2023/2024

West Sussex Safeguarding Adults Board
Making Safeguarding Personal

West Sussex Safeguarding Adults Board | **Annual Report** | 2023/2024

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Foreword

This year's report details the Board's work carried out during 2023/24 to improve safeguarding for adults with care and support needs in West Sussex. It reflects real progress on our two priorities; embedding learning and assurance, and self-neglect.

I am pleased to share that the Board Support Team and I have met with over 250 staff across the partnership to share our work and the vital learning from Safeguarding Adults Reviews. We have also attended a number of staff forums across the partnership and received positive feedback on how information shared has improved knowledge of the Board and helped practice be current.

This year, we commissioned a Thematic Self-Neglect Safeguarding Adults Review and carried out a staff self-neglect survey. There was an impressive engagement of 112 staff. We will continue with self-neglect as a priority for 2024/25.

I am happy to report that we have been able to deliver on the majority of our annual business plan objectives. To highlight a few, our bi-annual self-assessment process, led on by our Quality and Performance subgroup, has been our most successful to-date.

The process gave us the quality of challenge required for the assurance we need. Our focus on embedding learning and assurance in our Learning and Policy subgroup has led to the creation of a short e-learning course about our Board. Other learning resources we have produced are being adopted by Boards across the country. Our Multi-Agency Risk Management subgroup has continued to support and find solutions for high-risk and complex cases. This includes monitoring and considering actions related to any safeguarding risks identified by the cost-of-living crisis.

I acknowledge and greatly appreciate the continued commitment of all our members, and diligent work of our Board Support Team. This work is reflected in our successes with improvements to the safety for adults. I am confident that we will be equally effective in continuing on our improvements for adult safeguarding next year.

Annie Callanan
Independent Chair
West Sussex Safeguarding Adults Board

About us

Safeguarding Adults Boards have been set up in every Local Authority. Safeguarding Adults Boards are a multi-agency partnership with strategic oversight of adult safeguarding. Boards oversee and seek assurance on the effectiveness of the safeguarding work of its members and partner agencies.

Our Board was first set up in 2011 and our current Independent Chair is Annie Callanan. It is formed of the following statutory partners:

- West Sussex County Council
- NHS Sussex Integrated Care Board
- Sussex Police

To fulfil its role, Boards are expected to involve a much wider range of organisations and individuals. You can find a list of our members on the 'Our members' page of our website.

The purpose of a Safeguarding Adults Board is to have oversight and assurance of safeguarding adults with care and support needs.

We do this by having assurance that:

- Local safeguarding arrangements are in place, as defined by the Care Act 2014 and statutory guidance.
- Safeguarding practice is person-centred and outcome-focused.
- Safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.
- Agencies give prompt and proportionate responses when abuse or neglect have occurred.
- Agencies are working collaboratively to prevent abuse and neglect where possible.

Boards have three core duties to fulfil statutory requirements:

- Have a Strategic Plan
- Produce an Annual Report
- Conduct Safeguarding Adult Reviews

Care and support needs

Care and support needs can arise from, for example, having a physical or learning disability, mental health needs, or illness. Adults with care and support needs may or may not be in receipt of services to meet their needs, but this should not affect their access to safeguarding support.

Case study

In December 2023, our Board published a Safeguarding Adults Review in respect of an adult, known here as DJT.

The following case study provides an overview of the Review, including who DJT was, his involvement with services and safeguarding processes, and the findings of the Review.

Pen picture of DJT

DJT was a Polish man who worked as a painter and decorator for much of his life; a job which he enjoyed. He was the proud father of two sons and a daughter, and enjoyed cycling, football, swimming, music, and had an interest in cars. Those who knew him described him as a caring man with a good sense of humour.

DJT's eldest son died, aged 21 years. Following the death of his son, DJT's alcohol use increased, and his marriage subsequently ended.

DJT suffered a second traumatic life event when he experienced an accident at work, which resulted in him requiring surgery and developing glaucoma. These life events led to DJT becoming reliant on alcohol, and making 'unwise' decisions, including those decisions related to self-care and financial responsibility.

Sadly, in May 2021, DJT passed away in hospital. His cause of death was multiple organ failure, related to his alcohol use.

Good practice

The Review identified that DJT had received some good quality care and safeguarding practice.

Sussex Police went above and beyond their remit to support DJT. This included escorting him to shops to purchase food, and cleaning and tidying for him, to improve his environment.

Representatives from West Sussex County Council also demonstrated good practice. They accompanied DJT to several banks to manage his finances, and spent considerable time with him, in an effort to resolve issues with his benefits.

Rehabilitation Officers from the Visually Impaired Team provided significant support to DJT to help him cope with his sight loss. This included resolving issues in relation to his finances and providing emotional support.

The Review did identify, though, a number of areas for multi-agency learning and improvements, to reduce future risk to adults with similar experiences to DJT.

Person-centred care including supporting adults with finances and medication

The Review identified that care agencies involved in DJT's care were not as person-centred in their approach as they could, and should, have been. When working with adults with complex needs, services should ensure that there are provisions in place to support all of their care needs. This should include medication and finances.

Trauma-informed approaches

Professionals were aware of the traumatic life experiences that DJT had faced, but more support could have been offered to support him with his mental health. The Review suggests that referrals to talking therapies, or bereavement counselling, may have demonstrated a more trauma-informed approach to working with him.

Multi-agency working and coordination

There were several agencies involved in DJT's care, but there was no single individual appointed to coordinate this care and his complex needs. This ultimately hampered a multi-agency approach to working. The Review recommended that partner agencies should promote the use of multi-agency meetings. Agencies should also identify one professional to coordinate agencies and their response to clients with complex needs.

Mental Capacity for adults who are self-neglecting

DJT's mental capacity was not assessed. It appears that he was largely assumed to have mental capacity. However, in light of his self-neglect, substance use, and experience of trauma, more consideration should have been given to assessing his capacity to make decisions. In future, agencies may consider whether the presence or suspicion of self-neglect is sufficient in itself to give rise to an assessment of mental capacity.

Safeguarding thresholds and referrals

There was insufficient evidence to demonstrate that agencies consistently applied the Sussex Safeguarding Adults Thresholds document. In some cases, concerns were, instead, handled under the quality issues pathway. Professionals must understand the distinction between abuse and neglect, and poor quality of service, and the processes for reporting these.

Consideration of fire safety measures and risk assessment

A referral for a fire risk assessment could have been triggered at an earlier stage (six months prior to the referral). It is important that fire services are involved, where needed, in multi-agency meetings and the development of risk enablement plans. Agencies must make referrals for fire risk assessments in a timely way.

Ongoing work

We are taking forward these key areas of learning in a multi-agency action plan. We will monitor this plan to seek assurance that actions have been completed to improve practice and minimise risk.

For more information on this case study, read the Safeguarding Adult Review in respect of DJT.

Our priorities for 2023/24

Agreeing our Board priorities
Our annual business plan is based on our two Board priorities for 2023/24. We agreed these during a bespoke Board meeting in March 2023, where we considered data, learning from Safeguarding Adults Reviews, learning from audits, and work undertaken in 2022/23.

The two priorities agreed for 2023/24 were:

- Self-neglect
- Embedding learning and assurance

Self-neglect
We commissioned a thematic Safeguarding Adults Review on self-neglect, which looked at all seven published Reviews featuring self-neglect from 2020–2023 across Sussex (including those carried out by East Sussex and Brighton and Hove Safeguarding Adults Boards). This Review is due to be published in 2024, the findings of which include improvement areas for self-neglect processes, multi-agency working, mental capacity, and risk management.

Our Quality and Performance subgroup led on our bi-annual partnership self-assessment, the tool of which included questions on self-neglect and multi-agency working.

This subgroup also monitored any impact on self-neglect by the cost of living, and we scheduled a self-neglect case study for our March 2024 Board meeting.

Embedding learning and assurance
This year, we held monthly staff briefing sessions from May 2023 to January 2024. These sessions gave the opportunity for all staff working across our partnership to learn about the work of our Board. The sessions included information about how our work is relevant to their roles, vital information about learning from our Safeguarding Adults Reviews, and the resources available to embed this learning, and support practice to be current. 258 staff members attended over the eight sessions and gave positive feedback.

Our Independent Chair, Board Manager, and Senior Data Support Officer also attended a number of staff forums across the partnership, to introduce themselves and to share information

about the work of the Board. These included engagement with teams within West Sussex County Council, Sussex Partnership NHS Foundation Trust, South East Coast Ambulance Service, West Sussex Fire & Rescue Service, District and Borough Councils, and the Probation Service.

This workstream has helped to increase the visibility and understanding of the Board's work, and learning needed across the partnership.

Further workstreams to deliver on these priorities can be found in 'Our subgroups' section of this report.

Our subgroups

The role of our subgroups
To support the work of the Board, there are five working subgroups, plus an overarching Chairs subgroup. Each subgroup focuses on the delivery of strategic objectives and priorities, as set out in the Strategic Plan.

Safeguarding Adult Review subgroup
The Safeguarding Adult Review subgroup is responsible for commissioning and leading on Safeguarding Adults Reviews (also referred to as Reviews) and other multi-agency learning reviews when there is an indication that there is learning for the agencies involved and a need to improve partnership working. This is to ensure that lessons are learned to improve partnership working. The subgroup meets monthly and is Chaired by a Board representative from West Sussex County Council.

Key achievements for this subgroup this year have been:

- Consideration of five new referrals, of which four met the criteria for a Review (further details can be found in the Safeguarding Adults Review section of this report).
- Progression of a total of seven Reviews, of which three were commissioned in 2022/23 and four commissioned in 2023/24.
- Publication of Safeguarding Adults Reviews in relation to DJT, John, and Clare.
- Agreement of action plan for Safeguarding Adults Reviews in relation to Beverley, John, DJT, and Clare.
- Final sign-off of action plans for our Kingswood Organisational Learning Review, and Safeguarding Adults Reviews in relation to TD, MT, and Beverley.
- Review of our Panel members' guidance and Reviewer Expectations Guidance to better support panel members' understanding of the process, and for Reviewers to be clear of expectations in relation to supporting panel members.
- Review of themes from Reviews relating to information-sharing and communication.
- Reviewing themes from Reviews, and re-promoting resources as needed.

- Re-promotion of the criteria and referral information for referrers.
- Consideration of, and response to, the draft National Safeguarding Adults Reviews Analysis findings.

Quality and Performance subgroup

The Quality and Performance subgroup is responsible for the effective monitoring, reporting, and evaluating of safeguarding evidence across organisations. The subgroup meets quarterly and is Chaired by a Board representative from Sussex Police.

This year, notable achievements for the Quality and Performance subgroup have included the following:

- Agreed and took forward a multi-agency action plan resulting from the outcome of our complex case file audit (undertaken in 2022/23).
- Developed and agreed a tool, and undertook an audit, in relation to safeguarding older people (workstream carried over from 2022/23).
- Agreed and took forward a multi-agency action plan resulting from the outcome of our safeguarding older adults case file audit.
- Accessed feedback from the partnership on issues, barriers, and positive factors of safeguarding older people via a survey.
- Carried out a self-neglect survey for staff across the partnership to identify issues, barriers, and what is needed to better support practice.
- Undertook our bi-annual self-assessment and challenge process and presented the outcome to Board.
- Presented to Board on the outcome of the self-assessment.
- Considered data in relation to the cost-of-living from across the partnership.
- Carried out Safeguarding Adults Review Assurance surveys in relation to Safeguarding Adults Reviews in relation to JW, Thematic Review, Review in Rapid Time, and Kingswood Organisational Learning Review, as well as an assurance survey in relation to the Safeguarding Adults Review in respect of John.

Quality Assurance and Safeguarding Information subgroup

The purpose of the Quality Assurance and Safeguarding Information subgroup is to develop and maintain a single picture of the quality and safety of the local care market.

The multi-agency format of this subgroup allows for early information-sharing and efficient collaborative working. The subgroup meets monthly and is co-chaired by representatives from West Sussex County Council and the Integrated Care Board, with participation from a range of organisations.

Key achievements for this subgroup this year are:

- Ongoing discussion of providers of concern, resulting in appropriate quality monitoring and escalation processes to mitigate risk.
- Escalation of areas of risk to the Strategic Provider Concerns Framework.
- Quarterly examination of providers who report a low or high number of safeguarding concerns and contact with these providers to seek assurance on their safeguarding activity and to offer support.
- Maintained oversight of care homes who are presenting with concerns.

Learning and Policy subgroup

The purpose of the Learning and Policy subgroup is to have in place systems for monitoring, reporting and evaluating training and learning across organisations. This subgroup meets quarterly and is Chaired by a representative from the Integrated Care Board.

This year, the Learning and Policy subgroup have achieved the following:

- Circulated across the partnership, on a quarterly basis, the list of all available safeguarding learning resources and training.
- Published and promoted a short e-learning course, featuring a series of short, animated videos about who we are, what we do, and what resources we have available.
- Promoted our What is Safeguarding Learning Briefing and podcast to include messaging about the difference between keeping people safe and safeguarding.
- Produced learning briefings and podcasts relating to:
    - The difference between quality and safeguarding
    - Safeguarding policy and procedure

    - Outcomes of our complex case file audit
    - Outcomes of our older people case file audit
    - Trauma-informed approaches
    - Safeguarding Adults Reviews for John, DJT, and Clare
- Ran eight staff briefing sessions, providing an opportunity for staff across the partnership to learn about the work of the Board, how our work is relevant to their role, information about learning from Reviews, and the resources available. This was attended by approximately 250 staff.
- Following staff briefing sessions, we sought staff feedback to seek understanding of the information shared, how it will improve practice and, feedback on any improvements on learning aids. The feedback was positive, and the majority of staff said that after attending they knew more about the work of the Board, that the quality of Board resources was 'good' or 'excellent', and that it was valuable to learn about the Safeguarding Adults Review criteria and recent learning from Reviews.
- Began creating a toolkit for staff to support managing complex cases/self-neglect.

Multi Agency Risk Management subgroup

The Multi Agency Risk Management subgroup considers some of the most challenging cases of adults who remain at considerable risk, despite efforts made to reduce risk. The purpose of the subgroup is to support practitioners with information and guidance, and to ensure multi-agency working is, or will be, in place. This subgroup meets monthly and is Chaired by a representative from West Sussex County Council.

Key achievements for the Multi Agency Risk Management subgroup this year have been:

- Ongoing collaborative working between member agencies.
- Support with mitigating risk for adults referred to the subgroup.
- Oversight and assurance that appropriate services and routes for multi-agency working are being accessed by professionals involved in the care of high-risk cases.

Chairs subgroup

This group is formed of the Chairs of each of the subgroups 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.

Additional achievements

Engaging with service user groups
In the production of our 2022/23 Easy Read Annual Report, we consulted with the Burnside Day Centre Digital Communications Group. The Group provided us with invaluable and constructive feedback, enabling us to make improvements to our report and to create a document that is fit-for-purpose and engaging.

We would like to take this opportunity to reiterate our appreciation to the Burnside Day Centre Digital Communications Group for their work on this project.

Safeguarding Adults Week
In November 2023 we joined the Ann Craft Trust Safeguarding Adults Week. During the week we promoted the five themes through daily newsletter bulletins.

- What's my role in safeguarding adults?
- Let's start talking – taking the lead on safeguarding in your organisation
- Who cares for the carers: secondary and vicarious trauma
- Adopting a trauma-informed approach to safeguarding adults
- Listen, learn, lead – co-production with experts by experience

Our bulletins featured articles by subject experts, as well as links to resources to support further learning. You can revisit these bulletins on the 'Safeguarding Adults Week' page of our website.

Sussex Safeguarding Adults Policy and Procedures website
We have led on the development of a new Sussex Safeguarding Adults Policy and Procedures website which will help staff navigate and access information more easily.

Promotion of our animations
In December, we promoted our animations, 'Tricky Friends' and 'Hidden Harms'. Promotions included through our newsletters and bulletins, and with the West Sussex Community Safety Partnership and the Domestic Abuse Board.

Distributing promotional resources
We are in the process of distributing our Sussex safeguarding adults leaflets and posters for display in 75 GP surgeries and 320 care providers across West Sussex.

What we did to improve safeguarding

Our quarterly Board meetings

In addition to work on our Board priorities, and the work undertaken by our subgroups, we are continually looking to improve the safety and wellbeing of adults with care and support needs in West Sussex. We do this work through our quarterly Board meetings.

Case studies

We have continued to start our Board meetings with a safeguarding case study, provided in turn, by each of our Board members to ensure that we are keeping adults with care and support needs central to our discussions. This year we have heard case studies from Gatwick Immigration Removal Centre, South East Coast Ambulance Service, Department for Work and Pensions, and Independent Lives.

Risk report

Board members have considered and reviewed indicators of any risks to safeguarding services in West Sussex, and how these risks can be mitigated. This has included the impact of the cost-of-living crisis.

Updates from services

The Board has heard updates about safeguarding practice from the following agencies; West Sussex Fire and Rescue Service, West Sussex County Council Adult Safeguarding, West Sussex County Council Community Safety, the Department for Work and Pensions, the Integrated Care Board, Sussex Police, and the Combatting Drugs Partnership.

In-person Board meeting

In December 2023 and March 2024 we held our first in-person Board meetings since the Covid-19 pandemic. Meeting in-person enabled Board members to network and develop new working relationships with colleagues across the partnership.

Safeguarding Adult Reviews

The Care Act 2014 places a statutory duty for Safeguarding Adult Boards to arrange a Safeguarding Adult Review (also known as a Review) when an adult dies as a result of abuse or neglect (whether known or suspected), where there is concern that partner agencies could have worked more effectively together to protect the adult. The overall purpose of a Review is to promote learning and improve practice; it is not to re-investigate or to apportion blame.

A Safeguarding Adult Review is considered if:

- an adult has died, and the Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died); or
- an adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity, or quality of life (whether or not it knew because of physical or psychological effects), 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.

Care Act 2014

The Care Act 2014 sets out the legislation related to Safeguarding Adults Reviews, including the conditions for arranging a Review, and the roles and responsibilities of Board members in the conducting of a Review. Find this information on the Legislation.gov.uk website (Section 44, 2014).

Our referrals and reviews

In 2023/24 we published three Safeguarding Adults Reviews with accompanying learning briefings and podcasts, in respect of DJT, John, and Clare. All three of these Review referrals were received prior to April 2023 by West Sussex County Council Adult Social Care and were all regarding concerns about neglect or acts of omission. There was also a theme of self-neglect for all three adults. The concerns occurred in a community service for two adults and in a care home for one adult.

We also received a further referral prior to April 2023 which is progressing as our Self-Neglect Meta-Analysis and will be published in 2024/25.

Demographics and protected characteristics for our three published Reviews in 2023-2024

Regarding:

- Age: one adult was aged 49 and one aged 88 at the time of their death, and one adult was aged 44 at the time of their Review.
- Sex: two were for males, one was for a female.
- Disability: all three adults had needs regarding their mental health; one also had a visual impairment and misused alcohol.
- Race: all adults were white; two were white English/Welsh/Scottish/Northern Irish or British and one adult was white Polish.
- Marriage or civil partnership: two of the adults had previously been married although one was separated and one widowed at the time of their death; the third adult had never been married or in a civil partnership.
- Religion or belief and, sexual orientation: of the three adults , this was not known or not recorded.

In 2023/24 we received a further three referrals which met the criteria for a Review. These Reviews will be published in 2024/25.

We also received one further referral which did not proceed to a Review due to the criteria for multi-agency working not being met.

Learning themes from our published reviews

We have published the following Reviews in the 2023/24 year.

Safeguarding Adult Review in respect of DJT

You can read about the Safeguarding Adult Review in respect of DJT in the case study portion of this report (see page 6).

For the full report, read the Safeguarding Adult Review in respect of DJT.

Safeguarding Adult Review in respect of John

John was an 88-year-old man, who was partially sighted and registered blind. John also had some difficulties with his mental health over the years.

After fracturing his hip in 2020, John required long-term care and was placed, initially temporarily, in a Care Home. John passed away in June 2022, after making the decision to end his own life, through refusal of foods and fluids. In the final weeks of John's life, several safeguarding concerns were raised. John's mental health was also assessed, and five mental capacity assessments were undertaken by different agencies.

It was acknowledged that there was learning for agencies involved with John, including professional curiosity, the determination of capacity, end-of-life care, and the care provided prior to John's decision to end his life.

Our Review found that we need to improve:

- Professional curiosity
- Defensible decision-making
- Self-neglect procedures
- The voice of carers and families
- Mental capacity

In response to this Review we:

- Re-promoted our professional curiosity learning resources.
- Shared the link to Bond Solon defensible decision-making training.
- Created an assurance survey, including professional curiosity, self-neglect, the voice of family and carers and mental capacity.
- Will further consider if a self-neglect audit is needed following consideration of the recommendations and actions agreed for our thematic

Safeguarding Adult Review on self-neglect.

- Sought assurance from West Sussex County Council mental health services on the risks arising from Approved Mental Health Professionals service pressures. This included having processes in place to manage risks, and working to achieve an Approved Mental Health Professionals service that can meet demand in line with statutory requirements.
- Asked West Sussex County Council and Sussex Partnership NHS Foundation Trust to explore potential partnership training around mental capacity, executive function, and fluctuating capacity.

Read the Safeguarding Adult Review in respect of John.

Safeguarding Adults Review in relation to Clare

Clare is 43 years-old and was born in Littlehampton with DiGeorge syndrome; a genetic condition that causes the underdevelopment of some systems in the body. Autism can also be associated with this syndrome, which was diagnosed in 2004.

Her father, who contributed to the Review, described Clare as a quiet child with few friends, who was sadly bullied at school due to her disability. Clare also has a history of mental health concerns, including auditory hallucinations. Clare has lived in supported housing from around the age of 20, but at the time this Review was written, she was unwell and in hospital.

From February 2022, Clare began to express concerns about her mobility, due to long-standing knee pain. Clare expressed that voices were telling her that her knee would break if she moved, which resulted in her remaining seated on her sofa for at least two weeks, leading to rapidly worsening hygiene circumstances. A Mental Health Act Assessment led to Clare's admission to hospital.

It was acknowledged that there were missed opportunities over many months for a robust multi-agency risk management meeting. This would have coordinated a comprehensive, personalised, and holistic risk management plan to support Clare.

Our Review found that we need to improve:

- Practitioner-led risk management
- Training opportunities on risk, safeguarding adults, mental capacity, and autism
- Dual mental and physical health needs
- Mental Health Act assessments

Read the Safeguarding Adult Review in relation to Clare.

Sharing learning and assurance

In order to share learning widely and effectively from our Reviews, we publish all of our Reviews with accompanying learning briefings and podcasts and promote these in our newsletters. We also share our reviews to be added to the National Safeguarding Adult Review library.

We hold a multi-agency action planning meeting for each Review to agree together, how each organisation will individually and collectively improve safeguarding practice. This method ensures multi-agency ownership and accountability for the changes that are needed to reduce safeguarding risk. Once this action plan is agreed, actions are taken forward and monitored by the Board to ensure completion.

Six months post-completion of the action plan, our Quality and Performance subgroup carries out an assurance survey with all involved agencies to ensure learning is embedding.

Learning from Safeguarding Adult Reviews
You can find the Safeguarding Adult Reviews published in the last 12 months, alongside their accompanying learning briefings and podcasts, on the 'Safeguarding Adult Reviews' page of our website. Reviews older than 12 months can also be found on our website

2023/24 data

A note about this data

West Sussex County Council is the lead for safeguarding and records safeguarding data. Concerns about abuse and neglect are reported using a West Sussex County Council online safeguarding referral form which is then triaged by their Safeguarding Hub. The following data provides an overview of safeguarding activity and the demographics of those safeguarded in West Sussex.

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 received and enquiries undertaken

In 2023/24, there were 2133 safeguarding concerns initiated. Of the concerns initiated, 1556 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 579 adults, financial abuse for 240 adults, and physical abuse for 194 adults. Together, these three categories total 1013 adults. Neglect and acts of omission have been the most reported form of abuse over the past six years.

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 457 adults. The next most common category was those who had no recorded support reason; this accounted for 368 adults.

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 2023/24, 768 were for women and 554 were for men. There were 12 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 854 adults. The highest of this figure was for those aged 85-94 years old, which accounts for 329 adults.

The vast majority of enquiries were for adults who identified as white, totalling 1128 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 19 adults. There were 153 enquiries where an adult's ethnicity was unknown, and this was either due to this information not yet being obtained, or because the adult declined to provide this information.

Location of abuse

This year, for completed enquiries, abuse and/or neglect in residential and nursing homes accounted for 538 adults, and 472 adults living in their own home. Whilst the location to experience abuse is higher in residential and nursing homes, the gap for this has continued to reduce in West Sussex.

Making Safeguarding Personal

As part of a Section 42 enquiry, adults are asked for their desired outcomes. In total 751 adults expressed desired outcomes. Of the concluded enquiries this year, 410 adults had these fully achieved and 341 adults had these partially achieved.

How safeguarding changed risk

For the enquiries concluded this year there were 617 adults where action was taken to reduce risk. There were 328 adults where the risk was removed, and 98 adults where actions were taken and the risk remained.

Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards
The Deprivation of Liberty Safeguards is 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 2023/24 West Sussex County Council carried out activity on 9,279 Deprivation of Liberty Safeguards cases. Of this activity, 5,066 were granted and 2,519 were not granted. At the point of this data being sourced there were 1,694 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 majority of adults who received a granted Deprivation of Liberty Safeguards were aged between 85-94 years old. In terms of ethnicity, most adults with a granted Deprivation of Liberty Safeguards were white.

Primary support reason for Deprivation of Liberty Safeguards authorisations
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'.

Please note: *if you would like the data from this report provided in graph format, please contact the Board Support Team.*

Our priorities for 2024/25

Agreeing our Board priorities

Our annual business plan is based on our two Board priorities for 2024/25. We considered and agreed these during a bespoke Board meeting in February 2024. We considered data, learning from Reviews, learning from audits, and work undertaken in 2023/24, in order to decide on the areas of focus.

The two priorities agreed for 2024/25 are:

- Self-neglect
- Multi-agency working

Self-neglect was also a priority for our Board in 2023/24 and remains an area identified for improvement in practice. It is also recognised that the majority of Safeguarding Adults Reviews in the 2nd National Safeguarding Adults Reviews Analysis feature adults who self-neglect.

Linking to both Board priorities will be the consideration of the Mental Capacity Act. We will develop tools and guidance for supporting a multi-agency approach to assessment of capacity for adults who are self-neglecting.

In addition, our Board recognises that there needs to be further consideration of protected characteristics and how these may impact on safeguarding referrals and Reviews.

In response to this, our Board will look for evidence of any increased risk for safeguarding for particular demographic groups. This will include considering data, details of referrals to our subgroups, and actions we can take to address any identified issues. This may include targeted promotion about safeguarding where this is indicated as a need.

Compliments and complaints

We did not receive any complaints about the work of the Board during 2023/24.

Feedback on our Safeguarding Adults Board team support for learning
We received the following feedback from a Newly Qualified Social Worker in relation to training provided:

"*Safeguarding adults board workshop – was brilliant – manager came to team to discuss with them.*"

Feedback on our Learning from Reviews presentation
We received compliments from workers in Children's Services and Place Services within West Sussex County Council, and the voluntary sector, regarding our Learning from Reviews presentation.

Feedback on our learning resources and website
Harrow Safeguarding Partnership commended us on our website learning materials, recognising the "commitment and dedication" we have made towards producing quality learning resources which they would like to consider adapting for their own use.

Feedback on our document templates
East Sussex Safeguarding Adults Board found our draft document feedback template so useful, that they used it as an example to create their own.

We welcome your feedback

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. However, 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.

Resources shared nationally

We are periodically contacted by other Safeguarding Adults Boards and Partnerships, asking whether we would be happy to share our resources with them. This can be either be for support in producing their own resources, or for them to replicate in their own organisations.

This year, we have shared the following resources with Safeguarding Adults Boards and Partnerships across the country:

- Our Safeguarding Adults Review Protocol
- Safeguarding Adults Review panel, action planning, and assurance resources
- Our Annual Business Plan
- Our Annual Reports
- Our Board Members' Pack
- Our Safeguarding Thresholds document
- Our subgroup Terms of Reference documents
- Our transition and safeguarding audit tools
- Our professionals feedback form
- Learning resources relating to trauma-informed approached, safeguarding young people 17.5+, and person-centred approaches
- Information about our Board Support Team structure
- Our Communication and Engagement Strategy

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.

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

Otherwise, please:

- Complete the West Sussex County Council online adult safeguarding concern report
- Contact West Sussex County Council Adults' CarePoint on 01243 642121
- 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
- Phone Sussex Police on 101

Contact us

If you would like to find out more about this report, or the work of our Board:

Visit: www.westsussexsab.org.uk

Email: safeguardingadultsboard@westsussex.gov.uk

Phone: 03302 227952

Accessing safeguarding training

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

Accessing learning resources

For our Board's safeguarding learning resources, please see 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 new Sussex website.