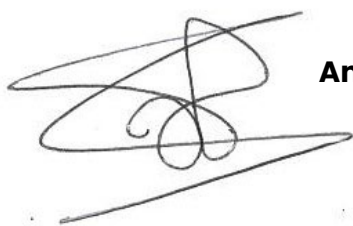
Welcome to this annual report, the eighth that I have had the pleasure of introducing in my time as Independent Chair of the West Sussex Safeguarding Adults Board.

This report proves to be important reading for our partners, stakeholders, and members of the public who are impacted by, interested in, or are influential in guiding change to adult safeguarding practice in West Sussex. This report celebrates the achievements of our Board, whilst recognising that there is always more to do to protect adults with care and support needs in our area.

I would like to draw your attention to two particular highlights from our work this year. The first being our continued work with Tom Somerset-How, the adult at the centre of our 2024 Safeguarding Adults Review in respect of Tom. Since the publication of that review, we have continued to work with Tom, to support him to share his message with adult safeguarding professionals on a national stage. Tom's drive to effect change in the adult safeguarding space has been nothing short of inspiring, and we are grateful that he has trusted us with his story.

The second highlight I would like to shine a light on, is our learning pathway; a self-directed study pathway for staff. I encourage you to spend some time reading about this in our report, as well as visiting our website to explore the pathway in more depth.

Of course, I must also take this opportunity to thank our trusted Board partners for their continued dedication to the improvement of adult safeguarding. And a special thanks to those colleagues who have moved on from our Board this year; we hope that this report is a worthy legacy for your valued contribution.



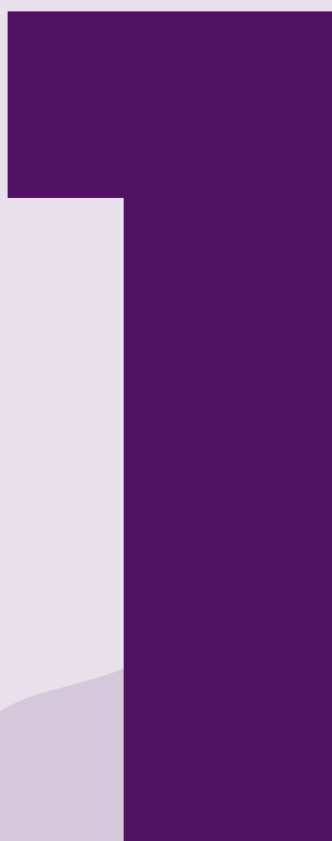
Annie Callanan, MBA, CQSW, and Dip Social Science
Independent Chair
West Sussex Safeguarding Adults Board

About us

Every local authority across the country has a responsibility to establish a multi-agency Safeguarding Adults Board. The purpose of these Boards is to oversee and seek assurance on the effectiveness of adult safeguarding work in its locality.

Read about the governance structure and functioning of our Safeguarding Adults Board in this section.

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The role of our Board

Since 2011 our statutory partners, West Sussex County Council, NHS Sussex Integrated Care Board, and Sussex Police have been working collaboratively with a host of other member organisations and individuals, as part of the West Sussex Safeguarding Adults Board.

The Board has oversight and seeks assurance of safeguarding adults with care and support needs. By this we mean, adults who have care and support needs as a result of a physical or learning disability, mental health needs, or illness.

It's our role to ensure that local safeguarding arrangements are in line with the Care Act (2014) and statutory guidance. This includes making sure that safeguarding practice is person-centred and outcome focused.

We also hold agencies to account, ensuring that they provide prompt and proportionate responses when abuse or neglect has occurred, and that they are working collaboratively.



The Board benefits from a Board Support Team with a wide range of skills, experience, and expertise with backgrounds in social work, psychology, central government, and learning and development including education.

The team has experience working with adults from a range of service user groups, including older adults, learning disability, acquired brain injury, mental health, and substance misuse, as well as children. This is both within front line work and senior management in health, social care, and education settings across the public, voluntary and provider sectors.

The team is passionate about safeguarding, taking a continually creative approach to support the Board to achieve innovative outcomes and products which reflect current thinking and research, and strives to support all workstreams to be service user focussed.

Our Independent Chair, Annie Callanan, has Chaired five Safeguarding Adults Boards and one Safeguarding Children's Board over the past 11 years.

Reflective practice

A reflective practice piece on provider concerns processes in West Sussex, by Joe Nhemachena, Deputy Director of Safeguarding and Complex Care (LDA), NHS Sussex

The Safeguarding Adults Board's work is supported through a number of subgroups. One of those, the Quality Assurance and Safeguarding Information (QASIG) subgroup, is tasked with multi-agency triangulation of quality and safeguarding intelligence. It is also the platform where early intervention, targeted support, and oversight can be directed towards providers of concern within the local health and care economy.

Where substantial concerns arise that require a wider system response, this group can recommend the Operational Provider Concerns process, and following a period of monitoring and evaluation, can further refer to the Strategic Provider Concerns protocol for strategic support to ensure that improvements are evidenced.

As a statutory member of the Board representing health, I had the opportunity to lead the Strategic Provider Concerns process relating to a health provider in October 2024, having recently commenced the role of Deputy Director of Safeguarding at NHS Sussex.



It was encouraging to see that there were protocols and policies that had already been followed, with a clear rationale of why the support of strategic partners was required, and in what way.

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Historically, there had been learning linked to gaps in multi-agency coordination and management of providers of concern, and this had led to the development of a new approach, with new processes and protocols.



*The ethos of the process is centred on collaboration.
openness. and support.*

The Strategic Provider Concerns protocol is laid out in a simple way with clear terms and templates and was therefore straightforward to instigate and bring statutory and relevant agencies together very quickly. My reflection was that the ethos of the process is centred on collaboration, openness, and support. It brought together the strategic statutory safeguarding partners (NHS Sussex, Sussex Police and West Sussex County Council), with the Care Quality Commission, the provider, and the Safeguarding Enquiries team, who were overseeing the operational process.

Strategic partners received an update of the nature of concerns and outstanding actions. When invited to attend, the provider was very responsive, providing a progress update on the action plan and outlining the challenges and barriers. Actions were agreed and implemented. This resulted in the Strategic Provider Concerns process being stood down and the operational process also concluded. Feedback from multi-agency visits to the provider's relevant sites had also provided assurance to statutory partners.

It was refreshing to note the significant actions that had already been addressed through the support of operational processes. QASIG has extensive membership across a number of agencies and is therefore able to strongly triangulate and share information. It has a structure to put effective measures in place, and an escalation route where an enhanced response is required.

This experience was an opportunity for me to both evaluate the effectiveness of approaches to the management of escalating provider concerns, and it also demonstrated to me the incredible levels of collaboration across agencies, the responsiveness, and effectiveness to bring better outcomes for people who use services.

Our subgroups

To progress the work streams identified in our annual business plan we have five working subgroups, plus an overarching Chairs subgroup. The subgroups are made up of staff from across our partnership, all bringing unique skills and experience from their substantive roles.

Our Safeguarding Adults Review subgroup leads on our statutory duty for Safeguarding Adults Reviews, and any other multi-agency learning reviews. Reviews are considered when abuse and neglect appears to have contributed to death or permanent harm, and there is indication of multi-agency learning. The subgroup meets monthly and are Chaired by a representative from West Sussex County Council.

Our Quality and Performance subgroup monitors how effective adult safeguarding practice is in our area. To do this, they monitor, report on, and evaluate safeguarding data and evidence from across the partnership. This subgroup meets quarterly and is Chaired by a representative from Sussex Police.

The Quality Assurance and Safeguarding Information subgroup was created to develop a single picture of the quality and safety of the local care market. The focus of this group is on information-sharing between agencies and supporting timely collaborative working. They meet monthly and the group is co-chaired by representatives from West Sussex County Council and the Integrated Care Board.

The Learning and Policy subgroup take the lead on monitoring and evaluating the effectiveness of training and learning. This includes leading on the development of Safeguarding Adults Board learning resources, such as learning briefings and podcasts. The group meets quarterly and is chaired by a representative from the NHS Sussex Integrated Care Board.

We also have our Multi-Agency Risk Management subgroup. This subgroup offers multi-agency support and advice for cases where adults remain at considerable risk, despite attempts to reduce this risk. The group meets monthly, led by a Chair from West Sussex County Council and vice Chair from Turning Tides.

Finally, we have our Chairs subgroup. This group is formed of the Chairs of each of the subgroups, statutory partners, and the Independent Chair of the Board. The group meets before each Board meeting, to share developments from the subgroups and prepare for the Board meeting.



In a meeting of the Board in March 2025, Board members discussed and agreed the following Board priorities for 2025/2026. Look out for the target icon in the next section of this report, for achievements related to these priorities.

Family involvement in safeguarding processes

As we move forward with an increasing demographic of adults with care and support needs remaining in their own homes for longer, there is a concurrent increasing involvement of family members and unpaid carers to support those adults. That's why this year, we focussed on how we can better involve families in safeguarding processes, whether this be in their role as a protective factor, as perpetrators of abuse (whether intentionally or otherwise), and as contributors in safeguarding enquiries or Safeguarding Adults Review processes.

Self-neglect in relation to mental capacity

In the 2024/25 year, we completed a number of workstreams related to improving staff awareness of the signs of self-neglect and how to work with adults who are self-neglecting. This year, we took this further and looked specifically at the impact of mental capacity on self-neglect, and at the criteria for considering self-neglect as safeguarding.

Making Safeguarding Personal

As our Board tagline suggests, Making Safeguarding Personal is important to us. It's an approach that aims to keep the adult at the centre of safeguarding work and maintain a focus on the outcomes that are important to the adult.

This means that safeguarding is a process that is done with, and not to, adults. It prioritises giving the adult choice, control, and involvement to have a say in the safeguarding process.

West Sussex County Council Adult Social Care

This year the Board heard from Adult Social Care on this topic.

They told us that between August 2024 and August 2025 2,134 adult safeguarding enquiries were completed. Of these, they were able to obtain feedback from 70 individuals at the centre of these enquiries.

Feedback indicated that most people involved in safeguarding enquiries felt listened to, with 68% of respondents feeling that they were able to say what they wanted to happen, and 67% feeling listened to by staff. Overall, 71% of respondents felt satisfied with the way that the safeguarding enquiry was handled.

Our Safeguarding Adults Reviews

Findings from our Safeguarding Adults Reviews consistently highlight the importance of practitioners understanding what matters to the adult.

Our reviews demonstrate that when professionals fail to meaningfully engage with people and listen to their voice, safeguarding becomes procedural rather than person centred. For example, our review in respect of Colin (published in August 2025) noted that the voices of Colin and his family got lost within the process.

The review made a recommendation for the Board to seek reassurance that Making Safeguarding Personal is accurately understood, and that understanding is embedded across partner agencies. Making Safeguarding Personal should inform decision making when working with adults with care and support needs, as it is critical to improving outcomes. There is also a need for services to work more effectively together to share information and manage presenting risks collectively.

Assurance from our self-assessment and audits

Our 2025/26 bi-annual self-assessment and assurance process required agencies to assess and rate themselves in four overarching areas, one of which was Making Safeguarding Personal.

The Board received assurance from partners agencies that since the last self-assessment process in 2023/24, there has been more focus and increased awareness of Making Safeguarding Personal, as well as trauma-informed care and professional (or compassionate) curiosity.

Our work

The work that we undertake each year is related to our annual business plan and progressed with the support of our Board subgroups and Board Support Team.

Read about the work we completed during 2025/26 in this section.

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Our achievements

Launching our learning pathway

In May 2025 we were thrilled to launch [our new learning pathway](#); a self-directed study pathway for staff across the partnership, which brings together learning resources produced by the Board.

Split into three parts, the pathway presents online learning resources according to essential adult safeguarding information, resources to develop skills, and guidance to enhance practice. The pathway is intended to be a useful resource for staff at all levels, either as an introduction to adult safeguarding, or as a comprehensive refresher.

Alongside the pathway, we produced a workbook, to support learners through their journey. The workbook guides the learner through each digital resource, providing opportunities for reflection, further reading, and discussion points for agencies.

Tom Weedon, Community Operations Manager, West Sussex County Council, said:

"I'm delighted to see the launch of this new learning pathway. This is a significant and comprehensive resource to help people explore, develop, refresh, and reflect on their safeguarding knowledge and skills. Making Safeguarding Personal is everyone's responsibility and the learning pathway is an invaluable tool to reinforce and expand our understanding of adult safeguarding practice with a pathway through the vast range of resources and learning available to us all."

Staff from across the health and social care sector, including staff from the voluntary, private, and independent sector, can [access the new learning pathway](#) and accompanying workbook on our website.



Reviewing our learning resources

Alongside our learning pathway, we also conducted a review of our learning resources, resulting in us developing three new ranges of resources.

The first of these are a range of resources aimed at frontline staff, called 'Summary guidance'. These documents are short summaries of more in-depth policies and protocols. They are intended to be quick reference guides for frontline staff and should support discussions with supervisors, managers, or safeguarding leads. This series includes topics such as the Mental Capacity Act, Regulation 18 Notification of other incidents, the Escalation and resolution protocol, and multi-agency working.

Following a review of our learning briefings, we noted that some themes and concepts need a bit more information than we can share in a short learning briefing. For this reason, we created a new 'Explore' series, featuring a more in-depth exploration of key adult safeguarding themes, such as person-centred approaches and disguised compliance.

This series can be used to support focussed discussions in team meetings and continued learning and development.

Lastly, we recognised that sometimes it's useful to have a quick reminder of the importance and relevance of specific adult safeguarding topics. To support with this, we published some 'Quick reference' guides, including Making Safeguarding Personal, early warning signs, and organisational abuse.



Creating our homelessness resource pack

In December 2024, we identified that there is a learning need in the partnership around homelessness.

This was specifically in relation to reducing the stigma experienced by people experiencing homelessness; supporting access to services; and reinforcing the need for trauma-informed care.

As a result of this, the West Sussex Safeguarding Adults Board have created a [resource pack](#) based on the film 'Clarissa', which is a short film by Chris Godwin and Jimmy McGovern, in collaboration with Groundswell. The resource pack has been designed to be used by teams, and to provide a starting point for discussions, and policy and practice reflection. It can be used in team meetings, or as part of internal training opportunities.

Developing our use of the Your Voice Engagement Hub

To support our communications with Board members and providers, we have developed our use of the Your Voice Engagement Hub to undertake surveys and audits.

Wherever possible, we are moving away from using document surveys, to using e-forms and electronic surveys to obtain feedback and assurance. It is our hope that this makes for a simpler and quicker process for those responding to our requests.

Sharing learning at national forums

Throughout this year we have shared our learning and experiences with a variety of national forums.

This has included attending forums with a service user, including the Board Managers Network meeting and the North West Association of Directors of Adults Social Services (ADASS) conference, where we promoted and discussed learning from one of our recent Safeguarding Adults Reviews.

Developing new approaches to our work

We have developed our understanding of, and process needed for, the 'proportionate Safeguarding Adults Review' approach.

This approach moves away from the traditional approach of a focus on learning based on what happened and instead identifies key lines of enquiry which focus on systems learning required. The approach is considered when we have evidence of delivering on similar themes from our previous reviews. As part of this work, we have developed a suite of three templates and guidance documents to support this approach.

We also reviewed how we share learning from Safeguarding Adults Reviews, and developed a new, more easily digestible bulletin template for promoting our reviews.



Publishing a new family-focused page on our website

Following a review of our website content, we published a [new webpage for families, friends, and carers](#).

This was in response to our 'family involvement in safeguarding processes' priority. The webpage provides information about what adult safeguarding is; what we mean by 'care and support needs'; what to do if you are worried about an adult with care and support needs; and how to access support as an unpaid carer.

Sharing multi-agency working guidance

Following the conclusion of our multi-agency working survey, we produced and circulated multi-agency working guidance.

The guidance covers the benefits of multi-agency working; challenges staff have reported they've faced; and top tips for participation in multi-agency meetings.

We also circulated and published a special edition newsletter, summarising all of our multi-agency working resources. To date, this newsletter has been viewed more than 700 times.



Achieving Shaw Trust Accessibility Accreditation

The West Sussex Safeguarding Adults Board and Sussex Safeguarding Adults Policy and Procedures sites were awarded the Shaw Trust Web Accessibility Accreditation.

This means that the sites were tested by people with a wide range of disabilities and found to be accessible. The Shaw Trust Digital Assessment and Accreditation process is rigorous. Over 60 hours of accessibility testing by users with a disability goes into each and every accreditation.

Learning from Prevention of Future Death Notices

We began to consider published [Prevention of Future Death Notices \(Courts and Tribunals Judiciary\)](#) from across Sussex and neighbouring areas to further our learning.

Where there appear to be care and support needs, as well as multi-agency learning, we are considering the coroner's recommendations, to identify whether there is learning for the partnership, locally.

Publishing sector-specific learning from reviews

Our sector learning briefing series has been produced to share learning from our reviews, including learning reviews and Safeguarding Adults Reviews.

Each [sector learning briefing](#) is aimed at a different area of the adult safeguarding sector and draws out particularly relevant learning from our published reviews. This is not to say that there isn't wider learning to be taken from our reviews, but that the learning contained in these briefings is particularly pertinent to the sector. These sector learning briefings are intended to be a concise exploration of key themes identified in our reviews and will be updated with any new identified learning or themes, as needed.

Completing our bi-annual self-assessment process

The purpose of our bi-annual self-assessment and assurance process is for the Board to source assurance about safeguarding activity across the partnership.

This process keeps us informed about how Board members are supporting our strategy. This year we had participation from 18 Board agencies, including our statutory partners; West Sussex County Council, Sussex Police, and the NHS Sussex Integrated Care Board.

Building on our learning from the 2023/24 process, this year we revised our RAG rating system for the self-assessment and ensured that the assurance process was more supportive, including offering targeted support for agencies where needed.

The process comprised of two parts:

- An online self-assessment completed by agencies, in which they RAG rated themselves against four safeguarding domains:
 - Recognising, monitoring, and responding to safeguarding concerns
 - Embedding learning and assurance
 - Making Safeguarding Personal
 - Leadership, governance, and accountability
- An assurance meeting where agencies met with our Independent Chair and a panel of representatives from the statutory agencies; this part was designed to provide challenge and assurance as to the accuracy of self-assessments.

The panel were pleased to hear strong evidence of improvements in safeguarding awareness, trauma-informed practice, training, the use of our guidance, and innovative approaches to safeguarding. Areas for development identified included consistent use of the Sussex Escalation and Resolution Protocol, more awareness of the Safeguarding Adults Hub Professionals' Line, and supporting staff wellbeing.

The feedback that we received from participating agencies was positive, particularly in relation to the more supportive approach and the quality of guidance documents shared. We will be considering other suggested improvements for the process ahead of the next self-assessment in 2027/28. This year the process demonstrated strengthened assurance, more openness to challenge, and evolving maturity in agency participation with the Board based on improved understanding of safeguarding and the importance of strategic safeguarding.

Launching our blog

In January 2026 we launched [our new blog](#).

The blog is intended to be a home for posts featuring input from subject experts, exploring key adult safeguarding topics, as well as discussions about health and adult social care policy, learning, and research.

It is intended to replace some of our special edition newsletters, and to allow us to post timely research and discussion content, written or curated by the Board Support Team.



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Sharing a special edition of our newsletter focussed on mental capacity

In June 2025 we published and promoted a special edition of our newsletter, focussing on the Mental Capacity Act.

This newsletter included information about what mental capacity is; what our responsibilities are when it comes to the implementation of the Mental Capacity Act; how we can support adults with decision-making; and recording the outcomes of capacity assessments.

To date, this newsletter has been viewed more than 1,700 times.

Safeguarding Adults Reviews

As set out in the Care Act (2014), Safeguarding Adults Boards have a duty to arrange a Safeguarding Adults Review when certain criteria are met.

Safeguarding Adults Reviews are intended to identify and promote learning, and to use this learning to improve adult safeguarding practice to reduce risk.

A Safeguarding Adults Review will be considered if:

- an adult has died, and the Board knows or suspects that the death resulted from abuse or neglect; or,
- an adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity, or quality of life, or the individual would have been likely to have died but for an intervention; and,
- there is concern that partner agencies could have worked more effectively to protect the adult.

This year we received eight referrals for Safeguarding Adults Reviews, of which two went forward to a Safeguarding Adults Review. We also received one referral in 2025/26, which is being taken forward as a Safeguarding Adults Review this year. One of the eight referrals is awaiting further information, before it is decided if the criteria has been met for a review.

Find out more

Visit our website for more information:

- [Our Safeguarding Adults Reviews](#)
- [Our Sussex Safeguarding Adults Review Protocol](#)

Learning from our published reviews

This year we have published two Safeguarding Adults Reviews. Alongside our reviews we have published and promoted learning materials, including learning briefings, podcasts, and recorded presentations, to support the learning needed across our partnership.

Provider learning review

In June 2025, we published our provider learning review of the system response and learning following an investigation into reports of organisational abuse and neglect across a large provider of residential and nursing care in West Sussex, during 2016 to 2019.

The reviewer acknowledged the positive changes made to prevent organisational abuse including:

- our Quality Assurance and Safeguarding Information Group, and our Strategic Provider Concerns Group Protocol
- our safeguarding processes including the Safeguarding Hub, our Safeguarding Thresholds Guidance and, our Escalation and Resolution Protocol
- CQC's statutory Guidance on Right Support, Right Care, Right Culture

The reviewer also found:

- health inequalities for people with learning disabilities are still widespread;
- there isn't enough consistency in approaches to managing concerns about providers, such as care homes, across Sussex;

- the current 9am–5pm Monday to Friday social care model is outdated.

The reviewer made a number of recommendations, including for regional and national organisations. You can read about these [in the published report](#).

Safeguarding Adults Review in respect of Colin

In July 2025 we published our Safeguarding Adults Review in respect of Colin. In October 2022 Colin was admitted to hospital. He died 18 days later, with a recorded cause of death of sepsis and multiple infected pressure sores.

The reviewer identified five key findings, which were a need for:

- improved ‘legal literacy’ amongst staff, particularly in relation to the interface between self-neglect and legislation;
- greater awareness of local multi-agency self-neglect procedures;
- more professional or concerned curiosity;
- improvements in family involvement in safeguarding processes;
- better application of the principles of Making Safeguarding Personal.

The reviewer made a number of recommendations, which you can read about [in the published report](#).

Our Safeguarding Adults Review action plans

A number of actions have been successfully completed as a result of Safeguarding Adult Review recommendations and action plans this year.

As a result of our Safeguarding Adults Review in respect of Tom, we worked with the Community Safety and Wellbeing Service to produce an interview-style training video featuring Tom. The feedback about this video has been extremely positive and inspired improvement, with partnership staff and Board colleagues across the country describing it as 'powerful', 'impactful' and 'very moving'. Tom has been very generous with his time and efforts to share his experiences to effect change and we continue to be enormously grateful for all his support.

Boards across the country have also asked us to thank Tom for his courage and commitment to change, noting that he is 'admirable' and 'makes our jobs worthwhile'. In September 2025 we circulated a special edition newsletter, highlighting everything Tom has taught us, and promoting our updated resources on person-centred approaches (including paternalistic practice), professional or concerned curiosity, disguised compliance, and the new training video.

As a result of the Provider Learning Review, the Board Support Team have progressed actions relating to organisational abuse, including the development of a fact sheet and updates to the relevant section of the Sussex Safeguarding Adults Policy and Procedures. These were promoted in a special edition newsletter on organisational abuse in November 2025, to draw much needed attention to the findings from the Provider Learning Review, and how staff members can take forward learning and improvements to address organisational abuse.

Finally, for our most recently published review in respect of Colin, joint work has been undertaken with our colleagues in West Sussex Fire & Rescue, to publish and promote the Safe and Habitable Homes Toolkit. This is a powerful resource which offers practical guidance for addressing unsafe or unsuitable living environments and is available to be used widely across the partnership.

Our data

West Sussex County Council is the lead for safeguarding in West Sussex. Concerns about abuse and neglect are reported to them and triaged by their Safeguarding Hub. This data provides an overview of safeguarding activity and the demographics of those safeguarded in our county.

The figures provided within this report relate to the first submission for NHS Digital and may be subject to change post-further analysis.

Safeguarding concerns and enquiries

In 2025/26, there were 3,013 safeguarding concerns initiated. Of the concerns initiated, 2,409 met the safeguarding criteria and proceeded to a safeguarding enquiry, known as a Section 42 enquiry.

Types of abuse people experienced

It is important to note that with this data one adult may have experienced more than one type of abuse. Therefore, multiple abuse types may be entered for one adult.

This year, of the concluded safeguarding enquiries, concerns regarding neglect and acts of omission accounted for 953 adults, financial abuse for 560 adults, and physical abuse for 381 adults. Together, these three categories make up 73.7% of all types of abuse experienced. Neglect and acts of omission have been the most reported forms of abuse over the past seven years.

Gender, age, and ethnicity of those safeguarded

Please note that the Board acknowledges the limitation of the gender categories currently available.

Of the enquiries undertaken in 2025/26, 1,159 were for women and 835 were for men. There were four enquiries undertaken where an adult's gender was not documented.

Consistent with previous years, the majority of adults involved in an enquiry were over 65 years old, which accounts for a total of 1,184 adults. The highest of this figure was for those aged 85–94 years old, which accounts for 461 adults.

The vast majority of enquiries were for adults who identified as white, totalling 1,637 adults. The data reflects the overall proportion of people's ethnicities in West Sussex and is consistent with previous years. Enquiries completed for all other ethnicity categories did not individually account for more than 55 adults. There were 234 enquiries where an adult's ethnicity was unknown; this was either due to this information not yet being obtained, or because the adult declined to provide this information.

Primary support needs of those safeguarded

Of the concerns received, where the Section 42 criteria was met, those with physical support needs were the most likely to require an enquiry. This accounted for 800 adults. The next most common category was those whose support reason was unknown; this accounted for 614 adults.

Location of abuse

This year, for completed enquiries, abuse and/or neglect in a person's own home accounted for 1,203 adults, and abuse in residential and nursing homes accounted for 672. Historically, West Sussex has been an outlier with a higher number of enquiries for adults in residential and nursing homes. This year, however, West Sussex is in line with national trends whereby abuse is most likely to occur in an adult's own home.

Making Safeguarding Personal

As part of a Section 42 enquiry, adults are asked for their desired outcomes. In total 1,529 adults expressed desired outcomes. Of the concluded enquiries this year, 670 adults had these fully achieved and 746 adults had these partially achieved.

How safeguarding changed risk

For the enquiries concluded this year there were 1,259 adults where action was taken to reduce risk. There were 497 adults where the risk was removed, and 168 adults where actions were taken and the risk remained.

Deprivation of Liberty Safeguards

West Sussex County Council is responsible for Deprivation of Liberty Safeguards in West Sussex. These safeguards are part of the Mental Capacity Act and is a legal measure to protect people who lack capacity to make decisions about their care and treatment.

Referrals received and the outcomes

In 2025/26 there were 6,380 Deprivation of Liberty Safeguards applications received. Of these applications, 1,400 were granted and 2,807 were not granted. At the point of this data being sourced, there were 2,173 not yet complete.

Gender, age, and ethnicity

The majority of Deprivation of Liberty Safeguards authorisations (i.e., where the Deprivation of Liberty Safeguards has been granted) were for females. The age group that received the largest number of granted Deprivation of Liberty Safeguards was 85 years old and over¹. In terms of ethnicity, most adults with a granted Deprivation of Liberty Safeguards were White.

Primary support reason

Adults were most likely to have had the mental health need of 'dementia', recorded as their primary support need. The second highest category was 'no disability recorded'.

¹ When comparing data within the age groupings 18-24, 25-44, 45-64, 65-84, and 85+.

Our awareness events

Safeguarding Adults Week 2025

Once again, in November we joined the Ann Craft Trust Safeguarding Adults Week.

This year, the theme was 'Prevention: Act before Abuse'. We circulated daily bulletins to our Board and subgroup members, exploring each of the daily topics. You can find each of these on our website:

- [Change the conversation](#)
- [Prevention in practice](#)
- [Creating empowering environments](#)
- [Trust your instincts](#)
- [Celebrate the safer cultures](#)

To date, these bulletins have been read more than 2,100 times.



Mental Capacity Act staff briefings

In early 2026, we were joined by our Board partners, Philip Blurton (Sussex Partnership NHS Foundation Trust) and Fiona Crimmins (NHS Surrey and Sussex), for a short briefing about mental capacity and its interface with self-neglect.

We delivered four webinars; two for all partnership staff, and two for managers and safeguarding leads. The briefings were well received by attendees, so we made [a recording of the briefing | YouTube](#) available to anyone who missed them.



Our year wrapped

Six



Pass It On...News newsletters circulated, with a combined readership of over 2,900.

50



Partnership News and Training bulletins shared with Board and subgroup members.

**Over
2,100**



readers of our Safeguarding Adults Week daily bulletins.

~130



attendees to our mental capacity act and self-neglect staff briefings.

Four

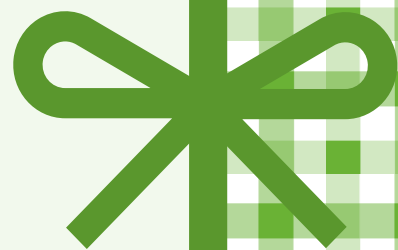


full Board meetings, each involving around 30 organisations and agencies.

54



planned meetings across our subgroups.



Our priorities for 2026/27

In February, we held our annual Board priorities meeting with our members from across the partnership, to decide on our topics of focus for the upcoming financial year (2026/27).

Coercive control and disguised compliance

Amongst the recommendations that we took forward as a result of our Safeguarding Adults Review in respect of Tom, was seeking assurance from agencies about seeing adults alone, providing opportunities for adults to disclose information if needed. The Board acknowledge the current lack of resources on addressing the issues of coercive control and disguised compliance via safeguarding and note that more work is needed across the partnership to develop knowledge and awareness in this area.

Financial abuse

As well as looking at findings from our recent Safeguarding Adults Reviews, audits, and bi-annual self-assessment to decide on Board priorities, we also looked at safeguarding data. The data from 2025 showed us that the category of abuse with the highest increase since the previous year is financial and material abuse. By setting financial abuse as a Board priority, along with coercive control, the Board can help to develop resources and tools to support staff members who are working with those who are at risk of, or experiencing, financial exploitation.

Compliments and complaints

The West Sussex Safeguarding Adults Board records compliments and complaints received, whether or not they meet the threshold for formal reporting to West Sussex County Council, who hold administrative oversight of the Board.

This year we received two complaints. One of these was regarding the outcome of a Safeguarding Adults Review referral, which did not meet the criteria. The Local Government Ombudsman confirmed that the statutory guidance had been applied, and that there was no evidence for taking forward an investigation. The second complaint was regarding safeguarding concern signposting. This complaint was responded to with no further action required.

We received compliments about our work both from our partners, and from safeguarding colleagues nationwide. These included compliments about our learning resources, our work with Tom Somerset-How, and our Multi-Agency Risk Management subgroup.

We welcome your feedback and the opportunity to improve our ways of working.

The Board has a role in coordinating and ensuring the effectiveness of local arrangements to safeguard and promote the welfare of adults with care and support needs. It is not accountable for the operational work of Board members or any other organisation working with adults with care and support needs.

The Board follows the [West Sussex County Council complaint process](#), which is informed by the 2009 Adults' Statutory Complaints Regulations.

Pan Sussex working

This year we have continued to work with the Brighton & Hove and East Sussex Safeguarding Adults Boards. By working collaboratively together, we are improving the experience and support received by our Sussex-wide agencies.

Read about our Pan Sussex work in this section.

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Sussex safeguarding adults policy and procedures

Launching version 6

In May 2025 we published an updated version of the Sussex safeguarding adults policy and procedures.

This was version 6.0. Both the [online and PDF versions](#) were updated, meaning that the PDF version included all updates previously made to the online version since the release of version 5.

Updating the organisational abuse chapter

In July 2025 we updated the [organisational abuse chapter](#) of the Sussex safeguarding adults policy and procedures.

This was updated to include more information about local reporting and responding to organisational abuse across the three Sussex areas.

Releasing the new discriminatory abuse chapter

In July 2025 we also released the new [discriminatory abuse chapter](#).

This new chapter includes definitions of discriminatory abuse; steps for effective practice when working with adults with care and support needs at risk of, or experiencing, discriminatory abuse; the importance of taking a trauma-informed approach; and information about reporting and responding to discriminatory abuse.

Digital communications

In the summer of 2025, we worked with our colleagues in East Sussex and Brighton & Hove to develop new digital communications.

We created digital display content for health providers across Sussex, such as GP surgeries. The display screen content promoted the referral routes for raising adult safeguarding concerns with the local authority and was circulated for use to health providers by NHS Sussex Integrated Care Board.



Updating the Sussex Adult Death Protocol

In December 2025 we published the updated version 3 of the [Sussex Adult Death Protocol](#).

The review of this protocol was led on by Sussex Police. It reflects a commitment to effective partnership working and information sharing across Sussex, and to ensuring a rapid, coordinated response to unexpected adult deaths involving abuse and neglect.

Reviewing the Sussex Self-Neglect Practice Guidance

In December 2025 we also conducted the initial review of the [Sussex Self-Neglect Practice Guidance for Staff](#).

Following its initial launch the previous year, version 2 was updated with some explanatory notes around language and terminology, as well as more detail about decisional capacity and executive functioning. We hope that this guidance will continue to be highly regarded, both within adult safeguarding spaces, and for cases where safeguarding thresholds have not been met.

Our work with others

Often, the best pieces of work come from a collaborative approach, which is why we endeavour, when we can, to work collaboratively with other Boards, other organisations, and service users.

Read about our work with others in this section.

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Resources shared nationally

Our learning pathway and workbook

This year, we shared our brand-new learning pathway and workbook with colleagues in the national Board Managers Network and the South East Region Chairs Group.

We received positive feedback from colleagues in other Boards, as well as requests for them to use and adapt our work for their own localities.

Our tools and templates

Upon request, we have made our internal tools and templates freely available to other Safeguarding Adults Boards.

This has included our formats for our quarterly Chairs reports, adult safeguarding factsheet for the voluntary sector and community groups, Safeguarding Adults Review Summary Guidance, Communication and Engagement Strategy, Mental Capacity Act learning resources, and our Memorandum of Understanding: Safeguarding Adults Reviews, Child Safeguarding Practice Reviews, and Domestic Abuse Related Death Reviews.

The Pan Sussex multi-agency working procedures

The multi-agency working section of the Sussex Safeguarding Adults Policy and Procedures was shared for use by Derby Safeguarding Adults Board.

They used the content to support them in the production of their own multi-agency procedures for use by agencies in Derby.

Our collaborative work with others

Independent Lives

Independent Lives is a user-led charity working to change the lives of disabled people, people with support needs, and carers. Their vision is for a fair society where everyone can participate and has the opportunity to fulfil their potential.



This year, we worked with Independent Lives to develop promotional materials aimed at raising awareness of how to report abuse and neglect. We hope to make these available to partners in 2026.

Burnside Day Centre

Burnside is a dynamic day-opportunity service in Burgess Hill, providing person-centred support for people over the age of 18 with a variety of care and support needs.

Once again, we worked with Burnside Day Centre to support the creation of [our easy read 2024/25 annual report](#). The Burnside Digital Community Group provide us with invaluable consultation services during the production of easy read documents, alongside our easy read supplier.



Tom Somerset-How

In October 2024, the West Sussex Safeguarding Adults Board published a Safeguarding Adults Review in respect of Tom.

Following his involvement in his Safeguarding Adults Review, Tom attended our conference in October 2024. At the conference, Tom shared his experience of abuse and neglect at the hands of his then-wife and paid carer, as well as his experience of the safeguarding process.

A message from our Board Support Officer:

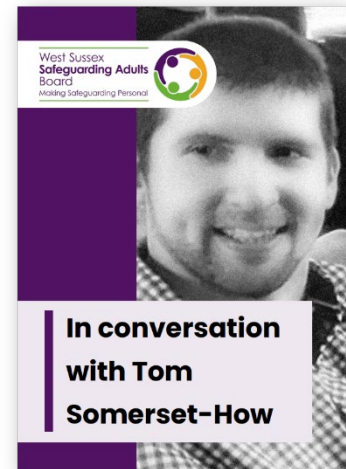
"I am pleased to share with you an article featuring Tom Somerset-How, which has been developed from an interview held at our Safeguarding Adults Board conference in October 2024. Tom shared his story with courage and clarity and made a real impact on all of us. The opportunity to read Tom's story in his own words, within this interview, is extremely powerful.

I've had the privilege of working with Tom as part of the Safeguarding Adults Review process, and I can honestly say his openness, transparency, and commitment to change have been admirable. To Tom, I'd like to say a huge thank you for your invaluable contribution to this process, and for always welcoming me with a cup of tea and a friendly smile! Your kindness and warmth throughout this journey has not gone unnoticed."

Read the article:

- [Safeguarding Adults Review in respect of Tom \(October 2024\) resources](#)

The impact of our Safeguarding Adults Review in respect of Tom has been far-reaching. The Board has received requests from various Safeguarding Adults Boards and forums for Tom to attend their meetings in order to share his experience and promote learning, as well as for us to share our learning and resources.



Community Safety and Wellbeing Service

The West Sussex County Council Community Safety and Wellbeing Service works to support safer, stronger, and more resilient communities.



**SAFER
WEST SUSSEX
PARTNERSHIP**

We developed [a new training video \(YouTube\)](#) in partnership with the Community Safety and Wellbeing Service, bringing to life the key learning from the *Safeguarding Adults Review in respect of Tom*. This new resource features Tom talking through his story and highlighting key themes to help staff understand the crucial role they play in identifying and responding to safeguarding for those experiencing exploitation and abuse.

West Sussex Fire and Rescue Service

We supported the West Sussex Fire and Rescue Service with the publication and promotion of their long-awaited and highly regarded [Safe and Habitable Homes Toolkit](#).

This toolkit has been in development for some time and includes a comprehensive six-step approach to supporting adults whose self-neglecting behaviour is presenting a risk to their living environment. This includes adults at risk of eviction due to hoarding concerns.



Contacts

If you need more information about adult safeguarding, you can get in touch.

Refer to the details in this section to either get in touch with us, or to contact the local authority for more information about reporting safeguarding concerns.

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Report a concern

If you or someone you know with care and support needs, is experiencing or at risk of experiencing abuse or neglect, please report this to West Sussex County Council.

To report your concerns, submit the West Sussex County Council [online adult safeguarding concern form](#). There, you will also find a link to our Safeguarding Thresholds document which has lots of helpful guidance of when to make a safeguarding referral and, when a safeguarding referral is not appropriate, what other options are available.

If you would like to speak to someone about your concerns, phone West Sussex County Council Adults' CarePoint on 01243 642121. Alternatively, call via Relay UK: 18001 01243 642121 (for deaf callers from a textphone or NGT Lite app downloaded to a computer, tablet, or smartphone).

Write to Adults' CarePoint at Adults' CarePoint, Second Floor, The Grange, County Hall, Chichester, PO19 1RG.

Important

If you think the danger is immediate, phone the emergency services on 999.

You can also contact Sussex Police by calling 101 in non-emergency situations.



Contact us

We welcome contact from anyone wanting to find out more about this report, or the work of our Board.

If you would like to access West Sussex County Council's safeguarding training programme or would like more information on safeguarding training in general, visit the [West Sussex Learning and Development Gateway](#).

For our Board's safeguarding learning resources, please visit our [website learning page](#) for a host of learning briefings, podcasts, and recorded presentations.

For the Sussex Safeguarding Adults Policy and Procedures, please see [our Sussex Safeguarding Adults website](#).

Contact us

Visit www.westsussexsab.org.uk

Email safeguardingadultsboard@westsussex.gov.uk

Phone 03302 227952

